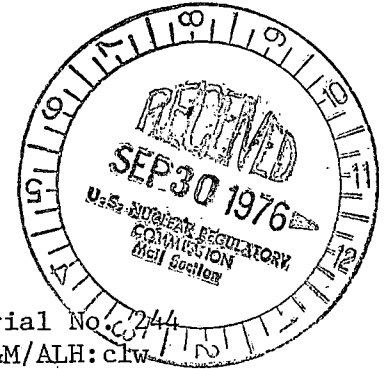


VIRGINIA ELECTRIC AND POWER COMPANY  
RICHMOND, VIRGINIA 23261

September 17, 1976



Mr. Norman C. Moseley, Director  
Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
Region II - Suite 818  
230 Peachtree Street, Northwest  
Atlanta, Georgia 30303

Serial No. 244  
PO&M/ALH:clw

Docket No. 50-281  
License No. DPR-37

Dear Mr. Moseley:

Pursuant to Surry Power Station Technical Specification 6.6.2, the Virginia Electric and Power Company hereby submits a copy of Reportable Occurrence No. USRE-S2-76-13.

The substance of this report has been reviewed by the Station Nuclear Safety and Operating Committee and will be placed on the agenda for the next meeting of the System Nuclear Safety and Operating Committee.

Very truly yours,

*C. M. Stallings*

C. M. Stallings  
Vice President-Power Supply  
and Production Operations

Enclosure

cc: Mr. Robert W. Reid, Chief  
Operating Reactors Branch 4  
(40 copies USRE-S2-76-13)

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# LICENSEE EVENT REPORT

USRE-S2-76-13

CONTROL BLOCK: 

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(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME						LICENSE NUMBER						LICENSE TYPE				EVENT TYPE									
01	V	A	S	P	S	2	0	0	-	0	0	0	0	0	-	0	0	4	1	1	1	0	0	3	
7	8	9			14	15					25	26											31	32	
CATEGORY		REPORT TYPE		REPORT SOURCE		DOCKET NUMBER						EVENT DATE				REPORT DATE									
01	CON'T	M	I	L	L	0	5	0	-	0	2	8	1	0	8	2	0	7	6	0	9	1	5	7	6
7	8	57	58	59	60	61						68	69											75	80

## EVENT DESCRIPTION

02 Preparation for routine recirculation of safety injection accumulator "B" revealed  
03 that the outside isolation valve (2-SI-73) in the accumulator test line was open.  
04 The valve is normally closed and administratively locked making this occurrence re-  
05 portable as per Technical Specification 6.6.2.A(3). The redundant valves were found  
06 closed thus providing containment integrity. The immediate action taken was to (con't)

SYSTEM CODE		CAUSE CODE		COMPONENT CODE				PRIME COMPONENT SUPPLIER		COMPONENT MANUFACTURER			VIOLATION		
07	S	F	A	V	A	L	V	E	X	N	R	3	4	0	N
7	8	9	10	11	12				17	43	44			47	48

## CAUSE DESCRIPTION

08 Inadequacy in the implementation of administrative controls caused a reduction of  
09 degree of redundancy in the containment isolation system. This valve (2-SI-73) is  
10 periodically opened and closed in conjunction with inside containment isolation (con't)

FACILITY STATUS		% POWER			OTHER STATUS			METHOD OF DISCOVERY		DISCOVERY DESCRIPTION			
11	E	1	0	0	N/A			B	N/A				
7	8	9	10	12	13			44	45	46			80
FORM OF ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY				LOCATION OF RELEASE					
12	Z	Z	N/A					N/A					
7	8	9	10	11				44	45				80

## PERSONNEL EXPOSURES

NUMBER		TYPE		DESCRIPTION	
13	0	0	Z	N/A	
7	8	9	11	12	13

## PERSONNEL INJURIES

NUMBER		DESCRIPTION		
14	0	0	N/A	
7	8	9	11	12

## OFFSITE CONSEQUENCES

15 N/A

## LOSS OR DAMAGE TO FACILITY

TYPE		DESCRIPTION	
16	Z	N/A	
7	8	9	10

## PUBLICITY

17 N/A

## ADDITIONAL FACTORS

18 The health and safety of the general public was not affected by this occurrence be-  
19 cause redundant valves were closed and provided containment integrity as required.

NAME: Tyndall L. Baucom

PHONE: (804) 357-3184

EVENT DESCRIPTION (con't)

recirculate the accumulator and then close and lock valve 2-SI-73. (USRE-S2-76-13)

CAUSE DESCRIPTION (con't)

valves for recirculation of all three (3) accumulators. The failure to lock shut administratively controlled valves has not been a recurring failure in the past; however, appropriate station personnel have been reinstructed in this matter.

U.S. A.E.C.  
REGULATORY OPERATIONS  
REGION III  
ATLANTA, GA.

SEP 20 11 26 AM '76