LICENSEE EVENT REPORT

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

01 | V A S P S 1 (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

CON'T 01 | REPORT SOURCE L (6) | 0 5 0 0 0 2 8 0 (7) DOCKET NUMBER | 0 4 2 9 8 2 (8) EVENT DATE | 0 5 2 8 8 2 (9) REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On April 29, 1982, with Unit 1 & Unit 2 at full power, MOP 21.3 revealed that the
03 Control Room envelope might not maintain a positive differential pressure of .05
04 inches of water. This event occurred again on April 30, May 1 and May 2, 1982.
05 This is contrary to T.S.3.19A and reportable per T.S.6.6.2.b(2). The emergency
06 ventilation system remained operable and the control room pressure envelope was
07 returned to satisfactory condition following each event, within the 24 hr. T.S.
08 limit. Therefore, the health and safety of the public were not affected.

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
09	S G (11)	E (12)	B (13)	X X X X X X (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 2	—	0 5 5	/	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
A (18)	B (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	X 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause has been attributed to leaking Control Room envelope door seals and
11 improper exterior ventilation line up which aggravated leakage through electrical
12 penetrations. The door seals were replaced and the exterior ventilation line up
13 corrected. A Special Test is being performed to inspect and upgrade as necessary
14 all electrical penetrations.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
15	E (28)	1 0 0 (29)	N/A	C (31)	Special Test

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

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
17	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
18	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
19	Z (42)	N/A

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
20	N (44)		

8206110271 820528
PDR ADOCK 05000280
S PDR

J. L. Wilson (804) 357-3184

ATTACHMENT 1
SURRY POWER STATION, UNIT NO. 1
DOCKET NO. 50-280
REPORT NO. 82-055/03L-0
EVENT DATE: 04-29-82

TITLE OF THE EVENT: Excessive Control Room Leakage

1. DESCRIPTION OF THE EVENT:

On April 29, 1982 with Unit 1 & Unit 2 at full power, MOP 21.3 (Control Room Pressure Test) was performed with unsatisfactory results. Doors to the pressure envelope were temporarily sealed and the Maintenance Operating Procedure was then satisfactorily completed. Similar events occurred again on April 30, May 1 and May 2, 1982. These events indicated that the Control Room pressure envelope might not be capable of maintaining a positive differential pressure of .05 inches of water with air supplied by the emergency bottled air system. These events are contrary to Technical Specification 3.19.A and are reportable per Technical Specification 6.6.2.b.(2).

2. PROBABLE CONSEQUENCES:

The requirement for the Control Room pressure envelope to be capable of maintaining a positive differential pressure of .05 inches of water insures that the bottled air system is sufficient to prevent any inleakage for a period of one hour following a Loss of Coolant Accident. The emergency ventilation system remained operable and the Control Room Pressure boundary was returned to satisfactory condition following each event, within the 24 hour Tech. Spec. time limit. Therefore, the health and safety of the public were not affected.

3. CAUSE:

The cause of the events has been attributed to excessive leakage through Control Room envelope fire doors and through sealed electrical penetrations between the Emergency Switchgear rooms and the cable vaults. This leakage was further aggravated by an improper ventilation line up in the cable vaults. A negative pressure was developed due to closed fire doors preventing the normal supply ventilation flow to the cable vault exhaust fans.

4. IMMEDIATE CORRECTIVE ACTION:

The emergency ventilation system was verified operational and an immediate investigation was initiated to determine the source of the leakage.

5. SUBSEQUENT CORRECTIVE ACTION:

For the April 29th and 30th event, all leaking control room doors were repaired and a satisfactory test was performed.

During the May 1 event, interim measures were taken which yielded test results that were not considered to be degrading to safety for the short term and also to demonstrate that the pressure envelope was capable of performing its intended function. However, it was also recognized at this time that the envelope still contained leakage which would have to be corrected in order for it to be considered fully acceptable.

On May 2nd, an improper ventilation line up for the cable vault was discovered and verified to be aggravating the leakage. After properly aligning the cable vault ventilation, the envelope pressure test was conducted satisfactorily.

6. ACTION TAKEN TO PREVENT RECURRENCE:

A Special Test, ST-140 (Control/Relay Room Penetration Test) has been written and is being performed to check all control room envelope penetrations to ensure air tightness and upgrade any which are discovered to be degraded. The fire doors which were inhibiting normal ventilation flow through the cable vault areas have been placed in a normally opened position with automatic closure devices. The doors have also been labeled to reflect this requirement. In addition, improved quality doors are being procured for installation in the critical envelope openings.

7. GENERIC IMPLICATIONS:

None.