10CFR50.73

Virginia Electric and Power Company
Surry Power Station
P. O. Box 315
Surry, Virginia 23883

June 3, 1992

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D. C. 20555

Serial No.: 92-351
SPS:RJS
Docket No.: 50-280
License No.: DPR-32

Dear Sirs:

Pursuant to Surry Power Station Technical Specifications, Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to Surry Power Station Unit 1.

REPORT NUMBER

50-280/92-007-00

This report has been reviewed by the Station Nuclear Safety and Operating Committee and will be forwarded to the Management Safety Review Committee for its review.

Very truly yours,

M. R. Kansler
Station Manager

Enclosure

cc: Regional Administrator
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

M. W. Branch
NRC Senior Resident Inspector
Surry Power Station

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NRC FORM 366 (6-89) | U.S. NUCLEAR REGULATORY COMMISSION | APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Surry Power Station, Unit 1	0 5 0 0 0 2 8 0	1 OF 0 3

TITLE (4) Unit 1 Reactor Trip/Turbine Trip Due To Contract Personnel Performing Unauthorized Turbine Maintenance

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 5	0 7	9 2	9 2	- 0 0 7	- 0 0	0 6	0 3	9 2		0 5 0 0 0
										DOCKET NUMBER(S) 0 5 0 0 0

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 7 8	20.402(b)	20.405(c)	[X] 50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
M. R. Kansler, Station Manager	AREA CODE 8 0 4 3 5 7 - 3 1 8 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
[ ] YES (If yes, complete EXPECTED SUBMISSION DATE)	[X] NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On May 7, 1992 at 1006 hours with Unit 1 at 78% power and Unit 2 at 100% power, a Unit 1 Reactor Trip by Turbine Trip occurred. The trip was caused when contract maintenance personnel were attempting to stop a body to bonnet oil leak on the thrust bearing trip test valve. When the bonnet of the test valve was loosened, the valve disc was lifted off its seat. This allowed oil pressure to simulate a thrust bearing high pressure, which initiated a turbine trip. The reactor then tripped due to turbine trip. Operators performed the appropriate emergency plant procedures and quickly stabilized the unit. All safety systems functioned as designed following the trip, therefore, the health and safety of the public were not affected. Maintenance activities being performed by turbine contract maintenance personnel were halted and personnel involved were instructed to leave the site. A Root Cause Evaluation and a vendor investigation were initiated to propose corrective actions to prevent recurrence. Proposed corrective actions will be reviewed by mangement and appropriate work control measures implemented to prevent recurrence, prior to the vendor performing future maintenance activities.

1.0 DESCRIPTION OF THE EVENT

On May 7, 1992 at 1006 hours with Unit 1 at 78% power and Unit 2 at 100% power, a Unit 1 Reactor Trip by Turbine Trip occurred. The trip was caused when contract maintenance personnel were attempting to stop a body to bonnet oil leak on the thrust bearing trip test valve [EIIS-TG,TV]. When the bonnet of the test valve was loosened, the valve disc was lifted off its seat. This allowed oil pressure to simulate a thrust bearing high oil pressure, which initiated a turbine trip. The reactor tripped due to turbine trip. Operators performed the appropriate emergency plant procedures and quickly stabilized the unit. All safety systems functioned as designed following the trip. A four hour non-emergency report was made to the Nuclear Regulatory Commission in accordance with 10 CFR 50.72.

This event is being reported pursuant to 10 CFR 50.73(a)(2)(iv).

2.0 SIGNIFICANT SAFETY CONSEQUENCES AND IMPLICATIONS

During the event, the turbine protection and reactor protection systems functioned as designed, therefore, the health and safety of the public were not affected.

3.0 CAUSE OF THE EVENT

This event was caused by personnel error. Contract maintenance personnel attempting to repair the oil leak had not been authorized by Operations to perform this work. A cognitive personnel error regarding valve construction was also made in assuming that the valve bonnet could be loosened sufficiently to repair the leak without lifting the valve disc off its seat.

4.0 IMMEDIATE CORRECTIVE ACTION(S)

Operators performed the appropriate emergency plant procedures and quickly stabilized the unit following the trip. Also, the Shift Technical Advisor monitored the critical safety function status trees to ensure specific plant parameters were noted and remained within safe bounds.

5.0 ADDITIONAL CORRECTIVE ACTION(S)

Maintenance activities being performed by the contract turbine maintenance group were halted. The oil leakage was corrected by properly torquing the valve bonnet and the unit was restarted following a restart assessment. Following debriefing, the contract maintenance personnel involved in this event

were instructed to leave the site.

6.0 ACTIONS TO PREVENT RECURRENCE

A Root Cause Evaluation was initiated to determine the circumstances surrounding the unauthorized maintenance activity, verify the root cause of the event, and propose corrective actions to prevent recurrence. Station management directed the vendor to perform their own investigation of this event and propose corrective actions to prevent recurrence. The recommendations of the Root Cause Evaluation and the vendor investigation will be reviewed by management and appropriate work control measures implemented to prevent recurrence, prior to the vendor performing future maintenance activities.

7.0 SIMILAR EVENTS

None.

8.0 ADDITIONAL INFORMATION

None.