NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	V A S P S 2 (2)	0 0 - 0 0 0 0 0 - 0 0 (3)	4 1 1 1 1 (4)	(5)
	LICENSEE CODE	LICENSE NUMBER	LICENSE TYPE	CAT

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0 1	REPORT SOURCE L (6)	0 5 0 0 0 2 8 1 (7)	0 5 2 3 8 3 (8)	0 6 2 3 8 3 (9)
		DOCKET NUMBER	EVENT DATE	REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 With Unit 2 at 100% power, investigation of a Low Temp Heat Tracing alarm revealed

0 3 that amp reading for heat tracing Panel 8, circuit 23C was below the acceptance

0 4 criteria stipulated in PT-27C. This event is contrary to T. S. 3.2.B.5 and is

0 5 reportable per T. S. 6.6.2.b(2). The redundant heat tracing circuit was operable,

0 6 therefore, the health and safety of the public were not affected.

0 7

0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S H (11)	E (12)	B (13)	H E A T E R (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 2 8	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
C (18)	F (19)	Z (20)	Z (21)	0 0 0 0 0	Y (23)	Y (24)	L (25)	T 1 8 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The loss of heat tracing was due to excessive heat. The defective heat tracing

1 1 was replaced and tested. A design change has been prepared to change the manner

1 2 by which these borated lines are heat traced. Installation of this design change

1 3 has commenced.

1 4

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	E (28)	1 0 0 (29)	N/A	(31)	Operator Observation

1 6	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z (33)	Z (34)	N/A	N/A

PERSONNEL EXPOSURES

1 7	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	N/A

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)
	N (44)	N/a

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PDR ADOCK 05000281
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NRC USE ONLY

NAME OF PREPARER ________________ PHONE: ________________

NRO REGION II
ATLANTA, GEORGIA

83 JUN 28 A10 : 19

VIRGINIA ELECTRIC AND POWER COMPANY
Surry Power Station
P. O. Box 315
Surry, Virginia 23883

Serial No: 83-046

Docket No: 50-281

License No: DPR-37

JUN 23 1983

Mr. James P. O'Reilly
Regional Administrator
Suite 2900
101 Marietta Street, NW
Atlanta, Georgia 30303

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 Number	Applicable Technical Specification
83-028/03L-0	T. S. 6.6.2.b(2)

This report has been reviewed by the Station Nuclear Safety and Operating Committee and will be reviewed by Safety Evaluation and Control.

Very truly yours,

J. L. Wilson
Station Manager

Enclosure

cc: Document Control Desk, USNRC
016 Phillips Bldg.
Washington, D. C. 20555

DESIGNATED ORIGINAL

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ATTACHMENT 1
SURRY POWER STATION, UNIT NO. 2
DOCKET NO: 50-281
REPORT NO: 83-028/03L-0
EVENT DATE: 05-23-83

TITLE OF THE EVENT: HEAT TRACING FAILURE

1. Description of the Event

With Unit No. 2 operating at 100% power, electricians investigating a Low Amp alarm on heat tracing panel 8 discovered that the amp reading for circuit 23C (Flow Transmitter from #2 Boric Acid Filter to charging pumps) was below the acceptance criteria stipulated in PT-27C. The event is contrary to Technical Specification 3.2.B.5 and is being reported in accordance with Technical Specification 6.6.2.b(2).

2. Probable Consequences and Status of Redundant Equipment

The heat tracing circuits are intended to maintain a fluid temperature above that needed for flow. The heat tracing circuits on the piping on either side of the flow transmitter remained operable. Therefore, the health and safety of the public were not affected.

3. Cause

The loss of heat tracing was caused by excessive heat.

4. Immediate Corrective Action

The immediate corrective action was to verify flow through the flow transmitter.

5. Subsequent Corrective Action

The defective heat tracing tape was replaced and tested within the time span specified by Technical Specifications.

6. Action Taken to Prevent Recurrence

No additional actions were deemed necessary.

7. Generic Implications

A task force has reviewed the total spectrum of the heat tracing system and a Design Change has been prepared as a result of the Task Force Study. The Design Change has been completed on Unit 1 CVCS. Unit 2 CVCS will be completed during the forthcoming refueling outage.