7-77)

LICENSEE EVENT REPORT

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

0 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)
LICENSEE CODE 9–14 | LICENSE NUMBER 15–25 | LICENSE TYPE 26–30 | CAT 57–58

CON'T
0 1 | REPORT SOURCE L (6) 0 5 0 0 0 2 8 0 (7) 0 2 1 1 8 3 (8) 0 3 0 4 8 3 (9)
REPORT SOURCE 60 | DOCKET NUMBER 61–68 | EVENT DATE 69–74 | REPORT DATE 75–80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | With the unit at cold shutdown during an investigation of a PCV-1455C malfunction,
0 3 | it was found that the instrument air check valve to the PORV was installed backwards.
0 4 | This event is contrary to T.S.-3.1.G.1.b.(3).and is reportable per T.S.-6.6.2.b(2).
0 5 | The emergency air bottles for the PORV remained operable to supply the motive force
0 6 | for the valve, therefore the health and safety of the public remained unaffected.
0 7 |
0 8 |

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	P A (11)	B (12)	C (13)	V A L V E X (14)	C (15)	A (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 3	—	0 1 1	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	L (25)	C 6 8 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The check valve was backwards in the line due to an installation error during
1 1 | implementation of Design Change 79-53. The valve was removed and reinstalled in the
1 2 | correct orientation.
1 3 |
1 4 |

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	G (28)	0 0 0 (29)	N/A	A (31)	PCV-1455C Investigation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	N/A	N/A

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	N/A

8303160211 830304
PDR ADOCK 05000280
S PDR

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	N/A	

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

ATTACHMENT 1
SURRY POWER STATION, UNIT NO. 1
DOCKET NO: 50-280
REPORT NO: 83-011/03L-0
EVENT DATE: 02-11-83

TITLE OF THE EVENT: PCV-1455C INOPERABLE

1. Description of the Event

With the unit at cold shutdown during an investigation of the inoperability of PCV-1455C (Pressurizer PORV) it was found that the check valve in the instrument air line to the PORV was in backwards. This event is contrary to T.S.-3.1.G.1.b.3 and is reportable per T.S.-6.6.2.b.(2).

2. Probable Consequences and Status of Redundant Equipment

Air supplied through the instrument air line for PCV-1455C provides the normal motive force to open the PORV. The emergency air bottles for the PORV remained available to open the PORV, therefore the health and safety of the public were not jeopardized.

3. Cause

The check valve was installed backwards during implementation of design change 79-53 due to personnel error. Failure to find the error during final design testing was due to loss of administrative control in that the final design testing procedure for unit 1 was not sufficient to find the problem.

4. Immediate Corrective Action

The check valve was removed from the line and reinstalled in the correct orientation.

5. Subsequent Corrective Action

None scheduled.

6. Action Taken to Prevent Recurrence

No further action is required. Design Change Program Modifications over the past three years have strengthened controls over plant design modifications.

7. Generic Implications

The unit 2 check valve was verified to be properly installed, there are therefore, no generic implications of this event.