

LICENSEE EVENT REPORT

CONTROL BLOCK (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

V A S P S 1 1 0 0 0 - 0 0 0 0 0 0 - 0 0 0 3 6 1 1 1 1 1 4 5
LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 31 DAY 36 37REPORT SOURCE 1 6 0 5 0 0 0 0 2 8 0 7 1 1 1 1 5 8 1 5 1 2 0 1 7 8 1 1 9
DOCKET NUMBER 61 62 EVENT DATE 66 67 REPORT DATE 80 81

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

With the unit operating at 100% steady state power, a loss of flow through RM-6M-101 and 102, Process Vent Monitors was discovered. The radiation monitor sample pump circuit breaker was noted to have tripped. This is contrary to T.S.-2.11.B.5, and reportable per T.S.6.6.2.b(4). The H.P. accountability sample, that was evaluated after this event, indicated that releases made during this event were within T.S. limits. The health and safety of the public were not affected.

SYSTEM CODE 11 M I C 12 X 13 Z 14 P U M P X X 15 H 16 Z
CAUSE CODE 11 X 12 X 13 Z 14 P U M P X X 15 H 16 Z
CAUSE SUBCODE 12 Z 13 Z 14 P U M P X X 15 H 16 Z
COMPONENT CODE 14 P U M P X X 15 H 16 Z
COMP SUBCODE 15 H 16 Z
VALVE SUBCODE 16 Z
LE/RC REPORT NUMBER 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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SHUTDOWN METHOD 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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ATTACHMENT SUBMITTED 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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COMPONENT MANUFACTURER 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

The loss of flow was the result of a tripped circuit breaker for the radiation monitor sample pump. A cause for the tripped breaker could not be determined. The breaker was reset and the pump started. The pump was verified to be turning freely and drawing normal current.

FACILITY STATUS 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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OTHER STATUS 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
METHOD OF DISCOVERY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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ACTIVITY RELEASED OF RELEASE 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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PERSONNEL EXPOSURES NUMBER 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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LOSS OF OR DAMAGE TO FACILITY TYPE 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
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NRC USE ONLY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

NAME OF REPORTER J. L. Wilson

PHONE (804) 357-3184

8000084 B42
LER # 280-81069
EVENT DATE 81 11 15
INFORMED 81 12 15 J.H.
*SAC REVD

TO: Records Center
INPO
1820 Water Place
Atlanta, Georgia 30339

SURRY POWER STATION

Please attach the enclosed to LER 81-069/03L-0
forwarded to you via VEPCO Letter Serial 81-074
dated December 7, 1981.

O. J. Costello
Staff Assistant

ATTACHMENT 1
SURREY POWER STATION, UNIT NO. 1
DOCPET NO: 50-280
REPORT NO: 81-069/03L-0
EVENT DATE: 11-15-81

TITLE OF THE EVENT: NO FLOW THROUGH RM-GW 101/102

1. DESCRIPTION OF EVENT:

With the unit operating at 100% steady state power, a loss of flow through RM-GW-101 and 102, Process Vent Gas and Particulate Monitors was discovered. The radiation monitor sample pump circuit breaker was discovered to have tripped. This event is contrary to I.S.-3.11.B.5 and reportable per T.S.-6.6.2.b.(4).

2. PROBABLE CONSEQUENCES OF OCCURRENCE:

The Process Vent System is monitored by RM-GW-101 and 102. In addition, a Health Physics accountability sampler provides cumulative samples. The HP accountability sample, that was analyzed after this occurrence, indicated that the releases made during the event were within allowable Tech. Spec. limits. Therefore, the health and safety of the public were not affected.

3. CAUSE:

The loss of flow through the radiation monitors was the result of a trip of the circuit breaker for the sample pump. A cause for the tripped breaker could not be determined.

4. IMMEDIATE CORRECTIVE ACTION:

The breaker was reset, and the pump started. Air flow was verified to be satisfactory. The monitor readings were verified to be within specifications.

5. SUBSEQUENT CORRECTIVE ACTION:

Electricians checked the pump motor and found it to be turning freely, and drawing normal current.

6. ACTION TAKEN TO PREVENT RECURRENCE:

None are deemed necessary.

7. GENERIC IMPLICATIONS:

None.