

LICENSEE EVENT REPORT

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

LICENSEE CODE: VASPS2; LICENSE NUMBER: 200-000000-000; LICENSE TYPE: 41111; CAT 58: 4

REPORT SOURCE: L; DOCKET NUMBER: 605000281; EVENT DATE: 092678; REPORT DATE: 101778

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

During steady state power operation, circulating water outlet valve MOV-CW-200D failed to close when operated electrically. This is reportable pursuant to Technical Specification 6.6.2.b.(2).

SYSTEM CODE: WA; CAUSE CODE: X; CAUSE SUBCODE: X; COMPONENT CODE: VALVOP; COMP. SUBCODE: J; VALVE SUBCODE: G; LER/RO REPORT NUMBER: 78; EVENT YEAR: 78; SEQUENTIAL REPORT NO.: 033; OCCURRENCE CODE: 03; REPORT TYPE: L; REVISION NO.: 0; ACTION TAKEN: F; FUTURE ACTION: F; EFFECT ON PLANT: Z; SHUTDOWN METHOD: Z; HOURS: 0000; ATTACHMENT SUBMITTED: Y; NPRD-4 FORM SUB.: Y; PRIME COMP. SUPPLIER: A; COMPONENT MANUFACTURER: L200

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

The actuator cam for the "shut" torque switch became wedged against a torque switch hold down screw. Corrective action was to modify the hold down screw locking hardware to increase clearance between the screw head and the actuator cam.

FACILITY STATUS: E; % POWER: 100; OTHER STATUS: NA; METHOD OF DISCOVERY: B; DISCOVERY DESCRIPTION: NA; ACTIVITY CONTENT RELEASED OF RELEASE: Z; AMOUNT OF ACTIVITY: NA; LOCATION OF RELEASE: NA; PERSONNEL EXPOSURES: 000; PERSONNEL INJURIES: 000; LOSS OF OR DAMAGE TO FACILITY: Z; PUBLICITY ISSUED: Z

NAME OF PREPARER: T. L. Baucom; PHONE: (804) 357-3184

7810200112

Surry Power Station, Unit 2
Docket No: 50-281
Report No: 78-033/03L-0
Event Date: 9-26-78

Failure of Circulating Water Outlet Valve MOV-CW-200D

1. Description of Event:

During steady state power operation, circulating water outlet valve MOV-CW-200D failed to operate electrically. This is reportable pursuant to Technical Specification 6.6.2.b.(2).

2. Probable Consequences and Status of Redundant Systems:

The corresponding inlet valve, MOV-CW-206D, was fully operable, providing full redundancy. In addition, MOV-CW-200D was operable in the manual mode. The health and safety of the general public were therefore not affected.

3. Cause:

Sometime prior to this event, MOV-CW-200D was manually closed to assure leak tight closure. Manual closure of this valve causes the torque switch actuator cam to travel farther than when operated electrically. This additional cam travel caused the torque switch cam to wedge against the torque switch hold down screw. This situation did not interfere with the remote opening signal to the valve, but, remote closure circuit was interrupted because of the wedged position of the switch.

4. Immediate Corrective Action:

An operator was immediately assigned for administrative control of MOV-CW-200D and it was closed manually.

5. Subsequent Corrective Action:

The torque switch hold down screw lock washer was removed to provide a clearance between the actual cam and the hold down screw, allowing full cam movement without interference. All other circulating water valve operators were inspected and found to have adequate clearance.

6. Action Taken to Prevent Recurrence:

Action has been taken to modify the hold down screw to provide adequate clearance.

7. Generic Implications:

None