

VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

May 30, 1978

Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Region II, Suite 816
230 Peachtree Street, Northwest
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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 2.

Report No.	Applicable Technical Specification
LER-78-016/03L-0	TS 6.6.2.b.(2)

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. W. Stallings

C. W. 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

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Low Current Heat Tracing Panel 10 Circuit 2

1. Description of Event:

With unit at rated power, during a routine check of heat tracing panel 10, an operator observed that a low temperature alarm was activated for heat tracing circuit 2, installed on the Boron Injection Tank Inlet pipe.

It is the failure of one of the two circuits of heat tracing that constitutes a condition contrary to Technical Specification 3.3.A.4 and is reportable in accordance with Technical Specification 6.6.2.b.(2).

2. Probable Consequences and Status of Redundant Systems

The inlet line of the Boron Injection Tank is provided with heat tracing to ensure that the boric acid solution is maintained at a temperature above the solubility limit. Since one of the two redundant heat tracing circuits installed on the piping was operable, the system involved was protected and operable.

The health and safety of the general public were not affected.

3. Cause:

This occurrence was caused by boric acid solution penetrating the heat tracing tape circuit, resulting in a decrease in current. The source of the boric acid solution was a leaking diaphragm valve located near the inlet pipe with the subject heat tracing on it.

4. Immediate Corrective Action:

A repair order was issued to have the failed heat tracing tape replaced.

5. Scheduled Corrective Action:

The heat tracing tape for panel 10 circuit 2 was replaced within 15 hours after the discovery of the low temperature alarm. The current measured in the replaced tape fell within manufacturer's specification. The circuit was returned to service.

6. Action Taken to Prevent Recurrence:

Continuous surveillance is maintained on the heat tracing systems required for unit operation. In addition, diaphragm valves in the boric acid system are periodically serviced under a planned maintenance program. No additional specific action is considered necessary.

7. Generic Implications:

This failure, as with others in the system, is considered random since no specific circuit or panel has exhibited repeated failures.