

UPDATE REPORT

LICENSEE EVENT REPORT

PREVIOUS REPORT DATE 03-05-80

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

0 1 V A S P S 1 2 0 0 - 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

CONT

0 1 REPORT SOURCE L 6 0 5 0 0 0 2 8 0 7 0 1 2 1 0 6 8 1 0 8 0 3 2 7 8 1 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

## EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 Unit #1 was at 100% power. Operating personnel were recirculating the accumulator  
0 3 tanks prior to obtaining samples. Valve HCV-1852A to tank 1-SI-TK-1A delayed closing  
0 4 30-50 seconds after the operator operated the control. This caused the tank to drain  
0 5 down to 45% level and reduced the pressure below 600 PSIG contrary to Tech. Spec.  
0 6 3.3.A.2. This is reportable in accordance with Tech. Spec. 6.6.2.b.2. The redundant  
0 7 accumulators were available, therefore, the safety and health of the public were not  
0 8 affected.  
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

0 9 SYSTEM CODE S F 11 CAUSE CODE E 12 CAUSE SUBCODE B 13 COMPONENT CODE V A L V E X 14 COMP. SUBCODE I 15 VALVE SUBCODE P 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

17 LER/RO REPORT NUMBER 8 0 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

18 0 1 3 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

19 X 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

20 1 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

21 Z 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

22 0 0 0 0 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

23 Y 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

24 N 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

25 N 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

26 C 6 3 5 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

## CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event is believed to be moisture in the air lines feeding the valve  
1 1 operator. Subsequent to this event, the valve has been cycled with satisfactory  
1 2 results.  
1 3  
1 4  
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

1 5 FACILITY STATUS E 28 % POWER 1 0 0 29 OTHER STATUS N/A 30 METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION Operator 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

1 6 ACTIVITY CONTENT Z 33 RELEASED OF RELEASE Z 34 AMOUNT OF ACTIVITY N/A 35 LOCATION OF RELEASE N/A 36  
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

1 7 PERSONNEL EXPOSURES NUMBER 0 0 0 37 TYPE Z 38 DESCRIPTION N/A 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

1 8 PERSONNEL INJURIES NUMBER 0 0 0 40 DESCRIPTION N/A 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION N/A 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

2 0 PUBLICITY ISSUED N 44 DESCRIPTION N/A 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

NAME OF PREPARER J. L. Wilson

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ATTACHMENT, PAGE 1 OF 1  
SURRY POWER STATION, UNIT 1  
DOCKET NO: 50-280  
REPORT NO: 80-013/03X-1  
EVENT DATE: 02-06-80

TITLE OF REPORT: ACCUMULATOR TANK 1-SI-TK-1A LEVEL AND PRESSURE OUT OF SPECIFICATION

1. DESCRIPTION OF EVENT:

Unit Number One was at a steady state condition at 100 percent power. The Operator was recirculating the accumulator tanks prior to taking samples. The Control Valve, HCV-1852A, to tank 1-SI-TK-1A, apparently stuck in the open position for 30-50 seconds after the operator set the valve to close. This allowed the tank level to drop to approximately 45 percent and the pressure to drop below 600 PSIG. Immediate steps were taken to refill and pressurize the tank. The tank was below the Technical Specifications requirements outlined in 3.3.A.2 for a period of 25 minutes. Paragraph 3.3.B.1 permits one accumulator to be isolated for period not to exceed 4 hours. This event is reportable in accordance with Technical Specification 6.6.2.b.2.

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT SYSTEMS:

The redundant accumulators were available, therefore, the health and safety of the public were not affected.

3. CAUSE:

The cause of the event is believed to be moisture in the airlines feeding the valve operator. Subsequent to this event, the valve had been cycled with satisfactory results.

4. IMMEDIATE CORRECTIVE ACTION:

The immediate corrective action was to restore the tank to Technical Specification limits.

5. SUBSEQUENT CORRECTIVE ACTION:

Since the valve has operated satisfactorily since the event, no further action is required.

6. ACTIONS TAKEN TO PREVENT RECURRENCE:

None required.

7. GENERIC IMPLICATIONS:

There are no generic implications.