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

May 4, 1983

Mr. James P. O'Reilly
Regional Administrator
U. S. Nuclear Regulatory Commission
Suite 2900
101 Marietta Street, NW
Atlanta, GA 30303

SUBJECT: Virgil C. Summer Nuclear Station
Docket No. 50/395
Operating License No. NPF-12
Notice of Violation
NRC Report 83-05
"Failure to Implement Written Procedures"

Dear Mr. O'Reilly:

South Carolina Electric and Gas Company is in agreement with the alleged violation addressed in Appendix A of NRC Inspection Report 50-395/83-05.

The following is submitted in response to the two (2) areas of concern in this violation:

1. The waste discharge line was not flushed at 100 gpm for 20 minutes in accordance with System Operating Procedure (SOP-108) because of procedural inadequacies and operator error. A post discharge flush of 2000 gallons of demineralized water is required by the Corporate Health Physics Department to ensure that the liquid release piping has been flushed of all contaminated liquids. SOP-108 was inadequate in that it established a flow rate of 100 gpm, which the flush system typically cannot achieve. Operations personnel complied with the requirement to perform a flush, but failed to revise procedure SOP-108 for a flush of 2000 gallons when they were unable to obtain a flow rate of 100 gpm.

In order to prevent a future recurrence, the licensee has taken the following action:

a. A revision to SOP-108 was issued on March 24, 1983, which requires a 2000 gallon flush regardless of the obtained flow rate.

b. Procedural adherence and/or the identification and correction of procedure errors has been stressed to operations personnel.

2. On February 28, 1983, operations personnel transferred the control room supply fans from Train "B" to Train "A" in accordance with Station Operating Procedure (SOP-505) to support a maintenance inspection of the system. Maintenance personnel were not performing any work which required the fans to be removed from service during this inspection.

When the Train "B" Control Room Supply Fan (XFN-32B) was stopped, the operator failed to return the control switch to the mid (AUTO) position, which rendered XFN-32B inoperable for automatic actuation upon receipt of a control room high radiation or safety injection signal. XFN-32B was still capable of a manual start and plant Emergency Operating Procedures (EOP-1 and EOP-10) direct the operator to start any equipment which was not automatically started. The inoperable automatic start condition had existed for approximately 15 to 30 minutes prior to the discovery by the Nuclear Regulatory Commission Resident Inspector. The condition was the result of operator error mitigated by the fact that the switch, which is not spring return to auto, was not labeled to indicate an automatic position.

The violation addresses Station Administrative Procedure (SAP-205), System Status and Equipment Removal and Restoration to Service, which provides administrative controls to track systems or equipment that are out of service. The procedure is intended to be applied when conditions exist that immediate operator action cannot correct. It is not intended to track those situations where systems or equipment are made inoperable due to an operator error that can be immediately corrected. Since the fan control switch was mispositioned as a result of operator error and was immediately corrected when discovered, SAP-205 was not applied.

In order to prevent a future recurrence, the licensee has taken the following actions:

a. Operations personnel involved in this occurrence were counseled on the importance of controlled operations of safeguard equipment.

b. Station Operating Procedure (SOP-505), Control Room Ventilation Systems, and Surveillance Test Procedure (STP-124.001), Control Room Emergency Air Cleanup System Operability Test, were revised to more clearly define the position that the fan control switches should be placed in when the fans are stopped. The procedure revisions were issued on March 24 and 30, 1983, respectively.

c. Temporary labels were affixed to the fan control switches to indicate the AUTO position. Permanent switch labels are being prepared. A modification request has been submitted to provide permanent labels indicating the auto position pending a human factor review. This is scheduled to be complete by May 31, 1983.

If there are any questions, please call at your convenience.

Very truly yours,

O. W. Dixon, Jr.

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