NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
01	Licensee Code (2)	V A S P S 1
01	License Number (3)	0 0 - 0 0 0 0 0 - 0 0
01	License Type (4)	4 1 1 1 1
01	CAT (5)	
01 CON'T	Report Source (6)	L
01	Docket Number (7)	0 5 0 0 0 2 8 0
01	Event Date (8)	0 6 2 0 8 2
01	Report Date (9)	0 7 1 4 8 2

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 With Unit 1 at 100%, "A" S.I. Accumulator was inadvertently drained to a level
03 below the T.S.minimum while "B" S.I. Accumulator's discharge valve was in the
04 closed position for surveillance testing. This is contrary to T.S.3.3.A.2 and is
05 reportable per T.S.6.6.2.b(2). The "C" S.I. accumulator remained available and
06 an operator had administrative control over the "B" S.I. accumulator discharge
07 valve. All other S.I. systems remained operable. Therefore, the health and
08 safety of the public were not affected.

09	System Code (11)	Cause Code (12)	Cause Subcode (13)	Component Code (14)	Comp. Subcode (15)	Valve Subcode (16)
	S F	A	A	V A L V E X	F	X

(17) LER/RO Report Number

Event Year		Sequential Report No.		Occurrence Code	Report Type		Revision No.
8 2	—	0 7 2	/	0 3	L	—	0

Action Taken (18)	Future Action (19)	Effect on Plant (20)	Shutdown Method (21)	Hours (22)	Attachment Submitted (23)	NPRD-4 Form Sub. (24)	Prime Comp. Supplier (25)	Component Manufacturer (26)
X	Z	Z	Z	0 0 0 0	Y	N	A	C 6 3 5

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The draining of the "A" S.I. Accumulator was due to an operator opening a test
11 valve on the accumulator discharge line. The "B" S.I. accumulator discharge
12 valve was opened and the "A" S.I. accumulator level was returned to the require-
13 ments of the Tech. Spec.
14

15	Facility Status (28)	% Power (29)	Other Status (30)	Method of Discovery (31)	Discovery Description (32)
	E	1 0 0	N/A	A	Operator Observation.

16	Activity Released (33)	Content of Release (34)	Amount of Activity (35)	Location of Release (36)
	Z	Z	N/A	N/A

PERSONNEL EXPOSURES

17	Number (37)	Type (38)	Description (39)
	0 0 0	Z	N/A

PERSONNEL INJURIES

18	Number (40)	Description (41)
	0 0 0	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

19	Type (42)	Description
	Z	N/A

8207230289 820714
PDR ADOCK 05000280
S PDR

PUBLICITY

20	Issued (44)	Description (45)	NRC USE ONLY
	N		

NAME OF PREPARER J. L. Wilson PHONE (804) 357-3184

ATTACHMENT 1
SURRY POWER STATION, UNIT NO. 1
DOCKET NO: 50-280
REPORT NO: 82-072/03L-0
EVENT DATE: 06-20-82

TITLE OF EVENT: "A" S.I. Accumulator Level Below T.S. Limit with "B" S.I. Acc. Discharge Valve Closed

1. DESCRIPTION OF EVENT:

With Unit 1 at 100% power, during the performance of P.T. 18.5 (Flushing of Sensitized Stainless Steel Piping), "A" Safety Injection Accumulator was inadvertantly drained to a level below the Tech. Spec. minimum. Also, at this time, "B" S.I. Accumulator discharge valve (MOV-1865B) was under administrative control, in the closed position, to facilitate performance of PT 18.5. This is contrary to Tech. Spec. 3.3.A.2 and is reportable per Tech. Spec. 6.6.2.b(2).

2. PROBABLE CONSEQUENCES and STATUS of REDUNDANT EQUIPMENT:

The "C" S.I. accumulator remained available during the event. An operator had administrative control over the "B" S.I. Accumulator discharge valve and immediately opened the valve after the discovery of the event. Also, the "B" accumulator discharge valve would have automatically opened on a safety injection signal. The "A" S.I. Accumulator level was returned to the Tech. Spec. requirements well within the four hour Tech. Spec. limit and all other Safety Injection Systems were available during the event. Therefore, the health and safety of the public were not affected.

3. CAUSE:

The cause of the event was due to an operator opening the wrong test valve during the performance of the P.T. This action may have been enhanced by the arrangement of the accumulator test valve switches on the control board.

4. IMMEDIATE CORRECTIVE ACTION:

The "A" accumulator test valve, HCV-1850B, was closed and the "B" accumulator discharge valve, MOV-1865B, was opened. Also, the "A" accumulator was refilled to its proper level.

5. SUBSEQUENT CORRECTIVE ACTION:

The arrangement of the accumulator test valve switches will be incorporated into the NUREG 0700 review process.

6. ACTION TAKEN TO PREVENT RECURRENCE:

The operator involved was disciplined and reinstructed on the importance of following procedures.

7. GENERIC IMPLICATIONS:

None.