NRC FORM 366 (12-81)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB 3150-0011 EXPIRES 4-30-82

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	LICENSEE CODE: S C V C S 1 (2)	LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3)	LICENSE TYPE: 4 1 0 0 0 (4)	CAT (5)				
CON'T 0 1	REPORT SOURCE: L (6)	DOCKET NUMBER: 0 5 0 0 0 3 9 5 (7)	EVENT DATE: 0 3 3 1 8 3 (8)	REPORT DATE: 0 8 0 4 8 3 (9)				

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During the Steam Generator Modification Outage from March to May 1983, it was
0 3 discovered that the surveillance of some Plant fire doors had not been performed
0 4 per Technical Specification 4.7.10.2(a) and (b). The event increased the proba-
0 5 bility that a fire door may not have been in the correct postion to serve as a
0 6 fire barrier. However, the Integrated Fire and Security System remained operable
0 7 for fire detection.
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	A B (11)	A (12)	A (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 8 0	/	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 (26)
G (18)	H (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Plant logs, which included the surveillance of these doors, became fragmented
1 1 when areas of the normal Radiation Control Area were altered for the outage.
1 2 As a result, watch stations failed to perform the amended surveillances as
1 3 required. Plant logs have been revised to aid in the transfer of watch
1 4 responsibilities in the future.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	D (28)	0 0 0 (29)	N/A	A (31)	Log Review

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	N/A	N/A

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	N/A

IE22

8308180255 830804
PDR ADOCK 05000395
S PDR

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	N/A	

NAME OF PREPARER H. C. Fields (signature) H. C. Fields PHONE: (803) 345-5209

SOUTH CAROLINA ELECTRIC & GAS COMPANY
POST OFFICE 764
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O. W. DIXON, JR.
VICE PRESIDENT
NUCLEAR OPERATIONS

August 4, 1983

Mr. James P. O'Reilly
Regional Administrator
U.S. Nuclear Regulatory Commission
Region II, Suite 2900
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 83-080

Dear Mr. O'Reilly:

Please find attached Licensee Event Report #83-080 for Virgil C. Summer Nuclear Station. This Thirty Day Report is required by Technical Specification 6.9.1.13.(c) as a result of not performing the surveillance requirements of Technical Specification 4.7.10.2(a) and (b), "Plant Systems, Fire Rated Assemblies," on March 17, 1983. This condition was discovered July 6, 1983.

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

Very truly yours,

O. W. Dixon, Jr.

HCF:OWD/mac/fjc
Attachment

cc: V. C. Summer
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Document Management Branch
INPO Records Center
NPCF
File (Lic./Eng.)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

During the Steam Generator Modification Outage of March 17, 1983 through May 20, 1983, fire door surveillances for various areas of the Auxiliary Building and Intermediate Building were not performed. This resulted in the failure to satisfy fully the surveillance requirements of Technical Specification 4.7.10.2(a) and (b).

The consequences of omitting the fire door surveillances increased the probability that a fire door may not have been in its correct position to serve as a fire barrier. However, the Integrated Fire and Security System (IF&S) remained operable to detect any fire in all areas affected.

Additionally, certain fire barrier penetrations were breached to accommodate modifications to plant feedwater piping during the outage. Hourly fire watch patrols were established in these areas which lessened the probability that a fire would have gone undetected.

It should be noted that the Plant was in an outage. Increased maintenance activities being performed resulted in an increased number of personnel in the Plant, and further decreased the possibility that a fire would have gone undetected.

CAUSE AND CORRECTIVE ACTIONS

The event is attributed to personnel error. The surveillance of the Intermediate Building 412' elevation is normally included on the Auxiliary Building checklist, since it is part of the Radiation Control Area (RCA). During the outage, the Intermediate Building 412' elevation was removed from the RCA and another watch station was to assume responsibility for monitoring the area. The associated logs became fragmented and as a result, neither station inspected the associated doors. This was not noted by the operators nor the Operations Supervisor.

The Auxiliary Building logs have been restructured to eliminate confusion when the Intermediate Building 412' elevation is excluded from the RCA.

Oversight on behalf of the supervisor is attributed to inattention to detail which has been addressed in a series of lectures. These lectures were completed May 27, 1983.

The licensee considers these actions adequate to prevent recurrence of this event.