SOUTH CAROLINA ELECTRIC & GAS COMPANY
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O. W. DIXON, JR.
VICE PRESIDENT
NUCLEAR OPERATIONS

December 21, 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 82-050

Dear Mr. O'Reilly:

Please find attached Licensee Event Report #82-050 for Virgil C. Summer Nuclear Station. This Fourteen Day Report is required by Technical Specification 6.9.1.12.(b) as a result of not complying with Action Statement (a) of Technical Specification 3.3.3.7, "Instrumentation, Fire Detection Instrumentation," on December 7, 1982.

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

Very truly yours,

O. W. Dixon, Jr.

HCF:OWD:meb
Attachment

cc: V. C. Summer
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DETAILED DESCRIPTION OF EVENT

Technical Specification 3.3.3.7, "Fire Detection Instrumentation," requires that Fire Detection Instruments listed in Table 3.3.11 be OPERABLE. Due to computer software problems, the smoke detectors located in Intermediate Building Zone FF (Elevation 423'6", Room 236-01) have not been declared operable. In accordance with Action Statement (a) of the Technical Specification, an hourly fire watch patrol had been implemented. On December 7, 1982 with the Plant operating in Mode 1, this patrol was not performed from 1600 hours to 2000 hours.

PROBABLE CONSEQUENCES

The potential for adverse consequences as a result of the event were minimized by the following:

a) Smoke detectors immediately adjacent to the area remained operable during the event.

b) Several entries were made into the general area during the period 1600 hours to 2000 hours. Since Room 236-01 is a mezzanine elevation above the rest of the area, the detection of a fire would have been likely.

c) The subject area is of very low fire loading.

CAUSE(S) OF THE OCCURRENCE

The cause of the event is attributed to the fact that two (2) Fire Watch personnel failed to notify the Operations Shift Supervisor of problems associated with attendance. Specifically, the Fire Watch Shift Leader became ill and departed the site shortly after having assumed the station watch responsibility, but did not notify the Operations Shift Supervisor. A second fire watch person did not report to work and failed to notify the Fire Watch Shift Leader or the Operations Shift Supervisor. The combination of personnel shortage and shift leadership resulted in the failure to cover the required posts.

IMMEDIATE CORRECTIVE ACTION TAKEN

Upon discovery that the Fire Watch for the subject area was deficient, the following actions were taken:

1) The Shift Supervisor was notified

2) The Fire Protection Coordinator was called in

3) Additional personnel were called in and the required Fire Watch was posted at approximately 2000 hours.

ACTION TAKEN TO PREVENT RECURRENCE

As a result of this event the subject fire watch personnel were terminated. Also, as a measure to prevent occurrences of this type in the future, the licensee has generated correspondence to inform the fire watch personnel of correct actions to be taken in the event of absenteeism.