10 CFR 50.73

Virginia Electric and Power Company
North Anna Power Station
P. O. Box 402
Mineral, Virginia 23117

March 25, 1995

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

NAPS: GSS
Docket No. 50-338
License No. NPF-4

Dear Sirs:

Pursuant to North Anna Power Station Technical Specifications, Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Unit 1.

Report No. 50-338/96-002-00

This Report has been reviewed by the Station Nuclear Safety and Operating Committee and will be forwarded to the Management Safety Review Committee for its review.

Very truly yours,

J. A. Stall
Station Manager

Enclosure:

cc: U.S. Nuclear Regulatory Commission
101 Marietta Street, N.W.
Suite 2900
Atlanta, Georgia 30323

R. D. McWhorter
NRC Senior Resident Inspector
North Anna Power Station

IE22

NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HOURS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, DC 20503.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
North Anna Power Station Unit 1	05000338	1 OF 4

TITLE (4)
CONTAINMENT PARTICULATE AND GASEOUS RADIATION MONITORS INOPERABLE DUE TO CONTAINMENT AIR RECIRCULATING FANS NOT OPERATING

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
										05000
03	03	96	96	002	00	03	25	96	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	6
POWER LEVEL (10)	0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.402(b)		20.405(c)	50.73(a)(2)(iv)	73.71(B)
	20.405(a)(1)(i)		50.36(c)(1)	50.73(a)(2)(v)	73.71(C)
	20.405(a)(1)(ii)		50.36(c)(2)	50.73(a)(2)(vii)	OTHER
	20.405(a)(1)(iii)	x	50.73(a)(2)(i) (B)	50.73(a)(2)(viii)(A)	(Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iv)		50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.405(a)(1)(v)		50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Mr. J. A. Stall	(540) 894-2101

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, completed EXPECTED SUBMISSION DATE)	X	NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On March 3, 1996, at 0339 hours with Unit 1 in Mode 6, Containment Purge and Exhaust was placed in service with all the containment air recirculation fans secured. The failure to have operating containment recirculation fans resulted in the containment gaseous and particulate radiation monitors being declared inoperable. The monitors must be operable for the containment purge and exhaust to be operable when in Mode 6 per Technical Specifications (TS) 3.3.3.1 and 3.9.9. This event is reportable pursuant to 10 CFR 50.73 (a) (2) (i) (B) for conditions prohibited by TS.

The cause of the event was an inadequate review of the containment gaseous and particulate radiation monitor TS Action Statement requirement. The review failed to identify that the containment purge and exhaust penetrations must be closed if the containment gaseous and particulate radiation monitors are inoperable.

This event posed no significant safety implications because no core alterations or movement of irradiated fuel in the containment were in progress. Additional containment radiation monitors were also operable and available to detect increasing radiation levels in the containment. The health and safety of the public were not affected by this event.

1.0 Description of the Event

On March 3, 1996, at 0335 hours with Unit 1 in Mode 6, all containment air recirculation fans (EIIS System Identifier BK, Component Identifier FAN) were secured to reduce the high noise level in containment to enhance communications during testing. The containment gaseous and particulate radiation monitors (EIIS System Identifier IL, Component Identifier MON), RM-RMS-159 and RM-RMS-160, were also declared inoperable due to the loss of a representative sample from the containment atmosphere. Technical Specifications (TS) action statements 3.3.3.1, 3.4.6.1, and 3.9.4 were entered. At 0339 hours, the Containment Purge and Exhaust was placed in service. The Control Room team verified core alterations were completed and based the decision on core alterations not being in progress.

A subsequent review of TS 3.3.3.1 determined that TS 3.9.9 should have been entered at the time the radiation monitors were declared inoperable. The radiation monitors continuously draw a sample from the containment atmosphere via an isokinetic nozzle (EIIS System Identifier BK, Component Identifier NZL) in the recirculating air ring duct (EIIS System Identifier BK, Component Identifier DUCT). When the containment air recirculation fans are not operating, a representative sample of containment air is not obtained. At 1122 hours, Containment Purge and Exhaust was secured and TS 3.9.9. action statement was entered. Action was cleared at 1458 hours when the containment air recirculation fan was returned to service.

2.0 Significant Safety Consequences and Implications

This event posed no significant safety implications because no core alterations or movement of irradiated fuel in the containment were in progress. Additional containment radiation monitors were also operable and available to detect increasing radiation levels in the containment. A Hi Hi signal from the manipulator crane radiation monitor, RM-RMS-162, will also cause the containment purge supply and exhaust fans to stop and the exhaust containment purge MOVs to close. The health and safety of the public were not affected at any time during this event.

This event is reportable pursuant to 10CFR50.73 (a)(2)(i)(B).

3.0 Cause of the Event

The cause of the event was an inadequate review and implementation of the containment gaseous and particulate radiation monitor TS Action Statement requirement. The review failed to identify that the containment purge and exhaust penetrations must be closed if the containment gaseous and particulate radiation monitors are inoperable.

3.0 Cause of the Event (continued)

A contributing factor was that the procedure used to place containment purge in service did not provide any warnings to inform the operators of the cautions associated with the operability of radiation monitors.

4.0 Immediate Corrective Actions

Upon the determination that the containment purge and exhaust isolation system was inoperable, the supply and exhaust MOVs were shut as required by TS 3.9.9 Action Statement.

A Deviation Report was initiated to identify and evaluate the cause of this event.

5.0 Additional Corrective Actions

Operator aides were placed on the Units 1 & 2 ventilation panel to inform operators that containment purge must be secured and isolated prior to securing containment air recirculation fans in Mode 6.

A Procedure Action Request was submitted and approved to Operating Procedures 1-OP-21.2 and 2-OP-21.2, "Containment Purge" to ensure that a containment air recirculation fan is in service prior to commencing containment purge while in Mode 6.

Station management discussed this event as part of the human performance focus day that was held with station personnel on site on March 13, 1996. The purpose of the focus day was for management to emphasize their expectations on human performance.

6.0 Actions to Prevent Recurrence

This event will be discussed in Licensed Operator Requalification Training, and the LER will be placed in the Operations Department required reading.

This requirement in the Technical Specifications is not necessary to comply with the design basis. The Standard Technical Specifications only require the automatic isolation feature during core alterations. We will correct this problem during the implementation of the improved TS.

7.0 Similar Events

A similar event where the containment gaseous and particulate radiation monitors were inoperable due to the containment air recirculating fans being secured occurred on February 12, 1993 and was reported by LER 50-338/93-004-00.

8.0 Additional Information

During this period, Unit 2 was operating at 100% power and was not affected by this event.