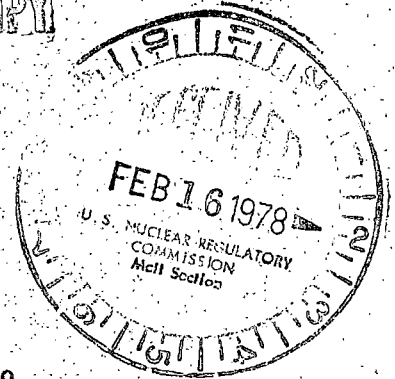


REGULATORY DOCKET FILE COPY

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)

3	1	V	A	S	P	S	2	2	0	0	-	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	L	6	0	5	0	0	0	2	8	1	7	0	1	2	6	7	8	8	0	2	1	5	7	8	9
8	9	REPORT SOURCE		60	61	DOCKET NUMBER						68	69	EVENT DATE				74	75	REPORT DATE				80		

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 |

0	9	X	X	11	X	12	Z	13	X	X	X	X	X	X	14	Z	15	Z	16	
7	8	SYSTEM CODE		9	10	11	12	13	COMPONENT CODE					18	19	COMP. SUBCODE		VALVE SUBCODE		20
17	LER/RO REPORT NUMBER		EVENT YEAR		23	SEQUENTIAL REPORT NO.		27	OCCURRENCE CODE		REPORT TYPE		REVISION NO.							
21	22	23	24	25	26	27	28	29	30	31	32									
X	18	H	19	Z	20	Z	21	HOURS		22	ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER		26	
33	34	35	36	37	38	39	40	41	42	43	44		45	46	47					

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 |

1 4 |

1	5	E	28	1	0	0	29	30	D	31	DISCOVERY DESCRIPTION					32			
7	8	FACILITY STATUS		9	10	% POWER		12	13	METHOD OF DISCOVERY					46	47	48	49	50
1	6	Z	33	Z	34	AMOUNT OF ACTIVITY					35	LOCATION OF RELEASE					36		
7	8	9	10	11	12	13					14	15					16		
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION					39								
7	8	9	10	11	12	13					14								
PERSONNEL INJURIES		NUMBER		DESCRIPTION					41										
7	8	9	10	11	12	13					14								
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION					43										
7	8	9	10	11	12	13					14								
PUBLICITY		ISSUED		DESCRIPTION					45										
7	8	9	10	11	12	13					14								

T. L. Baucom

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.

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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	0	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	L	0	5	0	0	0	0	2	8	1	0	1	2	7	7	8	0	2	1	5	7	8						
8	9	REPORT SOURCE	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	P	C	E	A	H	E	A	T	E	R	Z	Z		
7	8	9	10	11	12	13	14	15	16	17	18	19	20		
SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE						COMP. SUBCODE		VALVE SUBCODE	

17	7	8	0	0	5	0	3	L	0						
21	22	23	24	25	26	27	28	29	30	31	32				
LER/RO REPORT NUMBER	EVENT YEAR	SEQUENTIAL REPORT NO.	OCCURRENCE CODE	REPORT TYPE	REVISION NO.	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 | 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	E	1	0	0	N/A	A	Panel Alarm		
7	8	9	10	11	12	13	14	15		
FACILITY STATUS		% POWER		OTHER STATUS			METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	

1	6	Z	Z	N/A	N/A		
7	8	9	10	11	12		
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE	

1	7	0	0	0	Z	N/A	
7	8	9	10	11	12	13	
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION	

1	8	0	0	0	N/A
7	8	9	10	11	12
PERSONNEL INJURIES		NUMBER		DESCRIPTION	

1	9	Z	N/A
7	8	9	10
LOSS OF OR DAMAGE TO FACILITY		TYPE	

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

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.