

Stephen A. Byrne
Senior Vice President, Nuclear Operations
803.345.4622



July 30, 2002

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

Ladies and Gentlemen:

Subject: VIRGIL C. SUMMER NUCLEAR STATION
DOCKET NO. 50-395
OPERATING LICENSE NO. NPF-12
LICENSEE EVENT REPORT (LER 2002-003-00)
AUTOMATIC REACTOR TRIP DUE TO SPURIOUS NOISE ON NUCLEAR
INSTRUMENTATION CHANNEL

Attached is Licensee Event Report (LER) No. 2002-003-00, for the Virgil C. Summer Nuclear Station (VCSNS). The report describes the automatic reactor trip that occurred on June 1, 2002 initially determined to be the result of a failed circuit board in a nuclear instrumentation channel. This report is being submitted in accordance with the requirements of 10 CFR 50.73(a)(2)(iv).

Should you have any questions, please call Mr. Mel Browne at (803) 345-4141.

Very truly yours,

Stephen A. Byrne

PAR/SAB
Attachment

c: N. O. Lorick
N. S. Carns
T. G. Eppink (w/o attachment)
R. J. White
L. A. Reyes
K. R. Cotton
NRC Resident Inspector
F. Rehrig
Paulette Ledbetter
D. L. Abstance

EPIX Coordinator
K. M. Sutton
INPO Records Center
J&H Marsh & McLennan
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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503.

1. FACILITY NAME Virgil C. Summer Nuclear Station	2. DOCKET NUMBER 05000395	3. PAGE 1 OF 4
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4. TITLE
Automatic Reactor Trip due to Spurious Noise on a Nuclear Instrumentation Channel

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED		
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER	
06	01	02	2002	- 003	- 00	07	30	02	FACILITY NAME	DOCKET NUMBER	
9. OPERATING MODE		2	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)								
10. POWER LEVEL		2%	20.2201(b)	20.2203(a)(3)(ii)		50.73(a)(2)(ii)(B)		50.73(a)(2)(ix)(A)			
			20.2201(d)	20.2203(a)(4)		50.73(a)(2)(iii)		50.73(a)(2)(x)			
			20.2203(a)(1)	50.36(c)(1)(i)(A)		X	50.73(a)(2)(iv)(A)		73.71(a)(4)		
			20.2203(a)(2)(i)	50.36(c)(1)(ii)(A)		50.73(a)(2)(v)(A)		73.71(a)(5)			
			20.2203(a)(2)(ii)	50.36(c)(2)		50.73(a)(2)(v)(B)		OTHER Specify in Abstract below or in NRC Form 366A			
			20.2203(a)(2)(iii)	50.46(a)(3)(ii)		50.73(a)(2)(v)(C)					
			20.2203(a)(2)(iv)	50.73(a)(2)(i)(A)		50.73(a)(2)(v)(D)					
			20.2203(a)(2)(v)	50.73(a)(2)(i)(B)		50.73(a)(2)(vii)					
			20.2203(a)(2)(vi)	50.73(a)(2)(i)(C)		50.73(a)(2)(viii)(A)					
			20.2203(a)(3)(i)	50.73(a)(2)(ii)(A)		50.73(a)(2)(viii)(B)					

12. LICENSEE CONTACT FOR THIS LER

NAME M. N. Browne, Mgr., Nuclear Licensing & Operating Experience	TELEPHONE NUMBER (Include Area Code) (803) 345-4141
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
B	JC	RI	G077	Y					

14. SUPPLEMENTAL REPORT EXPECTED				15. EXPECTED SUBMISSION DATE		
X	YES (If yes, complete EXPECTED SUBMISSION DATE).	NO		MONTH	DAY	YEAR
				01	31	2003

16. ABSTRACT (Limit to 1400 spaces. i.e., approximately 15 single-spaced typewritten lines)

On June 1, 2002, at 1840, the reactor tripped automatically due to a spike on Nuclear Instrumentation (NI) Intermediate Range channel N-36. The reactor was being held steady at approximately 2% power and no significant plant evolutions were ongoing at the same time. The indicator for channel N-36 spiked to a value greater than the trip setpoint and the reactor protection system automatically tripped the plant. After the trip, spiking was still occurring on this channel. No other NI channel indicated any power increase during this event.

The cause was preliminarily determined to be noise resulting from a failed or degraded circuit card. Multiple circuit cards were replaced and the spiking problem did not reappear. The actual cause of the noise problem has not been determined. The vendor has indicated the power supply vintage has the potential to fail high and cause additional damage to circuit cards, although there is no evidence that a power supply failure occurred. The power supply was not replaced at this time. One circuit card (A-8) has the visual appearance of overheating. The card A8 will be sent off to the vendor for failure analysis.

A root cause investigation is ongoing and will document the results in corrective action report, CER 02-1899. The power supplies will be replaced before next refueling outage and a schedule for replacement of both the cards and power supplies will be developed.

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17. NARRATIVE (If more space is required, use additional copies of NRC Form 366A)

PLANT IDENTIFICATION

Westinghouse - Pressurized Water Reactor

EQUIPMENT IDENTIFICATION

(EISS - RI) Nuclear Instrumentation, Intermediate Range channel, NI-36

IDENTIFICATION OF EVENT

During the performance of startup testing, approximately 2 % power and steady, after refueling outage 13, the reactor tripped automatically on spurious high intermediate range (IR) neutron flux on one of two channels as indicated by IR nuclear instrument NI-36. This indicated power was determined to be a momentary surge or spike caused by noise on the instrument channel. The redundant IR channel, NI-35, did not indicate any power excursions. This event is documented on corrective action report CER 02-1899.

EVENT DATE

June 1, 2002

REPORT DATE

July 30, 2002

CONDITIONS PRIOR TO EVENT

Mode 2, 2% power

DESCRIPTION OF EVENT

On June 1st 2002, at 18:40 the reactor automatically tripped during startup testing in Mode 2 after completion of refueling outage 13. At the time of the trip power was steady at approximately 2 percent. The first out annunciator showed that the trip was due to IR channel NI-36 exceeding the high setpoint of 15 to 17 percent reactor power (lower setpoint used during physics testing). The reactor protection system supplied the trip signal once the required logic (1/2) was satisfied. Review of the recorded data showed that there was significant spiking output (noise) on that channel. This spiking exceeded the high setpoint. The channel data was compared with IR channel NI-35 to determine if a power excursion was occurring. No other power measurement indicated that reactor power was changing.

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After the plant was stabilized, NI-36 continued to demonstrate intermittent spiking. Emergency Feedwater was supplying feedwater to the steam generators at the time of the event; therefore, no Engineered Safeguard Feature actuation was required or occurred. All systems functioned as expected.

CAUSE OF EVENT

The cause of the event was preliminarily determined to be excessive noise in the instrument channel pre-amplifier, which resulted in intermittent spiking of the instrument loop output. The noise was traced to the instrumentation for this channel. The exact cause of the noise is not known but was eliminated after replacement of several circuit boards. One of the replaced cards contained components that appeared to be heat stressed. A root cause investigation is ongoing and will require the determination of the failure mechanism. A supplement to this LER will provide the results of the root cause evaluation.

ANALYSIS OF EVENT

The Reactor Protection System utilizes redundant safety grade instrument loops to assure that the plant and public remain safe during an event, which could create a potential for a release of radiation. The IR neutron flux high is one of these functions. This function is comprised of two instrument loops, NI-35 and NI-36, with one out of two logic. Should either of these loops indicate a reactor power level in excess of the setpoint before the channel output is manually blocked once the reactor reaches 10 percent (P-10), an automatic trip occurs on IR high neutron flux.

The reactor was being held at approximately 2 percent power so no block was performed yet. The system comparator recognized the spike as exceeding the setpoint and the logic was satisfied. The system reacted as designed to protect the plant and the public.

During the troubleshooting activities, maintenance replaced cards A1, 2, 3 & 8 for channel NI-36. Card A8 in the wide range amplifier had visual degradation of components but verifiable circuitry affects are unknown at this time. During discussions with vendor Gamma-Metrics (G-M) failure mechanisms for the power supplies were discussed. The present version of power supply can fail high and cause additional equipment damage. A newer version is available that in the event of a failure, fails low and minimizes the impact on additional components. The power supplies do not appear to be on a preventative maintenance (PM) program for replacement and are nearing end of life. There is no indication that the power supplies played any role in this trip but have the potential to cause problems in the future if not addressed. In prior discussions with G-M concerning an intermittent failure on N35 there is no recommendation from G-M to replace cards on a set frequency. The plant PM program has not included these cards in any type of replacement program. The circuit cards in this system have not been replaced since installation in 1985.

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CORRECTIVE ACTIONS

The plant automatically shut down and the control room operations personnel entered Emergency Operations Procedure EOP-1.0 to assure the plant was shut down and remained stable.

Instrumentation and Control personnel preliminarily determined the noise was located in the instrumentation for the channel and replaced circuit boards in the pre-amplifier. Nonconformance report NCN 02-1900 was generated to address card replacement as well as cause and corrective action. Testing showed that the spiking was no longer present on the channel.

OTHER CORRECTIVE ACTIONS

A replacement schedule is being developed for the power supplies with initial replacement to be completed by the end of the next refueling outage.

A root cause evaluation has been initiated to determine the actual cause of the event and assign actions to preclude recurrence. A supplemental LER should be submitted by January 31, 2003 providing the results of the evaluation.

PRIOR OCCURRANCES

None