

SOUTH CAROLINA ELECTRIC & GAS COMPANY

POST OFFICE 764

COLUMBIA, SOUTH CAROLINA 29218

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

April 20, 1983

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AID: 12
INPO REGION II
UNIT 2, GEORGIA

Mr. James P. O'Reilly
Regional Administrator
U.S. Nuclear Regulatory Commission
Region II, Suite 2900
101 Marietta Street, N.W.
Atlanta, Georgia 30303

SUBJECT: Virgil C. Summer Nuclear Station
Docket No. 50/395
Operating License No. NPF-12
Fourteen Day Written Report
LER 83-028

Dear Mr. O'Reilly:

Please find attached Licensee Event Report #83-028 for Virgil C. Summer Nuclear Station. This Fourteen Day Report is required by Technical Specification 6.9.1.12.(i) as a result of conditions discovered on April 6, 1983, concerning Reactor Trip Breakers (Westinghouse Model DS-416). This report also constitutes notification of a Substantial Safety Hazard as required by 10CFR21.

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

Very truly yours,



O. W. Dixon, Jr.

CJM:OWD/dwf/fjc
Attachment

cc: V. C. Summer	G. J. Braddick
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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

The licensee was requested by Westinghouse Electric Corporation to verify specified dimensions on the undervoltage (UV) trip device on the Westinghouse Model DS-416 Reactor Trip Breakers. They had determined on March 31, 1983, that a potential unreviewed safety question existed for operating plants under the criteria of 10 CFR 50.59. As a result of these inspections, on April 6, 1983, with the Plant in Mode 5, a potential substantial safety hazard concerning certain critical dimensions of the undervoltage (UV) trip device was identified by Virgil C. Summer Nuclear Station.

Our initial telephone report on April 6, 1983, was in error when it addressed two (2) critical dimensions on the UV trip device outside of the acceptance criteria. The inspection results were satisfactory with the exception of one (1) dimension between the moving core and rolling bracket on the UV trip device of Reactor Trip Breaker RTA. In addition, a lock ring on the shaft pin of the UV trip device was found to be missing on the same breaker. The missing lock ring could have allowed the shaft pin to slide out and render the UV trip device inoperable.

Had this condition gone undetected, the potential existed for common mode failure in both trains resulting from either intermittent operation or total failure of the UV trip device upon receipt of an automatic Reactor Trip Signal. The control room operators would then have had to actuate the manual reactor trip switch at the Main Control Board when a demand for a reactor trip was observed.

CAUSE AND CORRECTIVE ACTIONS

The dimensional error discovered on the UV trip device of Reactor Trip Breaker RTA has been attributed to manufacturing variations by Westinghouse Electric Corporation. Additionally, Westinghouse is in the process of evaluating the cause and safety significance of the missing lock ring on the shaft pin.

Virgil C. Summer Nuclear Station is presently in an outage for a modification to the Westinghouse D-3 Steam Generators and expects to replace the UV trip devices on all Reactor Trip Breakers upon receipt of new components from the manufacturer. This action will be completed prior to plant startup after the current outage. The licensee has also directed the control room operators to actuate the manual reactor trip from the Main Control Board when a demand for an automatic reactor trip is observed until this problem can be resolved by Westinghouse.