LICENSEE EVENT REPORT

	CONTROL BLOCK
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0 -	SOURCE L 6 0 5 0 0 0 2 8 0 7 0 7 2 3 8 1 E 0 8 1 8 8 1 E 6 6 6 6 6 6 6 6 6
972	With the unit at steady state full power, it was discovered that there was no lock
0 12	on the breaker handle for Loop "A" hot leg stop valve. The valve was in its proper
014	position and the breaker was verified open; therefore, the health and safety of the
(C B	public were not affected. This event is contrary to T.S. 3.3.A.12 and is reportable
0 / 6	per T.S. 6.6.2.b.(3).
0 -	
318	Bo
0 19	SYSTEM CODE CODE SUBCODE CODE SUBCODE
	SEQUENTIAL DISCOURTEROS REPORT NO. SEQUENTIAL REPORT NO. OCCURRENCS REPORT TYPE NO. NO. 17 REPORT 8 1
	ACTION FUTURE SEFECT SHUTDOWN HOURS 3 ATTACHMENT FORM SUE PRIME COMPONENT MANUFACTURES MANUFACTU
110	This event resulted from the inadvertant omission of the lock from the breaker handle
111	for the loop "A" hot leg stop valve. The corrective action was to immediately verify
112	the breaker as being open and put a lock on the breaker. The procedure will be modi-
113	fied to require a second verification of lock installation.
114	80
1 1 5	ACILITY POWER OTHER STATUS 30 METHOD OF DISCOVERY DESCRIPTION 32 E 28 1 0 0 29 N/A B 31 Operator Observation
1 6	Z (33) Z (34) N/A N/A
	# ### DESCRIPTION (39) O O O (37) Z (38) N/A
2	PERSONNEL INJURIES NUMBER DESCRIPTION (1)
	S 12 LOSS OF OR DAMAGE TO FACILITY 43 TYPE DESCRIPTION
1 9	N/ A NEC USE ONLY
2 0	SSUEZ DESCRIPTION (E) N/A SSUEZ DESCRIPTION (E)
8108	(804) 357-3184 E
PDR	NDOCK 05000280 PDR

ATTACHMENT 1

SURRY POWER STATION, UNIT 1

DGCKET NO: 50-280

REPORT NO: 81-031/03L-0 EVENT DATE: 07-23-81

TILE OF THE EVENT: "A" LOOP STOP VALVE BREAKER NOT LOCKED OPEN

1. DESCRIPTION OF THE EVENT:

With the unit at steady state full power, it was discovered that the breaker for Loop "A" hot leg isolation valve was not locked in the open position. This is contrary to T.S. 3.3.A.12 and is reportable per T.S. -6.6.2.b.(3).

2. PROBABLE CONSEQUENCES OF OCCURRENCE:

The valve was in its proper position and its breaker was open as required by Technical Specifications; therefore, the health and safety of the public were not affected.

3. CAUSE OF THE EVENT:

This event resulted from the inaccertant omission of the lock from the circuit breaker for the Loop "A" hot leg isolation valve.

4. IMMEDIATE CORRECTIVE ACTION:

The immediate corrective action was to verify the breaker in its proper position and lock it, thus satisfying the applicable Technical Specification.

5. SUBSEQUENT CORRECTIVE ACTION:

No further actions were required.

6. ACTIONS TAKEN TO PREVENT RECURRENCE:

The procedure will be modified to require a second verification of lock installation.

7. GENERIC IMPLICATIONS:

None.