



UNITED STATES  
 NUCLEAR REGULATORY COMMISSION  
 REGION II  
 101 MARIETTA STREET, N.W.  
 ATLANTA, GEORGIA 30323

Report No.: 50-400/87-31

Licensee: Carolina Power and Light Company  
 P. O. Box 1551  
 Raleigh, NC 27602

Docket No.: 50-400

License No.: NPF-63

Facility Name: Shearon Harris 1

Inspection Conducted: July 20 - August 20, 1987

Inspectors: S. J. Vias 9/8/87  
 for G. F. Maxwell Date Signed

S. J. Vias 9/8/87  
 for S. P. Burris Date Signed

Approved by: S. J. Vias 9/8/87  
 for P. E. Fredrickson, Section Chief Date Signed  
 Division of Reactor Projects

SUMMARY

Scope: This routine, announced inspection involved inspection in the areas of Open NRC Items, Survey of Licensee's Response to Selected Safety Issues, Operational Safety Verification, Monthly Surveillance Observation, and Monthly Maintenance Observation.

Results: Two violations were identified - "Incorrect Position of a Compressed Air Valve During Clearance Restoration" - Paragraph 5.b.(4), and "Failure to Report an ESF Activation Within Four Hours" - Paragraph 5.b.(5).

## REPORT DETAILS

### 1. Persons Contacted

#### Licensee Employees

G. G. Campbell, Manager of Maintenance  
J. M. Collins, Manager, Operations  
G. L. Forehand, Director, QA/QC  
L. I. Loflin, Manager, H arris Plant Engineering Support  
G. A. Myer, General Manager, Milestone Completion  
D. L. Tibbitts, Director, Regulatory Compliance  
R. B. Van Metre, Manager, H arris Plant Technical Support  
R. A. Watson, Vice President, H arris Nuclear Project  
J. L. Willis, Plant General Manager, Operations

Other licensee employees contacted included technicians, operators, mechanics, security force members, engineering personnel and office personnel.

### 2. Exit Interview

The inspection scope and findings were summarized on August 24, 1987, with the Plant General Manager, Operations. No written material was provided to the licensee by the resident inspectors during this reporting period. The licensee did not identify as proprietary any of the materials provided to or reviewed by the resident inspectors during this inspection. The violations identified in this report have been discussed in detail with the licensee.

### 3. Open NRC Items (92701, 36100)

- a. (Closed) NRC Circular 80-CI-13 "Grid Strap Damage in Westinghouse Fuel Assemblies". The inspectors evaluated the site fuel handling procedure, FHP-001, Rev. 0, "Handling Limitations for New and Irradiated Fuel Assemblies", and fuel management procedure FMP-107, Rev. 0, "Irradiated Fuel Visual Inspection". The inspectors found the procedures addressed the Westinghouse recommendations identified in Circular 80-CI-13.

Procedure FHP-001 contained the recommended precautions to aid in minimizing corner-to-corner interaction between grid assemblies. The procedure included a fuel handling sequence which should generate only side-to-side contact between the assemblies.

Procedure FMP-107 provided detailed instructions concerning visual inspections to be completed on fuel assemblies. The instructions included requirements that the assembly be inspected and the results documented to record the condition of the grids. Based on the procedure evaluation and interviews with those responsible for

implementing the procedures, the inspectors concluded that the licensee has considered the recommended actions described in Circular 80-CI-13. This item is closed.

- b. (Closed) 10 CFR Part 21 Item P2185-01, "AAF Intake Silencer TDM or FTDM for Diesel Generators". The inspectors evaluated the licensee's documentation concerning this Part 21 item which was communicated to the NRC by the vendor, American Air Filter Company (AAF).

In September 1985, the licensee received a letter from the NRC stating that the supplier of the air silencers for the Harris Plant emergency diesel generators had reported a potential manufacturing defect in the silencers. The potential defect was described as "an internal part not being welded into place". The vendor further indicated that the part which was not welded into place was identified as an air baffle. To assure that the potential defect was properly tracked and resolved, the licensee documented the vendor's concern on a Nonconformance Report (NCR-85-1963).

In mid-October 1985, the licensee dismantled the installed air silencers and conducted an extensive detailed visual inspection of their internals. The licensee's inspectors found that the air baffles located inside the air silencers had been welded into place as required by design documents. The licensee concluded that the conditions described by AAF, in the vendor's report to the NRC, did not apply to the air silencers which AAF supplied for the Harris Plant. The licensee closed NCR-85-1963, and the vendor's Part 21 report was not considered applicable to Harris. The inspectors concurred with the licensee's conclusion. This item is closed.

- c. (Closed) 10 CFR Part 21 Item P2184-02. "Deficient Valves for Auxiliary Feedwater Pump Drive Turbine". In 1984 the licensee was advised through correspondence from the Institute of Nuclear Power Operations (INPO) that a utility had experienced problems with a motor-operated semibalanced globe valve supplied by Gimpel Machine Works/Gimpel Corporation. The problem was identified during operability testing of a turbine-driven auxiliary feedwater pump. During the test the turbine steam inlet isolation valve would stop or hesitate in the mid-position when the turbine was operating under no load or minimum load conditions.

The Harris Plant was identified as having one of these valves installed in the steam header for the turbine-driven auxiliary feedwater pump. The supplier of the turbine, Terry, a part of Ingersoll-Rand, Inc., advised the licensee that a design review revealed that the installed Gimpel valve could be repaired by increasing the valve closure spring tension. Increasing the spring tension would eliminate the possibility of the valve stalling in a mid-position.

The valve manufacturer supplied an improved closing spring to replace the existing spring on the installed Gimpel valve. The new spring installation was authorized by Work Request WR/85-AKHL1. The installation was completed and accepted on November 6, 1985. The inspectors evaluated the documentation associated with WR/85-AKHL1 and interviewed responsible licensee personnel concerning the spring replacement. This item is closed.

4. Survey of Licensee's Response to Selected Safety Issues (TI 2515/77, 92701)

The inspectors reviewed the licensee's marine growth control program with respect to biofouling of cooling water heat exchangers and verified the following:

- The licensee had a formal program which would monitor changes in flow capabilities of all open-cycle systems, including those closed-cycle systems which were capable of being cross-connected to the open-cycle systems. The program included monitoring the pressure drop instrumentation, temperature instruments, and visual inspections of the heat exchangers on a routine basis.
- The licensee's program identified above was routinely reviewed and evaluated against design considerations to ensure that any potential marine growth would be detected prior to loss of a heat exchanger required by safety equipment.
- Incorporation of lessons learned from events at other facilities was conducted by operations personnel. Specific procedures for the degradation of heat exchangers due to marine growth do not exist, because the licensee considers blockage of flow from marine growth to be a loss of the heat exchanger.
- The licensee performs routine periodic inspections of the service water and fire protection systems in accordance with its documented surveillance testing program.

During this review the inspectors reviewed IE Bulletin 81-03, "Flow Blockage of Cooling Water to Safety Components by Coribicula Sp. (Asiatic Clam) and Mytilus Sp. (Mussel)", which was closed in I&E Report 84-14. The licensee continues to maintain surveillance for the control and removal of any identified marine growth at the Shearon Harris Plant.

5. Operational Safety Verification (71707, 71710)

a. Plant Tours

The inspectors conducted routine plant tours during this inspection period to verify that the licensee's requirements and commitments were being implemented. These tours were performed to verify that systems, valves and breakers required for safe plant operations were in their correct position; fire protection equipment, spare equipment and materials were being maintained and stored properly; plant

operators were aware of the current plant status; plant operations personnel were documenting the status of out-of-service equipment; security and health physics controls were being implemented as required by procedures; there were no undocumented cases of unusual fluid leaks, piping vibration, abnormal hanger or seismic restraint movements; and all reviewed equipment requiring calibration was current.

Tours of the plant included review of site documentation and interviews with plant personnel. The inspectors reviewed the shift foreman's log, control room operator's log, clearance center tag out logs, system status logs, chemistry and health physics logs, and control status board. During these tours the inspectors noted that the operators appeared to be alert and aware of changing plant conditions.

The inspectors evaluated operations shift turnovers and attended shift briefings. They observed that the briefings and turnovers provided sufficient detail for the next shift crew.

The inspectors verified that various plant spaces were not in a condition which would degrade the performance capabilities of any required system or component. This inspection included checking the condition of electrical cabinets to ensure that they were free of foreign and loose debris, or material.

Site security was evaluated by observing personnel in the protected and vital areas to ensure that these persons had the proper authorization to be in the respective areas. The security personnel appeared to be alert and attentive to their duties and those officers performing personnel and vehicular searches were thorough and systematic. Responses to security alarm conditions appeared to be prompt and adequate. The inspectors observed that the licensee had established additional active and passive security measures at the correct levels, to be consistent with NRC Information Notice 87-27.

b. Plant Events

- (1) On July 22, 1987 the licensee notified the NRC Duty Officer concerning an event that resulted in an automatic actuation of the engineered safety features. When the event occurred, the reactor was critical and stable at approximately two percent power with the "B" main feedwater pump supplying feedwater to the steam generators. The licensee reported that the motor-driven auxiliary feedwater pumps (AFW) started at 5 a.m. as a result of the "B" main feedwater pump tripping.

Upon losing the main feedwater pump, both of the electrically-driven AFW pumps started, as expected. The operators maintained steam generator water level with the AFW

pumps until the "A" main feedwater pump was started. The AFW pumps were then secured and the AFW system was returned to its normal emergency standby condition.

The licensee first reported that the event was initiated by the circuit breaker for the "B" main feedwater pump motor tripping, due to overcurrent. However, the inspectors were informed that after the maintenance technicians inspected and tested the pump's protective circuitry, they determined that it was unlikely that it tripped on overcurrent. The inspectors evaluated the site electrical drawings for the circuit breaker and noted the following:

- When the overcurrent relay energizes it causes contacts to close which lockout the circuit breaker once it has tripped open.
- The lockout device would then require resetting before the breaker could be operated again.

The inspectors interviewed the responsible technicians and were told that the lockout device was not activated when the circuit breaker tripped. Based on this observation and the electrical tests which were conducted on the pump motor and its circuits, the technicians determined that the main feedwater pump did not trip on overcurrent. The circuit tests and inspections revealed that a mechanical fastener on the valve linkage for the "B" main feedwater pump recirculating valve had vibrated loose. The loose valve linkage caused a false valve position to be indicated. The false indication resulted in a feedwater pump low flow alarm followed by a low feedwater pump flow trip.

On July 23, 1987 the licensee contacted the NRC and provided a correction to the initial report of this event. The licensee has documented the event on a Licensee Event Report identified as LER-87-46.

- (2) On July 24, 1987 the licensee experienced a loss of the Emergency Response Facility Information System (ERFIS) computer. The licensee informed the inspectors that the plant had been experiencing a "random" fault on the "A" train ERFIS computer. The fault had been identified as an input/output processor failure in the "A" Central Processor Unit (CPU), which effectively locked up the ability of the computer to update the CRT (cathode ray tube) monitors. A lockup of one of the trains of ERFIS will automatically shift the input/output to the other train. However, a computer operator was in the process of performing a routine surveillance on train "B" and therefore the automatic shift over did not occur. Prior to this event the licensee's computer personnel were able to correct the lockup problems by restarting the ERFIS program within 15 minutes. The



Plant Emergency Plan allowed the licensee 15 minutes to be without the ERFIS computer, however, on this date the computer operator was unable to restart the system within the specified time. The licensee declared an Unusual Event at 1:15 a.m. and notified the appropriate federal, state and local officials. The ERFIS computer was returned to service at 1:42 a.m. and the licensee began an investigation of the cause and corrective actions for this event. Subsequent to this event the licensee revised its Emergency Plan, in accordance with 10 CFR 50.54q., to allow an hour time period prior to making a determination of an Unusual Event for all future computer failures. Acceptability of this change will be reviewed during subsequent inspections.

On July 25, 1987, at about 1:45 p.m., the site experienced a loss of both trains of the ERFIS computer. The licensee declared an Unusual Event, and notified the appropriate local, state and federal agencies. The "A" train of the ERFIS computer was repaired and the site terminated the Unusual Event at 1:58 p.m.

On July 27, 1987 the licensee removed both trains of the ERFIS computer for troubleshooting. The troubleshooting was performed to try to locate the cause of the previous computer failures. Removal from service of the ERFIS computer was coordinated with local, state and federal agencies prior to system deenergizing. The troubleshooting was completed and both ERFIS trains were returned to service.

- (3) On July 31, 1987 the licensee identified a problem with the containment wide range level (CWRL) instrumentation. The CWRL system is divided into "A" and "B" trains which meet the redundant train requirements. Operations personnel noted that the "A" train instrument pegged low and that there was an alarm condition on the computer monitoring system. The operations section generated two Work Request and Authorizations (87-AYJT1 and 87-AYJU1) to locate and correct these problems. With both trains of the instruments out of service, it placed the plant in a 48-hour Limiting Condition for Operation (LCO) action statement in accordance with Technical Specification (TS) 3.3.3.6.b. Licensee Instrumentation and Control personnel found that the "B" train instrument loop had a short to ground between a potentiometer and metal housing, which was repaired, allowing the "B" train to be returned to service. Correction of the "B" train ended the 48-hour LCO. However, with only one loop of instruments available, TS 3.3.6.a specifies that the inoperable loop must be returned to service within seven days, or the plant must be in Hot Standby within the following six hours, and in at least Hot Shutdown within the following six hours.



While operations personnel were reviewing the probable causes for the "A" train failure, engineering personnel were reviewing a Plant Change Request (PCR), PCR-2138, which would replace the control room meter with one capable of receiving direct signals from a sensing device. The analysis for the PCR was based on the following facts:

- Location of the detectors inside containment would not allow repairs due to high radiation levels while the reactor was at power operation.
- The CWRL instrumentation system was not normally used during routine plant operation.
- A local instrument in the reactor auxiliary building was available during all operational and accident phases to monitor the water level in the containment pit.
- System reliability would not be affected by this change, and a safety evaluation would be completed prior to implementation of the PCR.

The licensee obtained the replacement meter and performed all necessary certifications to ensure that the meter met site specifications. The inspectors evaluated the maintenance activities associated with the Work Request (87-AZAG1) which replaced and calibrated the sensing device, as specified in

PCR-2138, and they found that the work performed appeared to be satisfactory.

- (4) At 9:54 p.m. on August 4, 1987, while the reactor was operating at 100 percent power, personnel error caused the plant to experience a reactor trip when the "B" train compressed air system was being returned to its normal valve lineup. The compressed air system is composed to two separate trains, each consisting of an air compressor, an air dryer tower, support equipment, valves and piping. The "A" train compressed air system was out of service, with the "B" train system supplying plant air loads. A clearance was required to allow maintenance personnel to replace the desiccant material in the "B" air dryer. The clearance (OP-87-1418) removed the "B" air dryer from service by electrically isolating the air dryer power, closing the isolation valves and opening the bypass valve. Bypassing the air dryer allowed the "B" train compressed air system to remain in service, supplying all plant air loads. When restoring the "B" train air dryer to service, the clearance center mistakenly identified that the air dryer outlet valve (1IA-852) was to remain closed. With the air dryer outlet valve shut and the air dryer bypass valve shut, no flow path was available for compressed air. Based on a low air alarm in the

control room, the control operator instructed the auxiliary operator to investigate the cause for the loss of air. Subsequently, the reduced air pressure to feed flow controller reduced the capability to control feed flow, therefore the turbine load was reduced. During the load reduction the plant experienced a loss of both heater drain pumps and a trip of the "A" main feedwater pump, resulting in an automatic runback. After the runback, the reactor tripped on an "A" steam generator low level, coincident with a feed flow/steam flow mismatch. The "A" steam generator level decrease was due to the turbine throttle valves closing, thereby causing the steam header pressure to increase which led to a steam generator shrink (decrease). All safety systems started as required.

The inspectors reviewed the circumstances leading up to this event and determined that the clearance center operator failed to appropriately identify the correct position of an outlet valve (1IA-852) on the restoration section of clearance OP-87-1418 in accordance with Operations Procedure OP-151-01, Compressed Air System Operation, while returning the system to service. The inspectors informed licensee management that failure to show the correct operational position of this valve on the clearance procedure was a violation of Administrative Procedure AP-020, Clearance Procedure, and will be identified as "Incorrect Position of a Compressed Air Valve During Clearance Restoration" 50-400/87-31-01.

- (5) During the restart of the plant on the morning of August 5, 1987, at approximately 2:01 a.m., following the reactor trip the previous day, the plant experienced an actuation of the engineered safety features (ESF) system. While approaching Mode 2 (Start-up) from Mode 3 (Hot Standby), the plant lost the running "A" main feedwater pump which generated an ESF signal for the standby motor-driven AFW pumps to start and supply the necessary steam generator feed requirements, as designed. Preliminary investigations by the licensee determined that the cause for the main feedwater pump trip was due to high discharge pressure.

The inspectors interviewed licensee personnel and reviewed the licensee's documentation for this event, which included Work Request and Authorization 87-AYZR1, instrument calibration data sheets, and the initial Licensee Event Report information. The inspectors verified that the licensee's evaluation of this event correctly identified the reasons for the main feedwater pump tripping. The inspectors determined that the event was initiated due to incorrect settings on the main feedwater pump discharge pressure switches. These incorrect settings were a result of the pressure sensors drifting out of calibration.

The event was evaluated by the licensee as a four-hour reportable event under the requirements of 10 CFR 50.72. However, the licensee did not make the "Red Phone" call to the NRC Duty Officer until approximately 9:44 a.m. on August 5, 1987. When the inspectors inquired about the licensee's allowing nearly eight hours to pass prior to reporting the event, they were informed by responsible licensee supervision that failure to report this event within four hours was due to personnel incorrectly interpreting the reportable requirements of 10 CFR 50.72. Additionally, the interpretation error was a result of not distinguishing this event from the reactor trip which occurred at 9:54 p.m. on August 4, 1987. The inspectors informed licensee management that failure to make the appropriate event report within the four-hour reporting requirement is a violation of 10 CFR 50.72, and will be identified as "Failure to Report an ESF Actuation Within Four Hours" (50-400/87-31-02).

- (6) On August 10, 1987 the licensee experienced a loss of the capability to collect weather data from the onsite meteorological weather station and therefore declared an Unusual Event at 5:36 a.m. State and local officials were notified in accordance with the Emergency Plan requirements, and the Unusual Event was terminated at 9:00 a.m. The cause of the event was attributed to the power supply breaker for the meteorological tower modem tripping. The breaker was reset and the meteorological tower station was placed back in service. The licensee is evaluating this event to determine the root cause for the loss of the power supply breaker.
- (7) On August 15, 1987 the licensee identified that the ERFIS computer was not updating plant parameters, as designed. Operations personnel initiated an investigation to determine the cause and to correct the problem. Plant management declared an Unusual Event at 4:41 a.m. in accordance with the Emergency Plan and notified all appropriate agencies. The event was terminated at 5:15 a.m.
- (8) On August 15, 1987 the plant experienced a loss of the ERFIS computer and declared an Unusual Event at 12:15 p.m. All local, state and federal response organizations were notified within the required time period. The licensee repaired the computer and returned it to service, terminating the Unusual event at 1:12 p.m. Both of the ERFIS events which occurred on August 15 were attributed to a defective electrical card in the "B" computer circuit. The card provided a path for the high speed data link connecting the "A" and "B" computers. The computer technicians replaced the card on the afternoon of the 15th. Replacement of the defective card appears to have corrected the cause of these two Unusual Events.



Two violations were identified in the areas inspected.

6. Monthly Surveillance Observation (61726)

The inspectors witnessed the licensee conducting maintenance surveillance test activities on safety-related systems and components to verify that the licensee performed the activities in accordance with licensee requirements. These observations included witnessing selected portions of each surveillance, review of the surveillance procedure to ensure that administrative controls were in force, determining that approval was obtained prior to conducting the surveillance test and the individuals conducting the test were qualified in accordance with plant-approved procedures. Other observations included ascertaining that test instrumentation used was calibrated, data collected was within the specified requirements of Technical Specifications, any identified discrepancies were properly noted, and the systems were correctly returned to service. The following specific activities were observed:

- The inspectors reviewed the test procedure and witnessed maintenance personnel during the performance of Maintenance Surveillance Test MST-I-0001, Rev. 3, Train "A" Solid State Protection System Actuation Logic and Master Relay Test. This test verified operation of the reactor trip breaker, reactor trip bypass breaker and verification of the P-4 permissive. MST-I-0001 also verified the requirements of Technical Specifications 4.3.2.1, Table 4.3-2, Sections 1.b, 2.b, 3.a.2, 3.a.3, 3.b.2, 3.c.2, 3.c.3, 4.b, 5.a, 5.c, 6.b, 6.d, 6.g, 7.a, 8.a and 8.b. Portions of Technical Specifications 4.3.1.1, Table 4.3-1, Sections 20, 21 and 22 were also verified during the performance of this test. FSAR commitments 3.1.17-002, 7.3.2-044, 7.3.2-049, 7.3.2-051 and 15.0.6-003 were verified upon completion of the test and acceptance of the test results.

The inspectors obtained a copy of the MST procedure and reviewed the procedure to ensure the following: a current copy of the procedure was being used by personnel performing the test; prerequisites for the test were met prior to commencing the test; maintenance personnel performing the test were familiar with the precautions and limitations; communications for the completion of the test were established as required; special tools and equipment were properly obtained and calibrated as required; acceptance criteria were clearly understood by test personnel; procedural steps were clear and progressed logically throughout the testing sequence; data collected by the test personnel were formally documented in the test procedure; and all test data sheets were attached to the test after completion for proper review and acceptance.

The inspectors witnessed maintenance and operations personnel during the performance of the MST to verify that: personnel performing the required activities were qualified to accomplish the task; operations personnel performing selected test portions were aware of any test requirements which would impact test results; and personnel involved

in the test maintained a professional attitude during the test performance.

Maintenance personnel completed the test in accordance with testing requirements specified in the procedure and documented the test results for acceptance/rejection by plant management. All areas observed by the inspectors appeared to be satisfactorily performed by maintenance and operations personnel.

- The inspectors witnessed portions of Operational Surveillance Test OST-1026, Rev. 2, Reactor Coolant System Leakage Evaluation - Daily Modes 1-2-3-4. The licensee performed the test to verify that the unidentified leakage and identified leakage of the reactor coolant system was within the values specified in Technical Specification 4.4.6.2.1.d. Verification of these leakages is accomplished by performing an inventory water balance of the reactor coolant system.

The inspectors verified that operations personnel were in compliance with the procedure, in that test prerequisites were met and signed off prior to data collection; precautions and limitations were reviewed by the necessary operations personnel prior to starting the test; operations personnel performed and signed off on each procedure step as required; operations management reviewed and verified that the test data and calculations met the acceptance criteria established in the procedure; and mathematical review of the calculations used for determination of the identified and unidentified leak rates appeared to be correct.

Portions witnessed and reviewed by the inspectors appeared to be completed in accordance with site approved procedures.

No violations or deviations were identified in the areas inspected.

#### 7. Monthly Maintenance Observation (62703, 62700, 37700)

The inspectors reviewed the licensee's maintenance activities during this inspection period to verify the following: maintenance personnel were obtaining the appropriate tag out and clearance approvals prior to commencing work activities, correct documentation was available for all requested parts and material prior to use, procedures were available and adequate for the work being conducted, maintenance personnel performing work activities were qualified to accomplish these tasks, no maintenance activities reviewed were violating any limiting conditions for operation during the specific evolutions; the required QA/QC reviews and QC hold points were implemented; post-maintenance testing activities were completed, and equipment was properly returned to service after the completion of work activities.

- Maintenance activities were evaluated for the "B" main feedwater pump motor. The maintenance was performed to determine and correct the cause for the motor's circuit breaker tripping open. The work was



authorized by Work Request WR-87-AXMN1. Maintenance personnel determined that the circuit breaker tripped open due to incorrect signals received from the feedwater flow circuit. The incorrect signals were caused by a loose fastener located on the feed pump's recirculating valve. The fastener was tightened and the pump was returned to service on July 23, 1987.

- Maintenance activities were evaluated for the replacement and calibration of the containment wide range sump level instrument. The work was authorized by WR-87-AZAG1, which implemented a Plant Change Request PCR-2138. The new level instrument was installed and placed into service on August 7, 1987.
- Maintenance activities were evaluated for the "A" main feedwater pump, which tripped and caused an ESF actuation. The work was authorized by WR-87-AYZR1. The pump trip was caused by incorrect settings on the feedwater pump discharge pressure switches PS-2100A1, 2100A2 and 2100A3. The switches were readjusted and returned to service.
- On August 7 and 8, 1987 the licensee removed the plant from the electrical grid and placed the plant in Mode 2 (Start-up). The plant was placed in this mode to allow maintenance activities on the main turbine. The maintenance was authorized by Work Request WR-87-A CP1. The inspectors evaluated the work associated with the Work Request. The maintenance was required to repair a steam leak. The leak developed around the weld which fastened a three inch drain line to the main steam line for governor valve #4.

The leaking weld was ground out and replaced by qualified welders using a site weld procedure which was reviewed and accepted by Westinghouse. Upon completion the weld was inspected both visually and by magnetic particle testing.

No violations or deviations were identified in the areas inspected.