VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

March 18, 1977

Mr. Norman C. Moseley, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Region II - Suite 818
230 Peachtree Street, Northwest
Atlanta, Ga. 30303

Serial No. 110
PO&M/TAP:dgt

Docket No. 50-280
License No. DPR-32

Dear Mr. Moseley:

Pursuant to Surry Power Station Technical Specification 6.6.2, the Virginia Electric and Power Company hereby submits a copy of Reportable Occurrence No. RO-S1-77-09.

The substance of this report has 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,

C. M. Stallings
Vice President-Power Supply
and Production Operations

Enclosures
40 Copies RO-S1-77-09

cc: Mr. Robert W. Reid, Chief
Operating Reactors Branch 4

CONTROL BLOCK: [ ] (1–6)

(PLEASE PRINT ALL REQUIRED INFORMATION)

	LICENSEE NAME	LICENSE NUMBER	LICENSE TYPE	EVENT TYPE
01	VASP S 1 (7–8, 9–14)	00–00000–00 (15–25)	4 1 1 1 0 (26–30)	0 3 (31–32)

	CATEGORY	REPORT TYPE	REPORT SOURCE	DOCKET NUMBER	EVENT DATE	REPORT DATE
01 CON'T	P 0 (57–58)	L (59)	L (60)	0 5 0–0 2 8 0 (61–68)	0 2 1 9 7 7 (69–74)	0 3 1 8 7 7 (75–80)

EVENT DESCRIPTION

02 During normal operation, it was noted that the valve position indicating lights were
03 extinguished for chemical addition tank discharge valve MOV-CS-102A. Subsequent in-
04 vestigation revealed the motor breaker had tripped from a thermal overload, rendering
05 the valve inoperable. The redundant valve was operable. This is the first reported
06 failure of this type. This event is contrary to Technical Specification (Continued)

	SYSTEM CODE	CAUSE CODE	COMPONENT CODE	PRIME COMPONENT SUPPLIER	COMPONENT MANUFACTURER	VIOLATION
07	S A (10)	A (11)	V A L V O P (12–17)	A (43)	L 2 0 0 (44–47)	Y (48)

CAUSE DESCRIPTION

08 The torque switch in the valve operator would not de-energize the motor as required on
09 a valve closing cycle, thus causing the breaker to trip from a thermal overload after
10 closing. The switch had been wired incorrectly during maintenance performed (Con't)

	FACILITY STATUS	% POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION
11	E (9)	1 0 0 (10–12)	NA (13–44)	A (45)	NA (46–80)

	FORM OF ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY	LOCATION OF RELEASE
12	Z (9)	Z (10)	NA (11–44)	NA (45–80)

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION
13	0 0 0 (9–11)	Z (12)	NA (13–80)

PERSONNEL INJURIES

	NUMBER	DESCRIPTION
14	0 0 0 (9–11)	NA (12–80)

OFFSITE CONSEQUENCES

15 NA

LOSS OR DAMAGE TO FACILITY

	TYPE	DESCRIPTION
16	E (9)	NA (10–80)

PUBLICITY

17 NA

ADDITIONAL FACTORS

18 The health and safety of the public were not affected by this event because a re-
19 dundant valve would have provided chemical addition had it been necessary.

NAME: T. L. Baucom PHONE: 357-3184

GPO 881-667

EVENT DESCRIPTION (CONTINUED)

3.4.A.5 and is reportable under Technical Specification 6.6.2.b(2). (RO-S1-77-09)

CAUSE DESCRIPTION (CONTINUED)

in the latter stages of Cycle IV Refueling.

Valve operability was satisfactorily proven with Monthly Periodic Test 19.1 when performed in February. Routine control board checks following the performance test detected the loss of valve position indication.

The maintenance procedure involved has been revised to improve the post maintenance test procedure and the control board valve position indicating lights will be scanned daily to verify their operability.

The valve operator was manufactured by the Limitorque Corp., Type SMB-000.