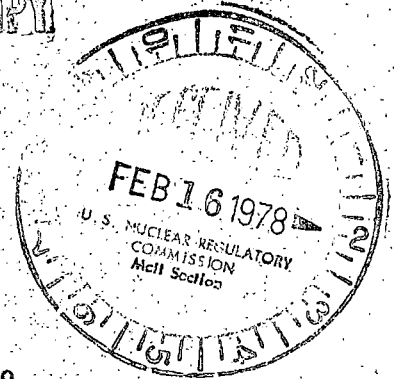


REGULATORY DOCKET FILE COPY

VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

February 15, 1975



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. 089
PO&M/DLB:das
Docket No. 50-281
License No. DPR-37

20503
604820

Dear Mr. O'Reilly:

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

Report Number

Applicable Technical Specification

LER 003/03-L-0
LER 004/03-L-0
LER 005/03-L-0

6.6.2(b)1
6.6.2(b)3
6.6.2(b)2

These reports have 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

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

Enclosures (3 copies)

cc: Dr. Ernst Volgenau, Director (40 copies)
Office of Inspection and Enforcement

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

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VIRGINIA ELECTRIC AND POWER COMPANY
SURRY POWER STATION, UNIT 2
DOCKET NO: 050-0281
EVENT DATE: 1-20-78

During rampdown, following detection of a primary coolant leak to containment, it was observed that ΔT was low for Loop "A" Protection Channel. This was contrary to known unit conditions. Channel "A" was placed in the trip mode.

Further tests indicated that the erroneous temperature readings obtained from TE-2412B, were caused by steam and water penetrating the insulation of the RTD, which resulted in the decrease of resistance between the conductors and ground. The corrective action implemented was to place a spare RTD in service until TE-2412B can be replaced. The steam and water came from the primary leak on MOV-2700, reported in LER 78-002/03-L-0.

This event is reported in accordance with Technical Specification 6.6.2.b(1). The health and safety of the general public were not affected since the failed channel was placed in the trip mode, therefore, the protection system remained fully functional.

LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

8	9	14	15	25	26	30	57	58
3	1	V	A	S	P	S	2	2
		0	0	0	0	0	0	0
		-	0	0	0	0	0	3
		4	1	1	1	1	4	5

LICENSEE CODE
LICENSE NUMBER
LICENSE TYPE
CAT 58

NON'T

8	60	61	68	69	74	75	80
0	1	L	6	0	5	0	0
		0	0	0	2	8	1
		7	0	1	2	6	7
		8	8	0	2	1	5
		7	8	8	8	9	9

REPORT SOURCE
DOCKET NUMBER
EVENT DATE
REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | A company employee alleged that two diaphragm welds on RS heat exchangers had been made

0 3 | by unqualified welders. Investigation indicated that apparently, on two occasions, a

0 4 | qualified welder had closely supervised welding by an unqualified welder. NDT documents

0 5 | show that both welds were satisfactory. The welds in question serve only in a "gasket"

0 6 | capacity. This is reportable per T.S. 6.6.2b.(3).

0 7 |

0 8 | 80

9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32				
0	9	X	X	X	X	X	X	X	X	X	Z	Z	Z	7	8	—	0	0	4	/	0	3	L	—	0	
SYSTEM CODE			CAUSE CODE			CAUSE SUBCODE			COMPONENT CODE				COMP. SUBCODE		VALVE SUBCODE		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.	

18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47
X	H	Z	Z	0	0	0	0	0	Y	N	Z	Z	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS			ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER												

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The apparent cause of this event was a matter of interpretation by the employees per-

1 1 | forming the welding. Station personnel have been specifically re-instructed as to

1 2 | interpretation and application of company policies and procedures.

1 3 |

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28	29	30	31	32	33	34	35	36	37	38	39		
E	1	0	0	D	Z	Z	N/A	N/A	N/A	N/A	N/A		
FACILITY STATUS			% POWER			OTHER STATUS		METHOD OF DISCOVERY				DISCOVERY DESCRIPTION	

33	34	35	36	37	38	39
Z	Z	N/A	N/A	N/A	N/A	N/A
ACTIVITY TAKEN		CONTENT OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE

1 7 | 80

37	38	39
0	0	0
PERSONNEL EXPOSURES		

1 8 | 80

40	41
0	0
PERSONNEL INJURIES	

1 9 | 80

42	43
Z	N/A
LOSS OF OR DAMAGE TO FACILITY	

2 0 | 80

44	45	46
Z	N/A	N/A
PUBLICITY		

VIRGINIA ELECTRIC AND POWER CO.
SURRY POWER STATION, UNIT 2
DOCKET NO. 050-0281
EVENT DATE: 1-26-78

This report summarizes the results of an investigation convened to validate allegations of improper welding practices employed in the welding of seal diaphragms on Recirculation Spray Heat Exchangers on two occasions.

The first alleged occasion involved the fabrication of diaphragm - to - shell weld at the lower channel head manway of the A Recirculation Spray Cooler (2-RS-E-1A) in May of 1976. The apparent sequence, derived from personnel interviews, was that a qualified contract welder completed about 75% of the weld before sustaining an injury that left him unable to weld. The weld was apparently completed by an unqualified welder under the close supervision of the qualified man, although the documentation does not support same. The subsequent Penetrant Test of the weld was satisfactory, and is substantiated by documents in station records.

The second alleged occasion involved a weld made on the upper channel head diaphragm of "B" Recirculation Spray Cooler (2-RS-E-1B) in November 1977. A qualified company welder completed all but about one foot of the weld before he became fatigued. Apparently the weld was completed by the unqualified assistant, under the supervision of the qualified man. Again, the appropriate documentation indicates that the qualified welder completed the weld. Penetrant Test was satisfactory, and this fact is documented.

The consequences of these alleged events are negligible, and the health and safety of the general public are not affected for reasons as stated below.

(1) The diaphragms serve only as a gasket, in essence preventing access of brackish service water to the carbon steel channel head cover and the carbon steel bolts, which hold the channel head covers in place. In normal operation, the service water sides of the coolers are dry; service water is admitted only under major accident conditions.

LER 78 - 0 0 4 / 03-L-0

VIRGINIA ELECTRIC AND POWER COMPANY
SURRY POWER STATION, UNIT 2
DOCKET NO: 050-0281
EVENT DATE: 1-26-78

(2) The diaphragms serve no strength function. The strength is inherent in the channel head covers.

(3) In the unlikely event of a large scale accident requiring use of the cooler and, had there been indications that the diaphragm were not intact, the cooler in question could have been removed from service with no loss of capability. The remaining companion coolers would have provided 150% of cooling capability. (Only 100% assumed in accident analysis.)

The allegations could not be substantiated by documents in station records. It was also determined through interviews with welders and their immediated supervisors that there was no evidence of deliberate attempt to bypass established procedures, or conduct work in a non-quality manner. The company has specifically instructed concerned personnel as to acceptable methods for carrying out the established policies and procedures.

This event is reported in accordance with Technical Specification 6.6.2.b(3).

LICENSEE EVENT REPORT

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

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

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | During normal operation, heat tracing from Panel 8 CKT 21A was indicating a low current

0 3 | condition. Panel 9 CKT 21A, the redundant heat tracing line, was operable. This

0 4 | event is contrary to T.S. 3.2.B.5 and is reportable under T.S. 6.6.2.b(2). The

0 5 | health and safety of the public were not affected.

0 6 |

0 7 |

0 8 |

0	9	SYSTEM CODE	P	C	11	CAUSE CODE	E	12	CAUSE SUBCODE	A	13	COMPONENT CODE	H	E	A	T	E	R	14	COMP. SUBCODE	Z	15	VALVE SUBCODE	Z	16
7	8	9	10	11	12	13	14	15	16	17	18	19	20												

17	LER/RO REPORT NUMBER	EVENT YEAR	7	8	22	SEQUENTIAL REPORT NO.	0	0	5	26	OCCURRENCE CODE	0	3	28	29	REPORT TYPE	L	30	REVISION NO.	0	32										
33	ACTION TAKEN	FUTURE ACTION	Z	19	EFFECT ON PLANT	Z	20	SHUTDOWN METHOD	Z	21	HOURS	0	0	0	0	22	ATTACHMENT SUBMITTED	Y	23	NPRD-4 FORM SUB.	N	24	PRIME COMP. SUPPLIER	A	25	COMPONENT MANUFACTURER	C	2	6	8	26
33	34	35	36	37	40	41	42	43	44	47																					

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | An investigation revealed the heat tracing tape had failed. The failed tape was

1 1 | replaced, and the panel was returned to service.

1 2 |

1 3 |

1 4 |

1	5	FACILITY STATUS	E	28	% POWER	1	0	0	29	OTHER STATUS	N/A	30	METHOD OF DISCOVERY	A	31	DISCOVERY DESCRIPTION	Panel Alarm	32
7	8	9	10	12	13	44	45	46	80									

1	6	ACTIVITY CONTENT	Z	33	Z	34	AMOUNT OF ACTIVITY	N/A	35	LOCATION OF RELEASE	N/A	36
7	8	9	10	11	44	45	80					

1	7	PERSONNEL EXPOSURES	0	0	0	37	Z	38	DESCRIPTION	N/A	39
7	8	9	11	12	13	80					

1	8	PERSONNEL INJURIES	0	0	0	40	DESCRIPTION	N/A	41
7	8	9	11	12	80				

1	9	LOSS OF OR DAMAGE TO FACILITY	Z	42	DESCRIPTION	N/A	43
7	8	9	10	80			

2	0	PUBLICITY ISSUED	N	44	DESCRIPTION	N/A	45
7	8	9	10	80			

VIRGINIA ELECTRIC AND POWER COMPANY
DOCKET NO: 050-0281
EVENT DATE: 1-27-78

During normal unit operation, heat tracing from Panel 8 CKT 21A was indicating low current condition. This current heats the inlet line to the boric acid filter. The redundant circuit, Panel 9 CKT 21A, was fully operable. A maintenance order (MR2801271228) was issued for investigation and repair. The tape was found to have failed and was replaced. Panel 8 CKT 21A was returned to service eight (8) hours after the problem was observed.

With one heat tracing circuit still in operation, unit shutdown was not required. The health and safety of the public were not affected because the redundant heat tracing circuit remained operable.