

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Surry Power Station, Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 2 8 1 1	PAGE (3) 1 OF 0 3
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TITLE (4)
Isolation of Component Cooling to Operating Residual Heat Removal Loop

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 2	1 9	8 6	8 6	0 0 4	0 0	0 3	1 8	8 6			0 5 0 0 0
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 8: (Check one or more of the following) (11)											

OPERATING MODE (9) N	POWER LEVEL (10) 0 10 10	20.402(b)	20.405(a)(1)(i)	20.405(a)(1)(ii)	20.405(a)(1)(iii)	20.405(a)(1)(iv)	20.405(a)(1)(v)	20.406(c)	50.36(e)(1)	50.36(c)(2)	50.73(a)(2)(i)	50.73(a)(2)(ii)	50.73(a)(2)(iii)	50.73(a)(2)(iv)	50.73(a)(2)(v)	50.73(a)(2)(vii)	50.73(a)(2)(viii)(A)	50.73(a)(2)(viii)(B)	50.73(a)(2)(x)	73.71(b)	73.71(c)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
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LICENSEE CONTACT FOR THIS LER (12)

NAME R. F. Saunders, Station Manager	TELEPHONE NUMBER AREA CODE: 810 4 315 71-13 0 18 4
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On 2/19/86 with unit 2 at cold shutdown, operators were performing a test of the component cooling (CC) check valves in the residual heat removal (RHR) system. During this test, an operator made an incorrect valve lineup which resulted in the isolation of CC flow to the 'A' RHR heat exchanger and RHR flow to the 'B' RHR heat exchanger for approx. 10 minutes. During this period, RCS temperature and pressure were closely monitored and no abnormal increases were noted.

The operators involved in this event prepared a report describing the circumstances which led to this error and it will be placed in the operator's required reading manual. This event will also be evaluated by the Human Performance Evaluation Coordinator.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Isolation of Component Cooling to Operating Residual Heat Removal Loop

1. Description of the Event

On 2/19/86 with Unit 2 at cold shutdown and with 'A' residual heat removal (RHR) heat exchanger and 'B' RHR pump in service, operators were performing PT 41.2 (Cold Shutdown Testing of Component Cooling Check Valves). As part of the preparation to test the component cooling (CC) check valve on the 'A' CC loop to the 'A' RHR heat exchanger, operators were required to place the 'B' RHR heat exchanger in service. Due to miscommunication with the control room operator, the operator performing the valve lineup believed that the 'B' heat exchanger was already in service. In fact, the 'A' heat exchanger was in service. After the test rigs were in place, operators continued the valve lineup which included closing TV-CC-209A (CC return from 'A' RHR heat exchanger containment trip valve). This resulted in isolating CC flow to the 'A' RHR heat exchanger for a short period while the check valve was being tested.

The event was discovered when operators were preparing to test the check valve on the 'B' CC loop to RHR. It was then noted that CC flow had been isolated to the 'A' heat exchanger, and that RHR flow had been isolated to the 'B' heat exchanger. This is contrary to Technical Specification 3.1.A.d.2.

2. Safety Consequences and Implications

The RHR system is designed to remove core decay heat and control reactor coolant system (RCS) temperature and pressure when the reactor is shutdown and the RCS system is below 350°F/450#. During the short time CC was isolated to the 'A' RHR heat exchanger (approximately 10 minutes), RCS temperature and pressure were closely monitored and no abnormal increases were noted. In addition, operators performing the test would have been instructed to reopen the CC valves if the RCS temperature and pressure had significantly increased. Therefore, this event did not constitute an unreviewed safety question, and the health and safety of the public were not affected.

3. Cause

The root cause of this event was human error in that the operator failed to follow the steps in the written procedure which would have ensured the proper valve lineup. A contributing factor was poor communication between the control room operator and the operator performing the valve lineup.

4. Immediate Corrective Actions

Since CC had been fully restored to the operating heat exchanger at the time of discovery, no immediate actions were required.

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5. Additional Corrective Actions

None required.

6. Actions Taken to Prevent Recurrence

Operators involved in performance of the PT were directed to prepare a significant event report describing the circumstances surrounding this event. This report will be placed in the operations required reading manual in order to preclude a similar occurrence.

In addition, this event will be evaluated by the Human Performance Evaluation Coordinator, and a report will be submitted to station management.

7. Generic Implications

None.