NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

UPDATED REPORT-PREVIOUS REPORT DATED 3-27-81

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	VASPS1 (2)	00-00000-00 (3)	41111 (4)	(5)
	LICENSEE CODE	LICENSE NUMBER	LICENSE TYPE	CAT

CON'T

0 1	REPORT SOURCE L (6)	0500028 0 (7)	022581 (8)	050481 (9)
		DOCKET NUMBER	EVENT DATE	REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On February 25,1981, radiation monitor recorder (RR-175) was found to be printing
0 3 erratically. This is contrary to T.S. 3.11A.5, 3.11.B.4, 4.9C and is reportable per
0 4 T.S. -6.6.2.b(4). A liquid waste release that was in progress was terminated
0 5 immediately. The associated radiation monitors, including the alarm and automatic
0 6 actuating functions, were operable. Therefore, the health and safety of the public
0 7 were not affected.
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	MC (11)	E (12)	B (13)	INSTRU (14)	R (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	81	—	004	/	03	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
A (18)	Z (19)	Z (20)	Z (21)	0000	Y (23)	N (24)	A (25)	H260 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause was a loose gear on the balance motor, thereby allowing the drive cable to
1 1 slip. A set screw on the drive gear was tightened and the recorder returned to
1 2 service.
1 3
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	H (28)	000 (29)	N/A	A (31)	Operator Observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	N/A	N/A

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	000 (37)	Z (38)	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	000 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	N/A

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	N/A	

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UPDATED REPORT-PREVIOUS REPORT DATED 3-27-81

ATTACHMENT 1 (PAGE 1 of 1)
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 81-004/03X-1
EVENT DATE: 02-25-81

TITLE OF REPORT: RADIATION MONITOR RECORDER (RR-175) MALFUNCTION

1. DESCRIPTION OF EVENT:

With Unit 1 defueled, and Unit 2 operating steady state at 100% power, radiation monitor recorder (RR-175) was found to be printing erratically and therefore was declared inoperable. This is contrary to T.S. 3.11.A.5, T.S. 3.11.B.4, and T.S. 4.9C and is reportable as per T.S. 6.6.2.b.(4).

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT SYSTEMS:

The radiation monitor recorder (RR-175) serves to record, for permanent record, the gross activity of liquids and gases being released. The recorder, in itself, does not mitigate the consequences of any system malfunction. The associated radiation monitors, including the alarm and automatic actuating functions, remained operable. The discharge tunnel radiation monitor and its recorder remained operable. Therefore, the health and safety of the public were not affected.

3. CAUSE:

The cause of the recorder malfunction was due to a loose gear on the balance motor which allowed the drive cable to slip.

4. IMMEDIATE CORRECTIVE ACTION:

The immediate corrective action was to terminate a liquid waste release that had just started. Also, as outlined in abnormal procedure 5.16 and 5.17, a check was made to insure no other releases were progress.

5. SUBSEQUENT CORRECTIVE ACTION:

A set screw on the loose drive gear was tightened and the drive cable was replaced. The recorder was proven operable and returned to service.

6. ACTIONS TAKEN TO PREVENT RECURRENCE:

Preventative maintenance is performed on these recorders at least twice per year. Therefore, no additional actions are deemed necessary.

7. GENERIC IMPLICATIONS:

This is a random event and as such is not considered to be generic.