PRIORITY 1
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REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

DOC.DATE: 94/09/30 NOTARIZED: NO

FACIL: 50-400 Shearon Harris Nuclear Power Plant, Unit 1, Carolina 05000400 AUTH. NAME AUTHOR AFFILIATION VERRILLI,M. Carolina Power & Light Co. DONAHUE, J.W. Carolina Power & Light Co. RECIP. NAME RECIPIENT AFFILIATION SUBJECT: LER 94-005-00: on 940901, TS surveillance violation occurred. Caused by personnel error during sample analysis process. Individuals involved in incident counseled & event reviewed w/applicable E&C personnel.W/940930 ltr. DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR ENCL 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 Plant PO Box 165 New Hill NC 27562

SEP 3 0 1994

Letter Number: HO-941071

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 94-005-00

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.

Sincerely,

J. W. Donahue General Manager Harris Plant

MV

Enclosure

cc: Mr. S. D. Ebneter (NRC - RII)

Mr. N. B. Le (NRC - PM/NRR)

Mr. J. E. Tedrow (NRC - SHNPP)

Mr. W. R. Robinson

9410070254 940930 PDR ADDCK 05000400 S PDR

State Road 1134 New Hill NC

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FACILITY NAME (1)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Shearon Harris Nuclear Plant-Unit #1

ESTIMATED BURDEN PER' RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, MASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

DOCKET NUMBER (2) 05000/400

PAGE (3) 1 OF 3

TITLE (4) Technical Specification surveillance violation due to failure to perform an analysis of a batch release prior to the release.

EVENT DATE (5) LER NUMBER (6))	REPORT DATE (7)			(7)	OTHER FACILITIES INVOLVED (8)				
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LICENSEE CONTACT FOR THIS LER (12)

NAME

Michael Verrilli Sr. Specialist - Licensing

TELEPHONE NUMBER (Include Area Code)

(919) 362-2303

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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On September 1, 1994, it was discovered that the contents of the Treated Laundry & Hot Shower Tank (TL&HS) "A" had been released prior to an analysis being performed as required by Technical Specification (TS) Surveillance Requirement 4.11.1.1.1. This constitutes a violation of the TS surveillance requirement and is being reported in accordance with 10CFR50.73. The cause of this event was personnel error during the sample analysis process. A grab sample of the TL&HS Tank "A" was obtained in preparation for the release and was placed into detector #2 of a multiple channel analyzer. However, data acquisition (sample analysis) was performed on detector #1, which was empty at the time. The analysis results of the empty detector were then used to complete the release permit for the TL&HS Tank "A" and to establish the alarm setpoints for the release path radiation monitor. Immediate corrective actions were to correctly reanalyze the sample and revise the release permit to indicate the actual activity that was released from the tank. The personnel directly involved were counseled. The event was also reviewed with other applicable E&C personnel to reemphasize the need for good self-checking techniques and to stress attention to detail. Additional corrective actions will include an evaluation to determine if human factor enhancements can be made to alleviate this problem in the future. There were no adverse safety consequences as a result of this event. The analysis of the TL&HS grab sample indicated no abnormal radioactivity levels. Additionally, the TL&HS radiation monitor alarm setpoints were set at a value more conservatively than had they been set using the correct sample results. Also, the radiation monitor operated for the duration of the release and indicated no adverse levels of radioactivity.

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	LER MUMBER (6)		LER MUMBER (6)		PAGE (3)
Shearon Harris Nuclear Plant - Unit #1	050001400	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	0.07.0	
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

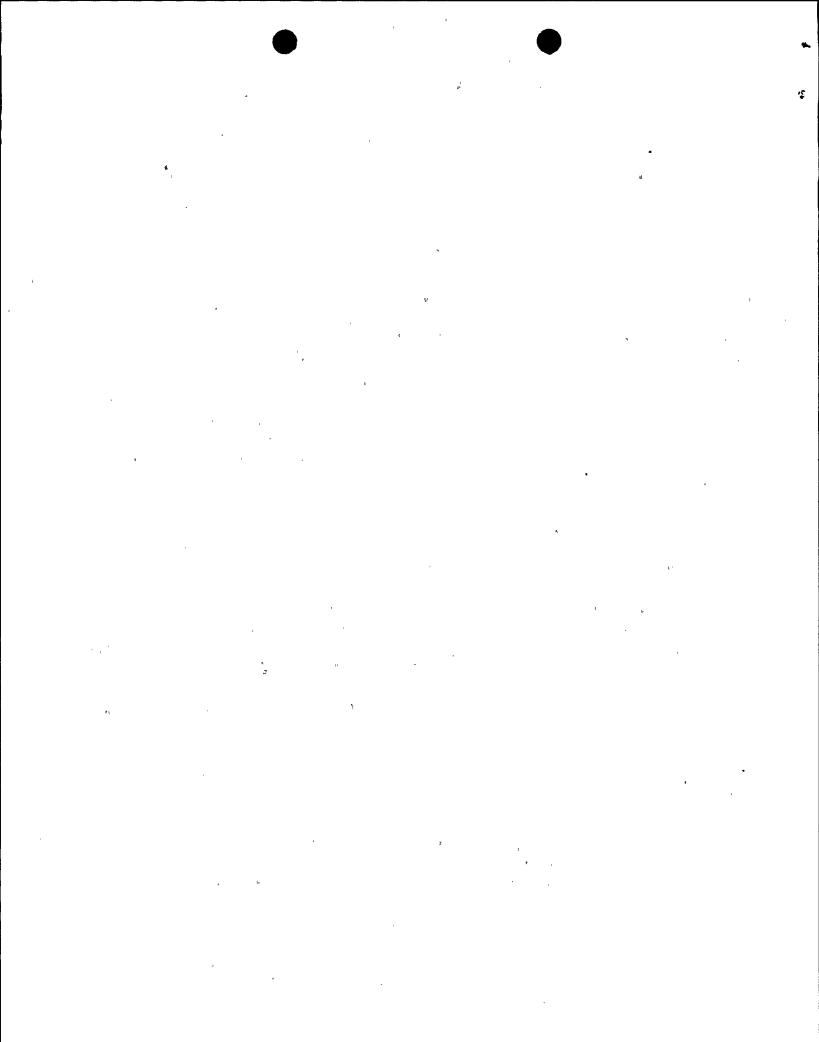
EVENT DESCRIPTION:

On August 28, 1994, Environmental & Chemistry (E&C) personnel were requested to sample the Treated Laundry & Hot Shower (TL&HS) Tank "A" for pH in preparation for a release of its contents. The sample was collected and at 0800 Radwaste personnel were notified of the results. Following pH adjustments, the TL&HS Tank "A" was again sampled at 1300. The sample was then prepared for analysis in accordance with RCP-660 (Sample Preparation for Determination of Radioactivity). The E&C Technician performing this activity placed the sample in detector #2 of a multiple channel analyzer, however, when he logged into the Data Acquisition System to begin the analysis, he mistakenly logged into detector #1 instead of detector #2. Detector #1 was empty during the analysis process. The analysis results (from the empty detector) were used to complete the release permit at 1630 and to establish the alarm setpoints for the radiation monitor on the release pathway. Release of the TL&HS Tank "A" started at 2017 and ended at 0635 the next morning. On August 29, 1994, at 0700, a print-out was obtained of Radiation Monitor 3540 (TL&HS Tank Pump Monitor) response for the previous twenty-four hours to review hourly trends. Routinely, the expected monitor response is calculated for each batch liquid release that is discharged and compared to actual monitor response recorded during the release. This is a new trending program that has been recently implemented to verify proper monitor response. An E&C Specialist updated the database for the calculated monitor response versus actual monitor response. He then observed a significant difference between the two responses and requested the TL&HS Tank "A" sample be reanalyzed. The results of the reanalysis indicated that the initial analysis was incorrect. Further evaluation revealed that the counting room submittal form with the initial analysis indicated the sample had been counted on Detector #2. The computer printout of the sample results also showed that detector #1 was used instead of detector #2. The posted release data was subsequently revised using the correct analysis results.

On August 30, 1994, the E&C Specialist began an evaluation of the Technical Specifications to determine compliance. Since the setpoint used for the radiation monitor was proven conservative, it was determined at that time that no compliance issue existed. However, upon additional investigation, it was determined that this condition constituted a TS surveillance requirement violation and would be reported in accordance with 10CFR50.73.

CAUSE:

The cause of this event was personnel error during the sample analysis process. Proper self-checking techniques were not used to ensure that the Data Acquisition System was aligned to the correct detector.



NRC	FORM	366A
15-0	221	

U.S. NUCLEAR REGULATORY COMMISSION



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FACILITY NAME (1) DOCKET NUMBER (2)			LER NUMBER (6	PAGE (3)	
Shearon Harris Nuclear Plant - Unit #1	05000/400	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2.07.2
	05000/400	94	005	00	3 OF 3

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

LICENSEE EVENT REPORT (LER)

SAFETY SIGNIFICANCE:

There were no adverse safety consequences as a result of this event. This is based on the fact that the analysis of the TL&HS grab sample indicated no abnormal radioactivity levels and that the TL&HS radiation monitor functioned as required through the duration of the release (with a conservative alarm setpoint installed) and indicated no abnormal levels of radioactivity.

CORRECTIVE ACTIONS:

- 1. The E&C individuals involved in this incident were counseled. The event was also reviewed with other applicable E&C personnel to reemphasize the need for good self-checking techniques and to stress attention to detail.
- 2. An evaluation of the sample analysis process will be performed to identify possible human factors enhancements to prevent recurrence of this type event.

EIIS INFORMATION:

N/A