SCE&G
A SCANA Company

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Refer to: RC-94-0180

Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, DC 20555

Gentlemen:

Subject: VIRGIL C. SUMMER NUCLEAR STATION
DOCKET NO. 50/395
OPERATING LICENSE NO. NPF-12
RESPONSE TO NOTICE OF VIOLATION
NRC EXAMINATION REPORT 94-300

Attached is the South Carolina Electric & Gas Company (SCE&G) response to the violation delineated in NRC Examination Report No. 50-395/94-300.

SCE&G is not in agreement with Violation 94-300-01. The basis for this disagreement is contained within the attached reply.

If there are any questions, please contact Mr. Gary J. Taylor at (803) 345-4344.

Very truly yours,

John L. Skolds

RRJ:lcd
Attachment

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RESPONSE TO NOTICE OF VIOLATION
VIOLATION NUMBER 50-395/94-300-01

I. RESTATEMENT OF VIOLATION

10 CFR 50, Appendix B, Criterion VI, states that measures shall be established to control the issuance of documents such as procedures ... which prescribe all activities affecting quality. These measures shall assure that documents,... are reviewed for adequacy and approved for release by authorized personnel and are distributed to and used at the location where the prescribed activity is performed.

Contrary to the above, the licensee failed to perform a proper review of AOP-501.2, "Total Loss of Chill Water," for adequacy prior to being distributed. The review of AOP-501.2 failed to identify the lack of operator aids necessary to complete the procedure.

II. SCE&G POSITION ON THIS VIOLATION

SCE&G denies the violation as stated above.

III. BASIS FOR SCE&G POSITION

SCE&G considers the procedure for response to a total loss of chilled water to be adequate for the successful mitigation of the event within the required time frame. The procedure was developed by an SRO licensed operator with significant review and input of the IPE engineer who also holds an SRO license and shift engineer qualification. The procedure was reviewed and verified through a "plant walkdown" utilizing an independent reviewer (SRO licensed shift supervisor).

The initial review at the time of procedure development included a walkdown of the local actions contained in the procedure. At the time of this walkdown all valves were verified to be properly identified and correctly tagged. A review of the plant labeling documentation and interviews conducted with the personnel involved with the procedure walkdowns confirms this to be the case.

During the initial procedure walkdowns a ladder was available for access in the area of the valve in question. It was expected that the ladder was normally maintained in this area and therefore the need for a dedicated ladder was not anticipated. The fact that a dedicated ladder was not available in the immediate area did not preclude the successful completion of the procedure in the required time frame.

Also, during the initial walkdown, the obscure location of two of the valves manipulated in this procedure was identified and a more descriptive location was included in the procedure. This description exceeds the normal location informati given for valves and was included in the procedure as an ad onal aid for the operator's timely and effective completion of the task.

Although some difficulties were experienced by the SRO license candidates in completing the procedure, it should be noted that all of the candidates successfully completed the associated JPM within the time frame used as the analytical basis for successful event mitigation.

SCE&G recognizes that the difficulty in locating components indicates the need for improvements in the performance of local actions for the procedure and that the operators should be more familiar with the actions of local valve manipulations. As such SCE&G has undertaken the following:

1. A shift-by-shift review of AOP-501.2 has been conducted to ensure familiarization with the task accomplished by this procedure and to increase the awareness of how these tasks are to be accomplished.

2. Dedicated ladders have been located within areas where AOP-501.2 valve manipulations require the use of such in order to gain access to the valves.

3. Immediate action was taken to correct the labeling deficiency for the missing label for the one valve identified in the inspection report.

4. Consideration for the validation of local operator actions will receive additional focus during the abnormal operating procedure review and upgrade currently in progress.