

SOUTH CAROLINA ELECTRIC & GAS COMPANY

POST OFFICE 764

COLUMBIA, SOUTH CAROLINA 29218

O. W. DIXON, JR.
VICE PRESIDENT
NUCLEAR OPERATIONS

February 3, 1983

Mr. James P. O'Reilly, Director
U.S. Nuclear Regulatory Commission
Region II, Suite 3100
101 Marietta Street, N.W.
Atlanta, Georgia 30303

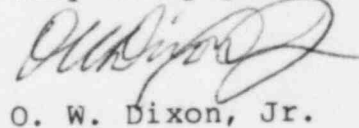
SUBJECT: Virgil C. Summer Nuclear Station
Docket No. 50/395
Operating License No. NPF-12
Thirty Day Written Report
LER 83-002

Dear Mr. O'Reilly:

Please find attached Licensee Event Report #83-002 for Virgil C. Summer Nuclear Station. This Thirty Day Report is required by Technical Specification 6.9.1.13.(b) as a result of entry into Action Statement (b) of Technical Specification 3.3.3.9, "Radioactive Gaseous Effluent Monitoring Instrumentation," on January 9, 1983.

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

Very truly yours,



O. W. Dixon, Jr.

CJM:OWD:dwf/fjc
Attachment

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DETAILED DESCRIPTION OF EVENT

On January 9, 1983, at 0010 hours with the Plant in Mode 1, the Main Plant Vent Exhaust System flow rate indication failed low. The flow rate channel is required to be operable at all times per Technical Specification 3.3.3.9, Table 3.3-13, Item 3d. The Plant was prepared to estimate the flow rate on a four (4) hour basis in compliance with Action Statement 39 if the channel remained inoperable.

PROBABLE CONSEQUENCES

There were no adverse consequences in regards to this event. The flow rate indication was returned to operable status within 2 hours and 20 minutes of the event occurrence. The Plant was prepared to monitor the flow rate on a four (4) hour basis in compliance with the Technical Specification Action Statement.

CAUSE(S) OF THE OCCURRENCE

The cause of this occurrence is attributed to corrosion on either the card edge connector or the fuse block of the Mixing Amplifier Circuit Board FY-9697.

IMMEDIATE CORRECTIVE ACTIONS TAKEN

Maintenance personnel cleaned the card edge connector and the fuse block of Mixing Amplifier Circuit Board FY-9697. The channel was returned to service at 0230 hours on January 9, 1983, when flow rate indication returned to normal.

ACTION TAKEN TO PREVENT RECURRENCE

Since this is an isolated incident, the licensee plans no additional action other than the normal surveillance testing.