Stephen A. Byrne Senior Vice President, Nuclear Operations 803.345.4622



RC-03-0124 June 13, 2003

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

Dear Sir / Madam:

Subject: VIRGIL C. SUMMER NUCLEAR STATION DOCKET NO. 50-395 OPERATING LICENSE NO. NPF-12 LICENSEE EVENT REPORT (LER 2003-001-00) STEAM PROPAGATION BARRIER DOOR FOUND SECURED IN OPEN POSITION

Attached is Licensee Event Report (LER) No. 2003-001-00, for the Virgil C. Summer Nuclear Station (VCSNS). The report describes an event in which a steam propagation barrier door was found secured in the open position. This LER is being submitted in accordance with 10 CFR 50.73(a)(2)(i)(B).

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

Very truly yours,

Stephen A. Byrne

AJC/SAB/dr 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 Paulette Ledbetter D. L. Abstance

EPIX Coordinator K. M. Sutton INPO Records Center J&H Marsh & McLennan NSRC RTS (0-C-03-1364-3) File (818.07) DMS (RC-03-0124)

TEão

					,				:						
NRC FORM 36 (7-2001) LICE	NSEE			PORT (LI	OMMI	TORY SSION	Estima reques and fer Manag 20555- Informa	ted burden t: 50 hours. d back to i ement Brar 0001, or by	per Re indu: nch (/ intu egula	ported lessons stry. Send com (T-6 E6), U.S. I ernet e-mall to atory Affairs, NE	comply with learned an ments rega Nuclear Re bis1@nrc.	e incorpora arding bui egulatory (.gov, and	ndatory ited into den esti Commiss to the D	inform the like mate sion, V Desk C	ES 7-31-2004 hation collection censing process to the Records Vashington, DC Officer, Office of anagement and
1. FACILITY NAI Virgil C. Sur		uclear S	Station				2. DOC	KET NUME 05		0395		3. PAGE	1	OF	4
4. TITLE STEAM PRO		FION B	ARRIE	R DOOR F	OUN	DSEC	CURE	d in op	EN	POSITION	ł				
5. EVE	INT DATE		6,	LER NUMBER		7.1	REPORT	PORT DATE 8. OTHER FACILITIES INVOLVED							
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	мо	DAY	YEAR	FA	CILITY NAME			OCKET NUMBER 05000395		
04	22	2003	2003	- 001 -	00	06	13	2003	FACILITY NAME			DOCKET NUMBER			
9. OPERA MODE		1	20 3	11. THIS REPO 2201(b)	DRT IS	IS SUBMITTED PURSUANT 1 20.2203(a)(3)(ii)			O THE REQUIREMENTS OF 50.73(a)(2)(ii)(B)		10 CFR §: (Check all that apply) 50.73(a)(2)(ix)(A)				
10. POW		<u> </u>	1			1)3(a)(4)			50.73(a)(2)(ii)(C)		50.73(a)(2)(x)			
LEVE		100			(313 m4) $(313 m4)$ $(313 m4)$ $(313 m4)$ $(313 m4)$ $(313 m2)$ $(313$			73.71(a)(4)							
	-	1 100	1	203(a)(1) 2203(a)(2)(i)										-	
			203(a)(2)(ii)				c¥1¥ii¥A)		50.73(a)(2)(v)(A) 50.73(a)(2)(v)(B)		73.71(a)(5)				
					+		0.36(c)(2) 0.46(a)(3)(ii) 0.73(a)(2)(i)(A)		50.73(a)(2)(v)(C) 50.73(a)(2)(v)(D)		OTHER Specify in Abstract beig			ct below or in	
				2203(a)(2)(iii) 2203(a)(2)(iv)	+	· · · · ·					Specify in Abstract below or in NRC Form 366A				
				2203(a)(2)(v) 2203(a)(2)(v)	x		a)(2)(i)(i			50.73(a)(2)(v					
				203(a)(2)(v) 2203(a)(2)(vi)	+^	· · · ·									
			203(a)(2)(vi) 2203(a)(3)(i)	-	50.73(a)(2))(2)(ii)(A)		50.73(a)(2)(viii)(A) 50.73(a)(2)(viii)(B)						
			20.4					CT FOR T	! นเร		/iii/(D)				
NAME M. N. Brown	ie, Mgr.,	Nuclea	ar Licen						TE	LEPHONE NUM 03) 345-41		ude Area (ode)		
		13. CON	NPLETE	ONE LINE FO	DR EA	СН СО	MPONE	ENT FAIL	JRE	DESCRIBED	IN THIS	REPORT	г		
CAUSE	SYSTEM COMPO		PONENT	NENT MANU- FACTURER TO EPIX		CAUSE		SYSTEM COMPON		IENT FA CTURER		ER	REPORTABLE TO EPIX		
x						N									
	14.	SUPPLI	EMENTA	L REPORT E	XPEC	TED				15. EXPE SUBMISS		MONTI	1 D/	NY	YEAR
YES (If y	res, comp	lete EXP	ECTED	SUBMISSION	DAT	E).	XN	0		DATI					
16. ABSTRAC	r (Limit to	1400 so	aces. i.e.	. approximate	dv 15	sinale-s	oaced t	vpewritten	line	s)					

On April 22-23, 2003, steam propagation barrier door DRIB/107 was first discovered chained and strapped open and later found blocked open.

This event was caused by a lack of specific training for the Security Officers assigned to continuously monitor materials stored in the room behind the door. The door was being opened to provide cooling to the Security Officer on duty in the area. Upon first discovery, the chains and straps were removed and the door was secured. Approximately 10 hours later, the door was found blocked open by the Security Officer on duty by physically standing with his back against the door. At this time the door was secured again.

Investigation revealed the event was reportable under 10 CFR 50.73(a)(2)(i)(B). Opening door DRIB/107 beyond normal ingress and egress impacted both trains of control room ventilation as a result of breaching the pressure boundary encompassing all three Heating, Ventilation, and Cooling Water (HVAC) rooms. Loss of both trains of Control Room Ventilation is prohibited by Technical Specifications (TS) 3.7.6.

Ż

C FORM 366A 001)			U.S. NUCLE	AR REGULATO	RY COMMISSIO
•	ICENSEE EVENT I	REPORT (L	LER)		
1. FACILITY NAME	2. DOCKET	<u></u>	6. LER NUMBER		3. PAGE
I. FACILIT I DAML		YEAR	SEQUENTIAL	REVISION	J.TAGE
V.C. Summer Nuclear Station	05000395	2003	<u> </u>	NUMBER 00	2 of 4
NARRATIVE (If more space is required, use additional	l copies of NRC Form 366A)	<u></u>		R	- <u></u>
PLANT IDENTIFICATION					
Westinghouse - Pressurized Wate	er Reactor				
EQUIPMENT IDENTIFICAT	ION				
DRIB/107					
IDENTIFICATION OF EVEN	<u>TT</u>				
On April 22-23, 2003, steam pro strapped open and later found bl the Security Officer assigned to The door was immediately retur proper control of doors/barriers	locked open. The doo continuously monitor ned to the required po	or was in this r two drums	s configuration of refrigerant s	to allow cool tored in the r	ling for oom.
EVENT DATE					
04/22/03					
REPORT DATE					
06/13/03					
CONDITIONS PRIOR TO EVI	<u>ent</u>				
Mode 1, 100% Power					
DESCRIPTION OF EVENT					
On April 22-23, 2003 Security (while maintenance was being per maintenance crew completed work night as required by station secur propagation barrier for protection	erformed on "C" HVA ork on April 22, the d rity procedure. Door	C chiller, w rums were c DRIB/107 i	hich is the swin ontinuously mo s a double door	ng componer onitored throu r designed as	nt. After the ughout the a steam

YEAR SEQUENTIAL REVISION	FORM 366A	U.S. NUCLEAR REGULA	TORY COMMISSION				
1. FACILITY NAME 2. DOCKET 6. LER NUMBER 3. PAGE V. C. Summer Nuclear Station 05000395 1203 -001 -00 3 of 4 ARRATIVE (#more space is required, use actiliance copies of NFC Form 3664) DESCRIPTION OF EVENT 3 of 4 Ine break. The temperature in the chiller room behind the door is relatively hot and not conducive to long stay times. As a result, a Security Officer opened the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During his rounds, an Operations Test Specialist noticed the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(0)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barrier tadors. <th>01)</th> <th>LIC</th> <th>ENSEE EVENT F</th> <th>REPORT (L</th> <th>ER)</th> <th></th> <th></th>	01)	LIC	ENSEE EVENT F	REPORT (L	ER)		
V. C. Summer Nuclear Station 05000395 security 2003 security 001 3 of 4 ARRATWE (# more space is required, use additional copies of NRC Form 3664) DESCRIPTION OF EVENT Inhe break. The temperature in the chiller room behind the door is relatively hot and not conducive to long stay times. As a result, a Security Officer opened the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the							
V. C. Summer Nuclear Station 05000395 vest instance instance 3 of 4 ARRATIVE (If more space is required, use additional copies of NRC Form 3664) DESCRIPTION OF EVENT Instance 3 of 4 Ine break. The temperature in the chiller room behind the door is relatively hot and not conducive to long stay times. As a result, a Security Officer opened the door in order to cool himself by securing one side of the door with a hoist chain and the other with a lifting strap. During his rounds, an Operations Test Specialist noticed the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barriers in that doors may be opened for norma	1. FAC		2. DOCKET				3. PAGE
ARRATIVE (If more space is required, use additional copies of NRC Form 3664) DESCRIPTION OF EVENT line break. The temperature in the chiller room behind the door is relatively hot and not conducive to long stay times. As a result, a Security Officer opened the door in order to cool himself by securing one side of the door with a hoist chain and the other with a lifting strap. During his rounds, an Operations Test Specialist noticed the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT	V. C. Summe	r Nuclear Station	05000395		NUMBER	NUMBER	3 of 4
 line break. The temperature in the chiller room behind the door is relatively hot and not conducive to long stay times. As a result, a Security Officer opened the door in order to cool himself by securing one side of the door with a hoist chain and the other with a lifting strap. During his rounds, an Operations Test Specialist noticed the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effecti	ARRATIVE (If mor	space is required, use additiona	al copies of NRC Form 366			l.	
 long stay times. As a result, a Security Officer opened the door in order to cool himself by securing one side of the door with a hoist chain and the other with a lifting strap. During his rounds, an Operations Test Specialist noticed the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific t	DESCRIP	<u>FION OF EVENT</u>					
 long stay times. As a result, a Security Officer opened the door in order to cool himself by securing one side of the door with a hoist chain and the other with a lifting strap. During his rounds, an Operations Test Specialist noticed the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific t	line herel	The transform in the	shillon no one haking	l dha daan in .			
 one side of the door with a hoist chain and the other with a lifting strap. During his rounds, an Operations Test Specialist noticed the door secured open and notified the duty Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 		-			•		
 Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions include Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 		•					, and the second
 Shift Supervisor. The door was returned to the closed position and the Security Officer was informed as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions include Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 				·	-		
 as to the required position of the door. During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 							
 During shift rounds on the morning of April 23, the Auxiliary Building Operator found the door open again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 				position and	the Security C	Officer was in	formed
 again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 	as to the re	juirea position of the do	xor.				
 again by another Security Officer who was standing with his back against the door. The Auxiliary Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 	During shift	t rounds on the morning	of April 23 the A	uxiliary Ruil	ding Operator	found the day	or onen
 Building Operator closed the door and informed the Security Officer as to the required position of the door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 	-			•			-
 door. With DRIB/107 open, both trains of Chilled Water are considered inoperable due to steam line break accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 		•	•		-		•
 accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 	-	•		•	-	•	•
 accident environment. This condition results in both trains of Control Room Ventilation being inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 							
 inoperable. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 							
 Investigation of the event determined that the maximum time the door was opened for any given time was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 							5
 was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 	inoperable.	This condition is repor	table in accordance	e with 10 CPI	K 50.75(8)(2)(1)(В).	
 was four hours and forty minutes. Fire protection procedures specifically address steam propagation barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 							
 barriers in that doors may be opened for normal ingress and egress only. However, it was determined that Security training does not include requirements for steam propagation barrier doors. In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 	Investigatio	on of the event determin	ed that the maximu		oor was opene	d for any give	en time
In addition to immediately returning the door to the required position, immediate corrective actions included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for	-			m time the d	-		
 included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 	was four ho	ours and forty minutes.	Fire protection proc	m time the d cedures speci	ifically address	steam propa	gation
 included Security training addressing the proper control of doors/barriers in the plant and that no door in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for 	was four he barriers in t	ours and forty minutes. that doors may be opene	Fire protection proceed for normal ingress	m time the d cedures speci is and egress	ifically address only. Howeve	steam propa r, it was dete	gation
 in the plant should be used for anything other than normal ingress/egress without prior approval from Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. <u>CAUSE OF EVENT</u> The cause of this event is a lack of specific training for the Security force on the requirements for 	was four he barriers in t that Securit	ours and forty minutes. that doors may be opene ty training does not inclu	Fire protection proc of for normal ingres ude requirements fo	m time the d cedures speci s and egress or steam prop	ifically address only. Howeve agation barrier	steam propa r, it was dete doors.	gation rmined
Operations. Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. <u>CAUSE OF EVENT</u> The cause of this event is a lack of specific training for the Security force on the requirements for	was four he barriers in t that Securit In addition	ours and forty minutes. that doors may be opene ty training does not inclu to immediately returnin	Fire protection proc of for normal ingres ude requirements for ag the door to the re	m time the d cedures speci is and egress or steam prop quired positi	ifically address only. Howeve agation barrier on, immediate	steam propa r, it was dete doors. corrective ac	gation rmined tions
Condition Event Report C-03-1364 was generated to address the event and to perform a root cause evaluation to understand why the event happened and to design effective corrective actions. <u>CAUSE OF EVENT</u> The cause of this event is a lack of specific training for the Security force on the requirements for	was four he barriers in t that Securit In addition included Se	ours and forty minutes. that doors may be opene by training does not inclu- to immediately returnin ecurity training addressi	Fire protection proc of for normal ingres ude requirements for the door to the re- ng the proper contro	m time the d cedures species and egress or steam prop quired position of doors/b	ifically address only. However agation barrier on, immediate arriers in the p	steam propa er, it was dete doors. corrective ac	gation ermined tions no door
evaluation to understand why the event happened and to design effective corrective actions. <u>CAUSE OF EVENT</u> The cause of this event is a lack of specific training for the Security force on the requirements for	was four he barriers in t that Securit In addition included Se in the plant	ours and forty minutes. that doors may be opened ty training does not inclue to immediately returning curity training addressing should be used for any	Fire protection proc of for normal ingres ude requirements for the door to the re- ng the proper contro	m time the d cedures species and egress or steam prop quired position of doors/b	ifically address only. However agation barrier on, immediate arriers in the p	steam propa er, it was dete doors. corrective ac	gation ermined tions no door
CAUSE OF EVENT The cause of this event is a lack of specific training for the Security force on the requirements for	was four he barriers in t that Securit In addition included Se in the plant	ours and forty minutes. that doors may be opened ty training does not inclue to immediately returning curity training addressing should be used for any	Fire protection proc of for normal ingres ude requirements for the door to the re- ng the proper contro	m time the d cedures species and egress or steam prop quired position of doors/b	ifically address only. However agation barrier on, immediate arriers in the p	steam propa er, it was dete doors. corrective ac	gation ermined tions no door
The cause of this event is a lack of specific training for the Security force on the requirements for	was four he barriers in t that Securit In addition included Se in the plant Operations	ours and forty minutes. that doors may be opened ty training does not inclu to immediately returnin ecurity training addressi should be used for anyt	Fire protection proc ed for normal ingres ude requirements for ag the door to the re- ng the proper contro- thing other than nor	m time the d cedures speci is and egress or steam prop quired positi ol of doors/b mal ingress/o	ifically address only. Howeve agation barrier on, immediate arriers in the p egress without	steam propa er, it was dete doors. corrective ac lant and that t prior approva	gation ermined tions no door al from
The cause of this event is a lack of specific training for the Security force on the requirements for	was four he barriers in t that Securit In addition included Se in the plant Operations Condition I	ours and forty minutes. that doors may be opened ty training does not inclu- to immediately returnin ecurity training addressi- should be used for anythe Event Report C-03-1364	Fire protection proc ed for normal ingres ude requirements for ag the door to the re- ng the proper contro- thing other than nor was generated to a	m time the d cedures speci is and egress or steam prop quired positi ol of doors/b mal ingress/o	ifically address only. However agation barrier on, immediate arriers in the p egress without vent and to per	steam propa er, it was deter doors. corrective ac lant and that n prior approva	gation ermined tions no door al from
	was four he barriers in t that Securit In addition included Se in the plant Operations Condition I evaluation	burs and forty minutes. that doors may be opened by training does not inclu- to immediately returning ecurity training addressi- should be used for anythe Event Report C-03-1364 to understand why the e	Fire protection proc ed for normal ingres ude requirements for ag the door to the re- ng the proper contro- thing other than nor was generated to a	m time the d cedures speci is and egress or steam prop quired positi ol of doors/b mal ingress/o	ifically address only. However agation barrier on, immediate arriers in the p egress without vent and to per	steam propa er, it was deter doors. corrective ac lant and that n prior approva	gation ermined tions no door al from
	was four he barriers in t that Securit In addition included Se in the plant Operations Condition I evaluation	burs and forty minutes. that doors may be opened by training does not inclu- to immediately returning ecurity training addressi- should be used for anythe Event Report C-03-1364 to understand why the e	Fire protection proc ed for normal ingres ude requirements for ag the door to the re- ng the proper contro- thing other than nor was generated to a	m time the d cedures speci is and egress or steam prop quired positi ol of doors/b mal ingress/o	ifically address only. However agation barrier on, immediate arriers in the p egress without vent and to per	steam propa er, it was deter doors. corrective ac lant and that n prior approva	gation ermined tions no door al from
	was four he barriers in that that Securit In addition included Se in the plant Operations Condition I evaluation	ours and forty minutes. that doors may be opened by training does not inclu- to immediately returning ecurity training addressi- should be used for anythe Event Report C-03-1364 to understand why the e <u>FEVENT</u>	Fire protection proc ed for normal ingres ude requirements for ag the door to the re- ng the proper contro- thing other than nor was generated to a event happened and	m time the d cedures speci is and egress or steam prop quired positi- ol of doors/b mal ingress/o address the ev- to design eff	ifically address only. However agation barrier on, immediate arriers in the p egress without vent and to per fective correctiv	steam propa er, it was deter doors. corrective ac- lant and that is prior approva form a root ca ve actions.	gation crmined tions no door al from ause

NRC FORM 366A (7-2001) **U.S. NUCLEAR REGULATORY COMMISSION**

LICENSEE EVENT REPORT (LER)

•			¥ ()			
1. FACILITY NAME	2. DOCKET		3. PAGE			
	05000005	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
V.C. Summer Nuclear Station	05000395	2003	001 -	00	4 of 4	

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

ANALYSIS OF EVENT

During the investigation of this event, it was discovered that a Security Officer had restrained DRIB/107 in the open position using a hoist chain and lifting strap in an effort to provide cooling to himself in a hot environment. Another Security Officer used his body to block the door for cooling.

While the door was opened beyond normal ingress/egress, both trains of Chilled Water were considered inoperable which resulted in both trains of Control Room Ventilation being inoperable.

CORRECTIVE ACTIONS

The door was immediately returned to the required position when discovered open on both occasions. The Security force was trained on the requirements for steam propagation barrier doors in the plant. The event was documented in Condition Event Report C-03-1364 and root cause evaluation RCA03-1364 was performed. As an immediate interim measure, an information notice on Steam Propagation Barrier doors was provided to all personnel. Steam Propagation Barrier awareness training will be provided to all site personnel during initial and annual Station Orientation Training.

PRIOR OCCURRENCES

In August 2002, a non-cited violation (NCV) evaluated as having very low safety significance (Green) was issued for failure to follow procedural controls for steam propagation barrier doors. During the post maintenance testing process for a diesel generator jacket water heater replacement, the water fill hose was routed through a steam propagation barrier (SPB) door. Operators performing the fill evolution did not understand that routing a hose through the door did not constitute minor maintenance. Procedurally, SPB doors could remain open for up to one hour for minor maintenance. After discussions with control room supervision the activity was suspended until the alternate method of supplying water was implemented.

In order to prevent recurrence Condition Event Report (CER) C-02-2704 was generated with the following corrective actions.

- Fire Protection Procedure, FPP-025, Revision 3, Change E was issued 11/20/02 to clarify that minor maintenance applies only to the respective door.
- Station Operating Procedure, SOP-306, Revision 15, Change B was issued 11/11/02 to add mode requirements to which valve (or which door) is used to fill the expansion tank.
- Enhancements to Licensed/Auxiliary Operator Initial and Requal programs are being made to include training modules consisting of Steam Propagation Barriers, Flood Barriers and Fire Barriers. This action is scheduled for completion in December, 2003.
- A synopsis of CER C-02-2704 was included in the October 2002 Operator Required Reading.

SCE&G believes that completion of actions identified for the prior occurrence, supplemented by those for the most recent event, will ensure future compliance.