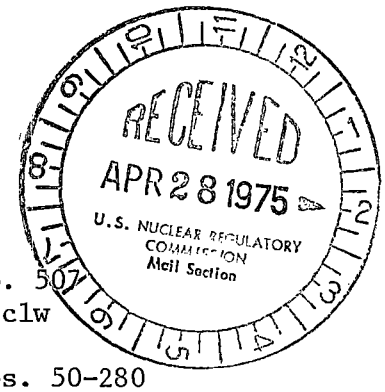
VIRGINIA ELECTRIC AND POWER COMPANY

RICHMOND, VIRGINIA 23261

April 22, 1975



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

Serial No. 507
PO&M/JTB:clw

Docket Nos. 50-280
License Nos. DPR-32

Dear Mr. Moseley:

Pursuant to Surry Power Station Technical Specification 6.6.B.1, the Virginia Electric and Power Company hereby submits forty (40) copies of Abnormal Occurrence Report No. AO-S1-75-10.

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

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

Enclosures
40 copies of AO-S1-75-10

cc: Mr. K. R. Goller

4666

LICENSEE EVENT REPORT

AO-S1-75-10

CONTROL BLOCK: [ ] (1–6)

(PLEASE PRINT ALL REQUIRED INFORMATION)

1	2	LICENSEE NAME (7–14)	LICENSE NUMBER (15–25)	LICENSE TYPE (26–30)	EVENT TYPE (31–32)
0	1	VASPS1	00-00000-00	4 1 1 1 0	0 1

1	2	CON'T	CATEGORY (57–58)	REPORT TYPE (59)	REPORT SOURCE (60)	DOCKET NUMBER (61–68)	EVENT DATE (69–74)	REPORT DATE (75–80)
0	1		P 0	T	L	0 5 0-0 2 8 0	0 4 1 2 7 5	0 4 1 8 7 5

EVENT DESCRIPTION

02 During normal operation the Process Vent System Particulate Radiation Monitor Alarm
03 was manually initiated to demonstrate the actuation of automatic shutoff valves in
04 the system to a trainee. Valve FCV-GW-260 failed to shut as required by Technical
05 Specification 3.7-2E. AO-S1-75-10
06

	SYSTEM CODE (9–10)	CAUSE CODE (11)	COMPONENT CODE (12–17)	PRIME COMPONENT SUPPLIER (43)	COMPONENT MANUFACTURER (44–47)	VIOLATION (48)
07	8 8	E	R E L A Y X	A	W 1 2 0	Y

CAUSE DESCRIPTION

08 A Westinghouse Electric Corporation Model MG-6 relay (Latch-Reset) in the control
09 circuit for valve FCV-GW-260 was found to be stuck in the "operate" position causing
10 FCV-GW-260 not to shut.

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

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

PERSONNEL EXPOSURES

	NUMBER (9–11)	TYPE (12)	DESCRIPTION (13–80)
13	0 0 0	Z	N/A

PERSONNEL INJURIES

	NUMBER (9–11)	DESCRIPTION (12–80)
14	0 0 0	N/A

OFFSITE CONSEQUENCES

15 N/A

LOSS OR DAMAGE TO FACILITY

	TYPE (9)	DESCRIPTION (10–80)
16	Z	N/A

PUBLICITY

17 N/A

ADDITIONAL FACTORS

18 N/A

19

NAME: E. M. Sweeney, Jr. PHONE: (804) 357-3184

GPO 881-667

SUPPLEMENTARY INFORMATION
FAILURE OF VALVE FCV-FW-260
TO OPERATE PROPERLY
AO-S1-75-10

On April 12, 1975 at about 0515 an alarm was manually initiated on the Process Vent System particulate radiation monitor to demonstrate the operation of various trip valves in the system to a trainee. The automatic isolation valve for the Unit No. 2 containment vacuum pump discharge (FCV-GW-260) would not shut as required by Technical Specification 3.7-2E.

Investigation into the problem revealed that the valve was mechanically operable, but was not receiving a "shut" signal from the control circuit. Further troubleshooting revealed that a relay in the control circuit was stuck in the "operate" position preventing FCV-GW-260 from shutting. The affected relay was found to be excessively dirty thus preventing proper operation.

The relay was thoroughly cleaned, adjusted, tested and placed back in operation.