

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Surry Power Station, Unit 1	DOCKET NUMBER (2) 0   5   0   0   0   2   8   0	PAGE (3) 1   OF   0   4
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TITLE (4)  
Failure to Initiate Alternate Radiological Sampling of Ventilation Vent Due to Personnel Error

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 NAMES		DOCKET NUMBER(S)
0   3	0   2	8   9	8   9	0   0   7	0   0	0   3	2   9	8   9			0   5   0   0   0
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)											

OPERATING MODE (9) N	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 0   0   0	20.405(a)(1)(i)	50.38(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(ii)	50.38(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(ii)	50.73(a)(2)(viii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(iii)	50.73(a)(2)(vii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME M. R. Kansler, Station Manager	TELEPHONE NUMBER
	AREA CODE: 8   0   4   3   5   7   -   3   1   8   4

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
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO			

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

On March 2, 1989, at 1220 hours, with Units 1 and 2 at cold shutdown, Special Test 1-ST-240 was initiated. The purpose of the test was to verify that the "1H" emergency bus loads are properly re-sequenced onto the bus following an undervoltage condition that occurs on the bus five minutes after an Engineered Safety Features (ESF) actuation. The planned ESF actuation resulted in the lockout of the ventilation vent radiation monitor sample pump as expected. Technical Specification Table 3.7-5(b) requires that alternate continuous sampling be initiated within one hour if the sampling pump is not in operation. Contrary to this requirement, the alternate sampling was not initiated. The cause of the event was the incorrect assumption that the sample pump would be returned to operation within the one hour time period. Operations and Health Physics personnel were reinstructed that whenever a Technical Specification action item is entered, the appropriate compensatory actions shall be initiated promptly and not terminated or suspended until actual conditions exist that allow termination of the actions. Similar special tests will be performed on the remaining emergency buses in both units. These tests will be revised to alert the shift supervisor and Health Physics personnel that a Technical Specification action item will be entered during the test.

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		YEAR 8   9	SEQUENTIAL NUMBER -   0   0   7	REVISION NUMBER -   0   0	0   2	OF	0   4

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

1.0 Description of the Event

On March 2, 1989, at 1220 hours, with Units 1 and 2 at cold shutdown, the Unit 1 "Engineered Safety Features (ESF) Actuation With Delayed Undervoltage Test" was initiated. The purpose of the test was to verify that the "1H" emergency bus loads are properly re-sequenced onto the bus following an undervoltage condition that occurs on the bus five minutes after an ESF (EIIS-JE) actuation. As designed, the auxiliary ventilation system aligned to its emergency mode configuration upon the ESF actuation signal. Part of this emergency mode alignment includes the lockout of the ventilation vent radiation monitor (EIIS-IL) sample pump. Technical Specification Table 3.7-5(b) requires that alternate continuous sampling be initiated within one hour if the sampling pump is not in operation. Contrary to this requirement, when the pump was locked out upon the ESF actuation at 1220 hours, the alternate sampling was not initiated. The pump was not returned to operation until 1340 hours, a period of one hour and twenty minutes following the lockout of the pump.

2.0 Safety Consequences and Implications

The ventilation vent stack is monitored by the ventilation vent stack particulate/gas monitor, RM-VG-109/110, to identify and quantify releases of radioactive gases. The ventilation vent accountability sampler takes a sample from the supply line of RM-VG-109/110 via the monitor pump to be used for input to the semiannual effluent release report.

The ESF signal was part of a planned special test and was not the result of an accident condition. Strip charts for the ventilation vent radiation monitors which are designed for accident assessment, were reviewed following the event, and no abnormal releases were detected. Iodine and particulate samples taken later that day verified that gaseous effluent dose rate limits were not exceeded during this event. Therefore, the health and safety of the public were not affected.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

3.0 Cause

The ventilation vent radiation monitor sample pump receives a lockout signal when the auxiliary ventilation system aligns to its emergency mode following an ESF actuation. The sample pump remains locked out until the auxiliary vent emergency mode alignment is reset at which time the sample pump automatically starts. The auxiliary ventilation system emergency alignment could not be reset within the one hour time span due to the requirements of the test.

Following the lockout of the sample pump, operators performed the appropriate abnormal procedure (AP) and notified Health Physics as directed by the AP at 1246 hours. The AP was not initiated immediately upon the lockout of the sample pump because the operators' immediate attentions were directed toward the verification of the alignment of the ESF components. Operations personnel informed Health Physics personnel that they anticipated the sample would be returned to operation within the one hour time limit; thus, the count room personnel did not initiate the required sampling.

4.0 Immediate Corrective Action(s)

Health Physics personnel were notified that the sample pump was not in operation and were requested to initiate the required alternate sampling.

5.0 Additional Corrective Action(s)

The auxiliary ventilation emergency mode was reset and the radiation monitor sample pump automatically started.

6.0 Action(s) Taken to Prevent Recurrence

Operations and Health Physics personnel were reinstructed that whenever a Technical Specification action item is entered, the appropriate compensatory actions shall be initiated promptly and not terminated or suspended until actual conditions exist that allow termination of the actions.

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Similar special tests will be performed on Unit 1 "J" bus and Unit 2 "H" and "J" bus. These tests will be revised to alert the shift supervisor and Health Physics personnel that the sample pump will be locked out and that a Technical Specification action item will be entered.

7.0 Similar Events

None.

8.0 Manufacturer/Model Number(s)

N/A

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

March 29, 1989

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

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Docket No.: 50-280  
License No. DPR-32

Gentlemen:

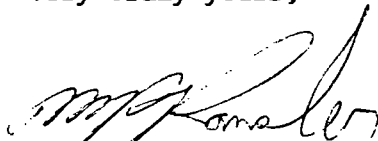
Pursuant to Surry Power Station Technical Specifications, Virginia Electric and Power Company hereby submits the following Licensee Event Report for Unit 1.

REPORT NUMBER

89-007-00

This report has been reviewed by the Station Nuclear Safety and Operating Committee and will be reviewed by Safety Evaluation and Control.

Very truly yours,



M. R. Kansler  
Station Manager

Enclosure

cc: Regional Administrator  
Suite 2900  
101 Marietta Street, NW  
Atlanta, Georgia 30323

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