

SOUTH CAROLINA ELECTRIC & GAS COMPANY

POST OFFICE 764

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O. W. DIXON, JR.
VICE PRESIDENT
NUCLEAR OPERATIONS

NOV 8 1982 P3:01
November 2, 1982

Mr. James P. O'Reilly, Director
U.S. Nuclear Regulatory Commission
Region II, Suite 3100
101 Marietta Street, N.W.
Atlanta, Georgia 30303

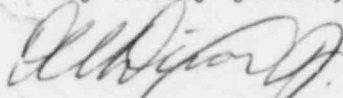
SUBJECT: Virgil C. Summer Nuclear Station
Docket No. 50/395
Operating License No. NPF-12
Thirty Day Written Report
LER 82-015

Dear Mr. O'Reilly:

Please find attached Licensee Event Report #02-015 for Virgil C. Summer Nuclear Station. This Thirty Day Report is required by Technical Specification 6.9.1.13.(b) as a result of entry into Action Statement 17 of Technical Specification 3.3.2, "Engineered Safety Feature Actuation System Instrumentation," and Action Statement 26 of Technical Specification 3.3.3.1, "Radiation Monitoring Instrumentation," on October 3, 1982.

Should there be any questions, please call us at your convenience.

Very truly yours,


O. W. Dixon, Jr.

ARK:OWD:dwf
Attachment

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DETAILED DESCRIPTION OF EVENT

On October 3, 1982, at 1008 hours, with the Plant operating in Mode 3, the sample pumps on Radiation Monitor RMA-2 (Reactor Building Air Sample) tripped due to overheated conditions in the cabinet. RMA-2 is required to be operable by Technical Specifications 3.3.2 [Table 3.3-3, Item 3. C.(2)], and 3.3.3.1 [Table 3.3-6, Item 1.b.(ii)]. The Action Statements of both Technical Specifications were complied with. The doors on the Radiation Monitor cabinet were opened in order to allow the pumps to cool. The pumps were restarted, and the monitor was returned to service on October 3, 1982, at 1400 hours.

PROBABLE CONSEQUENCES

There were no adverse consequences in that the Action Statement of both Technical Specifications referenced above were complied with. (The Reactor Building Purge Isolation Valves were closed, and redundant means were available for Reactor Coolant System leak detection.) Also, there was no radiation inventory available since the Plant had not yet achieved initial criticality.

CAUSE(S) OF THE OCCURRENCE

The cause of the occurrence was that the sample pumps in RMA-2 cabinet tripped on overheated condition due to inadequate cabinet ventilation.

IMMEDIATE CORRECTIVE ACTIONS TAKEN

Immediate corrective action was taken to open the cabinet doors in order to allow the pumps to cool. The pumps were then restarted and RMA-2 was returned to service. The monitor was out of service for approximately four (4) hours.

ACTION TAKEN TO PREVENT RECURRENCE

A Station Modification Request Form (MRF-10317) has been initiated in order to perform an engineering evaluation of the overheating condition. The results of this evaluation will determine any required modifications to the cabinet.