NRC FORM 366 (4-95)

FACILITY NAME (1)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 **EXPIRES 4/30/98**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE

LICENSEE EVENT REPORT (LER)

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

NEPORTED LESSONS LEARNED ANE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (16-873), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET,

PAGE (3)

SURRY POWER STATION, Unit 1

DOCKET NUMBER (2) 05000 - 280

1 OF 4

Fire Watch Released Prematurely Resulting in Violation of TS 3.21.B.7

EVENT DATE (5)		LER NUMBER (6)			REPORT DATE (7)				OTHER FACILITIES INVOLVED (8)							
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	монтн	DAY	YEAR	FACILITY	ACILITY NAME			DOCUMENT NUMBER 05000-			
02	06	98	1998	004	00	03	06	98	FACILITY	FACILITY NAME				DOCUMENT NUMBER 05000-		
OPERATING THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)									1)							
MODE (9) N		N_	20.2201(b)			20.2	20.2203(a)(2)(v)			х		50.73(a)(2)(i)	.73(a)(2)(viii)			
POWER			20).2203(a)(1)		20.2	20.2203(a)(3)(i)					50.73(a)(2)(ii)	50.73(a)(2)(x)			
LEVEL (10) 100 %			20).2203(a)(2)(i)		20.2	2203(a)(3)(ii)			Ι	50.73(a)(2)(iii)			.71	
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			20).2203(a)(2)(iii)	50.3	50.36(c)(1)					50.73(a)(2)(v)			Specify in Abstract below	
			20.2203(a)(2)(iv)			50.3	50.36(c)(2)				\prod	50.73(a)(2)(vii)	or in NR		Form 366A	
LICENSEE CONTACT FOR THIS LER (12)																
NAME							TELEPHONE NUMBER (Include Area Code)									
D. A. Christian, Station Manage									(757) 365-2000							
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	: 8	YSTEM	СОМРО	NENT MANUFA	CTURER	REPORTABL			CAUSE	SYSTEM		COMPONENT	MANUFACTURER		REPORTABLE	
						TO NPRDS									TO NPRDS	
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	SUPPLEMENTAL REPORT EXPECTED (14)					4)				E)	XPECTED	MONTH	DAY	YEAR		
YE	YES					X	NO	_	1 5	SUBMISSION						
(If ves. complete EXPECTED SUBMISSION DATE).					ļ	1		l		DATE		1				

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

On February 6, 1998, a fire watch, which was established as a technical specification required action for a non-functional fire barrier, was released prematurely. This event occurred with Units 1 and 2 operating at 100% power. On February 5, 1998, a crack was discovered between the frame of a fire door and the wall. The fire door between the Unit 1 Cable Vault and Auxiliary Building was declared inoperable, and a continuous fire watch was posted. Following repair of the crack, the fire watch was released. The fire watch was re-established on February 9, 1998, when it was identified that the cure time for the caulking used for the repair had not elapsed. The cause of this event was that the planning of this repair activity failed to identify that an approved procedure, which provided the manufacturer's cure time, existed and should have been used. Model work orders, which will include reference to applicable procedures, will be developed to assist in the planning of fire barrier repairs. This event resulted in no safety consequences or implications and is being reported pursuant to 10CFR50.73(a)(2)(i)(B).

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LICENSEE EVENT REPORT (LER)

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

1.0 DESCRIPTION OF THE EVENT

On February 6, 1998, a fire watch, which was established as a technical specification required action, was released prematurely. Unit 1 was operating at 100% power at the time of the event.

During a walkdown by Safety & Loss Prevention and Corporate Engineering personnel on February 5, 1998, a crack approximately four feet long and approximately 1/8 inch wide was discovered between the door frame of fire door 1-BS-DR-22 [EIIS – NF, DR] and the wall. This fire door between the Unit 1 Cable Vault and Auxiliary Building was declared inoperable at 1315 hours, and a one-hour Technical Specification (TS) 3.21.B.7 action statement was entered to establish a continuous fire watch. A station deviation report was submitted, a fire watch was posted at 1337 hours, and the TS action statement was exited. At approximately 1600 hours on February 6, 1998, repair of the crack was initiated using an approved caulking. The repair was completed at approximately 1700 hours, and the fire watch was released at 1800 hours on February 6, 1998.

While preparing to repair another fire door on February 9, 1998, it was identified that the ½ inch depth of caulking used on door 1-BS-DR-22 requires 96 hours to cure to achieve a three-hour fire rating. The 96-hour cure time for the February 6, 1998 repair would not have elapsed until 1700 hours on February 10, 1998. A one-hour TS 3.21.B.7 action statement was entered again at 1720 hours and a station deviation was submitted. A continuous fire watch was re-established for door 1-BS-DR-22 at 1733 hours, and the fire watch remained in place until after the 96-hour cure time had elapsed.

This event is being reported pursuant to 10CFR50.73(a)(2)(i)(B) as a condition prohibited by Technical Specifications.

2.0 SIGNIFICANT SAFETY CONSEQUENCES AND IMPLICATIONS

This event resulted in no significant safety consequences or implications. The caulking manufacturer has informed us that, upon installation, the caulking will prevent the passage of flame immediately, but may not satisfy other three-hour fire rating requirements (i. e., hose stream requirements) until cured. In addition, the Unit 1 Cable Vault and the Auxiliary Building are equipped with fire detection and suppression systems.

In the event of a fire, the detection equipment would have alerted the Control Room operators. In turn, the Control Room operators would have notified fire brigade

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2.0 SIGNIFICANT SAFETY CONSEQUENCES AND IMPLICATIONS (continued)

members, who would have promptly responded to extinguish the fire. Until the fire brigade's arrival, the caulking would have prevented the passage of flame. In addition, the Unit 1 Cable Vault is equipped with an automatic CO₂ system (with sprinkler backup), and there are several fire hose stations located in the Auxiliary Building. These fire detection and suppression systems were operable during the time frame of interest. A fire in the area (i. e., Unit 1 Cable Vault or Auxiliary Building) would have been promptly detected, reported, prevented from spreading, and extinguished. Therefore, the health and safety of the public were not affected.

3.0 CAUSE

The cause of this event was that the planning of this repair activity failed to identify that an approved procedure existed and should have been used. The existing approved procedure provided sufficient guidance to perform the repair of door 1-BS-DR-22, including the manufacturer's specified cure time.

4.0 IMMEDIATE CORRECTIVE ACTION(S)

On February 9, 1998, a station deviation report was submitted, and a continuous fire watch was re-established for door 1-BS-DR-22 when it was realized that the cure time for the February 6, 1998 repair had not elapsed. The fire watch remained in place until after the 96-hour cure time had elapsed.

5.0 ADDITIONAL CORRECTIVE ACTIONS

A Category 2 Root Cause Evaluation (RCE) was conducted to determine the cause of the prematurely released fire watch.

6.0 ACTIONS TO PREVENT RECURRENCE

Model work orders, which will include reference to applicable procedures, will be developed for use in planning the repair of fire barriers.

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7.0 SIMILAR EVENTS

None.

8.0 MANUFACTURER/MODEL NUMBER

Not applicable.

9.0 ADDITIONAL INFORMATION

Unit 2 was operating at 100% power at the time of this event.