SCE&G
A SCANA Company

South Carolina Electric & Gas Company
P.O. Box 88
Jenkinsville, SC 29065
(803) 345-4040

John L. Skolds
Vice President
Nuclear Operations

10CFR50.73

February 28, 1992

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
LER 92-002 (ONO 920006)

Attached is Licensee Event Report No. 92-002 for the Virgil C. Summer Nuclear Station. This report is submitted pursuant to the requirements of 10CFR50.73(a)(2)(i).

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

Very truly yours,

John L. Skolds

CJM:JLS:cjm
Attachment

c: O. W. Dixon Jr.
R. R. Mahan
R. J. White
S. D. Ebneter
G. F. Wunder
General Managers
Marsh & McLennan
G. J. Taylor
T. L. Matlosz
S. R. Hunt
J. W. Flitter
L. J. Montondo
NRC Resident Inspector
J. B. Knotts Jr.
INPO Records Center
ANI Library
NSRC
RTS (ONO 920006)
File (818.05 & 818.07)

000053

NUCLEAR EXCELLENCE - A SUMMER TRADITION!

IE22 1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Virgil C. Summer Nuclear Station	0 5 0 0 0 3 9 5	1 OF 0 3

TITLE (4)

Improper Operation of Containment Isolation Valve Due to Personnel Error

EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR		SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
											0 5 0 0 0
0 1 2 8	9 2	9 2	—		0 0 2	— 0 0	0 2	2 8	9 2		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
W. R. Higgins, Supervisor, Licensing Support & Operating Experience	AREA CODE 8 0 3 3 4 5 - 4 0 4 2

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
A	B D	Z I S	E 0 0 5	Y							

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On January 28, 1992, at approximately 1930 hours, Operations personnel identified a noncompliance with the action requirements of Technical Specification 3.6.4, "Containment Isolation Valves." A status review of inoperable equipment logs found that on three (3) separate occasions containment isolation valve XVA-9312B, "Sample Line Return From Radiation Monitor," had been temporarily opened to facilitate the performance of a required surveillance activity. This valve had been declared inoperable on January 27, 1992, at 0400 hours, when it did not appear to close during a slave relay surveillance test that simulated a Containment Phase A Isolation. Valve XVA-9312B is located in the sample line return for Radiation Monitor RM-A2, which provides measurement of the airborne activity (Particulate, Iodine, Gas) inside the Reactor Building.

This event resulted from personnel error. During the coordination of a Reactor Building atmosphere surveillance under Technical Specification 3.4.6.2, "Operational Leakage," Operations personnel failed to recognize that the temporary restoration of the inoperable valve would be in conflict with the intent of Technical Specifications and plant procedures.

Operations and Health Physics personnel discontinued the use of the sample line return for subsequent surveillances of the Reactor Building atmosphere. The valve was found to be functional with a malfunctioning close limit switch. The valve was repaired and returned to service on February 8, 1992. In addition to these actions, Operations shift personnel will receive additional training by May 1, 1992, on the guidelines for temporary restoration of equipment as contained in Station Administrative Procedure (SAP) 205, Status Control and Removal and Restoration.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Virgil C. Summer Nuclear Static	0 5 0 0 0 3 9 5	9 2	— 0 0 2	— 0 0	0 2 OF 0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

PLANT IDENTIFICATION:

Westinghouse - Pressurized Water Reactor

EQUIPMENT IDENTIFICATION:

Containment Isolation Valve; EIIS System Code - BD

IDENTIFICATION OF EVENT:

On January 28, 1992, at approximately 1930 hours, Operations personnel identified a noncompliance with the action requirements of Technical Specification 3.6.4, "Containment Isolation Valves." A status review of inoperable equipment logs found that on three (3) separate occasions containment isolation valve XVA-9312B, "Sample Line Return From Radiation Monitor," had been temporarily opened to facilitate the performance of a required surveillance activity. Restorations of this nature are in conflict with the intent of the Technical Specification which requires the isolation of the affected penetration until repairs/troubleshooting are complete and the affected valve has been tested to prove operability.

EVENT DATE AND TIME:

January 28, 1992, at 1930 hours.

REPORT DATE:

February 28, 1992

This report was initiated by Off-Normal Occurrence Report 92-006.

CONDITIONS PRIOR TO EVENT:

Mode 1, 100% reactor power

DESCRIPTION OF EVENT:

Containment isolation valve XVA-9312B was declared inoperable on January 27, 1992, at 0400 hours, when it did not appear to close during a quarterly slave relay surveillance test. This valve is located in the sample line return for Radiation Monitor RM-A2, which provides measurement of the airborne activity (Particulate, Iodine, Gas) inside the Reactor Building.

During normal plant operation, RM-A2 is one of the instruments used to monitor for primary coolant system leakage as addressed in Technical Specification 3.4.6.2, "Operational Leakage." When this monitor is rendered inoperable through either equipment failure or isolation of the sample lines, plant personnel must obtain a grab sample of the Reactor Building atmosphere at least once per 12 hours until RM-A2 is returned to operable status.

When Operations and Health Physics personnel evaluated the method of obtaining the sample, there were concerns over connecting the sampler to the operable sample line and releasing the Reactor Building atmosphere to the Penetration Room where RM-A2 is located. To prevent the Penetration Room from becoming an airborne contaminated area, the sampler was connected to both supply and return lines for RM-A2, and Operations personnel cleared the tagout so that XVA-9312B could be temporarily (less than 1 hour) opened for sampling. The surveillance was performed in this manner on January 27, at 1512 hours, and again on January 28, at 0250 and 1445 hours, before an oncoming Operations shift determined that the action was in conflict with the intent of Technical Specifications and plant procedural requirements for inoperable equipment.

CAUSE OF EVENT:

This event resulted from personnel error. During the coordination of the Reactor Building atmosphere surveillance, Operations personnel failed to recognize that the temporary restoration of the inoperable valve would be in conflict with the intent of Technical Specifications and plant procedures. Temporary restorations of this nature are only allowed for troubleshooting, maintenance, and surveillance testing to prove operability.

ANALYSIS OF EVENT:

Plant safety was not compromised by the temporary opening of XVA-9312B. During the surveillance of the Reactor Building atmosphere, Operations personnel performing the realignment were standing by and prepared to close the valve in the event of a Containment Phase A Isolation.

IMMEDIATE CORRECTIVE ACTIONS:

Operations and Health Physics personnel discontinued the use of the sample line return for subsequent surveillances of the Reactor Building atmosphere. Samples taken through February 7, 1992, were obtained from the supply line and discharged into the Penetration Room. During this period the room was properly posted as an airborne contaminated area in accordance with plant procedures.

Maintenance investigation into the failure of XVA-9312B to fully close found a limit switch positioner to be pivoting on the valve stem. The improper function of this limit switch was causing position indication problems; however, the valve function was not impaired. The positioner was repaired and the valve returned to operable status at 0200 hours on February 8, 1992.

ADDITIONAL CORRECTIVE ACTIONS:

Operations shift personnel will receive additional training by May 1, 1992, on the guidelines for temporary restoration of equipment as contained in Station Administrative Procedure (SAP) 205, Status Control and Removal and Restoration.

PRIOR OCCURRENCES:

None.