

UPDATE REPORT - PREVIOUS REPORT DATE 07-14-82  
(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONT

REPORT SOURCE	DOCKET NUMBER	EVENT DATE	REPORT DATE
L 6	050002807	061482	80506839

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

012 | With Unit 1 and Unit 2 at full power, the fire detection system was discovered to  
013 | have lost its program, thereby rendering it inoperable. This is contrary to  
014 | T.S.3.21.A.1 and is reportable per T.S.6.6.2.b.(2). The fire suppression systems  
015 | remained operable and hourly walkdowns were performed during the time the fire  
016 | detection system was inoperable. Therefore, the health and safety of the public  
017 | were not affected.

SYSTEM CODE A B 11		CAUSE CODE X 12		CAUSE SUBCODE Z 13		COMP. SUBCODE X 15				VALVE SUBCODE Z 16	
EVENT YEAR 8 2 21		SEQUENTIAL REPORT NO. 0 6 8 23		OCCURRENCE CODE 0 3 28				REPORT TYPE X 30		REVISION NO. 1 32	
ACTION TAKEN X 18		FUTURE ACTION X 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22		ATTACHMENT SUBMITTED Y 23	
NPRD FORM SUB. N 24		PRIME COMP. SUPPLIER Z 25		COMPONENT MANUFACTURER Z 9 9 9 9 26							

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The exact cause of the event has not been determined, however, at the time of the  
11 event, the Central Processing Unit was not installed in its enclosure cabinet and as  
12 a result, the program reset button remained vulnerable to manipulation. Therefore, it  
13 is believed that the program button was inadvertently reset. The system was repro-  
14 grammed and verified operational and the C.P.U. was installed in its enclosure cabinet.

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
15	E	28	100	29	N/A	30	A	31	Operator Discovery
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE			
15	Z	33	34	35	N/A	36	N/A		
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION			
17	000	37	Z	38	N/A				
PERSONNEL INJURIES		NUMBER		DESCRIPTION					
18	000	40		41	N/A				
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION					
19	Z	42		43	N/A	8305130203 830506 PDR ADOCK 05000280 S PDR			
PUBLICITY		ISSUED		DESCRIPTION					
20	N	44		45	N/A	NRC USE ONLY			

NAME OF DECEASED J. L. Wilson

DATE: (804) 357-3184

ATTACHMENT 1

SURRY POWER STATION, UNIT NO. 1

DOCKET NO: 50-280

REPORT NO: 82-068/03X-1

EVENT DATE: 06-14-82

TITLE OF THE EVENT: INOPERABLE FIRE DETECTION SYSTEM

1. Description of the Event

With Unit 1 and Unit 2 at full power, the fire detection system was declared inoperable as a result of indications on the Operator Control Module. Upon further investigation, it was determined that the fire detection system had lost its program, which rendered it inoperable. This is contrary to Tech. Spec. 2.21.A.1 and is reportable per Technical Specification 6.6.2.b.(2).

2. Probable Consequences and Status of Redundant Equipment

With the system deprogrammed, a fire in the areas monitored by the detectors would not have been indicated in the control room. However, the fire suppression systems in these areas were not affected and remained operable, and hourly walkdowns were performed during the time the fire detection system was inoperable. Therefore, the health and safety of the public were not affected.

3. Cause

A discussion with a representative of the system manufacturer suggested three possible causes for the system memory loss; a total loss of normal and battery backup power, manipulation of switches within the O.C.M. or the Central Processing Unit (C.P.U.), or a voltage spike in the system. No specific indications implicating these causes could be found. However, at the time of the event, the C.P.U. was not installed in its enclosure cabinet. (The original cabinet was not the correct size and another cabinet had been ordered.) As a result, the program reset button on the C.P.U. remained vulnerable to manipulation. Therefore, it is believed that while attempting to clear or acknowledge alarms, plant personnel pressed the program reset button and unknowingly cleared the system memory.

4. Immediate Corrective Action

Hourly plant walkdowns were performed to monitor the affected areas.

5. Subsequent Corrective Action

The fire detection system was reprogrammed and verified operational.

6. Action Taken to Prevent Recurrence

The C.P.U has been installed in its enclosure cabinet, eliminating the possibility of inadvertant manipulation of the reset button. Also, no similar events have occurred since this event, therefore no additional action is deemed necessary.

7. Generic Implications

None.