Virginia Electric and Power Company
Surry Power Station
P. O. Box 315
Surry, Virginia 23883

July 20, 1990

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

Serial No.: 90-454
Docket No.: 50-280
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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 Unit 1.

REPORT NUMBER

90-005-00

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: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
SURRY POWER STATION, UNIT 1	0 5 0 0 0 2 8 0	1 OF 0 4

TITLE (4) Containment Pressure Channel Rendered Inoperable and Not Placed in Trip Condition Due to Procedure Inadequacy

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
0 6	2 1	9 0	9 0	– 0 0 5	– 0 0	0 7	2 0	9 0		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
	N	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	1 0 0	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 June 21, 1990, with Unit 1 at 100% power, Instrument Technicians opened a vent valve on a containment leakage monitoring line while performing a troubleshooting procedure. This resulted in rendering one of the four wide range containment pressure channels inoperable. Since the channel was not placed in the trip condition while inoperable, the minimum degree of redundancy required by Technical Specifications was not met. The event was caused by an inadequate procedure change to the troubleshooting procedure. The procedure change failed to direct that the associated bistable for the containment pressure protection channel affected be placed in the tripped condition. The shift supervisor, immediately upon noting the inoperable channel, directed the instrument technicians to close the vent valve to restore the affected pressure channel to operation. Procedures for venting containment leakage monitoring lines will be written to include requirements for placing the affected protection channel in the tripped condition.

1.0 DESCRIPTION OF THE EVENT

On June 21, 1990 at 0954 hours, with Unit 1 at 100% power, Instrument Technicians were troubleshooting a containment vacuum system pressure instrument (EIIS-PT). A procedure change to the troubleshooting procedure directed the instrument technicians to open a vent valve (EIIS-VTV) on a containment leakage monitoring line (EIIS-IJ) and maintain it under administrative control to allow the pressure difference between containment and atmosphere to blow suspected moisture out of the line. About seven minutes later, at 1001 hours, the Unit 1 reactor operator noted that one of the four wide range containment pressure channels (Channel IV) was indicating atmospheric pressure. The other three channels were indicating the actual containment pressure, approximately 9 psia. The operations shift supervisor, realizing that the containment pressure Channel IV sensing instrument was connected to the line the technicians had vented, notified the technicians to close the vent valve. By 1005 hours, the technicians had closed the vent valve, and the affected pressure channel was indicating actual containment pressure. Technical Specifications (TS) 3.7 requires that a minimum of three channels of containment pressure protection to be operable with a minimum degree of redundancy of one maintained. With Channel IV inoperable and not in the tripped condition, the minimum degree of redundancy required by TS was not maintained. A six hour TS action statement was entered at 0954 hours when the vent valve was opened and exited 11 minutes later at 1005 hours when the valve was closed. This event is reportable pursuant to 10CFR50.73(a)(2)(i)(B).

2.0 SAFETY CONSEQUENCES AND IMPLICATIONS

The containment pressure protection channels function to cause a High Consequence Limiting Safeguards (Hi CLS) signal to actuate at 17.7 psia containment pressure, and a Hi Hi CLS signal to actuate at 23.0 psia containment pressure These signals actuate safeguards equipment to mitigate the consequences of a large break primary or secondary loss of coolant accident. The coincidence required for safeguards actuation is three out of four of the channels exceeding the setpoint. Three channels of containment pressure protection remained operable throughout the event. In addition, consequences of the event were minimized by its short duration of eleven minutes. Consequently, the health and safety of the public were not affected.

3.0 CAUSE

The event was caused by an inadequate procedure change to the troubleshooting procedure. The procedure change failed to direct that the associated bistable for the containment pressure protection channel affected be placed in the tripped condition. The procedural inadequacy was due to a failure of the procedure change writers and reviewers to identify that a containment pressure protection channel would be affected.

4.0 IMMEDIATE CORRECTIVE ACTION(S)

The shift supervisor directed the instrument technicians to close the vent valve to restore the affected pressure channel to operation.

5.0 ADDITIONAL CORRECTIVE ACTION(S)

No additional corrective actions were required.

6.0 ACTIONS TO PREVENT RECURRENCE

Procedures for venting containment leakage monitoring lines will be written to include requirements for placing the affected protection channel in the tripped condition. Also, procedure writers and reviewers will be further cautioned to thoroughly review procedure revisions and changes for impact on communicating systems.

7.0 SIMILAR EVENTS

None.

8.0 MANUFACTURER/MODEL NUMBER

N/A