

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

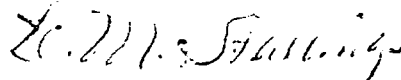
Serial No. 110
PO&M/TAP:dgt
Docket No. 50-280
License No. DPR-32

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:

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(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME:

0	1	V	A	S	P	S	1
---	---	---	---	---	---	---	---

 LICENSE NUMBER:

0	0	-	0	0	0	0	0	-	0	0
---	---	---	---	---	---	---	---	---	---	---

 LICENSE TYPE:

4	1	1	1	0
---	---	---	---	---

 EVENT TYPE:

0	3
---	---

CONT:

P	0
---	---

 REPORT TYPE:

L

 REPORT SOURCE:

L

 DOCKET NUMBER:

0	5	0	-	0	2	8	0
---	---	---	---	---	---	---	---

 EVENT DATE:

0	2	1	9	7	7
---	---	---	---	---	---

 REPORT DATE:

0	3	1	8	7	7
---	---	---	---	---	---

EVENT DESCRIPTION

0	2
---	---

 During normal operation, it was noted that the valve position indicating lights were

0	3
---	---

 extinguished for chemical addition tank discharge valve MOV-CS-102A. Subsequent in-

0	4
---	---

 vestigation revealed the motor breaker had tripped from a thermal overload, rendering

0	5
---	---

 the valve inoperable. The redundant valve was operable. This is the first reported

0	6
---	---

 failure of this type. This event is contrary to Technical Specification (Continued)

SYSTEM CODE:

S	A
---	---

 CAUSE CODE:

A

 COMPONENT CODE:

V	A	L	V	O	P
---	---	---	---	---	---

 PRIME COMPONENT SUPPLIER:

A

 COMPONENT MANUFACTURER:

L	2	0	0
---	---	---	---

 VIOLATION:

Y

CAUSE DESCRIPTION

0	8
---	---

 The torque switch in the valve operator would not de-energize the motor as required on

0	9
---	---

 a valve closing cycle, thus causing the breaker to trip from a thermal overload after

1	0
---	---

 closing. The switch had been wired incorrectly during maintenance performed (Con't)

FACILITY STATUS:

E

 % POWER:

1	0	0
---	---	---

 OTHER STATUS:

NA

 METHOD OF DISCOVERY:

A

 DISCOVERY DESCRIPTION:

NA

FORM OF ACTIVITY RELEASED:

Z

 CONTENT OF RELEASE:

Z

 AMOUNT OF ACTIVITY:

NA

 LOCATION OF RELEASE:

NA

PERSONNEL EXPOSURES

NUMBER:

0	0	0
---	---	---

 TYPE:

Z

 DESCRIPTION:

NA

PERSONNEL INJURIES

NUMBER:

0	0	0
---	---	---

 DESCRIPTION:

NA

OFFSITE CONSEQUENCES

NA

LOSS OR DAMAGE TO FACILITY

TYPE:

E

 DESCRIPTION:

NA

PUBLICITY

NA

ADDITIONAL FACTORS

1	8
---	---

 The health and safety of the public were not affected by this event because a re-

1	9
---	---

 dundant valve would have provided chemical addition had it been necessary.

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

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.