NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

01 | LICENSEE CODE: V A S P S 1 (2) | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT (5)

CON'T 01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 2 8 0 (7) | EVENT DATE: 1 1 1 7 7 8 (8) | REPORT DATE: 1 2 1 1 7 8 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal power operation, manual valves 1-BD-8, 18, 28 were closed in an attempt
03 to stop a leak in a service water line on which maintenance was being performed.
04 Closure of these valves terminated flow through the blowdown radiation monitors
05 (RM-SS-112, 113). This is contrary to Technical Specification 3.11.A.6 and is
06 reportable per Technical Specification 6.6.2.b.(2).

09 | SYSTEM CODE: H I (11) | CAUSE CODE: A (12) | CAUSE SUBCODE: A (13) | COMPONENT CODE: V A L V E X (14) | COMP. SUBCODE: P (15) | VALVE SUBCODE: D (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR: 7 8 | — | SEQUENTIAL REPORT NO.: 0 4 2 | / | OCCURRENCE CODE: 0 3 | REPORT TYPE: L | — | REVISION NO.: 0

ACTION TAKEN: H (18) | FUTURE ACTION: Z (19) | EFFECT ON PLANT: Z (20) | SHUTDOWN METHOD: Z (21) | HOURS (22): 0 0 0 0 | ATTACHMENT SUBMITTED: Y (23) | NPRD-4 FORM SUB.: N (24) | PRIME COMP. SUPPLIER: Z (25) | COMPONENT MANUFACTURER: V 1 3 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Operator error was the cause of the event. Upon discovery of the discrepancy the
11 immediate corrective action was to re-establish flow through the blowdown radiation
12 monitors as required by Technical Specifications.

15 | FACILITY STATUS: E (28) | % POWER: 1 0 0 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: Z (31) | DISCOVERY DESCRIPTION (32): NA

16 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

17 | PERSONNEL EXPOSURES NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

18 | PERSONNEL INJURIES NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

19 | LOSS OF OR DAMAGE TO FACILITY (43) TYPE: Z (42) | DESCRIPTION: NA

20 | PUBLICITY ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

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NAME OF PREPARER: T. L. Baucom PHONE: (804) 357-3184

GPO 917-926

Surry Power Station, Unit 1
Docket No: 50-280
Report No: 78-042/03L-0
Event Date: 11/17/78

Title of Event: Blowdown Radiation Monitors Low Flow

1. Description of Event:

During normal power operation, manual valves 1-BD-8, 18, 28 were closed in an attempt to stop a leak in a service water line on which maintenance was being performed. Closure of these valves terminated flow through the blowdown radiation monitors (RM-SS-112, 113). This is contrary to Technical Specification 3.11.A.6 and is reportable per Technical Specification 6.6.2.b.(2).

2. Probable Consequences

Flow through the blowdown radiation monitors was interrupted for four to five minutes. The backup radiation monitor in the discharge tunnel remained operational during this interrupted period. Thus, the health and safety of the general public was not affected and there are no consequences of this event.

3. Cause of Event:

Operator error was the cause of the event. The closure of other valves could have provided leak isolation without interrupting flow to the blowdown radiation monitors.

4. Immediate Corrective Actions:

Upon discovering the discrepancy, the immediate operator action was to re-establish flow to the blowdown radiation monitors as required by Technical Specifications.

5. Subsequent Corrective Actions:

Appropriate personnel have been re-instructed in this matter.

6. Actions Taken to Prevent Recurrence:

None necessary.

7. Generic Implications:

None