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VIRGINIA ELECTRIC AND POWER COMPANY
Surry Power Station
P. O. Box 315
Surry, Virginia 23883

APR 30 1980

Serial No. 003
Docket Nos: 50-280

License Nos: DPR-32

Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

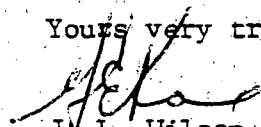
Dear Mr. O'Reilly:

Pursuant to Surry Power Station Technical Specifications, the Virginia Electric and Power Company hereby submits the following Licensee Event Report for Surry Unit No. 1.

<u>Report No.</u>	<u>Applicable Technical Specification</u>
80-23/01T-0	6.6.2.a.5

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

Yours very truly,


J. L. Wilson For
Station Manager

Enclosure

cc: Mr. Victor Stello, Director (3)
Office of Inspection and Enforcement

Mr. Norman Haller, Director (3)
Office of Management and Program Analysis

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ATTACHMENT (PAGE 1 of 1)
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 80-023/01T-0
EVENT DATE: 4-17-80

TITLE OF EVENT: AUX. FEED CHECK VALVE FAILURE

1. DESCRIPTION OF EVENT:

During an inspection of the internal parts of valves 1-FW-27 and 1-FW-89, it was discovered that the seat was detached in 1-FW-27 and disc was detached in 1-FW-89. This event is reportable in accordance with Technical specification 6.6.2.a.5.

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT SYSTEMS:

The detached seat and disc would have prevented these valves from fulfilling their intended function. In addition the loose parts could have become wedged in the valve body becoming a blockage and causing a reduction in feedwater flow. Since the problem occurred after the plant was brought to cold shutdown, the health and safety of the general public were not affected.

3. CAUSE:

At this time the cause for the detached seat in 1-FW-27 is unknown and is under investigation. The cause for the detached disc in 1-FW-89 is attributed to improper material for the disc retaining nut cotter pin (carbon steel v.s. stainless steel). The carbon steel cotter pin apparently deteriorated to the point of failure permitting the retaining nut to loosen until the valve disc detached.

4. IMMEDIATE CORRECTIVE ACTIONS:

The two valves were repaired and stainless steel cotter pins were utilized.

5. SUBSEQUENT CORRECTIVE ACTIONS:

The remaining check valve in Unit 1; 1-FW-58; was inspected and found operable, although the disc retaining nut cotter pin was missing. The valve was repaired utilizing a Stainless Steel Cotter Pin. The three check valves in Unit 2; 2-FW-27, 58, 89; were inspected and found to be fully operable with stainless steel pins installed.

6. ACTION TAKEN TO PREVENT RECURRENCE:

The detached seat in 1-FW-27 is under investigation and a follow-up will be submitted when the results are known.

7. GENERIC IMPLICATIONS:

Following the inspection of the Unit 1 valves, the Unit 2 valves were inspected and found fully operational with stainless steel pins installed and therefore this is not considered a generic problem.