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

August 16, 1991

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

Serial No.: 91-465
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

91-012-00

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

Very truly yours,

M. R. Kansler
Station Manager

Enclosure

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

9108220178 910816
PDR ADOCK 05000280
S PDR

IE22
1/1

NRC FORM 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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) Pressurizer Level Channel Not Placed in Trip Within Six Hours 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
0 7	2 0	9 1	9 1	— 0 1 2	— 0 0	0 8	1 6	9 1		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	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	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 July 20, 1991 at 0635, with Unit 1 at 100% power, it was discovered that pressurizer level indicator 1-RC-LI-1461 had exceeded channel check acceptance criteria specified in a surveillance procedure for greater than six hours and had not been declared inoperable. Consequently, the channel was not placed in trip as required by Technical Specification 3.7 Table 3.7-1. Following this discovery, the channel was declared inoperable and placed in trip. An emergency work order was initiated which checked channel calibration and vented the transmitter to resolve the problem. No safety implications were posed by this event. This event occurred as the result of cognitive personnel errors in failing to recognize an out of specification condition, and failure to properly supervise a trainee. Personnel involved were reinstructed in the review of recorded data and the supervision of trainees. This occurrence was considered to be a violation of Technical Specification 3.7 and is being reported pursuant to 10CFR50.73(a)(2)(i)(B).

1.0 DESCRIPTION OF THE EVENT

On July 19, 1991, at approximately 1000, with Unit 1 at 100% power, procedure 1-PT-36, "Instrument Surveillance" was being performed by a reactor operator trainee. During the performance of this procedure, the trainee recorded pressurizer levels which differed by 4% and thus exceeded acceptance criteria by 1%. At this point the reactor operator trainee should have red circled the readings, informed the reactor operator of this condition, and informed the shift supervisor. Because the trainee did not recognize the out of specification condition, these required actions were not taken. At approximately 1600, the trainee recorded a second set of pressurizer level readings which also exceeded acceptance criteria by 1% without recognizing that an out of specification condition existed.

The out of specification condition pressurizer levels were not detected by the reactor operator responsible for supervision of the trainee, and neither the day shift reactor operator or the shift supervisor completely reviewed the partially completed procedure prior to shift change. When pressurizer levels were recorded at approximately 2200 and 0400 by the night shift, thus completing the procedure, pressurizer levels had returned to within specification.

During shift turnover on the morning of July 20, 1991, it was noted that the pressurizer level channel check was just within specification. The now completed 1-PT-36 was reviewed by the oncoming shift for trends in pressurizer level. During this review, it was discovered that pressurizer level indicator 1-RC-LI-1461 [EIIS-AB,LT] had exceeded channel check acceptance criteria the previous day during their shift. This was confirmed by reviewing pressurizer level data from the plant computer. Because the channel should have been declared inoperable when the channel check acceptance criteria was exceeded and this condition existed for a period greater than six hours, the channel should have been placed in trip as required by Technical Specification 3.7 Table 3.7-1.

This occurrence was considered to be a violation of Technical Specification 3.7 and therefore is being reported pursuant to 10CFR50.73(a)(2)(i)(B).

2.0 SIGNIFICANT SAFETY CONSEQUENCES AND IMPLICATIONS

No safety implications were posed by this event. Pressurizer level is monitored by three separate channels which provide a trip signal to the reactor protection system when two of three channels reach the protection setpoint. Channel 1-RC-LI-1461 can also be selected for performing pressurizer level control including the functions of isolating letdown and deenergizing pressurizer heaters on low level. Although the accident analysis does not take credit for this high level reactor trip signal, a channel reading high, as in this instance, would conservatively generate a reactor trip signal earlier than required. Therefore, the health and safety of the public were not affected.

3.0 CAUSE OF THE EVENT

This event was an isolated incident caused by two cognitive personnel errors. First, a reactor operator trainee failed to properly review recorded data and compare it to acceptance criteria. And second, the licensed reactor operator failed to properly supervise a trainee who was taking logs for which the reactor operator was responsible.

4.0 IMMEDIATE CORRECTIVE ACTION(S)

Channel 1-RC-LI-1461 was declared inoperable and placed in trip, a station deviation submitted, and an emergency work order initiated to investigate and resolve the problem.

5.0 ADDITIONAL CORRECTIVE ACTION(S)

The calibration of channel 1-RC-LI-1461 was checked, no adjustment required, and the transmitter was vented. Following venting of the transmitter, level indication returned to normal. The channel was declared operable and returned to service at 1643 on July 20, 1991.

6.0 ACTIONS TO PREVENT RECURRENCE

The licensed reactor operator was counseled on his responsibility for the accuracy of recorded data and for the proper supervision of assigned trainees. This event and lessons learned will be included in Operation's Department required reading to reemphasize requirements fo the proper supervision of assigned trainees.

The reactor operator trainee was counseled on his responsibility for comparing recorded data to acceptance criteria and notifying

appropriate personnel when an out of specification condition is identified. This event and lessons learned will be reviewed with the current RO/SRO license course trainees prior to the next inplant training period. Enhanced instructions will also be provided to future RO/SRO trainees prior to beginning inplant training.

7.0 SIMILAR EVENTS

None.

8.0 ADDITIONAL INFORMATION

None.