7)

LICENSEE EVENT REPORT

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

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

8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

N'T

1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 8 0 (7) | 1 2 1 8 8 0 (8) | 0 1 1 5 8 1 (9)

8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

2 | With the unit at cold shutdown and defueled, it was discovered that the power leads

3 | to MOV-1867A & C had been reversed. This condition existed only after unit was

4 | shutdown. It has been concluded that this event may possibly be a lack of administra-

5 | tive control and hence reportable per T.S. 6.6.2.b.(3). The MOV's were operable when

6 | the unit was critical and these valves would have been tested during the startup

7 | testing program prior to unit startup, therefore the health and safety of the public

8 | were not affected.

8 9 80

9 | SYSTEM CODE S F (11) | CAUSE CODE X (12) | CAUSE SUBCODE X (13) | COMPONENT CODE V A L V E X (14) | COMP. SUBCODE E (15) | VALVE SUBCODE D (16)

8 9 10 11 12 13 18 19 20

(17) LER RO REPORT NUMBER | EVENT YEAR 8 0 | — | SEQUENTIAL REPORT NO. 0 7 4 | / | OCCURRENCE CODE 0 3 | REPORT TYPE L | — | REVISION NO. 0

21 22 23 24 26 27 28 29 30 31 32

ACTION TAKEN B (18) | FUTURE ACTION Z (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS 0 0 0 0 (22) | ATTACHMENT SUBMITTED Y (23) | NPRD-4 FORM SUB. N (24) | PRIME COMP. SUPPLIER A (25) | COMPONENT MANUFACTURER D 0 2 0 (26)

33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

0 | A review of the construction and maintenance activities in the surrounding area has not

1 | revealed a reason why the power leads were reversed. The extent of major modification

2 | and construction work in progress percludes a thorough review of all documentation. The

3 | power leads were returned to a normal condition and the valves tested.

4 |

8 9 80

5 | FACILITY STATUS B (28) | % POWER 0 0 0 (29) | OTHER STATUS (30) Extended Outage | METHOD OF DISCOVERY B (31) | DISCOVERY DESCRIPTION (32) Routine Test.

8 9 10 12 13 44 45 46 80

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

8 9 10 11 44 45 80

7 | PERSONNEL EXPOSURES NUMBER 0 0 0 (37) | TYPE Z (38) | DESCRIPTION (39) N/A

8 9 11 12 13 80

8 | PERSONNEL INJURIES NUMBER 0 0 0 (40) | DESCRIPTION (41) N/A

8 9 12 80

9 | LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) | DESCRIPTION (43) N/A

8 9 10 80

0 | PUBLICITY ISSUED N (44) | DESCRIPTION (45) N/A | NRC USE ONLY

8 9 68 69 80

NAME OF PREPARER 8101200348 PHONE

GPO 917-976

ATTACHMENT: 1
SURRY POWER STATION UNIT 1
DOCKET NO: 50-280
REPORT NO: 80-074/03L-0
EVENT DATE: 12-18-80

MOV-1867A & C MALFUNCTION

1. EVENT DESCRIPTION:

With Unit 1 at cold shutdown and defueled, the electrical preventative maintenance procedure for motor operated valves, demonstrated that MOV-1867 A and C (BIT inlet and outlet) stroked in the wrong direction. If this condition had existed when the unit was critical, it would have been a degraded mode of operation.
The extent of the major modification and construction work in progress precludes a through review of all documentation, thus this event is being reported as a possible lack of administrative control in accordance with Technical Specification 6.6.2.b(3).

2. PROBABLE CONSEQUENCES and STATUS OF REDUNDANT EQUIPMENT:

The Boron Injection Tank (BIT) inlet and outlet valves open upon receipt of a Safety Injection signal to inject the tank's contents into the Reactor Coolant System (RCS). Both pairs of inlet and outlet valves were verified operable prior to unit startup on 4-27-80 using PT-18.10.
On 9-14-80, the unit was shutdown to replace the steam generators and to perform other major modifications & construction work. When the unit was shutdown, the BIT was injected into RCS to borate the RCS and to prepare the BIT for long term layup. At this time, the BIT inlet and outlet valves were operable. Therefore, the BIT would have performed it's intended function, if required, between 4-27-80 and 9-14-80. It should be noted that Technical Specification does not require the BIT to be operable when the reactor is shutdown.

As stated above, Unit No.1 is currently undergoing extensive modifications to many systems. Although these valves are not scheduled to be affected by construction activities, they are located in an area where systems and/or components are being disassembled, modified, installed, etc. At the end of the current unit outage, a detailed and broad startup testing program on a component and system level will be conducted.
In addition to those systems and components that were affected by construction and maintenance activities, systems and components that may have been affected will also be covered by the startup testing program. A similar testing program was utilized during thestartup of Unit No.2 following the replacement of the steam generators. PT-18.2 "Safety Injection Functional Testing", which functionally test the BIT inlet and outlet valves, is normally performed at the beginning of a 30 day refueling outage. However, due to the scope and duration of the current outage, this PT has been intentionally scheduled at the end of the outage. Thus it will verify that the Safety Injection system is functional prior to startup.

Since the BIT Valves were operable when the reactor was critical and

Previously scheduled administrative control program (startup testing) will be implemented, the health and safety of the public were not affected.

3. CAUSE:

A review of the construction and maintenance activities in the surrounding area has not revealed a reason why the power leads were reversed. The extent of major modification and construction work in progress precludes a thorough review of all documentation. The power leads were returned to a normal condition. The power leads were returned to a normal condition and the valves tested.

4. IMMEDIATE CORRECTIVE ACTION:

Initiate actions to return the affected MOV's to an operable condition.

5. SUBSEQUENT CORRECTIVE ACTION:

The MOV's were verified operable and will be again verified operable prior to startup.

6. ACTION TAKEN TO PREVENT RECURRENCE:

Other than the scheduled startup testing program, no additional actions are deemed necessary.

7. GENERIC IMPLICATIONS:

None.