

# LICENSEE EVENT REPORT

AO-S2-76-02

CONTROL BLOCK: 1 2 3 4 5 6

[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME														LICENSE NUMBER														LICENSE TYPE						EVENT TYPE			
01	V	A	S	P	S	2									0	0	-	0	0	0	0	-	0	0					4	1	1	1	0			9	9
7	8	9				14				15				25				26				30				31			32								

  

CATEGORY				REPORT TYPE		REPORT SOURCE		DOCKET NUMBER										EVENT DATE						REPORT DATE							
01	CON'T			P	0	T	L											0	2	0	4	7	6			0	2	1	7	7	6
7	8				57	58	59	60				61				68				69				74			75				80

## EVENT DESCRIPTION

02	While at cold shutdown main steam trip valve, TV-MS-201A, failed to close when																																																																																80
03	operated from the control room. An inspection revealed that the valve was																																																																																80
04	mechanically bound in the open position. The valve subsequently closed after tapping																																																																																80
05	on the end of the rockshaft. This event is considered a reportable occurrence since																																																																																80
06	the failure of the trip valve to close is a malfunction of a component which (con't)																																																																																80

SYSTEM CODE				CAUSE CODE		COMPONENT CODE										PRIME COMPONENT SUPPLIER				COMPONENT MANUFACTURER						VIOLATION			
07	C	D			A											A				S	O	7	5			N			
7	8	9	10		11				12				17				43				44				47			48	

## CAUSE DESCRIPTION

08	Investigation revealed that the valve disc was binding against the valve body when																																																																																80
09	in the full open position. Measurements indicated that the disc was opening ap-																																																																																80
10	proximately 34 degrees instead of the design disc opening of 80 degrees. It (con't)																																																																																80

FACILITY STATUS				% POWER				OTHER STATUS				METHOD OF DISCOVERY				DISCOVERY DESCRIPTION																												
11	G			0	0	0			N/A				A				N/A																											
7	8	9			10	11	12	13					44	45	46																													

  

FORM OF ACTIVITY RELEASED				CONTENT OF RELEASE				AMOUNT OF ACTIVITY										LOCATION OF RELEASE																											
12	Z			Z				N/A										N/A																											
7	8	9			10	11					44	45																																	

## PERSONNEL EXPOSURES

NUMBER				TYPE		DESCRIPTION										
13	0	0	0	Z	N/A											
7	8	9			11	12										

## PERSONNEL INJURIES

NUMBER				DESCRIPTION												
14	0	0	0	N/A												
7	8	9			11	12										

## OFFSITE CONSEQUENCES

15	N/A																																																																																80
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## LOSS OR DAMAGE TO FACILITY

TYPE				DESCRIPTION											
16	Z				N/A										
7	8	9			10										

## PUBLICITY

17	N/A																																																																																80
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## ADDITIONAL FACTORS

18	N/A																																																																																80
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19																																																																																	80
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NAME: E. M. Sweeney, Jr.

PHONE: (804) 357-3184

EVENT DESCRIPTION (con't)

could prevent, by itself, the fulfillment of the functional requirements of systems used to cope with accidents analyzed in the FSAR (TS 6.6.2.a.5).  
(AO-S2-76-02)

CAUSE DESCRIPTION (con't)

was determined that the disc opening had not been set properly when the valve rockshaft was replaced approximately two weeks earlier during a previous outage. The disc opening was adjusted to 80 degrees and it was verified that the disc did not strike the valve body when in the full open position. It was also found that one of the stuffing boxes was misaligned possibly causing binding of the valve rockshaft. The stuffing box was subsequently aligned. Testing conducted at hot shutdown conditions verified that the valve was operating properly.

The corrective action taken should prevent recurrence of this event. In addition, installation of a positive stop which would limit the disc opening is currently under evaluation. The positive stop would further ensure that the valve did not open sufficiently to allow binding of the disc against the valve body.

It is believed that the valve would have closed in the event of a main steam line break requiring steam line isolation. Since the valve was not tightly bound, and the fact that the valve disc normally extends into the steam flow, the downward force applied to the disc by the steam flow would have forced the valve closed, if required. It is concluded that the health and safety of station personnel and the public were not affected by this event.

VIRGINIA ELECTRIC AND POWER COMPANY  
RICHMOND, VIRGINIA 23261

February 18, 1976

Mr. Norman C. Moseley, Director  
Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
Region II - Suite 818  
230 Peachtree Street, Northwest  
Atlanta, Georgia 30303

Serial No. 902  
PO&M/ALH:clw

Docket No. 50-281  
License No. DPR-37

Dear Mr. Moseley:

Pursuant to Surry Power Station Technical Specification 6.6.2, the Virginia Electric and Power Company hereby submits forty (40) copies of Reportable Occurrence No. AO-S2-76-02.

The substance of this report has been reviewed by the Station Nuclear Safety and Operating Committee and will be placed on the agenda for the next meeting of the System Nuclear Safety and Operating Committee.

Very truly yours,

*C. M. Stallings*

C. M. Stallings  
Vice President-Power Supply  
and Production Operations

Enclosures

40 copies of AO-S2-76-02

cc: Mr. Robert W. Reid, Chief ✓  
Operating Reactors Branch 4

