

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | V | A | S | P | S | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 56

CONT

01 | L | 0 | 5 | 0 | 0 | 0 | 2 | 8 | 1 | 7 | 0 | 5 | 2 | 1 | 8 | 0 | 8 | 0 | 6 | 0 | 4 | 8 | 0 | 9

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

012 | During cold shutdown, with the RCS in a solid condition, PT 458 was inoperable

013 | due to a wiring problem. Subsequently, the isolation valve for PT 403 was

014 | found closed. This condition negated the Overpressure Mitigating System

015 | by eliminating the two pressure inputs of the PORV's. This event is

016 | contrary to T.S. 3.1.G.1(b) and reportable Per T.S. 6.6.2.a(2).

017 |

018 |

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

09 | S | H | 11 | A | 12 | C | 13 | I | N | S | T | R | U | 14 | T | 15 | Z | 16

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE

17 | 8 | 0 | 1 | 0 | 0 | 4 | 1 | 0 | 1 | T | 0

21 22 23 24 25 26 27 28 29 30 31 32

LER/RO REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO OCCURRENCE CODE REPORT TYPE REVISION NO.

18 | E | 19 | Z | 20 | Z | 21 | Z | 22 | 0 | 0 | 0 | 0 | 23 | Y | 24 | N | 25 | A | 26 | F | 1 | 2 | 0 | 26

33 34 35 36 37 38 39 40 41 42 43 44 45 46 47

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

110 | The narrow range pressure transmitter had been tagged out, and the tag was

111 | not cleared prior to putting PT 403 in service. The malfunction of pressure

112 | transmitter 458 was due to a cable problem. At no time during the loss of

113 | pressure signals to the PORV's was the Overpressure Mitigating System needed.

114 |

15 | G | 28 | 0 | 0 | 0 | 29 | NA | 30 | A | 31 | Operator's observation | 32

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION

16 | Z | 33 | Z | 34 | NA | 35 | NA | 36 | NA | 37

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE

17 | 0 | 0 | 0 | 37 | Z | 38 | NA | 39

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION

12 | 0 | 0 | 0 | 40 | NA | 41

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

PERSONNEL INJURIES NUMBER DESCRIPTION

19 | Z | 42 | NA | 43

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION

20 | N | 44 | NA | 45

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

PUBLICITY ISSUED DESCRIPTION

NAME OF PREPARER J. L. Wilson

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ATTACHMENT, PAGE 1
SURRY POWER STATION, UNIT 2
DOCKET NO: 050-0281
REPORT NO: 80-004/01T-0
EVENT DATE: 5-21-80

TITLE OF REPORT: OVERPRESSURE MITIGATING SYSTEM

1. DESCRIPTION OF EVENT:

With the unit at cold shutdown, solid and pressurized to 230 PSIA, PCV-456 was inoperable due to a wiring problem with the controlling pressure transmitter PT-458. T.S. 3.1.6.2(a) allows pressurized operation in this mode for up to 7 days. Subsequently, PT 403 was found isolated from system pressure, which made the Overpressure Mitigation system inoperable. A second valve line-up was performed to correct the discrepancies prior to solid plant operation. However, this second valve line-up was improperly performed, and did not identify the PT 403 isolation valve out of position. It should be noted that PT 403 did indicate some lower pressure than actual system pressure.

2. PROBABLE CONSEQUENCES OF EVENT:

The inoperability of the Overpressure Mitigating system had no effect upon the health or safety of the general public because at no time during the loss of pressure signals to the PORV's was the Overpressure Mitigating system needed.

3. CAUSE OF EVENT:

The inoperability of the Overpressure Mitigating system was due to an improper valve line-up.

4. IMMEDIATE CORRECTIVE ACTION:

The immediate corrective action taken was to open PT 403's isolation valve 2-RC-71.

5. SCHEDULED CORRECTIVE ACTION:

None

6. ACTION TAKEN TO PREVENT RECURRENCE:

The importance of proper valve line up was discussed with the operators involved. In addition, discussions were held with all shift supervisors and asst. shift supervisors relating to the importance of safe and proper plant operation. A test matrix has been prepared and issued which delineates an integrated thorough system check-out and start-up following the extended outage of Unit #2.

7. GENERIC IMPLICATIONS:

None