

VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

March 16, 1977

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. 102
PO&M/TAP:dgt
Docket No. 50-280
License No. DPR-32

Dear Mr. Moseley:

Pursuant to Surry Power Station Technical Specification 6.6.2, the Virginia Electric and Power Company hereby submits a copy of Reportable Occurrence No. RO-S1-77-08.

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,

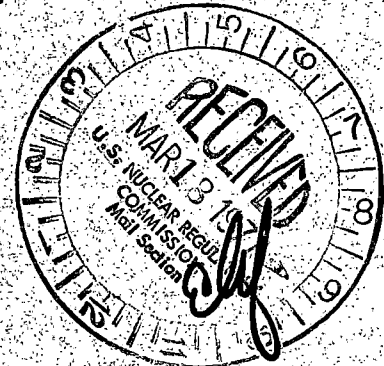
C. M. Stallings

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

Enclosures

40 copies RO-S1-77-08

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



770780014

LICENSEE EVENT REPORT

CONTROL BLOCK:

--	--	--	--	--	--	--	--	--	--

[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME:

0	1	V	A	S	P	S	1
---	---	---	---	---	---	---	---

 LICENSE NUMBER:

0	0	0	-	0	0	0	0	0	0	-	0	0
---	---	---	---	---	---	---	---	---	---	---	---	---

 LICENSE TYPE:

4	1	1	1	0
---	---	---	---	---

 EVENT TYPE:

0	3
---	---

CATEGORY:

0	1
---	---

 CONT P O REPORT TYPE:

L

 REPORT SOURCE:

L

 DOCKET NUMBER:

0	5	0	-	0	2	8	0
---	---	---	---	---	---	---	---

 EVENT DATE:

0	2	2	0	7	7
---	---	---	---	---	---

 REPORT DATE:

0	3	0	9	7	7
---	---	---	---	---	---

EVENT DESCRIPTION

0	2
---	---

 During normal operation at 100% power, recirculation from the Boric Acid Storage Tank

0	3
---	---

 "B" and the Boron Injection Tank (BIT) was secured briefly to replace a leaking

0	4
---	---

 diaphragm in valve 1-CH-98. A 150MWe/hr rampdown was initiated when recirculation was

0	5
---	---

 halted. This event is contrary to Technical Specification 3.2.C.6 and is reportable

0	6
---	---

 per Technical Specification 6.6.2.6(2). (RO-S1-77-08)

SYSTEM CODE:

P	C
---	---

 CAUSE CODE:

E

 COMPONENT CODE:

V	A	L	V	E	X
---	---	---	---	---	---

 PRIME COMPONENT SUPPLIER:

A

 COMPONENT MANUFACTURER:

G	2	5	5
---	---	---	---

 VIOLATION:

Y

CAUSE DESCRIPTION

0	8
---	---

 Due to excessive wear of the diaphragm in valve 1-CH-98, the valve displayed evidence

0	9
---	---

 of leakage. The diaphragm failure experienced was most probably related to valve

1	0
---	---

 overtightening when shutting. However, because the diaphragm material (con't)

FACILITY STATUS:

E

 % POWER:

1	0	0
---	---	---

 OTHER STATUS:

NA

 METHOD OF DISCOVERY:

B

 DISCOVERY DESCRIPTION:

NA

FORM OF ACTIVITY RELEASED:

Z

 CONTENT OF RELEASE:

Z

 AMOUNT OF ACTIVITY:

NA

 LOCATION OF RELEASE:

NA

PERSONNEL EXPOSURES

NUMBER:

0	0	0
---	---	---

 TYPE:

Z

 DESCRIPTION:

NA

PERSONNEL INJURIES

NUMBER:

0	0	0
---	---	---

 DESCRIPTION:

NA

OFFSITE CONSEQUENCES

1	5
---	---

 NA

LOSS OR DAMAGE TO FACILITY

TYPE:

Z

 DESCRIPTION:

NA

PUBLICITY

1	7
---	---

 NA

ADDITIONAL FACTORS

1	8
---	---

 Because the capabilities of the Safety Injection System were not impaired by this

1	9
---	---

 event, the health and safety of the general public were not affected.

NAME: T. L. Baucom PHONE: 357-3134

CAUSE DESCRIPTION (CONTINUED)

has a limited life span, this could have been a contributing factor to the failure. This has been a recurring failure; therefore, to reduce the probability of further such occurrences, two programs have been devised.

1. A preventive maintenance program which directs the periodic replacement of all diaphragms in borated systems before the end of their life span has been implemented as of March 1, 1977.
2. A training program to educate the affected individuals in the proper care and operation of Grinnell diaphragm valves is under development.

During this repair, the BIT remained at full capacity and would have performed as expected if it had been required.