(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | V A S P S 1 | (2) | 0 0 - 0 0 0 0 0 - 0 0 | (3) | 4 1 1 1 1 | (4) | | (5)
LICENSEE CODE — LICENSE NUMBER — LICENSE TYPE — CAT

CON'T
0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 8 0 (7) | 1 1 1 5 7 8 (8) | 1 2 1 1 7 8 (9)
DOCKET NUMBER — EVENT DATE — REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During normal operation, Channel I of the Pressurizer Level (Protection) Instrumen-
0 3 tation, LI-1-459, drifted low. This is contrary to Technical Specifications 3.7.B
0 4 and is reportable per Technical Specifications 6.6.2.b. (1).
0 5
0 6
0 7
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	I B (11)	C (12)	Z (13)	I N S T R U (14)	T (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 8	—	0 3 9	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
E (18)	E (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	N (25)	I 2 0 4 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event is not known at this time. Channel I Pressurizer Level was
1 1 placed in the trip mode. The transmitter was recalibrated monitored and later returned
1 2 to service.
1 3
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	1 0 0 (29)	NA	A (31)	Operator Observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	(38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

7812140126

NAME OF PREPARER T. L. Baucom PHONE: (804) 357-3184

GPO 917-926

Surry Power Station, Unit 1
Docket No: 50-280
Report No: 78-039/03L-0
Event Date: 11-15-78

Title of Report: Drift in Pressurizer Level Channel

1. Description of Event:

During normal operation, Channel I of the Pressurizer Level (Protection) Instrumentation, LI-1-459, drifted 5% low. This exceeded the margin between Technical Specifications and the administrative limit by 1% and resulted in the inability of this channel to supply a reliable signal of high pressurizer level to the Reactor Trip logics. The required degree of redundancy was not maintained and this is contrary to Technical Specifications 3.7.B and is reportable per Technical Specifications 6.6.2.b.(1).

2. Probable Consequences and Status of Redundant Systems:

Channel I Pressurizer Level was put in the trip mode. All other pressurizer level instrumentation remained operable. Because the required immediate corrective action was taken and the degree of redundancy regained, the health and safety of the general public were not affected.

3. Cause:

It is not known at this time what is causing this intermittent drift of the transmitter's electronics. The results of further investigation will be reported in a supplemental report.

4. Immediate Corrective Action:

Channel I of Pressurizer Level was immediately placed in the trip mode. This regained the required degree of redundancy.

5. Subsequent Corrective Action:

Channel I of Pressurizer Level will be thoroughly examined and the cause determined and corrected at the next unit outage.

The transmitter was recalibrated, monitored and later returned to service. This channel will be monitored closely and the appropriate action taken if an intermittent drift occurs again.

6. Actions Taken to Prevent Recurrence:

It is not known at this time what actions will be necessary to prevent recurrence. If additional nonconservative drifts occur, the system will be placed in the trip mode.

7. Generic Implications:

None

NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Field	Value
01 LICENSEE CODE (2)	V A S P S 1
LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
LICENSE TYPE (4)	4 1 1 1 1
CAT (5)	
CON'T 01 REPORT SOURCE (6)	L
DOCKET NUMBER (7)	0 5 0 0 0 2 8 0
EVENT DATE (8)	1 1 2 1 7 8
REPORT DATE (9)	1 2 1 1 7 8

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On 11/21/78, with the unit at full power, while performing PT-39.1, Snubber
03 1-WAPD-HSS-141B was observed with zero fluid level in the reservoir. The engineer
04 assisting in the test, declared the snubber inoperable. This event is reportable in
05 accordance with T.S. 6.6.2.b.(2). Since the snubber was replaced within the time
06 allowed by T.S. 3.20.B, there were no consequences and the health and safety of the
07 public were not affected.
08

09	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
	Z Z	E	B	S U P O R T	D	Z

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 8	—	0 4 1	/	0 3	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
C	Z	Z	Z	0 0 0 0	Y	Y	A	I 2 0 7

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 A close inspection of the snubber revealed that the fluid had leaked out through
11 faulty reservoir seals. The snubber was replaced with a Q.C. accepted shop spare.
12
13
14

15	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
	E	1 0 0	NA	B	Routine Inspection

16	ACTIVITY RELEASED (33)	CONTENT OF RELEASE (34)	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z	Z	NA	NA

17 PERSONNEL EXPOSURES	NUMBER (37)	TYPE (38)	DESCRIPTION (39)
	0 0 0	Z	NA

18 PERSONNEL INJURIES	NUMBER (40)	DESCRIPTION (41)
	0 0 0	NA

19 LOSS OF OR DAMAGE TO FACILITY (43)	TYPE (42)	DESCRIPTION
	Z	NA

20 PUBLICITY	ISSUED (44)	DESCRIPTION (45)	NRC USE ONLY
	N	NA	

NAME OF PREPARER T. L. Baucom PHONE: (804) 357-3184

GPO 917-926

Surry Power Station, Unit 1
Docket No: 50-280
Report No: 78-041/03L-0
Event Date: 11/21/78

Inoperable Snubber

1. Description of Event:

On 11/21/78, with the unit at full power, while performing PT-39.1, Snubber 1-WAPD-HSS-141B was observed with zero fluid level in the reservoir. This snubber is not listed on PT-39.1, but was observed in the course of performing PT-39.1. The engineer assisting in the test, declared the snubber inoperable. This event is reportable in accordance with T.S. 6.6.2.b.(2).

2. Probable Consequences of Event:

Tech. Spec. 3.20.B allows a period of 72 hrs. in which any snubber found to be inoperable be repaired or replaced before a power rampdown is required. Since the inoperable snubber was replaced within the allowed time, there were no consequences from this event. The health and safety of the public were not affected.

3. Cause of Event:

Upon removal from containment, a close inspection of the snubber was made and revealed that the fluid had leaked out through faulty reservoir seals.

4. Immediate Corrective Action:

The snubber was replaced with a rebuilt Q.C. accepted shop spare.

5. Subsequent Corrective Action:

None required.

6. Actions Taken to Prevent Recurrence:

All snubbers will be inspected under PT-39B at the next required inspection.

7. Generic Implications:

The snubber in question is the newer type ITT Grinnell Fig. 200 model, which comes equipped with all EPR seals. This snubber has not been reworked at the station. Therefore, it is felt that this is not a generic problem but a random failure of factory equipment.

NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 — LICENSEE CODE: VASPS1 (2) LICENSE NUMBER: 00-00000-00 (3) LICENSE TYPE: 41111 (4) CAT (5)

CON'T 01 — REPORT SOURCE: L (6) DOCKET NUMBER: 05000280 (7) EVENT DATE: 111778 (8) REPORT DATE: 121178 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal power operation, manual valves 1-BD-8, 18, 28 were closed in an attempt
03 to stop a leak in a service water line on which maintenance was being performed.
04 Closure of these valves terminated flow through the blowdown radiation monitors
05 (RM-SS-112, 113). This is contrary to Technical Specification 3.11.A.6 and is
06 reportable per Technical Specification 6.6.2.b.(2).

09 — SYSTEM CODE: HI (11) CAUSE CODE: A (12) CAUSE SUBCODE: A (13) COMPONENT CODE: VALVEX (14) COMP. SUBCODE: P (15) VALVE SUBCODE: D (16)

(17) LER/RO REPORT NUMBER — EVENT YEAR: 78; — ; SEQUENTIAL REPORT NO.: 042; / ; OCCURRENCE CODE: 03; REPORT TYPE: L; — ; REVISION NO.: 0

ACTION TAKEN: H (18) FUTURE ACTION: Z (19) EFFECT ON PLANT: Z (20) SHUTDOWN METHOD: Z (21) HOURS (22): 0000 ATTACHMENT SUBMITTED: Y (23) NPRD-4 FORM SUB.: N (24) PRIME COMP. SUPPLIER: Z (25) COMPONENT MANUFACTURER: V135 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Operator error was the cause of the event. Upon discovery of the discrepancy the
11 immediate corrective action was to re-establish flow through the blowdown radiation
12 monitors as required by Technical Specifications.

15 — FACILITY STATUS: E (28) % POWER: 100 (29) OTHER STATUS (30): NA METHOD OF DISCOVERY: Z (31) DISCOVERY DESCRIPTION (32): NA

16 — ACTIVITY RELEASED: Z (33) CONTENT OF RELEASE: Z (34) AMOUNT OF ACTIVITY (35): NA LOCATION OF RELEASE (36): NA

17 — PERSONNEL EXPOSURES NUMBER: 000 (37) TYPE: Z (38) DESCRIPTION (39): NA

18 — PERSONNEL INJURIES NUMBER: 000 (40) DESCRIPTION (41): NA

19 — LOSS OF OR DAMAGE TO FACILITY TYPE: Z (42) DESCRIPTION (43): NA

20 — PUBLICITY ISSUED: N (44) DESCRIPTION (45): NA NRC USE ONLY

NAME OF PREPARER: T. L. Baucom PHONE: (804) 357-3184

GPO 917-926

Surry Power Station, Unit 1
Docket No: 50-280
Report No: 78-042/03L-0
Event Date: 11/17/78

Title of Event: Blowdown Radiation Monitors Low Flow

1. Description of Event:

During normal power operation, manual valves 1-BD-8, 18, 28 were closed in an attempt to stop a leak in a service water line on which maintenance was being performed. Closure of these valves terminated flow through the blowdown radiation monitors (RM-SS-112, 113). This is contrary to Technical Specification 3.11.A.6 and is reportable per Technical Specification 6.6.2.b.(2).

2. Probable Consequences

Flow through the blowdown radiation monitors was interrupted for four to five minutes. The backup radiation monitor in the discharge tunnel remained operational during this interrupted period. Thus, the health and safety of the general public was not affected and there are no consequences of this event.

3. Cause of Event:

Operator error was the cause of the event. The closure of other valves could have provided leak isolation without interrupting flow to the blowdown radiation monitors.

4. Immediate Corrective Actions:

Upon discovering the discrepancy, the immediate operator action was to re-establish flow to the blowdown radiation monitors as required by Technical Specifications.

5. Subsequent Corrective Actions:

Appropriate personnel have been re-instructed in this matter.

6. Actions Taken to Prevent Recurrence:

None necessary.

7. Generic Implications:

None