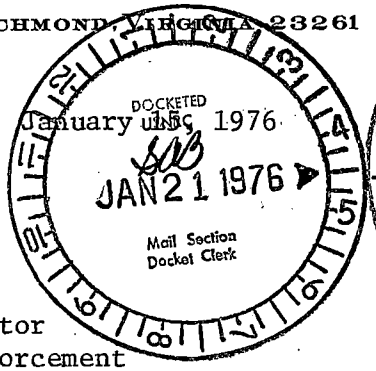
Regulatory File Cy

VIRGINIA ELECTRIC AND POWER COMPANY

RICHMOND, VIRGINIA 23261



January 15, 1976

Mr. Norman C. Moseley, Director
Office of Inspection and Enforcement
United States Nuclear Regulatory Commission
Region II - Suite 818
230 Peachtree Street, Northwest
Atlanta, Georgia 30303

Serial No. 840
PO&M/JTB:clw

Docket No. 50-281
License No. DPR-37

Dear Mr. Moseley:

Pursuant to Surry Power Station Technical Specification 6.6.B.1, the Virginia Electric and Power Company hereby submits forty (40) copies of Abnormal Occurrence Report No. AO-S2-75-20.

The substance of 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

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

Enclosures
40 copies of AO-S2-75-20

cc: Mr. Robert W. Reid

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LICENSEE EVENT REPORT

AO-S2-75-20

CONTROL BLOCK: [1 6] (PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME	LICENSE NUMBER	LICENSE TYPE	EVENT TYPE
01 VASPS2 (7 8 9 14)	00-00000-00 (15 25)	4 1 1 1 1 (26 30)	0 1 (31 32)

CON'T	CATEGORY	REPORT TYPE	REPORT SOURCE	DOCKET NUMBER	EVENT DATE	REPORT DATE
01 (7 8)	P 0 (57 58)	T (59)	L (60)	050-0281 (61 68)	12 19 75 (69 74)	01 02 76 (75 80)

EVENT DESCRIPTION

02 During normal operation of Unit No. 2 at 100 per cent power "C" steam generator pres-
03 sure indication-496-Channel IV failed high. This is a violation of section 3.7 of the
04 Technical Specifications. An immediate rampdown of 150 MWe per hour was initiated and
05 an instrument technician was dispatched to place the channel in the trip mode.
06 (A0-S2-75-20)

	SYSTEM CODE	CAUSE CODE	COMPONENT CODE	PRIME COMPONENT SUPPLIER	COMPONENT MANUFACTURER	VIOLATION
07	C C (10)	C (11)	PIPEXX (12 17)	N (43)	2999 (44 47)	Y (48)

CAUSE DESCRIPTION

08 Examination of the failed transmitter revealed the sensing line to be frozen. This
09 condition was caused by abnormally cold outside air being drawn through a set of in-
10 take louvers (located adjacent to the sensing line in the safeguards building (con't)

	FACILITY STATUS	% POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION
11	E (9)	100 (10 12)	N/A (13 44)	A (45)	N/A (46 80)

	FORM OF ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY	LOCATION OF RELEASE
12	Z (9)	Z (10)	N/A (11 44)	N/A (45 80)

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION
13	000 (9 11)	Z (12)	N/A (13 80)

PERSONNEL INJURIES

	NUMBER	DESCRIPTION
14	000 (9 11)	N/A (12 80)

OFFSITE CONSEQUENCES

15 N/A

LOSS OR DAMAGE TO FACILITY

	TYPE	DESCRIPTION
16	Z (9)	N/A (10 80)

PUBLICITY

17 N/A

ADDITIONAL FACTORS

18 The probability of a similar failure of another transmitter has been eliminated by
19 sealing the intake louvers and will be further removed by the installation (con't)

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

GPO 881-667

CAUSE DESCRIPTION (con't)

wall) and over the sensing line. The louvers were closed and sealed allowing the line to thaw and the transmitter to be returned to normal service.

ADDITIONAL FACTORS (con't)

of heat tracing on the sensing lines which are located adjacent to the ventilation louvers.

The ability of the safety injection system to perform its function was in no way impaired by this failure. Although the transmitter failed in the nonconservative direction (drifted high) it was only in this condition for a brief period of time before it was placed in the trip mode. In addition the other two remaining channels were in proper working order and could have provided a safety injection signal, if required, since only two out of three channels are required to initiate a safety injection.

The health and safety of the general public was in no way endangered since the safety injection system was able to perform its intended function at all times during this occurrence.

This is a similar occurrence to that noted on Unit No. 1 on December 19, 1975.