NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
0 1	LICENSEE CODE (2)	V A S P S 2
	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
	LICENSE TYPE (4)	4 1 1 1 1
	CAT (5)	
0 1 CON'T	REPORT SOURCE (6)	L
	DOCKET NUMBER (7)	0 5 0 0 0 2 8 1
	EVENT DATE (8)	0 2 1 5 8 2
	REPORT DATE (9)	0 3 1 6 8 2

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

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

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

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 2	—	0 1 5	/	0 3	L	—	0

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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of the event was determined to be a faulty pilot valve that controls air
1 1 flow to the valve actuator. The pilot valve was replaced and the valve was tested
1 2 satisfactorily.
1 3
1 4

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

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE (42)	DESCRIPTION
	Z	N/A

8204020517 820316
PDR ADOCK 05000280
S PDR

2 0	ISSUE	DESCRIPTION	NRC USE ONLY
	N	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: 82-015/03L-0
EVENT DATE: 02-15-82

TITLE OF THE EVENT: TRIP VALVE, TV-CC-209B, MALFUNCTION

1. DESCRIPTION OF THE EVENT:

On 02-15-82, with the unit at 100% power, the reactor operator was performing PT-18.6B, Quarterly Testing of Miscellaneous Containment Trip Valves, when he discovered that trip valve, TV-CC-209B (component cooling to residual heat removal) would not 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 OF OCCURRENCE:

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 OF THE EVENT:

The cause of this event was determined to be a faulty 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:

The subsequent corrective action was to notify the electrical department. When no electrical malfunction was identified, the instrument department was notified. Investigation led the instrument technicians to suspect a faulty pilot valve. When the pilot valve was replaced, the valve tested satisfactorily. The valve was subsequently returned to service.

6. ACTIONS TAKEN TO PREVENT RECURRENCE:

None have been deemed necessary.

7. GENERIC IMPLICATIONS:

A similar failure has been experienced on Unit No. 1, although the same failure mechanism could not be confirmed.