



VIRGINIA ELECTRIC AND POWER COMPANY
Surry Power Station
P. O. Box 315
Surry, Virginia 23883

JUN 6 1980

Serial No. 008

Docket Nos: 50-281

License Nos: DPR-37

Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

Pursuant to Surry Power Station Technical Specifications, the Virginia Electric and Power Company hereby submits the following Licensee Event Reports for Surry Unit 2.

<u>Report No.</u>	<u>Applicable Technical Specification</u>
80-003/03L-0	3.14.A.1
80-005/01T-0	6.6.2.a.9

These reports have 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,

J. L. Wilson
Station Manager

Enclosures

cc: Mr. Victor Stello, Director (3)
Office of Inspection and Enforcement

Mr. Norman Haller, Director (3)
Office of Management and Program Analysis

US NRC
c/o Document Management Branch
Washington, D. C.

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ATTACHMENT, PAGE 1 OF 1
SURRY POWER STATION, UNIT 2
DOCKET NO: 50-281
REPORT NO: 80-003/03L-0
EVENT DATE: 5-14-80

TITLE OF EVENT: MOV-CW-200B INOPERATIVE

1. DESCRIPTION OF EVENT:

With the unit at cold shutdown, MOV-CW-200B was under mechanical repair to adjust the limitorque. While in this condition, an attempt was made to close the valve electrically. MOV-CW-200B would not operate electrically. This event is non-conservative with respect to T.S. 3.14.A.1 and reportable per Technical Specification 6.6.2.b.2.

2. PROBABLE CONSEQUENCES OF EVENT:

The inoperability of MOV-CW-200B had no effect upon the health or safety of the general public because the intake canal level was controlled by closing water box inlet valve (MOV-CW-206B). The automatic safety related function of the redundant valve was operable.

3. CAUSE OF EVENT:

While MOV-CW-200B was under repair to adjust the limitorque, it was found not to cycle electrically. When mechanical adjustments were near completion, the valve was checked electrically and found to cycle correctly. The electrical malfunction of MOV-CW-200B was attributed to the mechanical repair in progress.

4. IMMEDIATE CORRECTIVE ACTIONS:

The immediate corrective action was to shut the water box inlet valve MOV-CW-206B.

5. SCHEDULED CORRECTIVE ACTION:

The scheduled corrective action was to complete the mechanical repair and verify electrical operability of the circulating water valve.

6. ACTION TAKEN TO PREVENT RECURRENCE:

None

7. GENERIC IMPLICATIONS

None