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ACCESSION NBR: 8906060491 DOC. DATE: 89/05/30 NOTARIZED: NO DOCKET #
 FACIL: 50-400 Shearon Harris Nuclear Power Plant, Unit 1, Carolina 05000400
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 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-009-00: on 890501, failure to obtain grab sample from turbine bldg floor drain effluent w/inoperable monitor.
 W/8 ltr.,

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: Application for permit renewal filed. 05000400

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Carolina Power & Light Company

HARRIS NUCLEAR PROJECT
P.O. Box 165
New Hill, NC 27562

MAY 3 0 1989

File Number: SHF/10-13510C
Letter Number: HO-890059 (0)

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

SHEARON HARRIS NUCLEAR POWER PLANT UNIT 1
DOCKET NO. 50-400
LICENSE NO. NPF-63
LICENSEE EVENT REPORT 89-009-00

Gentlemen:

In accordance with Title 10 to the Code of Federal Regulations, the enclosed Licensee Event Report is submitted. This report fulfills the requirement for a written report within thirty (30) days of a reportable occurrence and is in accordance with the format set forth in NUREG-1022, September 1983.

Very truly yours,

R. B. Richey, Manager
Harris Nuclear Project

RBR:tbb

Enclosure

cc: Mr. R. A. Becker (NRR)
Mr. W. H. Bradford (NRC - SHNPP)
Mr. S. D. Ebnetter (NRC - RII)

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PDR ADCK 05000400
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MEM/LER-89-009/1/OS1

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1/1

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) SHEARON HARRIS NUCLEAR POWER PLANT UNIT ONE	DOCKET NUMBER (2) 0 5 0 0 0 4 0 0 1	PAGE (3) 1 OF 0 4
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TITLE (4) **FAILURE TO OBTAIN GRAB SAMPLE FROM TURBINE BUILDING FLOOR DRAIN EFFLUENT WHILE RADIATION MONITOR WAS INOPERABLE**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	
0 5	0 1	8 9	8 9	0 0	0 0	0 5	3 0	8 9	DOCKET NUMBER(S) 0 5 0 0 0 0	

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)				
POWER LEVEL (10) 1 0 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(e)	<input type="checkbox"/> 60.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 60.38(e)(1)	<input type="checkbox"/> 60.73(a)(2)(v)	<input type="checkbox"/> 73.71(e)	
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 60.38(e)(2)	<input type="checkbox"/> 60.73(a)(2)(vi)		
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 60.73(a)(2)(i)	<input type="checkbox"/> 60.73(a)(2)(vii)(A)		
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 60.73(a)(2)(ii)	<input type="checkbox"/> 60.73(a)(2)(vii)(B)		
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 60.73(a)(2)(iii)	<input type="checkbox"/> 60.73(a)(2)(viii)			

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
NAME G. T. Lew, Project Engineer Regulatory Compliance		AREA CODE 9 1 1 9	3 6 1 2 1 - 1 2 1 0 3 1 5

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO						

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

ABSTRACT

On May 1, 1989, it was discovered that monitoring for radioactivity in the Turbine Building Floor Drain Effluent Line was not performed in accordance with Technical Specifications during the period of April 29 and April 30, 1989. Technical Specification Table 3.3-12, Action Statement 36, requires that a grab sample be analyzed for radioactivity at least once per 24 hours if the monitor is inoperable. The required sample was not taken on April 29 and April 30, 1989. The plant operated at full power throughout the period of time considered by this event.

A sample was taken and analyzed on May 1, 1989, as soon as supervisory personnel realized the error. The sample results showed that effluent radioactivity levels had not changed throughout the period of time in question.

The failure to collect the required sample was the result of isolation of the sample collection path for calibration of the detector. Corrective action consisted of locating an alternate sample point and appropriate procedure changes.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

DESCRIPTION

The Turbine Building Drain Monitor (REM-01MD-3528) provides an indication to plant operating personnel of the activity in the effluent from the Turbine Building industrial waste sumps to the cooling tower blowdown via the yard oil separator. The monitor was declared inoperable at 1410 on July 23, 1988, as a result of equipment problems and a work request was initiated to accomplish repairs. The repairs required design changes which required a significant amount of time to design and implement. Daily compensatory grab sampling was initiated as required by Technical Specification Table 3.3-12, Action Statement 36. The sample is normally taken from a grab sample collection valve located on the radiation monitoring skid. Grab samples were drawn and analyzed as required until this event.

On April 27, 1989, repairs to the monitor were completed and a calibration of the monitor was initiated in accordance with procedure RST-011. As a part of this procedure, the flow path to the monitor is isolated and the detector assembly disconnected and removed for calibration. In this condition, a grab sample cannot be drawn from the normal grab sample connection. On April 27 and April 28, the technician performing the sampling was assisted in obtaining the sample by the Radiation Monitoring System Technicians on shift. To obtain sample flow, the sample lines to the detector were plugged, a valve bypassing the detector opened, and the isolation valve opened. The isolation valve was closed after the sample was obtained. This action isolated the grab sample connection from the process flow path.

Work on the monitor was suspended for the weekend of April 29 and April 30. The technicians on duty during the preceding week did not make any log entries concerning the status of the sample path or the additional actions needed to obtain a grab sample. The chemistry technician coming on duty for the weekend was not aware of, or informed of, the fact that the grab sample path was not in service. On April 29 and April 30, the technician on duty attempted to obtain the sample and was not able to obtain sample flow because of the isolated flow path. He assumed that the lack of sample flow indicated that the effluent flow path was not in service and; therefore, a sample was not required. Log entries on April 29 and April 30 to the effect that the effluent path was not in service were made.

On the morning of May 1, 1989, a supervisor's review of the records disclosed that the required samples were not taken. A compensatory sample was obtained at 1140. The results of this sample indicated no increase in the activity levels of the floor drain effluent. There was no observed primary to secondary leakage during the time interval of this event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 306A's) (17)

CAUSE

This event was caused by personnel error. The following elements should be considered as factors contributing to the cause of this event:

1. The sampling procedure assumed that a grab sample could be taken from the sample point on the skid at all times. This procedure and repair and calibration procedures did not allow for the possibility of isolating the sample path. The sampling procedure assumes that a lack of sample flow means that the system flow path is secured.
2. System status was not effectively communicated to personnel responsible for obtaining samples. Technicians aware of the abnormal conditions needed to draw a sample did not communicate this condition to personnel coming on duty.
3. The technician taking the sample incorrectly evaluated the significance of the absence of sample flow. He assumed that the lack of sample flow was due to no effluent system flow.

ANALYSIS

There are no adverse safety consequences as a result of this event. The only potential source of radioactive material to the Turbine Building would be the result of primary to secondary leakage. There was no change in the activity levels of the secondary coolant and samples taken before and after the period of missed samples show that there was no change in the radioactivity levels of the effluent.

There have been other previous Licensee Event Reports that pertain to the failure to meet technical specification sampling requirements. These include LER 86-001, LER 86-010, LER 87-015, LER 87-016, LER 88-015, and LER 88-027. These reports deal with sampling requirements that were missed. The current event is the only one that resulted from an incorrect assessment of system status.

CORRECTIVE ACTION

1. The sampling procedure was changed to provide for a sampling point that is not subject to isolation by radiation monitor calibration procedures.
2. Procedures will be revised to account for the possibility of losing sample flow.
3. The cause and implications of this event will be reviewed with the appropriate personnel.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 305A's) (17)

ENERGY INDUSTRY IDENTIFICATION SYSTEM (EIIS) CODES:

<u>Component or System</u>	<u>EIIS Code</u>
Cooling Tower Blowdown	NN
Radiation Monitor	IL
Radiation Monitoring System	IL
Yard Oil Separator	WH