

V A S P S 1 (2) 0 0 - 0 0 0 0 0 - 0 0 (3) 4 1 1 1 1 (4) (5)  
8 9      14 15                  25 26                  57 CAT 58  
 LICENSEE CODE                  LICENSE NUMBER                  LICENSE TYPE

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | With Unit 1 at 100% power, steady state operation, isolation valve for 1-BR-TK-2B was  
0 3 | found leaking during release of 1-BR-TK-2A causing an unsampled release from Tank B.  
0 4 | This is less conservative then described in T.S. 3.11.A.4 and reportable per T.S. 6.6.2  
0 5 | .b.2.Liquid waste monitor (RM-LW-108) was operable and the system had the capability  
0 6 | to terminate any release which exceeded the set point for the monitor. Therefore the  
0 7 | health and safety of the public were not affected.

SYSTEM CODE M A (11) CAUSE CODE E (12) CAUSE SUBCODE B (13) COMPONENT CODE V A L V E X (14) COMP. SUBCODE D (15) VALVE SUBCODE D (16)  
9 10                  11 12                  13                  18                  19 20  
 EVENT YEAR 8 0 (17) LER/RO REPORT NUMBER (17) SEQUENTIAL REPORT NO. 0 3 8 OCCURRENCE CODE 0 3 REPORT TYPE L REVISION NO. 0  
21 22                  23                  24 26                  27                  28 29                  30 31                  32  
 ACTION TAKEN B (18) FUTURE ACTION F (19) EFFECT ON PLANT Z (20) SHUTDOWN METHOD Z (21) HOURS 0 0 0 0 ATTACHMENT SUBMITTED Y (23) NPRD-4 FORM SUB. N (24) PRIME COMP. SUPPLIER A (25) COMPONENT MANUFACTURER G 2 5 7 (26)  
33 34                  35                  36                  37 40                  41                  42                  43                  44                  47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The cause is determined to be deterioration of the diaphragm. The valve was repaired  
1 1 | and the release was evaluated and determined to be 0.0084.7% of the Tech Spec. limits.  
1 2 |  
1 3 |  
1 4 |

FACILITY STATUS E (28) % POWER 1 0 0 (29) OTHER STATUS NA (30) METHOD OF DISCOVERY A (31) DISCOVERY DESCRIPTION Operator Observation (32)  
8 9      10 12 13                  44 45      46                  80  
 ACTIVITY CONTENT RELEASED OF RELEASE L (33) M (34) AMOUNT OF ACTIVITY 0.2062 Ci (35) LOCATION OF RELEASE Tank to Discharge Canel (36)  
8 9      10 11                  44 45                  80  
 PERSONNEL EXPOSURES NUMBER 0 0 0 (37) TYPE Z (38) DESCRIPTION NA (39)  
8 9      11 12 13                  44 45                  80  
 PERSONNEL INJURIES NUMBER 0 0 0 (40) DESCRIPTION NA (41)  
8 9      11 12 13                  44 45                  80  
 LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) DESCRIPTION NA (43)  
8 9      11 12 13                  44 45                  80  
 PUBLICITY ISSUED DESCRIPTION N (44) 8007070 397 (45) NRC USE ONLY  
8 9      10                  44 45                  68 69                  80

ATTACHMENT 2

SURRY POWER STATION, UNIT NO. 1

DOCKET NO: 50-280

REPORT NO: 80-038/03L-0

EVENT DATE: 6-10-1980

TITLE OF REPORT

VALVE 1-BR-236 MALFUNCTION

1. Description of Event:

During steady state operation of Surry Unit No. 1 at 100% Power, an operator discovered that the isolation valve (1-BR-236) for 1-BR-TK-2B was leaking during the release of 1-BR-TK-2A thereby causing an unsampled release from Tank B.

2. Probable Consequences/Status of Redundant Systems:

The flow path and flow rate were being monitored by the installed instrumentation. The system had the capability to close the flow path to the discharge canal header if the activity in the discharge line exceeded the set point for the radiation monitor. Therefore the health and safety of the public were not affected.

3. Cause of Event:

The cause is determined to be deterioration of valve diaphragm.

4. Immediate Corrective Action:

The release was evaluated and determined to be 0.00847% of the Tech. Spec. Limits. The valve was repaired.

5. Scheduled Corrective Action:

None required.

6. Action Taken to Prevent Recurrence:

A program for the routine inspection of the valves(MMP-C-V-001.) is in effect. The diaphragms or other components that do not pass the inspection are being replaced. The diaphragm in question was replaced on May 12, 1980. Therefore the event is determined to be a random event. Therefore no other action is considered necessary.

7. Generic Implications:

None