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 | Licensee Code: V A S P S 1 (2) | License Number: 0 0 - 0 0 0 0 0 - 0 0 (3) | License Type: 4 1 1 1 1 (4) | CAT: (5) |

CON'T 0 1 — REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 2 8 0 (7) | EVENT DATE: 0 1 1 6 8 0 (8) | REPORT DATE: 0 1 3 0 8 0 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During power operation, a valve was inadvertently closed which prevented boric acid
0 3 flow in one of two required flow paths to the core for approximately three (3) hours.
0 4 This event is contrary to Technical Specifications 3.2.B.4, and is reportable as per
0 5 T.S. 6.6.2(a.).2. The health and safety of the general public were not affected.
0 6
0 7
0 8

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	C H (11)	A (12)	B (13)	Z Z Z Z Z Z (14)	X (15)	X (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 0	—	0 0 8	/	0 1	T	—	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)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The discharge valve (1-CH-83) from the Unit #1 boric acid filter was inadvertently closed
1 1 preventing boric acid flow to the blender, emergency borate line and recirculation
1 2 to the Boron Injection Tank. The valve was immediately opened and boric acid
1 3 flow verified.
1 4

1 5 FACILITY STATUS: E (28) | % POWER: 1 0 0 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Operations Personnel

1 6 ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

PERSONNEL EXPOSURES
1 7 NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES
1 8 NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

369

LOSS OF OR DAMAGE TO FACILITY (43)
1 9 TYPE: Z (42) | DESCRIPTION: NA

8002010010

PUBLICITY
2 0 ISSUED: N (44) | DESCRIPTION (45): NA

NRC USE ONLY

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GPO 917-926

ATTACHMENT (PAGE 1 OF 2)
SURRY POWER STATION, UNIT 1
REPORT NO: 80-008/01T-0
EVENT DATE: 1/16/80
TITLE OF REPORT: Improper Valve Lineup

1. DESCRIPTION OF EVENT:

During power operation, the discharge valve (1-CH-83) from the Unit #1 Boric Acid Filter was inadvertantly closed for approximately three hours. This prevented boric acid flow in one of two paths to the core.

This event is contrary to Technical Specification 3.2.B.4 and is reportable per Technical Specification 6.6.2.a.2.

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT SYSTEMS:

During an accident condition, the normal boric acid supply is isolated and boric acid is supplied from the Refueling Water Storage Tank. The isolated valve was discovered when operators noticed that there was no boric acid for blending to the Volume Control Tank.

Boric Acid is supplied from the Boric Acid Tanks through the Boric Acid Filter during normal plant operation and from the RWST during accident conditions. Therefore, the health and safety of the general public were not affected.

3. CAUSE:

A clerical error was made in preparing a tagging report required to perform maintenance on the Unit #2 Boric Acid System diaphram valves. The report erroneously listed 1-CH-83 to be closed and tagged instead of 2-CH-83 (discharge valve from Unit #2 Boric Acid Filter). When the actual lineup was made, the error was not discovered; hence, 1-CH-83 was closed resulting in the event.

4. IMMEDIATE CORRECTIVE ACTION:

The immediate corrective action taken was to open 1-CH-83 and to verify boric acid flow to the blender, emergency borate line, and recirculation to the Boron Injection Tank.

5. & 6. SUBSEQUENT CORRECTIVE ACTIONS & ACTION TAKEN TO PREVENT RECURRENCE:

The seriousness of this violation was stressed to the personnel involved and the event was reviewed with the entire Operations Department. To prevent incidents of this nature in the future, the following actions have been taken:

1.) A new tagging report system is now in use whereby the Shift Supervisor must review and sign the report prior to performance of the lineup.

ATTACHMENT (PAGE 2 OF 2)
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 80-008/01T-0
EVENT DATE: 1/16/80
TITLE OF REPORT: Improper Valve Lineup

5. & 6. (CONTINUED)

2.) The valves in question (1-CH-83 & 2-CH-83) will be labelled with a warning to anyone attempting to operate the valves. The warning will state that the valves must remain open during power operation of the respective unit.

3.) All Operations personnel have been lectured on the importance of reviewing a tagging report to insure all items are correct and show purpose prior to performing the lineup.

7. GENERIC IMPLICATIONS:

None.