LICENSEE EVENT REPORT

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 2 0 4 8 3 (8) | 0 3 0 4 8 3 (9)

DOCKET NUMBER · EVENT DATE · REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | With the unit at 85%, it was discovered that the latch mechanism of fire door #20

0 3 | had been taped over, causing the fire barrier to be inoperable. This is contrary to

0 4 | T.S. 3.21.G.2 and is reportable per T.S.6.6.2.b.(2). Since other fire protection

0 5 | systems remained operable, the health and safety of the public was not affected.

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0 7 |

0 8 |

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
A B (11)	A (12)	E (13)	X X X X X X (14)	Z (15)	Z (16)

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

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
B (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | Construction personnel in the area had taped over the latch. The tape was

1 1 | removed and the door was returned to operable status.

1 2 |

1 3 |

1 4 |

FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
E (28)	0 8 5 (29)	N/A	B (31)	Q. C. Inspection

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

PERSONNEL EXPOSURES

NUMBER	TYPE	DESCRIPTION (39)
0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

NUMBER	DESCRIPTION (41)
0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

TYPE	DESCRIPTION
Z (42)	N/A

8303150166 830304
PDR ADOCK 05000280
S PDR

PUBLICITY

ISSUED	DESCRIPTION (45)
N (44)	

NRC USE ONLY

NAME OF PREPARER J. L. Wilson PHONE: (804) 357-3184

ATTACHMENT 1
SURRY POWER STATION, UNIT NO. 1
DOCKET NO: 50-280
REPORT NO: 83-007/03L-0
EVENT DATE: 02-04-83

TITLE OF THE EVENT: FIRE DOOR INOPERABLE

1. Description of the Event

On 02-04-83, with both units at power, it was discovered that the latching mechanism of fire door #20 (from the Emergency Switchgear Room to the Stairwell) had been taped over, causing the door to be inoperable. This is contrary to Technical Specification 3.21.G.2 and is reportable per Technical Specification 6.6.2.b.(2).

2. Probable Consequences and Status of Redundant Equipment

The integrity of fire barriers ensures that a fire in one area of the plant will be confined, or adequately retarded from spreading to adjacent areas. All other fire doors leading to the stairwell were properly latched. Since all other fire warning and suppression systems were operable during the event, the health and safety of the public were not affected.

3. Cause

Construction Personnel taped over the door latch to provide easier access to their work area. The electric latch had not been releasing properly.

4. Immediate Corrective Action

The immediate corrective action was to remove the tape from the latch, which returned the door to operable status and re-established the fire barrier.

5. Subsequent Corrective Action

The defective latch has been repaired.

6. Action Taken to Prevent Recurrence

Management of the Construction Personnel have been informed of this event and have instructed their personnel in the proper use of fire doors.

7. Generic Implications

None.