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ACCESSION NBR:9201280382 DOC.DATE: 92/01/22 NOTARIZED: NO DOCKET #
FACIL:50-400 Shearon Harris Nuclear Power Plant, Unit 1, Carolina 05000400
AUTH.NAME AUTHOR AFFILIATION
HINNANT,C.S. Carolina Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Informs that supplemental rept for LER 91-019-00 will be issued following refueling outage scheduled to commence on 920912 based on recommendations from vendor,revealing that necessary testing could only be performed during shutdown.

DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 14
TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:Application for permit renewal filed. 05000400

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD2-1 LA	1	1	PD2-1 PD	1	1
	MOZAFARI,B.	1	1			
INTERNAL:	ACNW	2	2	ACRS	2	2
	AEOD/DOA	1	1	AEOD/DSP/TPAB	1	1
	AEOD/ROAB/DSP	2	2	NRR/DET/ECMB 9H	1	1
	NRR/DET/EMEB 7E	1	1	NRR/DLPQ/LHFB10	1	1
	NRR/DLPQ/LPEB10	1	1	NRR/DOEA/OEAB	1	1
	NRR/DREP/PRPB11	2	2	NRR/DST/SELB 8D	1	1
	NRR/DST/SICB8H3	1	1	NRR/DST/SPLB8D1	1	1
	NRR/DST/SRXB 8E	1	1	REG FILE 02	1	1
	RES/DSIR/EIB	1	1	RGN2 FILE 01	1	1
EXTERNAL:	EG&G BRYCE,J.H	3	3	L ST LOBBY WARD	1	1
	NRC PDR	1	1	NSIC MURPHY,G.A	1	1
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RIDS/ADDS

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CP&L
Carolina Power & Light Company
P.O. Box 165 • New Hill, N.C. 27562
HARRIS NUCLEAR PROJECT
P.O. Box 165
New Hill, NC 27562

C. S. HINNANT
General Manager - Harris Plant

JAN 2 2 1992

Letter Number: HO-920011 (O)

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

Gentlemen:

Licensee Event Report #91-019-00 was submitted on 11/21/91 to document an unplanned actuation of an Engineered Safety Feature component. The event occurred due to an inadvertent spike on one of the four Containment Ventilation System Radiation Monitors. (see attached LER) The specific cause for this spike was unknown at the time of submittal. The LER stated that a supplemental report would be issued upon completion of additional testing and investigation to determine the root cause of the monitor spike. The expected submission date for this report was January 21, 1992. Recommendations from the vendor revealed that the necessary testing could only be performed during a plant shutdown. Therefore, the supplemental report will be issued following our refueling outage scheduled to commence on September 12, 1992.

Very truly yours

for CSH

C. S. Hinnant
General Manager
Harris Plant

MV:dmw

Enclosure

cc: Mr. S. D. Ebneter (NRC - RII)
Ms. B. L. Mozafari (NRC - RII)
Mr. J. E. Tedrow (NRC - SHNPP)

270021

MEM/HO-920011.O/1/OS1

IE22

FORM 22

CP&L

Carolina Power & Light Company

COPY

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

NOV 2 1 1991

Letter Number: HO-910217 (O)

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 91-019-00

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
Original Signed By:
R. B. RICHEY

R. B. Richey
Vice President
Harris Nuclear Project

MV:dmw

Enclosure

cc: Mr. S. D. Ebneter (NRC - RII)
Ms. B. L. Mozafari (NRC - RII)
Mr. J. E. Tedrow (NRC - SHNPP)

9111270064 4PP

MEM/LER91-019/1/OS1

NRC FORM 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Shearon Harris Nuclear Plant - Unit #1	0 5 0 0 0 4 0 0	1 OF 0 3

TITLE (4) Unplanned ESF Actuation (Containment Ventilation Isolation) due to spike on radiation monitor.

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	DOCKET NUMBER(S)
1 0	2 2	9 1	9 1	0 1 9	0 0	1 1	2 1	9 1		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
1	1 0 0	20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Michael Verrilli - Regulatory Compliance Specialist	AREA CODE 9 1 9 — 3 6 2 - 2 3 0 3

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
B	I L	M 0 N	G 0 6 3	Y					

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
X YES (If yes, complete EXPECTED SUBMISSION DATE)	NO		0 1	2 1	9 2

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

ABSTRACT:

On 10/22/91, at 1505 hours, a Containment Ventilation Isolation signal was generated. This constituted an unplanned actuation of an Engineered Safety Feature (ESF) component. The event occurred while removing one of the four containment ventilation radiation monitors from service during surveillance testing. The cause of the signal was an inadvertent spike on one of the three radiation monitors that remained operable (RM-3561A). The control room staff immediately verified that all associated containment ventilation components had functioned as required and that no abnormal radiation levels actually existed. The system was then realigned to its normal operating lineup. Corrective actions to prevent recurrence will include needed repairs and/or adjustments to the power supply circuitry for radiation monitor RM-3561A. There were no significant safety consequences as a result of this event as the Containment Ventilation System was in the required emergency mode had an actual event occurred.

This is being reported in accordance with 10CFR50.73 (a)(2)(iv) as an unplanned actuation of an ESF component.

EVENT DESCRIPTION:

On 10/22/91, while operating in Mode-1 at 100 percent power, surveillance testing was being conducted on the supply breakers for the four Containment Ventilation Radiation Monitors. This process required securing the power to one radiation monitor at a time, performing an over current trip test on the supply breaker, then restoring the monitor to service. After successful testing and restoration of the first two radiation monitors, the supply breaker for the third monitor (RM-3561C) was opened. At this time, the monitor that had just been placed back into service (RM-3561A) spiked into high alarm. This satisfied the two out of four logic that is required to generate a Containment Ventilation Isolation signal. The control room staff immediately verified that all associated containment ventilation components had functioned as required and that no abnormal radiation levels actually existed. The system was then realigned to its normal operating lineup.

This is being reported in accordance with 10CFR50.73 (a)(2)(iv) as an unplanned actuation of an ESF component.

No events with a similar root cause have been reported.

CAUSE:

The cause of this event was the inadvertent spike that resulted in radiation monitor #RM-3561A going into high alarm, which subsequently created the Containment Ventilation Isolation Signal. Investigation as to why the monitor spiked into high alarm is still in progress. Research up to this point has determined that the most probable cause for this spike was a deficiency in the monitor's supply power circuitry. Further testing will be conducted to verify the exact cause by recreating the initial scenario with appropriate monitoring equipment installed. Upon completion of this testing a supplemental report will be issued to provide additional information, including the specific corrective actions taken.

SAFETY SIGNIFICANCE:

There were no significant safety consequences as a result of this event. No abnormal radiation levels actually existed and the Containment Ventilation System was in the required emergency mode had an actual event occurred.

CORRECTIVE ACTIONS:

Upon completion of the testing described above and identification of the specific problem, repairs and/or adjustments will be made as necessary, to the supply power circuitry for radiation monitor RM-3561A. These corrective actions will be clearly delineated in a supplemental report.