NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

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

CON'T 01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 2 8 0 (7) | EVENT DATE: 0 1 0 6 8 2 (8) | REPORT DATE: 0 2 0 1 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 With the Unit at hot shutdown, a spurious safety injection caused a phase 1
03 containment isolation. Trip Valve-CC-109B failed to close as required by
04 T.S.3.8.A.1. This event is reportable as per T.S.6.6.2.b.(4). Since the system
05 was capable of being isolated manually had the need arisen, the health and safety
06 of the public was not affected.
07
08

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
09	S D (11)	B (12)	C (13)	V A L V E X (14)	D (15)	E (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 2	—	0 0 1	/	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
B (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	A 4 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of the event was determined to be a piece of teflon tape (type used to
11 seal threaded air fittings) which prevented operation of the three way SOV that
12 controls TV-CC-109B. Corrective actions consisted of checking valve operator
13 circuit, establishing administrative control of the valve, removing foreign material,
14 testing as per PT-18.6B and returning to service.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
15	G (28)	0 0 0 (29)	N/A	A (31)	Operational Event

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

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
17	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
18	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
19	Z (42)	N/A

8202160243 820201
PDR ADOCK 05000280
S PDR

PUBLICITY

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

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

ATTACHMENT 1
SURRY POWER STATION, UNIT NO.1
DOCKET NO: 50-280
REPORT NO: 82-001/03L-0
EVENT DATE: 01-06-82

TITLE OF THE EVENT: LOSS OF CONTAINMENT INTEGRITY

1. DESCRIPTION OF EVENT:

With the Unit at hot shutdown, a spurious safety injection caused a phase 1 containment isolation. Valve TV-CC-109B failed to indicate closed. Investigation showed the valve failed to respond to the SI signal. This event is contrary to Technical Specification (TS) 3.8.A.1 and is thus reportable as per T.S.6.6.2.b.(4).

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT SYSTEMS:

The Design Basis for the containment isolation system is that during accident conditions, at least two barriers exist between the atmosphere inside the containment and the atmosphere outside the containment. 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 any connecting system, and the containment atmosphere by a membrane barrier, as well as check or trip valves. 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 the event was determined to be a small piece of teflon tape (as used to seal threaded air fittings) lodged in the SOV. This prevented the bleeding off of the TV-CC-109B control air, thus preventing TV-CC-109B from closing.

4. IMMEDIATE CORRECTIVE ACTION:

Electricians were sent to investigate the cause of the failure and correct the problem. All the electrical components tested satisfactory.

5. SUBSEQUENT CORRECTIVE ACTION:

Administrative control of manual isolation was established in case a need to isolate the system developed. Mechanical disassembly of the SOV disclosed a small piece of teflon tape blocking operation of the valve. The valve was reassembled, tested satisfactorily as per PT-18.6B, and declared operable.

6. ACTION TAKEN TO PREVENT RECURRENCE:

Review of applicable maintenance procedures is being accomplished to prevent future occurrences.

7. GENERIC IMPLICATIONS:

None.