SCE&G
A SCANA Company

South Carolina Electric & Gas Company
P.O. Box 88
Jenkinsville, SC 29065
(803) 345-4344

Gary J. Taylor
Vice President
Nuclear Operations

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RC-95-0227

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

Gentlemen:

Subject: VIRGIL C. SUMMER NUCLEAR STATION
DOCKET NO. 50/395
OPERATING LICENSE NO. NPF-12
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT 95-12

This letter provides South Carolina Electric & Gas Company (SCE&G) reply to a Notice of Violation delineated in NRC Inspection Report No. 50-395/95-12.

SCE&G is in agreement with this violation. The basis for this agreement is contained within the attached reply.

Should your have any questions, please call Mr. Ricky Myers at (803) 345-4384, at your convenience.

Very truly yours,

Gary J. Taylor

RAM:ews
Attachment

c: J. L. Skolds
O. W. Dixon
J. B. Knotts Jr.
R. J. White
S. D. Ebneter
R. R. Mahan
S. F. Fipps
NRC Resident Inspector
K. R. Jackson
NSRC
Central File System
RTS (IE 951202)
File (815.01)

IE01

REPLY TO NOTICE OF VIOLATION
VIOLATION NUMBER 50-395/95-12

I. RESTATEMENT OF VIOLATION

Technical Specification 6.8.1.c requires that written procedures be established, implemented and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Section 1.d of Appendix A, recommends administrative procedures for controlling procedural adherence.

Station Administrative Procedure, SAP-123, Procedure Use and Adherence, Section 6.1.1 states, in part, "Procedures shall always be adhered to during the course of activities."

Surveillance Test Procedure, STP-209.002, Incore vs Excore Axial Offset, Note 7.3, states, in part, "Data reduction should be independently reviewed." Station Administrative Procedure, SAP-153, Independent Verification, Defines independent verification as "the act of checking a condition separately from activities establishing the condition."

Contrary to the above requirements,

1. On June 19, 1995, a mechanical maintenance technician failed to implement Station Administrative Procedure, SAP-123, when he performed work on a diesel room ventilation damper which he had not received authorization to work on. This activity resulted in a condition where the associated diesel room ventilation fan had been rendered inoperable for a period of five days before the licensee became aware of the problem.

2. On May 9, 1995, reactor engineering personnel failed to implement the requirements of Surveillance Test Procedure, STP-209.002, by failing to properly perform an independent review of data prior to using that data to calculate nuclear instrument current values. This failure allowed an error to go undetected until June 2, 1995, resulting in incorrect current values being used in the nuclear instruments.

II. SCE&G POSITION ON THIS VIOLATION

SCE&G is in agreement with the violation as stated above.

III. REASON FOR THE VIOLATION

This violation resulted from human performance errors on the part of individuals who failed to meet plant management's expectations for procedural compliance.

IV. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

Corrective actions taken in response to an individual working on and incorrectly reassembling the wrong emergency diesel generator room ventilation fan damper were:

1. The effected diesel room ventilation fan damper was correctly reassembled, tested satisfactorily, and returned to service.

2. An investigation has been conducted which determined how the damper was incorrectly assembled.

3. Employee disciplinary action has been taken for this event.

4. This event was reviewed during a Management Review Board meeting conducted on July 17, 1995. This review by senior onsite management reflects the seriousness that has been placed on this event. The purpose of this meeting was to identify the cause of the human performance error and to identify actions to minimize the incidences of human performance errors.

5. An evaluation has confirmed that the emergency diesel generator remained operable during the period that this damper was not available.

Corrective actions taken in response to an individual failing to perform an adequate independent review of data used to calculate nuclear instrument current values were:

1. The nuclear instruments were recalibrated with correct input which was independently verified by the Independent Safety Engineering Group.

2. Employee disciplinary action has been taken for this event.

3. This event was extensively reviewed during a Management Review Board meeting conducted on June 7, 1995. During this meeting personnel directly associated with the event were interviewed by senior plant management. Some of the corrective actions mentioned in this report are the result of this Management Review Board meeting.

4. An independent review of this event and reactor engineering's work on the startup from the last refueling outage was conducted by the station's Quality Systems Group with no additional problems noted.

5. An evaluation has determined that at no time were actual or indicated axial offset limits exceeded and determined that the nuclear instrumentation was maintained in an operable status.

V. CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATIONS

On July 12, 1995, the General Manager, Nuclear Plant Operations issued a stop work order to inform all station personnel of the human performance incidents and the potential seriousness of these incidents. During this stop work order all personnel were thoroughly briefed on these events and adviced of the need to reduce the occurrence of human performance errors. Some topics discussed included a concern with complacency, procedural compliance, maintaining a questioning attitude, performance of thorough independent reviews, process ownership, personal accountability, and the potential for future disciplinary actions.

VI. DATE OF FULL COMPLIANCE

The Virgil C. Summer Nuclear Station is currently in full compliance with respect to the referenced Technical Specification requirements.