# LICENSEE EVENT REPORT

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SOURCE 60 ET DOCKET NUMBER 66 6	1 1 1 0 8 8 1 1 8 1 1 1 1 1 1 1 1 1 1 1
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)	Safety Injection System Test, with the
	iled to open when operated from the control
This was in contrast to T C 2 2	A.7 and is reportable in accordance with
Landaud language agranus and a second and a	The state of the s
harmonial beauty at the second of the second	OV-2869A, remained operable and the unit was
0 6 at Cold Shutdown. The health and safety	of the public were not affected.
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	30
SYSTEM CAUSE CAUSE CODE SUBCODE SUBCOD	MPONENT CODE SUBCODE S
17 REPORT   8   1	OCCURRENCE REPORT COOR TYPE  10 3 LL 31 27 28 29 30 31 32 22 ATTACHMENT NAMED PRIME COMP. SUBMITTED FORM SUB SUPPLIER  10 Y 33 N 24 A 25 L 2 0 0 6  40 41 23 42 43 43
CAUSE DESCRIPTION AND CORRECTIVE & CTIONS (27)	control room switch was subsequently operated
[1] [ for maintenance personnel, a cause for t	he failure could not be definitively
determined.	
[5]3] [	
774)	
FACILITY STATUS SPOWER OTHER STATUS OD METH	DISCOVERY DESCRIPTION (33)  Periodic Test
ACTIVITY CONTENT 12 13 AMOUNT OF ACTIVITY (15)	LOCATION OF RELEASE (36)
15 2 @ 2 @ N/A	45 80
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (29)	
TITI O O O SIZ B	60
NUMBER DESCRIPTION(41)	
THE SECULITY 43	60
TP LE W.	
ISSUE SECTIVE OF SERVICENCES	NAC USE ONLY
7 8 8 9	58 68 80 5
NAME OF PREPARES J. L. Wilson	PHONE (804) 357-3184

ATTACHMENT 1

SURRY POWER STATION, UNIT 2

DOCKET NO: 50-281

REPORT NO: 81-072/031-0

EVENT DATE: 11-08-81

TITLE OF THE EVENT: MOV-2869B WOULD NOT OPEN

## 1. DESCRIPTION OF EVENT:

During the performance of Periodic Test 18.2, Safety Injection System Test, with the unit at refueling shutdown, MOV-2869B, Hot Leg High Head Safety Injection, failed to open when operated from the control room. This event is contrary to T.S. 3.3.A.7 and is reportable in accordance with T.S. 6.6.2.b.(2).

# 2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT EQUIPMENT:

The hot leg safety injection valves 2869A and B do not receive a safety injection signal. MOV-2869B could have been opened manually, if required. However, the redundant valve, MOV-2869A, remained operable. Therefore, the health and safety of the public were not affected.

#### 3. CAUSE:

Since the valve cycled normally when the control room switch was subsequently operated for maintenance personnel, the cause for the failure of the valve to open could not be definitely determined.

# 4. IMMEDIATE CORRECTIVE ACTION:

A work request was inftiated and subsequent operation of the control room switch resulted in normal valve operations.

### 5. SUBSEQUENT CORRECTIVE ACTION:

The valve motor and the associated control circuit were checked. The results were satisfactory.

## 6. ACTION TAKEN TO PREVENT RECURRENCE:

None deemed necessary.

# 7. GENERIC IMPLICATIONS:

None.