

VIRGINIA ELECTRIC AND POWER COMPANY  
RICHMOND, VIRGINIA 23261

July 13, 1976

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

Serial No. 121  
PO&M/ALH:jlf


Docket No. 50-281  
License No. DPR-37

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. USRE-S2-76-08.

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

Enclosure

cc: Mr. Robert W. Reid, Chief (40 copies)  
Operating Reactors Branch 4

# LICENSEE EVENT REPORT

CONTROL BLOCK: 

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(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME			LICENSE NUMBER										LICENSE TYPE				EVENT TYPE								
01	V	A	S	P	S	2	0	0	-	0	0	0	0	0	-	0	0	4	1	1	1	0	0	3	
7	8	9	14	15	25	26	30	31	32																
CATEGORY		REPORT TYPE	REPORT SOURCE	DOCKET NUMBER				EVENT DATE				REPORT DATE													
01	CON'T	P	O	L	L	0	5	0	-	0	2	8	1	0	6	1	4	7	6	0	7	0	6	7	6
7	8	57	58	59	60	61	68	69	74	75	80														

## EVENT DESCRIPTION

02	During normal operations, it was found that condenser outlet valve MOV-CW-200B would																							80
03	not operate electrically. This is in violation of Technical Specification 3.7, and re-																							80
04	portable under Technical Specification 6.6.2.b. (USRE-S2-76-08)																							80
05																								80
06																								80

SYSTEM CODE		CAUSE CODE		COMPONENT CODE				PRIME COMPONENT SUPPLIER		COMPONENT MANUFACTURER			VIOLATION		
07	H	F	E	V	A	L	V	O	P	A	L	2	0	0	Y
7	8	9	10	11	12	17	43	44	47	48					

## CAUSE DESCRIPTION

08	Condenser outlet valve MOV-CW-200B was throttled when it was found that it would not																							80
09	operate electrically. Manual operability was verified and a station operator was as-																							80
10	signed to standby and position the valve as necessary. The condenser inlet (continued)																							80

FACILITY STATUS		% POWER		OTHER STATUS				METHOD OF DISCOVERY		DISCOVERY DESCRIPTION			
11	F	0	8	9	N/A	A	N/A						
7	8	9	10	12	13	44	45	46					
FORM OF ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY				LOCATION OF RELEASE					
12	Z	Z	N/A					N/A					
7	8	9	10	11	44	45	80						

## PERSONNEL EXPOSURES

NUMBER		TYPE		DESCRIPTION	
13	0	0	0	Z	N/A
7	8	9	11	12	13

## PERSONNEL INJURIES

NUMBER		DESCRIPTION		
14	0	0	0	N/A
7	8	9	11	12

## OFFSITE CONSEQUENCES

15	N/A																							80
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## LOSS OR DAMAGE TO FACILITY

TYPE		DESCRIPTION	
16	Z	N/A	
7	8	9	10

## PUBLICITY

17	N/A																							80
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## ADDITIONAL FACTORS

18	The health and safety of the public were not affected by this occurrence because the																							80
19	redundant valve would have closed as required and maintained the required canal level.																							80

NAME: T. L. Baucom

PHONE: (804) 357-3184

CAUSE DESCRIPTION (CONTINUED)

valve, MOV-CW-206B, provides additional assurance that the proper intake canal level will be maintained.

An investigation revealed that the valve operator worm shaft tripper cam had broken off. Thus the motor shaft was not engaged and the valve would not operate electrically. The tripper cam was replaced and the valve tested and returned to service. All condenser inlet and outlet valves have similar valve operators; however, since this is the first known valve operator failure of this type no further corrective action is deemed necessary at this time.

The valve operators were manufactured by Limitorque Corporation, Type SMB-2.