

LICENSEE EVENT REPORT

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

0 1 V A S P S 1 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5
9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 37 CAT 38

CON'T
0 1 REPORT SOURCE L 6 0 5 0 0 0 2 8 0 7 0 1 0 5 8 2 8 0 2 1 9 8 2 9
50 51 DOCKET NUMBER 58 59 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At 2% power, while removing the unit from service, a spurious SI signal was generated.
0 3 Trip valve, TV-CC-109B, failed to close as designed. This event is contrary to
0 4 T.S.3.8.A.1 and is reportable per T.S.6.6.2.b.(2). The component cooling (CC)
0 5 system is a closed system and its integrity was maintained during the event; there-
0 6 fore, an isolation barrier existed between the containment and the environment.
0 7 The public health and safety were not affected.

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0 9
SYSTEM CODE W B 11 CAUSE CODE X 12 CAUSE SUBCODE X 13 COMPONENT CODE V A L V O P 14 COMP. SUBCODE D 15 VALVE SUBCODE Z 16
LER/RO REPORT NUMBER 17 8 2 21 EVENT YEAR 22 8 2 23 SEQUENTIAL REPORT NO. 24 0 1 0 25 OCCURRENCE CODE 26 0 3 27 REPORT TYPE 28 L 29 REVISION NO. 30 0 31
ACTION TAKEN 32 X 18 FUTURE ACTION 33 X 19 EFFECT ON PLANT 34 Z 20 SHUTDOWN METHOD 35 Z 21 HOURS 36 0 0 0 0 37 ATTACHMENT SUBMITTED 38 Y 23 NPD-4 FORM SUB. 39 N 24 PRIME COMP. SUPPLIER 40 A 25 COMPONENT MANUFACTURER 41 F 1 3 0 26
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 A search for an electrical cause for the valve malfunction revealed no problems.
1 1 No specific mechanical cause has been found. Efforts have been initiated to further
1 2 investigate the event but no definitive answers are available at this time.

1 3

1 4

1 5 FACILITY STATUS 28 D 29 0 0 2 29 OTHER STATUS 30 N/A METHOD OF DISCOVERY 31 A 32 Operator Observation
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 6 ACTIVITY CONTENT 33 Z 34 Z 35 N/A AMOUNT OF ACTIVITY 35 N/A LOCATION OF RELEASE 36 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 7 PERSONNEL EXPOSURES 37 0 0 0 38 Z 39 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 8 PERSONNEL INJURIES 40 0 0 0 41 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 9 LOSS OF OR DAMAGE TO FACILITY 42 Z 43 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

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NRC USE ONLY

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ATTACHMENT 1
SURRY POWER STATION, UNIT NO.1
DOCKET NO: 50-280
REPORT NO: 81-010/03L-0
EVENT DATE: 01-05-82

TITLE OF THE EVENT: Trip Valve, TV-CC-109B, Failure to Close

1. DESCRIPTION OF EVENT:

At 2% reactor power while removing the unit from service, a spurious safety injection (SI) signal was generated. Trip valve, TV-CC-109B (component cooling isolation valve to residual heat removal), did not close as designed on the SI signal. This event is contrary to Technical Specification 3.8.A.1 and is reportable per Technical Specification 6.6.2.b.(2).

2. PROBABLE CONSEQUENCES:

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:

A search for an electrical cause for the valve malfunction revealed no problems. No specific mechanical cause has been found. Consequently, the cause of the event is, at this time, undetermined.

4. IMMEDIATE CORRECTIVE ACTION:

The operators attempted to close the valve and submitted an urgent maintenance request to the electrical department.

5. SUBSEQUENT CORRECTIVE ACTION:

The attempt to close the valve from the control room was repeated and the valve repositioned properly. A test was made of the SI circuitry to determine if the cause was a faulty relay; no problems were found.

6. ACTIONS TAKEN TO PREVENT RECURRENCE:

A study is being undertaken to further investigate the cause for the trip valve malfunction.

7. GENERIC IMPLICATIONS:

None have been identified at this time.