NRC FORM 366
(7-77)

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (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)
7 8	9 LICENSEE CODE 14	15 LICENSE NUMBER 25	26 LICENSE TYPE 30	57 CAT 58

CON'T

0 1	REPORT SOURCE L (6)	0 5 0 0 0 2 8 0 (7)	0 2 1 8 8 0 (8)	0 3 1 4 8 0 (9)
7 8	60 61	DOCKET NUMBER 68	69 EVENT DATE 74	75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 With the unit at 100% power, Liquid Waste Test Tank 1-LW-TK-11B was inadvertently
0 3 released without being sampled. This is contrary to T.S. 3.11.A.4 and reportable per
0 4 T.S. 6.6.2.b.2. The operator in the Control Room was monitoring tank level and imme-
0 5 diately terminated the release when the level in 1-LW-TK-11B changed. Also, the
0 6 monitor in the discharge line was operable and would have terminated the release
0 7 if the activity had exceeded preset limits. Therefore, the health and safety of
0 8 the public were not affected.

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	M A (11)	A (12)	A (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 0	—	0 1 6	/	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
H (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Liquid Waste Test Tank 1-LW-TK-11A had been sampled and was ready for release. However,
1 1 when performing the necessary valve lineups, the discharge valve from 1-LW-P-11B
1 2 was opened instead of the valve for 1-LW-P-11A, resulting in 1-LW-TK-11B being par-
1 3 tially released. The release was terminated and tank 1-LW-TK-11B was sampled. Based
1 4 on the sample, an estimate was made as to the amount and activity released, and veri-
fied to be within allowable limits.

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	E (28)	1 0 0 (29)	NA	A (31)	Operator observation

1 6	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	L (33)	M (34)	.0000043 Ci	Liquid waste system to river

PERSONNEL EXPOSURES

1 7	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	NA

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)	NA	

8003170363

NAME OF PREPARER W. L. Stewart PHONE: (804)357-3184

GPO 917-926

ATTACHMENT (PAGE 1 OF 1)
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 80-016/03L-0
EVENT DATE: 2-18-80
TITLE OF REPORT: Liquid Waste Inadvertent Release

1. DESCRIPTION OF EVENT:

With the unit at 100% power, Liquid Waste Test 1-LW-TK-11b, was inadvertently released without being sampled. This is contrary to T.S. 3.11.A.4 and reportable per T.S. 6.6.2.b.2.

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT SYSTEMS:

The operator in the Control Room was monitoring tank level and immediately terminated the release when the level in 1-LW-TK-11B changed. Also, the monitor in the discharge line was operable and would have terminated the release if the activity had exceeded preset limits. Therefore, the health and safety of the public were not affected.

3. CAUSE OF EVENT:

Liquid Waste Test Tank 1-LW-TK-11A had been sampled and was ready for release. However, when performing the necessary valve lineups, the discharge valve from 1-LW-F-11B was opened instead of the valve for 1-LW-P-11A, resulting in 1-LW-TK-11B being partially released.

4. IMMEDIATE CORRECTIVE ACTION:

The release was terminated and tank 1-LW-TK-11B was sampled. Based on the sample, an estimate was made as to the amount and activity released and verified to be within allowable limits.

5. SCHEDULED CORRECTIVE ACTION:

None required.

6. ACTION TAKEN TO PREVENT RECURRENCE:

Operators have been instructed to insure proper valve lineups are performed prior to commencing liquid waste releases.

7. GENERIC IMPLICATIONS:

None.

(7-77)

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (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)
	LICENSEE CODE	LICENSE NUMBER	LICENSE TYPE	CAT

CON'T 0 1	REPORT SOURCE L (6)	0 5 0 0 0 2 8 0 (7)	0 2 1 8 8 0 (8)	0 3 1 4 8 0 (9)
		DOCKET NUMBER	EVENT DATE	REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 With unit at 100% power, the vacuum pump for process vent monitors RM-GW-101 and
0 3 RM-GW-102 was found tagged out of service. The pump had been out of service for app-
0 4 roximately two days, and the applicable procedures were not performed prior to tag-out.
0 5 This is contrary to T.S. 3.11.B.5 and T.S. Table 3.7-5 and reportable per T.S. 6.6.
0 6 2.b.2. During the period the monitors were out of service, no releases were made
0 7 from the waste gas decay tanks. A review of the accountability records revealed that
0 8 the activity levels released during the period were well within allowable limits. The health and safety of the public were not affected.

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	M C (11)	A (12)	A (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 0	—	0 1 7	/	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
H (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The failure to perform the applicable procedure prior to taking the vacuum pump out of
1 1 service led to the release of unmonitored gases. The immediate action taken was to
1 2 perform AP-5.16, Radiation Monitoring System Process Vent Particulate & Gaseous Mal-
1 3 function, notify Health Physics and analyze the accountability data. The system was
1 4 returned to normal operation, i.e. the vacuum pump was returned to service.

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	E (28)	1 0 0 (29)	NA	A (31)	Operator observation

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

PERSONNEL EXPOSURES

1 7	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	NA

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)	NA	

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ATTACHMENT (PAGE 1 OF 1)
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 80-017/03L-0
EVENT DATE: 2-18-80
TITLE OF REPORT: Inoperability of Radiation Monitors (RM-GW-101, 102)

1. DESCRIPTION OF EVENT:

With the unit at 100% power, the vacuum pump for process vent monitors RM-GW-101 and RM-GW-102 was found tagged out of service. Further investigation revealed the pump had been out of service for approximately two days and that the applicable procedure was not performed prior to the tag-out. This is contrary to T.S. 3.11.B.5 and T.S. Table 3.7-5, and is reportable per T.S. 6.6.2.b.2.

2. PROBABLE CONSEQUENCES/STATUS OF REDUNDANT SYSTEMS:

During the period the monitors were out of service, no releases were made from the waste gas decay tanks and the H.P. accountability sampling system was in operation. A review of the accountability records revealed that the activity levels released during the period were well within allowable limits. Therefore, the health and safety of the general public were not affected.

3. CAUSE OF EVENT:

The failure to perform the applicable procedure prior to taking the vacuum pump out of service led to the release of unmonitored gases, although that which was released was well within the allowable activity limits.

4. IMMEDIATE CORRECTIVE ACTION:

The immediate action taken was to perform AP-5.16, Radiation Monitoring System Process Vent Particulate and Gaseous Malfunction, notify Health Physics and analyze the accountability data.

5. SCHEDULED CORRECTIVE ACTION:

The system was returned to normal operation, i.e. the vacuum pump was returned to service.

6. ACTION TAKEN TO PREVENT RECURRENCE:

Operations personnel were reinstructed to insure that the appropriate procedures are performed prior to removing the process vent monitors from service.

7. GENERIC IMPLICATIONS:

None.