

SOUTH CAROLINA ELECTRIC & GAS COMPANY

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

October 15, 1982

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

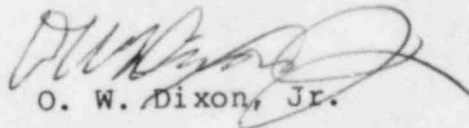
Subject: Virgil C. Summer Nuclear Station  
Docket No. 50/395  
Operating License No. NPF-12  
Thirty Day Written Report  
LER 82-004

Dear Mr. O'Reilly:

Please find attached Licensee Event Report #82-004 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 3.4.1.4, "Reactor Coolant System - Cold Shutdown - Loops Filled" on September 15, 1982.

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

Very truly yours,

  
O. W. Dixon, Jr.

ARK:OWD:dwf  
Attachment

cc: See Page Two

8210220438 821015  
PDR ADOCK 05000395  
S PDR

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#### DETAILED DESCRIPTION OF EVENT

On September 15, 1982, with the plant operating in Mode 5, maintenance personnel attempted to perform Surveillance Test Procedure STP-340.008, "PORV Analog Channel Operational Test (Cold Overpressurization Protection P-402 and P-403)". This test simulates high RCS pressure which closes RHR Train A and B header suction isolation valves to protect the low pressure RHR piping from overpressurization. Both trains of RHR suction consist of two isolation valves in series (all normally closed). Pressure transmitter P-402 and P-403 each feed one isolation valve in each train. In performing the STP on P-402, with Train "B" RHR in service, isolation valve 8702B shut when the test signal was generated. The operator immediately tripped the "B" RHR pump and maintenance cleared the test signal. The suction isolation valve was then reopened, and the associated RHR pump was restarted. The incident lasted approximately one minute.

#### PROBABLE CONSEQUENCES

There were no adverse consequences resulting from the occurrence since the RHR pumps are equipped with a minimum flow recirculation line. Also, the situation was corrected within one minute.

#### CAUSE(S) OF OCCURRENCE

This occurrence is attributed to the STP being incorrect in that it did not adequately address the closure of the pressure transmitter's associated isolation valves. Therefore, operations personnel did not expect inadvertent valve closure.

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IMMEDIATE CORRECTIVE ACTION TAKEN

The operator took prompt action to trip the "B" RHR pump and requested the maintenance personnel to exit the test. The RHR suction isolation valve, 8702B, was then reopened and the "B" RHR pump restarted.

ACTION TAKEN TO PREVENT RECURRENCE

STP-340.008 is being revised to require the suction isolation valve in the Operating RHR Train to be de-energized when the associated pressure transmitter is being tested. This precludes future occurrences of this nature. This action will be complete by October 31, 1982.