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

January 3, 1990

U. S. Nuclear Regulatory Commission
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License Nos.: DPR-32
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Gentlemen:

Pursuant to Surry Power Station Technical Specifications, Virginia Electric and Power Company hereby submits the following Licensee Event Report for Units 1 and 2.

REPORT NUMBER

89-041-00

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

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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NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Surry Power Station, Units 1 and 2	0 5 0 0 0 2 8 0	1 OF 0 3

TITLE (4) Auxiliary Vent Fan Taken Out of Service Without Implementing Technical Specification Action Statement 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 5 0 0 0
1 2	0 6	8 9	8 9	0 4 1	0 0	0 1	0 3	9 0		0 5 0 0 0

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 0 0	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 (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		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
M. R. Kansler, Station Manager	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
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On December 6, 1989, the "A" train of auxiliary ventilation was removed from service by placing the fan control switch in the pull-to-lock (PTL) position. This removed the automatic start feature of the fan rendering the fan technically inoperable and the appropriate Technical Specification action statement was not implemented. The cause of the event was personnel error. The shift supervisor involved failed to consider that placing the switch in PTL would render the fan inoperable. The fan was returned to automatic control when the switch was placed in the automatic position 30 minutes after the event. All operations personnel have been directed to consider safety related equipment inoperable whenever placing the controls in the PTL position.

1.0 Description of the Event

On December 6, 1989, with Unit 1 and Unit 2 at 100% power, the Superintendent of Operations discovered through a review of control room operator's logs that the "A" train auxiliary ventilation exhaust (ELLS-VF) fan (1-VS-F-58A) (ELLS-FAN) had been removed from service earlier that day for approximately 30 minutes. The fan's control switch had been placed in the pull-to-lock position at 1010 hours to support replacement of the fan's oil level sight glass. The shift supervisor had received instructions earlier that the maintenance on the fan was to be performed under operator standby. This is an approved method used to control operation of equipment while maintenance is being performed on it. In this case operator standby was achieved by placing the control switch in the PTL position under the direct control of a control room operator. In the PTL position the fan would not automatically start as designed upon the initiation of a safety injection. Consequently, the fan should have been considered inoperable. Technical Specifications 3.22 requires that when one train of the exhaust filter system is inoperable for any reason, the redundant train shall be demonstrated operable immediately and the inoperable train shall be returned to operable status within seven days or the unit be placed in at least hot shutdown. The seven day action statement was not entered nor was the "B" train demonstrated operable. At 1040 hours, fan control was returned to automatic after maintenance personnel determined that the correct parts were not available.

2.0 Safety Consequences and Implications

The auxiliary ventilation system is designed to remove heat from various areas in the plant to ensure proper operation of safety related equipment in the event of a design basis accident (DBA). In addition, this system is designed to remove particulate and iodine contaminants in the exhaust air from these areas following a DBA.

During the time that the control switch for the "A" train of filtered exhaust was in the pull-to-lock position, the "B" train was operable and in automatic. In addition, since the maintenance was not performed on the fan, the fan was available for operation at all times during this event. Therefore, the health and safety of the public were not affected.

3.0 Cause

The cause of failure to enter the Technical Specification action statement was due to personnel error. The senior reactor operator (SRO) involved with the event failed to consider that placing the fan's control switch in the PTL position rendered it technically inoperable. Consequently, the actions required by Technical Specification for an inoperable fan were not implemented.

4.0 Immediate Corrective Action(s)

None required since the fan had been returned to automatic control when the event was discovered.

5.0 Additional Corrective Action(s)

None required.

6.0 Action(s) Taken to Prevent Recurrence

A memorandum was issued by the operations coordinator to all operations shift supervisors directing that safety related equipment be considered inoperable whenever their controls are placed in the PTL position. The only exceptions would be if appropriate approved controls are taken. This memorandum has been placed in required reading for all licensed personnel.

7.0 Similar Events

None.

8.0 Manufacturer/Model Number(s)

N/A.