NRC FORM 366 (7-77) U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

"UPDATED REPORT-PREVIOUS REPORT DATED 04/13/81

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

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

CON'T 0 1 REPORT SOURCE L (6) | 0 5 0 0 0 2 8 0 (7) | 0 3 1 6 8 1 (8) | 0 5 0 7 8 1 (9)
DOCKET NUMBER — EVENT DATE — REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 With Unit 1 defueled and Unit 2 at 100% power, power was lost, for five minutes, to
0 3 the following radiation monitors: RM-GW0101, 102; RM-VG-103, 104; RM-LW-108; and
0 4 RM-SW-107. This is contrary to T.S. -3.11.A.5, 3.11.B.4, 3.7 and 4.9C and is
0 5 reportable per T.S. - 6.6.2.b(4). Since the applicable AP's were performed and the
0 6 release that was in progress was terminated immediately, the health and safety of
0 7 the public were not affected.
0 8

0 9 SYSTEM CODE: M C (11) | CAUSE CODE: A (12) | CAUSE SUBCODE: C (13) | COMPONENT CODE: C K T B R K (14) | COMP. SUBCODE: A (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR 8 1 | — | SEQUENTIAL REPORT NO. 0 0 7 | / | OCCURRENCE CODE 0 3 | REPORT TYPE X | — | REVISION NO. 1

ACTION TAKEN A (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 L (25) | COMPONENT MANUFACTURER X 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Inadvertent shorting of a test lead to ground caused a supply fuse to blow, thereby
1 1 creating a loss of power to the monitors. The fuse was replaced and the monitors
1 2 returned to service within five minutes.
1 3
1 4

1 5 FACILITY STATUS X (28) | % POWER 0 0 0 (29) | OTHER STATUS (30) Defueled | METHOD OF DISCOVERY A (31) | DISCOVERY DESCRIPTION (32) Operational Event

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

PERSONNEL EXPOSURES
1 7 NUMBER 0 0 0 (37) | TYPE Z (38) | DESCRIPTION (39) N/A

PERSONNEL INJURIES
1 8 NUMBER 0 0 0 (40) | DESCRIPTION (41) N/A

LOSS OF OR DAMAGE TO FACILITY (43)
1 9 TYPE Z (42) | DESCRIPTION N/A

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

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UPDATED REPORT-PREVIOUS REPORT DATED 04-13-81

ATTACHMENT 1
SURRY POWER STATION, UNIT 1
DOCKET NO: 50-280
REPORT NO: 81-007/03X-1
EVENT DATE: 3-16-81

TITLE OF EVENT: LOSS OF POWER TO RADIATION MONITORS

1. DESCRIPTION OF EVENT:

With Unit No. 1 defueled and Unit No.2 at 100% power, electrical power was lost to the following radiation monitors: RM-GW-101, 102 (process vent); RM-VG-103, 104 (Ventilation Vent); RM-LW-108 (Liquid Waste); and RM-SW-107 (component cooling service water). This is contrary to Tech. Spec. 3.11.A.5, 3.11.B.4, 4.9C and 3.7, table 3.7-5.
This event is reportable per Tech. Spec. 6.6.2.b(4).

2. PROBABLE CONSEQUENCES AND STATUS OF REDUNDANT EQUIPMENT:

The above radiation monitors serve to provide indication and recording of gross activity levels. In addition, they provide alarm functions and selected monitors provide control actions. Since the actions required by applicable abnormal procedures were performed, e.g. termination of liquid waste release, the release that was in progress was within allowable Tech. Spec. limits, and all the monitors were returned to service within five minutes, the health and safety of the public were not affected.

3. CAUSE:

The loss of power to the monitors was due to a blown fuse. The blown fuse was caused by the inadvertent shorting of a test lead to ground while performing radiation monitor calibration checks.

4. IMMEDIATE CORRECTIVE ACTION:

Applicable abnormal procedures were performed. The blown fuse was replaced and all radiation monitors were returned to service within five minutes.

5. SUBSEQUENT CORRECTIVE ACTION:

None.

6. ACTIONS TAKEN TO PREVENT RECURRENCE:

Since procedures are available to cope with this type failure and maintenance personnel are well versed in the possible results of personnel error, no additional action is deemed necessary.

7. GENERIC IMPLICATION:

None.