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Carolina Power & Light Company` PO Box 165 New Hill NC 27562 William R. Robinson Vice President Harris Nuclear Plant

Serial: HNP-94-070

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File: HO-940359

United States Nuclear Regulatory Commission Attention: Document Control Desk Washington, DC 20555

SHEARON HARRIS NUCLEAR POWER PLANT DOCKET NO. 50-400/LICENSE NO. NPF-63 REPLY TO A NOTICE OF VIOLATION

Gentlemen:

In reference to your letter of July 25, 1994 concerning NRC Inspection Report 50-400/94-13, the attached is Carolina Power & Light Company's reply to the violations identified in Enclosure 1.

It is considered that the corrective actions taken/planned are satisfactory for resolution of the violations. Questions regarding this matter may be referred to Mr. D. C. McCarthy at (919) 362-2100.

Sincerely,

W. R. Robinson

MV

Attachment

c: Mr. S. D. Ebneter (NRC-RII) Mr. N. B. Le (NRR) Mr. J. E. Tedrow (NRC-SHNPP)

9408310043

FDR

ADOCK 05000400 PDR

State Road 1134 New Hill NC

940824

Tel 919 362-2502 Fax 919 362-6950

REPLY TO A NOTICE OF VIOLATION NRC INSPECTION REPORT NO. 50-400/94-13

Reported Violation A:

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Technical Specification (TS) 6.8.1.a requires written procedures to be properly established and implemented covering activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Appendix A paragraph 9.e., requires procedures for the control of maintenance and modification work.

Procedure PLP-710, Work Management Process, section 4.3 and Attachment 5, require maintenance to be preplanned except for emergency situations that have an immediate and direct impact on the health and safety of the general public, pose a significant industrial hazard or require immediate attention to prevent the deterioration of plant conditions to a possible unsafe or unstable level.

Contrary to the above, on June 29, 1994, non-emergency safety-related maintenance was performed on Emergency Service Water Strainer Backflush Valve 1SW-20 without appropriate preplanning.

This is a Severity Level IV violation (Supplement I).

Denial or Admission:

The violation is denied.

Basis for Denial:

On June 29, 1994 the valve actuator air supply line for 1SW-20 was found sheared off with the valve in the shut position. A priority-1 Work Request & Authorization (WR&A) was initiated to facilitate repairs. Approximately fifteen minutes later the Shift Supervisor-Nuclear (SSN) upgraded the WR&A from Priority-1 to Priority-E (Emergency Work) based on a determination that both trains of Control Room Ventilation were inoperable and that the six hour plant shutdown requirement of TS 3.0.3 applied.

Procedure PLP-710, Work Management Process, Attachment 5, specifies that a TS 3.0.3 entry is an example where emergency work is warranted and assignment of priority-E is appropriate. This allows work to be performed immediately to avoid an unnecessary plant transient, with documentation of actions taking place after the fact. Shortly following the decision to upgrade the WR&A to priority-E, 1SW-20 was successfully opened by maintenance personnel, which places the valve in its required fail safe position, thus exiting TS 3.0.3 and terminating the condition. The use of priority-E was only intended to get 1SW-20 open and actual repair of the valve would be preplanned at a lower priority.





The determination made by the SSN on June 29, 1994 to apply the requirements of TS 3.0.3 and the subsequent decision to upgrade the WR&A to priority-E was correct and consistent with past operating experience and previous interpretations of TS requirements. His decision was conservative in nature and was based on guidance provided by Specappraisal (a computerized LCO identification and tracking program), discussion and agreement among his operating crew, including the Shift Technical Advisor, as well as guidance provided during past licensed operator training. It wasn't until the following day (June 30, 1994), during plant management's reportability review and evaluation of this event, that a conclusion was reached that the plant shutdown requirements of TS 3.0.3 were not applicable. This determination was based on the fact that with the AH-15B Air Handling Unit and the R2-A Recirculation Fan both available, one train of Control Room Ventilation was actually operable. The evaluation that resulted in this position involved several hours of additional system configuration and TS requirement evaluation. Additionally, an evaluation and subsequent testing was completed that validated the operability of the ... Emergency Service Water System, even with valve 1SW-20 failed shut. This information was not available at the time of the event, therefore, it was conservative but, appropriate for the SSN to apply TS 3.0.3 requirements on July 29, 1994.

Reported Violation B:

10CFR50, Appendix B, Criterion XII requires that measures be established to assure measuring and testing devices used in activities affecting quality be properly controlled, calibrated, and adjusted at specified periods to maintain accuracy.

The Licensee's Corporate Quality Assurance Program, Section 8, establishes requirements to assure measuring and test equipment be properly controlled and calibrated. This section specifies that portable measuring and test equipment be included in the calibration program.

Contrary to the above, on June 17, 1994, a portable high voltage probe which was not included in the licensee's calibration program, was utilized to measure voltage on a safety-related neutron flux monitoring system power supply during a periodic surveillance test of the instrumentation.

This is a Severity Level IV violation (Supplement I).

Denial or Admission:

The violation is admitted.

Reason for the Violation:



While performing MST-I0071, Neutron Flux Monitoring System Train A (NI-60) Source Range Calibration, it was discovered that the Fluke 80K-40 high voltage probe used to measure 800 volts DC was not a calibrated tool within the Measuring and Test Equipment (MTE) Calibration Program. The probe is connected to a test point and then connected to a calibrated digital volt meter (DVM) to obtain the voltage reading.

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This violation occurred due to an incorrect perception that the high voltage probe was actually an extension of the calibrated DVM. Maintenance procedures were in place that required the use of calibrated MTE for this activity and that personnel check to ensure that the MTE is within its calibration due date, but due to the perception that the probe was a portion of the DVM, verification of its calibration status has never been performed.

Corrective Steps Taken and Results Achieved:

High voltage probes (multiplier/divider type) used for this and other safety-related applications were verified to meet required accuracy requirements and have been placed in the calibrated MTE program with calibration stickers affixed.

Corrective Steps Taken to Prevent Further Violations:

Appropriate Maintenance Surveillance Test procedures (MST's) and Process Instrumentation Calibration procedures (PIC's) will be revised to specifically require the use of calibrated high voltage probes and to include the required measurement accuracies. Training sessions for Instrument & Control Technicians using this MTE will be performed to ensure a complete understanding of procedure requirements.

Date When Full Compliance Will Be Achieved:

Procedure revisions and I&C technician training will be completed by September 14, 1994.