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

October 26, 1982

Mr. James P. O'Reilly, Director
U.S. Nuclear Regulatory Commission
Region II, Suite 3100
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 82-009

Dear Mr. O'Reilly:

Please find attached Licensee Event Report #82-009 for Virgil C. Summer Nuclear Station. This Thirty Day Report is required by Technical Specification 6.9.1.13.(c) as a result of violation of the surveillance requirements of 4.7.10.2.(c) of Technical Specification 3.7.10, "Fire Rated Assemblies," on September 29, 1982.

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

Very truly yours,

O. W. Dixon, Jr.

O. W. Dixon, Jr.

ARK:OWD:dwf
Attachment

cc: See Page Two

IE 22

cc: V.C. Summer
T.C. Nichols, Jr.
G.H. Fischer
O.W. Dixon, Jr.
H.N. Cyrus
H.T. Babb
D.A. Nauman
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DETAILED DESCRIPTION OF EVENT

Per Technical Specification 4.7.10.2.(c), the verification of all locked closed fire doors is required to be conducted at least once every seven (7) days. Surveillance Test Procedure (STP) 128.017, "Weekly Inspection of Locked Closed Fire Doors," covers this requirement and was due to be performed on September 26, 1982. Instead, STP-128.007, "CO_2 System Lineup Verification," was performed. The error was discovered on September 29, 1982, thus violating the 1.25 surveillance tolerance limit per Technical Specification 4.0.2.(b). STP-128.017 was then performed.

PROBABLE CONSEQUENCES OF THE EVENT

There were no adverse consequences as a result of this event. When the correct STP (128.017) was performed on September 29, 1982, the fire rated doors were all found to be in the locked closed position as required. Also, the Station was in the Action Statement of Technical Specification 3.7.10, as amended, for inoperable fire barriers during the time of this event. Technical Specification 3.7.10 (amended) allowed the roving one hour fire watch patrol; therefore, it can be reasonably assured that had a fire occurred in the areas in question, it would have been detected in its early stages and promptly brought under control.

CAUSE(S) OF THE OCCURRENCE

The cause is attributed to a personnel/numerical oversight. Personnel assigned to the surveillance item performed the wrong Surveillance Test Procedure.

IMMEDIATE CORRECTIVE ACTION

STP-128.017 was performed on September 29, 1982. All of the affected fire rated doors were found to be in the locked closed position as required. The doors which have alarm supervision were checked and verified that no alarms had been triggered during the surveillance requirement time lapse.

ACTION TAKEN TO PREVENT RECURRENCE

Operations personnel involved in surveillance testing have been instructed to verify scheduled surveillance tests they are performing both by identification number and name.