UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA ST., N.W., SUITE 3100
ATLANTA, GEORGIA 30303

AUG 1 2 1982

INVESTIGATION REPORT NOS. 50-280/82-12 and 50-281/82-12

SUBJECT: Virginia Electric and Power Company
Surry Nuclear Power Plant

Possible Material False Statement

DATES OF INVESTIGATION: April 28 - May 26, 1982

INVESTIGATOR: [signature] 07-30-82
J. Y. Vorse, Regional Investigator Date Signed
Enforcement and Investigations Staff

REVIEWED BY: [signature] 7-30-82
C. E. Alderson, Director Date Signed
Enforcement and Investigations Staff

8209020549 820812
PDR ADOCK 05000280
Q PDR

SUMMARY OF INVESTIGATION

VIRGINIA ELECTRIC AND POWER COMPANY

SURRY NUCLEAR PLANT

APRIL 28 - MAY 26, 1982

A. INTRODUCTION

On April 18, 1982, a valve was opened to initiate the transfer of gaseous waste from the gas stripper surge tank to the waste gas surge drum. A relief valve between tanks opened unexpectedly, thereby causing an unplanned gaseous release exceeding Technical Specification limits. The licensee reported the event to the NRC via the Emergency Notification System. Licensee Event Report (LER) 82-047-01-T was initiated outlining details of the event.

On April 19, 1982, an NRC Radiation Specialist arrived on site to review the event. He also reviewed previous LERs to determine if the site had any similar events in the past. One LER, No. 82-022-03-L, showed a similar event had occurred on February 9, 1982. The radiation monitor strip chart was reviewed and it was noted that the process vent noble gas monitor had gone off scale during the earlier event. The NRC Radiation Specialist (inspector) reviewed appropriate documentation, conducted interviews, and concluded that the event should have been reported.

B. SCOPE OF INVESTIGATION

Pursuant to the authority provided by Section 161.c of the Atomic Energy Act of 1954, as amended, an investigation was initiated by the NRC on April 28, 1982. The purpose of the investigation was to determine the facts and circumstances surrounding the unreported February 1982 event and to identify any willful or deliberate attempt to withhold reportable information from the NRC.

The investigation included:

1. Interviews of responsible licensee personnel who were involved with or had knowledge of the incident.

2. Review of appropriate regulatory requirements, NRC records and licensee procedures and records including:

   - Title 10, Code of Federal Regulations
   - Control room radiation monitor strip charts
   - Boron recovery, liquid and gaseous waste log
   - Licensee Abnormal Procedure 5.1
   - Design Drawings for waste gas system
   - Licensee Event Reports
   - Licensee Maintenance Report

C. FINDINGS

1. The investigation did not disclose any information that would support a conclusion that reportable information was willfully withheld from the NRC. Rather, the information obtained indicates that an inadequate evaluation of the event by site personnel led them to the erroneous

conclusion that a reportable release had not occurred. The licensee was cited for an inadequate evaluation, exceeding radioactivity release limits and failure to report the release within one hour, in the Notice of Violation associated with the NRC Radiation Specialist's inspection report, Nos. 50-280/82-09 and 50-281/82-09.

2. The information obtained from personnel interviewed indicates an unacceptable attitude on the part of operations (control room) and health physics personnel with regard to control room indications of unusual plant conditions. That is, both control room and health physics personnel inappropriately discounted instrument readings which indicated abnormal plant conditions based on the assumption of instrument failure without sufficient data or evaluation to support that assumption.