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On August 7, 1984, a reactor trip occurred from the completion of the 2 of 3 logic matrix on overpower delta T protection.

Prior to this event, instrument technicians were performing periodic testing on nuclear instrument (NI-43) when a blown control power fuse in the instrument drawer resulted in completion of the NIS dropped rod protection circuitry which caused a turbine runback. Approximately 2 minutes following the start of the turbine runback, a reactor trip occurred from the completion of the 2 of 5 logic matrix on overpower delta T protection. Initiation of the OPAT trip function was caused by a decreasing OPAT setpoint. The blown fuse in instrument drawer NI-43 was caused when technicians improperly used an ungrounded power lead with a digital voltmeter to obtain a detector current measurement. Adequate instructions will be furnished for test equipment setups.

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POW 28-06-01-01

1. Description of the Event

On August 7, 1984, at 1425, with unit 2 rod control in manual at 100% power, technicians began trouble shooting a failed delta flux indicator (NI-43). In preparation to measure the detector current for channel 3 (NI-43), digital voltmeter test probes were inserted across a 1K resistor in series with a drawer mounted ammeter. Upon insertion of the test probes, one of the control power fuses blew on Nuclear Instrument (NI) 43 resulting in loss of power to the protection bistables in the NI drawer. The loss of power to the drawer resulted in completion of the NIS dropped rod protection circuitry which resulted in a turbine run-back to approximately 70%. Upon detecting the runback, the control room operator placed rods in automatic. Immediately following the dropped rod run-back, a series of overpower delta T runbacks, of approximately 5% each, ramped the turbine generator to about 300 megawatts electric.

Approximately 2 minutes following the start of the turbine run-backs, a reactor trip occurred from the completion of the 2 of 3 logic matrix on overpower delta T protection. Immediately after the reactor trip, an overtemperature delta T trip was received.

Following the reactor trip, all control and protection systems were noted to function properly except for MOV-FW-251C (EIIS No. HCV), which would not manually remain closed after the operator manually closed it.

Operators followed appropriate plant procedures and quickly stabilized the plant following the trip.

2. Safety Consequences and Implications

Four dual section, uncompensated ionization chambers are used for power range neutron flux detection. Each chamber generates current signal outputs which provide core flux signals for the power range low power trip (two of four), the power range high power trip (two of four), and a bias signal (a function of nuclear flux profile) used in the overpower and overtemperature delta T reactor trip circuits.

During the period of time that NI-43 was inoperable, the remaining three Nuclear Power Range Instruments and their protection circuits remained operable and thereby capable of performing their intended functions. A similar trip from full power would not have caused any safety limits to be exceeded as analyzed in the UFSAR. For these reasons, an unreviewed safety question was not created and the health and safety of the public were unaffected. LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

POW 28-06-01-01

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3. Cause

RC Form 366A

Instrument Technicians trouble shooting the NI 43 drawer determined that the blown fuse occurred when an AC voltage was superimposed into the protection circuitry. This happened when an ungrounded 120 VAC power cord was improperly used with a digital voltmeter to obtain detector current measurements. Grounded and ungrounded power cords can be interchanged with test equipment. In addition, the periodic test did not specify test equipment or the setup.

The initiation of the OP Δ T trip function was caused by a decreasing OP Δ T setpoint believed to be due to a negative swing in delta flux (as sensed by nuclear instrumentation).

Secondary Causes and Failures are:

Failure of the auxiliary feed MOV-FW-251C was caused by a malfunctioning timing control relay.

4. Immediate Corrective Action

Operators performed all appropriate emergency procedures and function restoration procedures to ensure the plant was returned to a stable condition.

Also, the STA performed the status tree review to ensure specific plant parameters were noted and appropriate procedures were used to maintain those parameters within safe bounds.

5. Additional Corrective Actions

The automatic control relay to the auxiliary feedwater valve MOV-FW-251C was replaced and the valve cycled satisfactorily. The reason for the decreasing OPAT setpoint is still under investigation. Additional testing, during an upcoming outage, will be needed to complete the investigation.

6. Action Taken to Prevent Recurrence

Action taken to prevent recurrence include:

- 1) Adequate instructions will be furnished for test equipment setup.
- 2) Timing control relays to auxiliary feedwater valves are being replaced with new relays on unit 2 as a precautionary measure.

7. Generic Implications

None.



VIRGINIA ELECTRIC AND POWER COMPANY

Surry Power Station P. O. Box 315 Surry, Virginia 23883

Serial No: 84-030

Docket No: 50-281

License No: DPR-37

U. S. Nuclear Regulatory Commission Document Control Desk 016 Phillips Building Washington, D.C. 20555

Gentlemen:

Pursuant to Surry Power Station Technical Specifications, the Virginia Electric and Power Company hereby submits the following Licensee Event Report for Surry Unit 2.

REPORT NUMBER

84-013-00

SEP 6 1984

This report has been reviewed by the Station Nuclear Safety and Operating Committee and will be reviewed by Safety Evaluation and Control.

Very truly yours,

R. F. Saunders Station Manager

Enclosure

cc: Mr. James P. O'Reilly Regional Administrator Suite 2900 101 Marietta Street, NW Atlanta, Georgia 30303

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