

VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

February 18, 1976

Mr. Norman C. 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. 902
PO&M/ALH:clw

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 forty (40) copies of Reportable Occurrence No. AO-S2-76-02.

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,

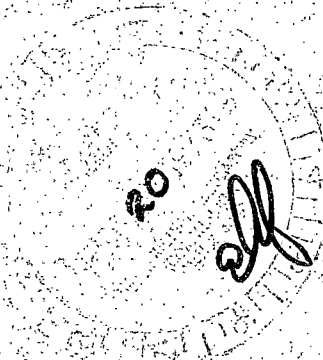
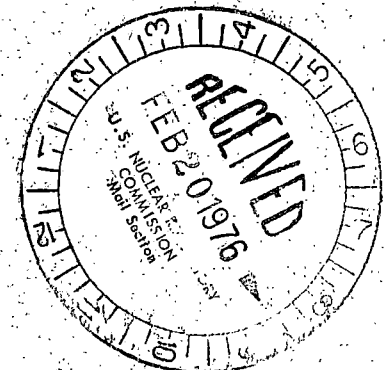
C. M. Stallings

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Vice President-Power Supply
and Production Operations

Enclosures

40 copies of AO-S2-76-02

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



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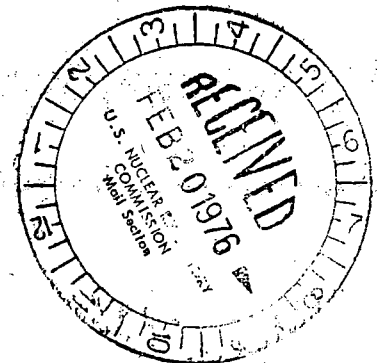
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LICENSEE EVENT REPORT

AO-S2-76-02

CONTROL BLOCK: [1][][][][][]

[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME [01] V A S P S 2														LICENSE NUMBER [00]-[00][00][00]-[0][0]										LICENSE TYPE [4][1][1][1][0]					EVENT TYPE [9][9]	
7	8	9	14	15	25	26	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50			

[01] CONT	CATEGORY [P][O]		REPORT TYPE [T]	REPORT SOURCE [L]	DOCKET NUMBER [0][5][0]-[0][2][8][1]							EVENT DATE [0][2][0][4][7][6]					REPORT DATE [0][2][1][7][7][6]								
7	8	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80

EVENT DESCRIPTION

[02] While at cold shutdown main steam trip valve, TV-MS-201A, failed to close when
 [03] operated from the control room. An inspection revealed that the valve was
 [04] mechanically bound in the open position. The valve subsequently closed after tapping
 [05] on the end of the rockshaft. This event is considered a reportable occurrence since
 [06] the failure of the trip valve to close is a malfunction of a component which (con't)

SYSTEM CODE [07] C D			CAUSE CODE [A]		COMPONENT CODE V A L V E X					PRIME COMPONENT SUPPLIER [A]	COMPONENT MANUFACTURER S O 7 5			VIOLATION [N]		
7	8	9	10	11	12	13	14	15	16	17	43	44	45	46	47	48

CAUSE DESCRIPTION

[08] Investigation revealed that the valve disc was binding against the valve body when
 [09] in the full open position. Measurements indicated that the disc was opening ap-
 [10] proximately 84 degrees instead of the design disc opening of 80 degrees. It (con't)

FACILITY STATUS [11] G		% POWER [0][0][0]			OTHER STATUS [N/A]				METHOD OF DISCOVERY [A]		DISCOVERY DESCRIPTION [N/A]				
7	8	9	10	11	12	13	14	15	44	45	46	47	48	49	50

FORM OF ACTIVITY RELEASED [12] Z		CONTENT OF RELEASE [Z]			AMOUNT OF ACTIVITY [N/A]					LOCATION OF RELEASE [N/A]					
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22

PERSONNEL EXPOSURES

NUMBER [13] 0 0 0			TYPE [Z]		DESCRIPTION [N/A]										
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22

PERSONNEL INJURIES

NUMBER [14] 0 0 0			DESCRIPTION [N/A]												
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22

OFFSITE CONSEQUENCES

[15] N/A

LOSS OR DAMAGE TO FACILITY

TYPE [16] Z		DESCRIPTION [N/A]													
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22

PUBLICITY

[17] N/A

ADDITIONAL FACTORS

[18] N/A

[19]

NAME: E. M. Sweeney, Jr.

PHONE: (804) 357-3184

EVENT DESCRIPTION (con't)

could prevent, by itself, the fulfillment of the functional requirements of systems used to cope with accidents analyzed in the FSAR (TS 6.6.2.a.5). (AO-S2-76-02)

CAUSE DESCRIPTION (con't)

was determined that the disc opening had not been set properly when the valve rockshaft was replaced approximately two weeks earlier during a previous outage. The disc opening was adjusted to 80 degrees and it was verified that the disc did not strike the valve body when in the full open position. It was also found that one of the stuffing boxes was misaligned possibly causing binding of the valve rockshaft. The stuffing box was subsequently aligned. Testing conducted at hot shutdown conditions verified that the valve was operating properly.

The corrective action taken should prevent recurrence of this event. In addition, installation of a positive stop which would limit the disc opening is currently under evaluation. The positive stop would further ensure that the valve did not open sufficiently to allow binding of the disc against the valve body.

It is believed that the valve would have closed in the event of a main steam line break requiring steam line isolation. Since the valve was not tightly bound, and the fact that the valve disc normally extends into the steam flow, the downward force applied to the disc by the steam flow would have forced the valve closed, if required. It is concluded that the health and safety of station personnel and the public were not affected by this event.

LICENSEE EVENT REPORT

AO-S2-76-02

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	9	9					
7	8	9	14	15	25	26	30	31	32	CATEGORY						REPORT TYPE	REPORT SOURCE	DOCKET NUMBER				EVENT DATE				REPORT DATE			
01	CONT	P	O	T	L	0	5	0	-	0	2	8	1	0	2	0	4	7	6	0	2	1	7	7	6				
7	8	57	58	59	60	61	68	69	74	75	80				80				80										

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07	C	D	A	V	A	L	V	E	X	A	S	O	7	5	N
7	8	9	10	11	12	17	43	44	47	48	80				

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11	G	0	0	0	N/A	A	N/A	80					
7	8	9	10	12	13	44	45	46	80				
FORM OF ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY				LOCATION OF RELEASE					
12	Z	Z	N/A	N/A	80								
7	8	9	10	11	44	45	80						

PERSONNEL EXPOSURES

NUMBER		TYPE	DESCRIPTION				
13	0	0	Z	N/A			
7	8	9	11	12	13	80	

PERSONNEL INJURIES

NUMBER		DESCRIPTION				
14	0	0	N/A			
7	8	9	11	12	80	

OFFSITE CONSEQUENCES

15 N/A

LOSS OR DAMAGE TO FACILITY

TYPE	DESCRIPTION				
16	Z	N/A			
7	8	9	10	80	

PUBLICITY

17 N/A

ADDITIONAL FACTORS

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