NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | V A S P S 2 (2) | 0 0 - 0 0 0 0 0 - 0 0 (3) | 4 1 1 1 1 (4) | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 8 1 (7) | 0 8 1 2 8 2 (8) | 0 9 0 7 8 2 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 With the unit at 100% power, during the performance of PT 18.6B, TV-CC-209B
0 3 would not close when manually operated from the control room. This event is
0 4 contrary to T.S.3.8.A.1 and is reportable per T.S.6.6.2.b(2). The component
0 5 cooling system is a closed system and it's integrity was maintained during the
0 6 event; therefore, an operable barrier existed between the containment and the
0 7 environment. Public health and safety were not affected.
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	W B (11)	E (12)	B (13)	V A L V O P (14)	D (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 2	—	0 4 7	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
A (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	H 0 3 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of the event has been attributed to a sticking pilot valve (pneumatic
1 1 operator) that controls air flow from the valve actuator. One minute after
1 2 disconnecting the air supply to the pilot valve, TV-CC-209B closed. The air supply
1 3 was restored and the valve tested satisfactorily. The failure could not be
1 4 duplicated.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	1 0 0 (29)	N/A	B (31)	Operator Observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	N/A	N/A

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	N/A

8209160606 820907
PDR ADOCK 05000281
S PDR

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	N/A	

NAME OF PREPARER J. L. Wilson PHONE (804) 357-3184

ATTACHMENT 1
SURRY POWER STATION, UNIT NO. 2
DOCKET NO: 50-281
REPORT NO: 82-047/03L-0
EVENT DATE: 08-12-82

TITLE OF THE EVENT: TV-CC-209B will not close

1. DESCRIPTION OF THE EVENT:

On 08-12-82, with the unit at 100% power, the reactor operator was performing PT-18.6B, Quarterly Testing of Miscellaneous Containment Trip Valves, when trip valve, TV-CC-209B (component cooling to residual heat removal) failed to close on demand from the control room. Inoperability of an automatic containment isolation valve is contrary to Technical Specification 3.8.A.1 and is reportable per Technical Specification 6.6.2.b(2).

2. PROBABLE CONSEQUENCES and STATUS of REDUNDANT EQUIPMENT:

The Design Basis for the containment isolation system is that during accident conditions, at least two barriers exist between the atmosphere outside the containment structure and

a) The atmosphere inside the containment structure

b) The reactor coolant and connecting systems.

Failure of one valve or barrier will not prevent isolation of the containment. Component cooling water piping is separated from the reactor coolant system, or a connecting system, and the atmosphere, by a membrane barrier.

Since the integrity of the membrane barrier, the component cooling water piping inside containment, was maintained, an isolation barrier between the inside of the containment structure and the environment was maintained during this event. Therefore, the health and safety of the public were not affected.

3. CAUSE:

The cause of this event was attributed to a sticking pilot valve which controls air flow to the diaphragm actuator of the component cooling trip valve.

4. IMMEDIATE CORRECTIVE ACTION:

The immediate corrective action was to dispatch an operator to take administrative control of the manual isolation valve.

5. SUBSEQUENT CORRECTIVE ACTION:

As part of the investigation, the Instrument Air Supply was disconnected from the pilot valve. After about a minute, air bled from the pilot valve and TV-CC-209B closed. The air line to the pilot valve was reconnected and the valve tested satisfactorily. The failure could not be duplicated, the valve was subsequently returned to service.

6. ACTIONS TAKEN TO PREVENT RECURRENCE:

Necessary actions to prevent recurrence have been specified in Engineering Study no. 82-48 and are pending implementation.

7. GENERIC IMPLICATIONS:

A similar failure has been experienced on TV-CC-209B, during the previous periodic test 18.6B.