LICENSEE EVENT REPORT

CONTROL BLOCK: [| | | | |] (1) (PLEASE PRINT OR TY LL REQUIRED INFORMATION)

Line	Field	Entry
0 1	LICENSEE CODE (9–14)	V A S P S 1 (2)
	LICENSE NUMBER (15–25)	0 0 - 0 0 0 0 0 - 0 0 (3)
	LICENSE TYPE (26–30)	4 1 1 1 1 (4)
	CAT (57–58)	(5)
CON'T 0 1	REPORT SOURCE (60)	L (6)
	DOCKET NUMBER (61–68)	0 5 0 0 0 2 8 0 (7)
	EVENT DATE (69–74)	0 4 1 0 8 1 (8)
	REPORT DATE (75–80)	0 5 0 8 8 1 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On April 10,1981, the Process Vent radiation monitor was found inoperable due to a
0 3 broken pump drive belt. A temporary repair to the failed belt was made. Approximately
0 4 sixteen hours later, the drive belt failed again. This is contrary to T.S.-3.11.B.5.
0 5 b and is reportable per T.S-6.6.2.b(4). An independent H.P. accountability sampler
0 6 verified that the normal release from the Process Vent system was within Tech. Spec.
0 7 limits. Therefore, the health and safety of the public were not affected.
0 8

Line	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
0 9	M C	E	B	P U M P X X	H	Z

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 1	—	0 0 8	/	0 3	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
A	Z	Z	Z	0 0 0 0	Y	N	A	V 1 1 5

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The exact cause cannot be determined, however, misalignment is suspected. Following
1 1 the second event, the drive belt was replaced with a new belt and the Radiation
1 2 Monitor verified operable.
1 3
1 4

Line	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
1 5	X	0 0 0	S/G Replacement	A	Operational Event

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

PERSONNEL EXPOSURES

Line	NUMBER (37)	TYPE (38)	DESCRIPTION (39)
1 7	0 0 0	Z	N/A

PERSONNEL INJURIES

Line	NUMBER (40)	DESCRIPTION (41)
1 8	0 0 0	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

Line	TYPE (42)	DESCRIPTION
1 9	Z	N/A

PUBLICITY

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

NAME OF PREPARER J. L. Wilson PHONE: (804) 357-3184

8105150296

ATTACHMENT i
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 81-008/03L-0
EVENT DATE: 04-10-81

TITLE OF EVENT: RADIATION MONITOR (GW-101/102) PUMP FAILURE

1. DESCRIPTION OF EVENT:

On April 10,1981, the Process Vent radiation monitor, RM-GW-101/102, was found inoperable due to a broken pump drive belt. Due to a lack of readily available drive belts, a temporary repair to the failed belt was made. Approximately sixteen hours later, the drive belt failed again. This is contrary to Technical Specification 3.11.B.5.b and is reportable per Technical Specification 6.6.2.b(4).

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT SYSTEMS:

The Process Vent System is monitored by RM-GW-101, 102 and the Health Physics accountability sampler. The H.P. 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 exact cause cannot be determined, however, misalignment is suspected.

4. IMMEDIATE CORRECTIVE ACTION:

For both events, the immediate corrective action was to carry out the actions setforth in abnormal procedure No. 5.16, e.g. input source isolation.

5. SUBSEQUENT CORRECTIVE ACTION:

Following the second event, the drive belt was replaced with a new belt and the Radiation Monitor verified operable.

6. ACTION TAKEN TO PREVENT RECURRENCE:

Since craft personnel are already aware of the consequences of misalignment, no additional action is deemed necessary.

7. GENERIC IMPLICATIONS:

This appears to be an isolated event, therefore not generic.