

LICENSEE EVENT REPORT

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

0 1 | V | A | S | P | S | 1 | 0 | 0 | - | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | _____ | _____ | _____ | 5
E 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 37 CAT 56 58

CONT
0 1 | L | 0 | 5 | 0 | 0 | 0 | 2 | 8 | 0 | 7 | 1 | 1 | 2 | 1 | 8 | 2 | 8 | 1 | 2 | 1 | 3 | 8 | 2 | 9
E 6 REPORT SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
0 1 | On November 21, 1982, radiation monitor recorder (RR-175) was found to be
0 2 | inoperable. This is contrary to T.S.3.11.B.4 and 4.9C and is reportable per
0 3 | T.S.6.6.2.b(4). All releases in progress were terminated immediately. The
0 4 | associated radiation monitors, including the alarms and automatic actuating
0 5 | functions, were operable. Therefore, the health and safety of the public would
0 6 | not have been affected.
0 7 | _____
0 8 | _____

0 9 | SYSTEM CODE | CAUSE CODE | CAUSE SUBCODE | COMPONENT CODE | COMP. SUBCODE | VALVE SUBCODE
M | C | E | I | N | S | T | R | U | R | Z
9 10 11 12 13 14 15 16
EVENT YEAR | SEQUENTIAL REPORT NO. | OCCURRENCE CODE | REPORT TYPE | REVISION NO.
8 | 2 | 1 | 1 | 3 | 0 | 3 | L | 0
21 22 23 24 25 26 27 28 29 30 31 32
LER/RO REPORT NUMBER | ACTION TAKEN | FUTURE ACTION | EFFECT ON PLANT | SHUTDOWN METHOD | HOURS | ATTACHMENT SUBMITTED | NPD-4 FORM SUB. | PRIME COMP. SUPPLIER | COMPONENT MANUFACTURER
B | Z | Z | Z | 0 | 0 | 0 | 0 | Y | N | A | H | 2 | 6 | 0
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
1 0 | The inoperability was caused by a slipped drive cable. The drive cable was
1 1 | re-installed and the recorder returned to service.
1 2 | _____
1 3 | _____
1 4 | _____

1 5 | FACILITY STATUS | % POWER | OTHER STATUS | METHOD OF DISCOVERY | DISCOVERY DESCRIPTION
E | 1 | 0 | 0 | N/A | A | Operator's Observation
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

1 6 | ACTIVITY RELEASED | CONTENT OF RELEASE | AMOUNT OF ACTIVITY | LOCATION OF RELEASE
Z | Z | N/A | N/A
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

1 7 | PERSONNEL EXPOSURES | NUMBER | TYPE | DESCRIPTION
0 | 0 | 0 | Z | N/A
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

1 8 | PERSONNEL INJURIES | NUMBER | DESCRIPTION
0 | 0 | 0 | 0 | N/A
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

1 9 | LOSS OF OR DAMAGE TO FACILITY | TYPE | DESCRIPTION
Z | N/A
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

2 0 | PUBLICITY ISSUED | DESCRIPTION
N | N/A
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

8212210388 821213
PDR ADOCK 05000280
S PDR

ATTACHMENT 1
SURRY POWER STATION, UNIT NO. 1
DOCKET NO: 50-280
REPORT NO: 82-113/03L-0
EVENT DATE: 11-21-82

TITLE OF THE EVENT: RR-175-MALFUNCTION

1. Description of the Event

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

2. Probable Consequences and Status of Redundant Equipment

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 recorder became inoperable due to a slipped drive cable.

4. Immediate Corrective Action

The immediate corrective action was to terminate all releases that were in progress.

5. Subsequent Corrective Action

The drive cable was replaced and the recorder was returned to service.

6. Actions Taken to Prevent Recurrence

Preventative maintenance is performed on these recorders at least once per month, therefore, no additional actions are deemed necessary.

7. Generic Implications

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