FILES

VIRGINIA ELECTRIC AND POWER COMPANY

RICHMOND, VIRGINIA 23261

July 17, 1978

Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Region II, Suite 818
230 Peachtree Street, Northwest
Atlanta, Georgia 30303

Serial No. 400
PO&M/DLB:dds
Docket No. 50-281
License No. DPR-37

Dear Mr. O'Reilly:

Pursuant to Surry Power Station Technical Specifications, the Virginia Electric and Power Company hereby submits the following Licensee Event Report for Surry Unit No. 2.

Report No.	Applicable Technical Specification
LER 78-025/03L-0	TS 6.6.2.b.2

Originally this event was thought to be non-reportable. However, following further consideration it was decided that a report should be submitted. As a result this report is approximately two weeks late based on 30 days from discovery date.

This report has been reviewed by the Station Nuclear Safety and Operating Committee and will be placed on the agenda for the next meeting of the System Nuclear Safety and Operating Committee.

Very truly yours,

C. M. Stallings
Vice President-Power Supply
and Production Operations

Enclosures (3 copies)

cc: Dr. Ernst Volgenau, Director (30 copies)
Office of Inspection and Enforcement

Mr. William G. McDonald, Director (3 copies)
Office of Management Information
and Program Control

A002
1/1

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	V A S P S 2 (2)	0 0 - 0 0 0 0 0 - 0 0 (3)	4 1 1 1 1 (4)	(5)
7	8	9 LICENSEE CODE 14	15 LICENSE NUMBER 25	26 LICENSE TYPE 30	57 CAT 58

CON'T

0	1	REPORT SOURCE L (6)	0 5 0 0 0 2 8 1 (7)	0 6 0 1 7 8 (8)	0 7 1 4 7 8 (9)
7	8	60	61 DOCKET NUMBER 68	69 EVENT DATE 74	75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During a routine inspection, an annular two-inch gap was found around the 2B battery

0 3 room ventilation duct where it penetrates the wall between the battery room and the

0 4 emergency switchgear room. This is contrary to T.S. 3.21.G.1 and reportable per T.S.

0 5 6.6.2.b.(2). The health and safety of the public were not affected.

0 6

0 7

0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	A B (11)	B (12)	C (13)	X X X X X X (14)	X (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 8	—	0 2 5	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
D (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	X (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The defect appears to be a condition undetected from the construction period. The gap

1 1 was packed with fire resistant material.

1 2

1 3

1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	1 0 0 (29)	NA	B (31)	Fire Protection Inspection

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

NAME OF PREPARER T. L. Baucom PHONE: (804)-357-3184

Surry Power Station
Docket No.: 50-281
Report No.: 78-025/03L-0
Event Date: 6-1-78

Defect in Fire Wall

1. Description of Event:

With the unit operating at rated power, a routine fire protection inspection disclosed a defect in the concrete fire wall between 2B battery room and the emergency switchgear room. The defect was a two inch annular gap around the battery room supply duct where the duct passed through the wall from the emergency switchgear room to the battery room. The condition is contrary to Technical Specification 3.21.G.1 and is reportable in accordance with Technical Specification 6.6.2.b.(2).

2. Probable Consequences/Status of Redundant Systems

In the event of a fire in the 2B battery room, flames might have propagated through the defect. Due to spacing of equipment in the emergency switchgear room, heat and flames would not have been able to reach safety related equipment. In the case of fire in the emergency switchgear area, flames would not have penetrated the defect because of an out flow of air through the defect. The health and safety of the general public were not affected.

3. Cause:

The defect appears to have been overlooked when the supply duct was installed during construction. The defect was found as the result of increasing attention to detail in current fire protection inspections.

4. Immediate Corrective Action:

Upon discovery, a fire watch was posted.

5. Subsequent Corrective Action:

The gap was packed with fire resistant material.

6. Actions Taken To Prevent Recurrence:

Since repair has been made, a recurrence is highly unlikely.

7. Generic Implications:

None