

LICENSEE EVENT REPORT

CONTROL BLOCK: 1

(PLEASE PRINT OR TYPE REQUIRED INFORMATION)

01 VASPS1200-00000-00341111145

CON'T

01 L605000280701238080218809

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 | During normal operation, flow was lost from Boric Acid Transfer Pump 1-CH-P-2A. Unit
03 | ramp down was commenced until the "B" pump was placed in service. This is contrary to
04 | T.S. 3.2.b.4 and is reportable according to T.S. 6.6.2.b.2. Since the redundant pump
05 | was operable and appropriate Tech. Spec. action initiated, the health and safety of
06 | the public were not affected.
07 |
08 |

09 PC11 B12 C13 PUMPXX14 B15 Z16
17 80 009 03 L 0
A18 G19 B20 Z21 0000 Y23 N24 A25 G200026

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 | Upon disassembly of 1-CH-P-2A, it was discovered that the pump shaft had broken inside
11 | the pump casing. Improper installation during previous maintenance on the pump is the
12 | suspected cause. A new shaft was installed in the "A" pump.
13 | The maintenance procedures for the pumps have been updated to provide proper
14 | dimensional verifications during manufacture of replacement parts and assembly of the pumps.

15 E28 10029 NA A31 Operator Observation
16 Z33 Z34 NA NA NA
17 00037 Z38 NA
18 00040 NA
19 Z42 NA
20 N44 NA

8002220 373

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NRC USE ONLY

GPO 617-926

ATTACHMENT 1 (PAGE 1 OF 1)
SURRY POWER STATION, UNIT 1

DOCKET NO: 50-280

REPORT NO: 80-009/03L-0

EVENT DATE: 01-23-80

TITLE OF REPORT: Failure of Boric Acid Transfer Pump 1-CH-P-2A

1. DESCRIPTION OF EVENT:

During normal operation, with the Unit at 100% power, Control Room indication revealed loss of flow from Boric Acid Transfer Pump 1-CH-P-2A which was in service at the time. Unit ramp down was commenced until the "B" pump was placed in service. This event is reportable in accordance with T.S. 6.6.2.b.2.

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT SYSTEMS:

Since the appropriate T.S. action was implemented and since the redundant pump was operable, the health and safety of the public were not affected.

3. CAUSE:

The suspected cause of the event was improper installation of the pump shaft sleeve and impellor during previous maintenance work on the pump. This caused the shaft to fail in service.

4. IMMEDIATE CORRECTIVE ACTION:

The redundant pump was placed in service. A new shaft was installed in the A pump.

5. SUBSEQUENT CORRECTIVE ACTION:

None required.

6. ACTION TAKEN TO PREVENT RECURRENCE:

The maintenance procedures for the pumps have been updated to provide proper dimensional verifications during manufacture of replacement parts and assembly of the pumps.

7. GENERIC IMPLICATIONS:

None.

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