

Vepco

VIRGINIA ELECTRIC AND POWER COMPANY
Surry Power Station
P. O. Box 315
Surry, VA 23883

JUN 23 1980

Serial No: 012
Docket Nos: 50-280
License Nos: DPR-32

Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

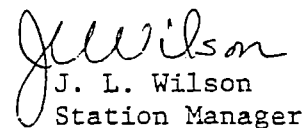
Dear Mr. O'Reilly:

Pursuant to Surry Power Station Technical Specifications, the Virginia Electric and Power Company hereby submits the following Licensee Event Reports for Surry Unit 1.

<u>Report Number</u>	<u>Applicable Technical Specification</u>
80-034/03L-0	3.3.B.5
80-035/03L-0	3.3.B.5

These reports have been reviewed by the Station Nuclear Safety and Operating Committee and will be placed on the agenda for the next meeting of the System Nuclear Safety and Operating Committee.

Very truly yours,


J. L. Wilson
Station Manager

ENCLOSURES

cc: Mr. Victor Stello, Director (3)
Office of Inspection and Enforcement

Mr. Norman Haller, Director (3)
Office of Management and Program Analysis

US NRC
c/o Document Management Branch
Washington, D.C. 20555

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ATTACHMENT 1
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 80-034/03L-0
EVENT DATE: 6-3-80

TITLE OF REPORT: HEAT TRACING FAILURE

1. Description of Event:

With Unit #1 critical at zero percent power PT-27A revealed that the amp readings for circuit 24D (Boron Injection Tank Recirc return & cross connect) Panel 2 were below the Acceptance Criteria Stipulated in the PT. Repair of the defective circuit was initiated immediately. This event is a degraded mode of operation as specified in T.S. 3.3.B.5 and is reportable in accordance with T.S. 6.6.2.b.2.

2. Probable Consequences & Status of Redundant Systems:

The redundant Heat Tracing Circuit was verified operable, which meant heat was being supplied to the Boric Acid Piping. Therefore, the Health and Safety of the public were not affected.

3. Cause:

The Heat Tracing Tape failed due to excessive heat.

4. Immediate Corrective Action:

The immediate corrective action was to replace the defective Heat Tracing Tape, and verify the operability of the affected Heat Tracing Circuit.

5. Subsequent Corrective Action:

A Design Change has been initiated to change the Heat Tracing Circuit 24D to prevent over heating.

6. Action Taken to Prevent Recurrence:

No additional actions were deemed necessary.

7. Generic Implications:

A task force has been established to study the total spectrum of the heat tracing system in an attempt to discern present problems and recommend solutions which will eliminate sporadic failures experienced.