

REGULATORY DOCKET FILE COPY

VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

May 23, 1978

REGULATORY SERVICES
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REGULATORY SERVICES UNIT

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. 288
PO&M/DLB:das
Docket No. 50-281
License No. DPR-37

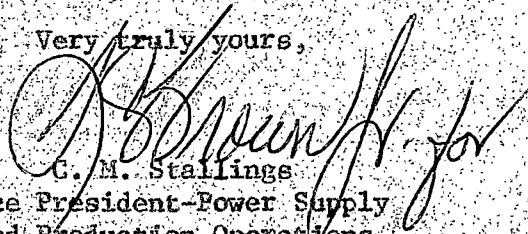
Dear Mr. O'Reilly:

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-78-015/03L-0	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. 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

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Title: Emergency Air Bottle Header - Control Room

1. Description of Events:

During normal operation at rated power, an air leak was found on the header of the control room emergency air supply bank. Leak isolation required isolation of each individual bottle at its valve. This constituted a condition contrary to Technical Specification 3.19.A and reportable in accordance with Technical Specification 6.6.2.b(2).

2. Probable Consequences/Status of Redundant Systems

The air bank is intended to provide air to the control room during that phase of an accident when containment out-leakage is occurring. The air system is backed up by emergency supply fans which take a suction from the turbine building through absolute and charcoal filter assemblies. Had an event occurred, the control room would have remained manned. The health and safety of the general public were not affected.

3. Cause of Event

The event was caused by failure of the coupling nut between the header and the emergency air pressure regulating valve. The nut cracked apparently due to work hardening.

4. Immediate Corrective Action

Each air bottle was individually isolated, and the header depressurized. The coupling nut was replaced and the system returned to normal configuration within four hours of identification.

5. Subsequent Corrective Action

None

6. Actions Taken To Prevent Recurrence

None

7. Generic Implications

None