UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
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ATLANTA, GEORGIA 30303-8931

April 23, 2002

South Carolina Electric & Gas Company
ATTN: Mr. Stephen A. Byrne
Senior Vice President, Nuclear Operations
Virgil C. Summer Nuclear Station
P. O. Box 88
Jenkinsville, SC 29065

SUBJECT: VIRGIL C. SUMMER NUCLEAR STATION - NRC INTEGRATED INSPECTION REPORT NO. 50-395/01-05

Dear Mr. Byrne:

On March 30, 2002, the NRC completed an inspection at your Virgil C. Summer Nuclear Station. The enclosed report documents the inspection findings which were discussed on April 4, 2002, with Mr. G. Halnon and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, the inspectors identified one finding of very low safety significance (Green).

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at *http://www.nrc.gov/reading-rm/adams.html* (the Public Electronic Reading Room).

Sincerely,

/RA/

Kerry D. Landis, Chief
Reactor Projects Branch 5
Division of Reactor Projects

Docket No.: 50-395
License No.: NPF-12

Enclosure: Integrated Inspection Report No. 50-395/01-05

cc w/encl.: See page 2

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No.:	50-395
License No.:	NPF-12
Report No.:	50-395/01-05
Licensee:	South Carolina Electric & Gas (SCE&G) Company
Facility:	Virgil C. Summer Nuclear Station
Location:	P. O. Box 88 Jenkinsville, SC 29065
Dates:	December 30, 2001 through March 30, 2002
Inspectors:	M. Widmann, Senior Resident Inspector M. King, Resident Inspector
Approved by:	K. D. Landis, Chief, Reactor Projects Branch 5 Division of Reactor Projects
Attachment:	Supplemental Information

Enclosure

SUMMARY OF FINDINGS

IR 05000395/01-05, on 12/30/2001 - 03/30/2002, South Carolina Electric & Gas Co., Virgil C. Summer Nuclear Station. Maintenance Risk Assessments and Emergent Work Evaluation and Licensee Identified Violation.

The inspection was conducted by the resident inspectors. The inspection identified one Green finding. The significance of the findings is indicated by its color (Green, White, Yellow, Red) using IMC 0609 "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at *http://www.nrc.gov/NRR/OVERSIGHT/ASSESS/index.html*.

A. Inspector Identified Finding

Cornerstone: Mitigating Systems

- Green. The inspectors identified a green finding concerning the licensee's failure to evaluate and specify mitigating actions appropriate to the circumstances for a loss of chill water. The abnormal operating procedure allowed mitigating actions which would block open the steam propagation barrier (SPB) doors to the room containing safeguards activation circuitry, thereby increasing risk. Alternative ways to cool the room were available and had not been evaluated for implementation rather than opening the SPBs.

  The safety significance of this finding was very low based upon the low likelihood of a steam line break accident during the 30 hours allowed by Technical Specifications to reach cold shutdown when chill water is unavailable. (Section 1R13).

B. Licensee Identified Violation

- A violation of very low significance which was identified by the licensee has been reviewed by the inspectors. Corrective actions taken or planned by the licensee appear reasonable. The violation is listed in Section 4OA7 of this report.

Report Details

Summary of Plant Status

The unit began the inspection period at 100 percent power and remained at or near full power for the entire inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R01 Adverse Weather Protection

a. Inspection Scope

Prior to and during sub-freezing weather in late February the inspectors reviewed the Operations Administrative Procedure OAP-109.1, "Guidelines for Severe Weather," and Electrical Maintenance Procedure EMP-120.002, "Freeze Protection Heat Tracing Inspection." The review assessed the adequacy of the procedures to provide guidance for preparation and response to adverse weather conditions, including the adequacy of cold weather protection of the refueling water storage tank and condensate storage tank level sensing lines. The inspectors conducted system walkdown inspections to assess the overall readiness of various heat tracing systems and to review the licensee's preparation prior to and during cold (sub-freezing) weather.

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment

a. Inspection Scope

To verify that systems / components were correctly aligned, the inspectors reviewed various documents including plant procedures, drawings and the Final Safety Analysis Report (FSAR). The inspectors also reviewed outstanding maintenance work requests (MWRs) and related Condition Evaluation Reports (CERs) to verify that the licensee had properly identified and resolved equipment alignment problems that could cause initiating events or impact mitigating system availability. In addition, the inspectors verified through plant walkdowns that with a train of equipment removed from service that the opposite train of equipment was correctly aligned, available and operable. The following systems / components were verified:

- A train reactor building spray (while the B train was out of service during surveillance valve testing);
- B Emergency Diesel Generator (EDG) (while A EDG was out of service for scheduled maintenance); and,
- Emergency feedwater system walkdown following Turbine Driven Emergency Feedwater (TDEFW) surveillance testing.

Correct alignment and operating conditions were determined from the applicable

portions of the following drawings, System Operating Procedures (SOPs), FSAR, and Technical Specifications (TSs):

- SOP-116, “Reactor Building Spray System;”
- SOP-211, “Emergency Feedwater System;”
- SOP-306, “Emergency Diesel Generator;”
- SOP-307, “Diesel Generator Fuel Oil System;”
- FSAR Sections 8.3.1, 9.5.4, and 10.4.9;
- TS Sections 3.8.1 and 3.7.1.2;
- D-302-085, “Emergency Feedwater (Nuclear);”
- D-302-351, “Diesel Generator - Fuel Oil;”
- D-302-351, “Diesel Generator - Miscellaneous Services;” and,
- D-302-661, “Reactor Building Spray System.”

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors reviewed current CERs, Work Orders (WO), and impairments associated with the fire suppression system. The inspectors reviewed the status of ongoing surveillance activities to determine whether they were current to support the operability and availability of the fire protection system. The inspectors assessed the material condition of the active and passive fire protection systems and features and verified proper control of transient combustibles and ignition sources.

The inspectors conducted routine inspection of the following areas:

- 1DA Switchgear Room (fire zone IB-20);
- NSSS Relay Room (fire zone CB-6);
- 1DB Switchgear Room (fire zone IB-22.2);
- Service Water Pump House (following piping replacement affecting fire barrier traces 56 and 62);
- Turbine Building (463 elevation, following degradation of a kaowool fire barrier, reference CER 0-C-02-0481); and,
- Control Room (fire zone CB-17.1).

These areas are important to safety based on the licensee’s fire risk analysis (Individual Plant Examination for External Events (IPEEE) External Fires Request for Additional Information dated January 1999).

The inspectors also observed and reviewed data for the fire protection system related Surveillance Test Procedure (STP)-128.024, “Cardox System Functional Refueling Test.”

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification

a. Inspection Scope

The inspectors observed senior reactor operators and reactor operators performance on the plant simulator during licensed operator requalification training. The scenario involved a pressurizer transient, a steam flow-feedwater flow mismatch, B reactor coolant pump seal failure, and a reactor coolant system leak > 50 gpm (LOR-ST-075). The inspectors verified that training included risk-significant operator actions and implementation of emergency classification and the emergency plan. The inspectors assessed overall crew performance, communication, oversight of supervision and the evaluator's critique.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule (MR) Implementation

a. Inspection Scope

The inspectors sampled portions of selected performance-based problems associated with structures, systems or components (SSCs), to assess the effectiveness of maintenance efforts. Reviews focused, as appropriate, on: (1) scoping in accordance with the MR (10 CFR 50.65); (2) characterization of failed SSCs; (3) safety significance classifications; (4) 10 CFR 50.65 (a)(1) or (a)(2) classifications; and (5) the appropriateness of performance criteria for SSCs classified as (a)(2) or goals and corrective actions for SSCs classified as (a)(1). The selected SSCs were the Emergency Feedwater System and the Electrical System.

The inspectors reviewed the licensee's implementation of the MR to determine if maintenance preventable functional failures may have existed that the licensee did not capture in their program or if other MR findings existed. Equipment issues described in the CERs listed below were reviewed:

- CER 0-C-00-1238 and non-conformance notice (NCN) 00-1238, water intrusion into motor control center 480V electrical panels in diesel generator building;
- NCN 00-1292 and NCN 00-1297, train B control room normal and emergency ventilation increased outside airflow (Root Cause 01-1643);
- CER 0-C-01-0025 and 0-C-01-0292, failure to maintain the capability to utilize service water as a backup source to component cooling due to failure of valve XVG09627A-CC to open;
- CER 0-C-01-0643, failure of fuel handling building ventilation exhaust damper XDP0235B for fan XFN23B to operate properly resulting in inadequate negative pressure being maintained;
- CER 0-C-01-2340 and 0-C-00-1342 review of cause evaluation for maintenance preventable functional failure human performance error during performance of

EMP-190.007, results in breaker XSW1DA04 tripping; and,
- CER 0-C-01-1400 and 0-C-00-0413 review of ES-514 Maintenance Rule Cause Evaluation, XFN0032A, control room cooling unit A fan tripped.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

The inspectors reviewed the licensee's assessments of the risk impacts of removing from service those components associated with emergent work items. The inspectors evaluated the selected SSCs listed below for, (1) the effectiveness of the risk assessments performed before maintenance activities were conducted; (2) the management of risk; (3) that, upon identification of an unforseen situation, necessary steps were taken to plan and control the resulting emergent work activities; and (4) that emergent work problems were adequately identified and resolved. The inspectors evaluated the licensee's work prioritization and risk determination to determine, as appropriate, whether necessary steps were properly planned, controlled, and executed for emergent work activities listed below:

- TDEFW pump out of service due to maintenance, along with the main generator circuit breaker air compressor not functioning;
- B EDG out of service for maintenance, main generator Alterex out of service per EMP-245.002, "Main Generator Alterex Inspection;"
- B chiller out of service, and A residual heat removal (RHR) out of service for routine maintenance;
- Both A and C main steam isolation valves declared out of service (emergent work) due to high accumulator air pressure (TS 3.0.3 entry); and,
- Control room emergency ventilation for XFN30A-AH out of service, and the A train chiller, pressurizer backup group 1 heaters, relay room cooler and diesel fire pump removed from service.

b. Findings

The inspectors identified a green finding concerning the licensee's failure to evaluate and specify mitigating actions appropriate to the circumstances for a loss of chill water. The abnormal operating procedure (AOP) allowed mitigating actions which would block open the steam propagation barrier (SPB) doors to the room containing safeguards activation circuitry, thereby increasing risk. Alternative ways to cool the room were available and had not been evaluated for implementation rather than opening the SPBs.

Procedure AOP-501.2, "Total Loss of Chill Water," Attachments 1 and 2 provided mitigating actions to cool various plant areas when chill water is lost. These attachments allowed operators to open the SPBs to the room containing safeguards activation circuitry to provide cooling from adjacent areas. As a result, risk would increase since both trains of safeguards activation circuitry, which were qualified for mild

environmental conditions, would be connected to a harsh environmental condition area. Certain steam line accidents with the SPBs open could cause both safeguards activation circuitry trains to fail when they were required to mitigate the accident. The inspectors determined that room cooling could be achieved without exposing the safeguards activation circuitry to potentially harsh environmental conditions. No actual loss of chill water has occurred which required the attachments to be performed.

The inspectors determined that the finding was more than minor, in that, it could have a credible impact on safety since a steam line break accident after the AOP is performed could result in failure of both trains of safeguards activation circuitry. The issue was determined to be of very low safety significance (Green) based upon the low likelihood of a steam line break accident during the 30 hours allowed by TS 3.0.3 to reach cold shutdown when chill water is unavailable. The licensee generated CER 0-C-02-0221 to address this finding.

1R14 Personnel Performance During Non-Routine Plant Evolutions

a. Inspection Scope

This inspection evaluated operator response for non-routine plant evolutions to ensure they were appropriate and in accordance with the required procedures. The inspectors also evaluated performance problems to ensure that they were entered into the corrective action program. The following events or evolutions were reviewed:

- Volume control tank temperature transient due to inadvertent letdown heat exchanger diverted flow (CER 0-C-02-0274);
- Reactor coolant system sample valve mispositioning causing a loss of inventory event (CER 0-C-01-2324); and,
- TS 3.0.3 entry due to two main steam isolation valves being out of service (CER 0-C-02-0361).

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed selected operability evaluations affecting risk significant mitigating systems to assess, as appropriate, (1) the technical adequacy of the evaluations; (2) whether operability was properly justified and the subject component or system remained available, such that no unrecognized increase in risk occurred; (3) whether other existing degraded conditions were considered; (4) where compensatory measures were involved, whether the compensatory measures were in place, would work as intended, and were appropriately controlled; and (5) the impact on TS Limiting Conditions for Operations (LCOs) and the risk significance in accordance with the Significance Determination Process (SDP). The inspectors reviewed the following CERs, issues and evaluations:

- 0-C-02-0038, TDEFW pump inboard oil at the labyrinth seal due to high pressure in oil system and availability to meet mission during an accident with loss of oil;
- 0-C-02-0054, EDG A low jacket water temperature immediately following shutdown at completion of surveillance testing;
- 0-C-02-0166, chiller B not controlling temperature within the required band due to a failed current limiter; and,
- 0-C-02-0388, pressurizer power operated relief valve inlet isolation valve (XVG08000A-RC) exceeded maximum limiting stroke time.

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds

a. Inspection Scope

The inspectors reviewed operator actions to compensate for the volume control tank gas continuous purge being terminated due to its purge check valve sticking closed (CER 0-C-01-1394). The inspectors reviewed a restricted change to the off-normal procedure section of SOP-102, "Chemical and Volume Control System," to provide an alternate means of supplying hydrogen to the VCT. Specifically, the inspectors evaluated whether this condition could potentially result in misoperation of the system or affect the operators' ability to implement abnormal or emergency operating procedures adversely.

b. Findings

No findings of significance were identified.

1R19 Post Maintenance Testing (PMT)

a. Inspection Scope

For the post maintenance tests listed below, the inspectors reviewed the test procedure and witnessed either the testing and/or reviewed test records to determine whether the scope of testing adequately verified that the work performed was correctly completed and demonstrated that the affected equipment was functional and operable:

- MWR 0119057, PMT to address valve XVG03105B-SW stuck in seat (PMTS 0120192);
- MWR 0202602, 480 volt switchgear bus breaker XSW1DA2-04 breaker powershield instantaneous trip setting adjusted per NCN 02-0363 and EMP-405.002;
- MWR 0210231, PMT to address failed transformer for fire dampers electronic thermal links separating cable spreading rooms from control room;
- PMTS 0117319, retest to verify proper operation of XFN32A-AH room cooler for safety-bus 1DA27 per EMP-295.004, Revision 10A and ICP-240.129;
- WO 0202855 / CER 0-C-02-0508, high vibration on B charging pump auxiliary lube oil pump / EMP-245.003 and MMP-320.001; and,

- WO 0202889 / CER 0-C-02-0537, PMT following a broken screw for thermocouple negative lead during STP-345.047 which affected subcooling margin monitor core exit thermocouple analog channel I, XCP6231B.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

For the surveillance tests listed below, the inspectors examined the test procedure and either witnessed the testing and/or reviewed test records to determine whether the scope of testing adequately demonstrated that the affected equipment was functional and operable:

- PTP-104.001, "Emergency Diesel Generator Fire Service Valve Backup Air Supply Test;"
- STP-112.003B, "Reactor Building Spray System Valve Operability Test;"
- STP-120.003, "Emergency Feedwater Valve Verification;"
- STP-144.001, "Containment Isolation Sampling Valve Operability Test;"
- STP-145-003, "Gaseous Radwaste Treatment and Ventilation Exhaust Treatment Operability Test," and review of CER 0-C-01-2420; and,
- STP-803.002, "Mechanical Snubber Visual Examination," and STP-803.003, "Mechanical Snubber Basic Operational Test," for snubber (MK-MSH-229) for main steam to TDEFW pump.

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed NCN 01-2141 that involved a temporary modification to the fire suppression CO_2 compressor motor. The suppression system protects the nuclear steam supply system relay room. The inspectors assessed the impact on risk-significant parameters, such as, availability, reliability and functional capability and evaluated the modification for adverse affects on safety functions of required systems.

b. Findings

No findings of significance were identified.

Cornerstone: Emergency Preparedness

1EP6 Drill Evaluation

a. Inspection Scope

On January 23, the inspectors reviewed and observed the performance of a simulator drill that involved a loss of all AC power which required a site area emergency to be declared (LOR-ST-041). The inspectors assessed emergency procedure usage, emergency plan classification, notifications and the licensee's identification and entrance of any problems into their corrective action program. This inspection evaluated the adequacy of the licensee's conduct of the drill and critique performance. The inspectors reviewed the licensee's decision not to include the drill in their performance indicator statistics. The licensee documented this decision in CER 0-C-01-1160.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator (PI) Verification

.1 Unplanned Scrams per 7,000 Critical Hours PI

a. Inspection Scope

The inspectors assessed the accuracy of the PI for "Unplanned scrams per 7,000 Critical Hours." The inspectors reviewed selective samples of station logs, NRC Inspection Reports, licensee event reports, monthly operating reports, and corrective action program database for the period of April 2001 through December 2001.

b. Findings

No findings of significance were identified.

.2 Scrams with Loss of Normal Heat Removal PI

a. Inspection Scope

The inspectors assessed the accuracy of the PI for "Scrams with a Loss of Normal Heat Removal." The inspectors reviewed selective samples of station logs, NRC Inspection Reports, licensee event report, monthly operating reports, and corrective action program database for the period of April 2001 through December 2001.

b. Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems

Selected Issue Follow-up Inspection

a. Inspection Scope

For CER 0-C-01-0582, Ferrography Tests Indicate Severe Wear Particles in Oil Analysis for XPP0021A, Emergency Feedwater Pump A, the inspectors conducted an in-depth review of the licensee's problem identification and resolution activities to ensure they included:

- Complete and accurate identification of the problem in a timely manner commensurate with its significance and ease of discovery;
- Evaluation and disposition of performance issues associated with maintenance effectiveness, including maintenance errors, maintenance practices, work controls, and risk assessment;
- Evaluation and disposition of operability / reportability issues;
- Consideration of extent of condition, generic implications, common cause, and previous occurrences;
- Classification and prioritization of the resolution of the problem commensurate with its safety significance;
- Identification of root and contributing causes of the problem;
- Identification of corrective actions which are appropriately focused to correct the problem; and,
- Completion of corrective actions in a timely manner commensurate with the safety significance of the issue.

b. Findings

The inspectors' review concluded the licensee had appropriately responded to the condition. Completed corrective actions, including replacing the outboard bearing and oil and monitoring pump vibration, adequately addressed the failure. Reviews and other actions, such as performing internal microscopic inspections, were sufficient to identify the apparent cause, improper straightening of a locking tab, and to determine that no common cause failure mode were applicable to the other pumps. The documentation for the common cause considerations was very limited. The inspectors concluded that overall the corrective actions were completed in a timely manner commensurate with the safety significance.

The licensee considered the event as an isolated case and determined that no formal training or procedure enhancements were necessary to address the maintenance performance issue. Through discussions with maintenance personnel the inspectors learned that the maintenance group was not involved in this determination. Mechanical maintenance supervision agreed that training on this event could preclude similar problems. The licensee subsequently added a corrective action to CER 0-C-01-0582 to include this plant operating experience in the next continuing training session for mechanical maintenance personnel. No findings of significance were identified.

4OA6 Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. G. Halnon and other members of the licensee's staff on April 4, 2002. The inspectors asked the licensee whether any of the material examined during the inspection should be considered proprietary. No proprietary information was identified.

.2 Annual Assessment Meeting Summary

Subsequent to the end of the inspection period, on April 9, 2002, the NRC Branch Chief and the Senior Resident Inspector assigned to Virgil C. Summer met with South Carolina Electric & Gas Company officials to discuss the NRC's Reactor Oversight Process (ROP) and the Virgil C. Summer annual assessment of safety performance for the period of April 1, 2001 - December 31, 2001. The major topics addressed were: the NRC's assessment program, the results of the Virgil C. Summer assessment, and the NRC's Agency Action Matrix. Attendees included Virgil C. Summer site management, members of the site staff, and three state employees.

This meeting was open to the public. Information used for the discussions of the ROP is available from the NRC's document system (ADAMS) as accession number ML020600179. ADAMS is accessible from the NRC Web site at *http://www.nrc.gov/reading-rm/adams.html* (the Public Electronic Reading Room).

4OA7 Licensee Identified Violation

The following finding of very low significance was identified by the licensee and is a violation of NRC requirements which meets the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as a non-cited violation (NCV).

NCV Tracking Number	Requirement Licensee Failed to Meet
NCV 50-395/01005-01	10 CFR 50.54(a)(4) requires NRC approval prior to making changes which reduce commitments in the quality assurance program as presented in the Final Safety Analysis Report. On December 26, 2001, Revision Notice (RN) 01-116, which reduced commitments, was implemented without prior NRC approval. This issue was entered in the corrective action program under CER 0-C-02-0228.

If the NCV is denied, provide a response with the basis for the denial, within 30 days of the date of this inspection report, to the United States Nuclear Regulatory Commission, ATTN: Document Control Desk, Washingtion, DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washingtion, DC 20555-0001; and the NRC Resident Inspector at the Virgil C. Summer Nuclear Station.

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

J. Archie, General Manager, Engineering Services
F. Bacon, Manager, Chemistry Services
L. Blue, Manager, Health Physics Services
M. Browne, Manager, Nuclear Licensing and Operating Experience
D. Gatlin, Manager, Operations
G. Halnon, General Manager, Nuclear Plant Operations
L. Hipp, Manager, Nuclear Protection Services
D. Lavigne, General Manager, Organization Effectiveness
G. Moffatt, Manager, Design Engineering
K. Nettles, General Manager, Nuclear Support Services
A. Rice, Manager, Plant Support Engineering
A. Torres, Manager, Planning/Scheduling and Project Management
R. White, Nuclear Coordinator, South Carolina Public Service Authority
G. Williams, Manager, Maintenance Services

ITEMS OPENED AND CLOSED

Opened and Closed

50-395/01005-01	NCV	Contrary to 10 CFR 50.54(a)(4) Final Safety Analysis Report Revision Notice 01-116, which reduced commitments in the quality assurance program, was implemented without prior NRC approval (Section 4OA7)

Attachment