

LICENSEE EVENT REPORT

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

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

LICENSEE CODE 14 LICENSE NUMBER 25 LICENSE TYPE 30 CAT 56

011 | L | 6 | 0 | 5 | 0 | 0 | 0 | 2 | 8 | 0 | 7 | 1 | 0 | 2 | 7 | 8 | 1 | 3 | 1 | 1 | 2 | 5 | 8 | 1 | 9

REPORT SOURCE 50 DOCKET NUMBER 56 EVENT DATE 74 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

012 | With the unit at 100% power, it was discovered that a Technical Review had not been

013 | initiated on a completed Design Change Package which had relocated portions of the

014 | yard firemain piping. This is considered reportable per T.S.6.6.2.b.(3). Station

015 | periodic testing proved the fire suppression water system capable of performing its

016 | design function; therefore, the health and safety of the public were not affected.

019 | SYSTEM CODE: A B 11 CAUSE CODE: A 12 CAUSE SUB CODE: X 13 COMPONENT CODE: Z Z Z Z Z Z 14 COMP SUBCODE: Z 15 VALVE SUBCODE: Z 16

17 | LER/RO REPORT NUMBER: 81 EVENT YEAR: 81 SEQUENTIAL REPORT NO.: 066 OCCURRENCE CODE: 03 REPORT TYPE: L REVISION NO.: 0

ACTION TAKEN: X 18 FUTURE ACTION: X 19 EFFECT ON PLANT: Z 20 SHUTDOWN METHOD: Z 21 HOURS: 0000 ATTACHMENT SUBMITTED: Y 22 NPRO-4 FORM SUB.: N 24 PRIME COMP SUPPLIER: Z 25 COMPONENT MANUFACTURER: Z 9 9 9 25

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

110 | The cause of the event was an administrative error on the part of the project engineer.

111 | By not initiating a Technical Review, no station drawings or procedures were annotated

112 | to include the DCP scope of work. Upon discovery of the error, the documents were

113 | updated.

115 | FACILITY STATUS: E 28 % POWER: 100 29 OTHER STATUS: N/A 30 METHOD OF DISCOVERY: A 31 DISCOVERY DESCRIPTION: Review of DCP 32

ACTIVITY RELEASED: Z 33 CONTENT: Z 34 AMOUNT OF ACTIVITY: N/A 35 LOCATION OF RELEASE: N/A 36

117 | PERSONNEL EXPOSURES: NUMBER: 0 0 0 37 TYPE: Z 38 DESCRIPTION: N/A 39

118 | PERSONNEL INJURIES: NUMBER: 0 0 0 40 DESCRIPTION: N/A 41

119 | LOSS OF OR DAMAGE TO FACILITY: TYPE: Z 42 DESCRIPTION: N/A 43

120 | PUBLICITY ISSUED: N 44 DESCRIPTION: 8112010400 811125 PDR ADDCK 05000280 PDR S N/A 45

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ATTACHMENT 1
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 81-066/03L-0
EVENT DATE: 10-27-81

TITLE OF THE EVENT: RELOCATED FIRE PROTECTION PIPING

1. DESCRIPTION OF EVENT:

On October 27, 1981, with the unit at 100% power, it was discovered that the fire main piping, valves, and hose station moved during the implementation of Design Change Package 81-18 had not had their new locations noted on station procedures and drawings. The annotation of applicable station documents following the implementation of a DCP is accomplished through the completion of a Technical Review. No Technical Review had been initiated following the completion of the construction work for the DCP (on or about 7-29-81) and, therefore, no documents had been annotated. In accordance with Section 3 of Vepco Nuclear Power Station Quality Assurance Manual, a Technical Review must be performed before a system affected by a DCP can be considered operable. Since the Technical Review had not been completed, the event is considered reportable per Technical Specification 6.6.2.b.(3).

2. PROBABLE CONSEQUENCES of OCCURRENCE:

Quarterly periodic test, PT-24.1A, is used to verify the operability of the fire main post indicator valves and yard hydrant valves. This PT was satisfactorily performed on 6-21-81 and 9-22-81. Semi-annual Periodic test, PT-24.9, is used to verify that the fire main loop is un-obstructed and clear. This PT was satisfactorily performed on 10-15-81. Weekly periodic test, PT 24.7, is used to drain critical lines, to check valve positions, and to inspect all outside post indicator valves, hydrants, and fuel building stop valves. This PT was satisfactorily performed 7-21-81, and every subsequent week up to the date of the event. For these reasons, it has been determined that the water suppression system was capable of performing its design function; therefore, the health and safety of the public were not affected.

3. CAUSE OF THE EVENT:

The cause of the event was a loss of administrative control of the documents required to complete the DCP and incorporate the modifications into the station records and procedures. The Project Engineer failed to initiate a Technical Review in accordance with the requirements of the Nuclear Power Station Quality Assurance Manual.

4. IMMEDIATE CORRECTIVE ACTION:

The immediate corrective actions were to update the station drawings and issue copies to the Operations Department for the correction of applicable procedures.

5. SUBSEQUENT CORRECTIVE ACTIONS:

The subsequent corrective action was to notify the Project Engineer and request that a Technical Review be initiated.

6. ACTIONS TAKEN TO PREVENT RECURRENCE:

As this was an isolated event, and the proper policies and procedures are contained in the Vepco Nuclear Power Station Quality Assurance Manual, no further action is deemed necessary.

7. GENERIC IMPLICATIONS:

None.