CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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FACIL:50-400 Shearon Harris Nuclear Power Plant, Unit 1, Carolina 05000400
AUTH.NAME AUTHOR AFFILIATION
ROBINSON,W.R. Carolina Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Forwards response to NRC 960520 ltr re violations noted in insp rept 50-400/96-04.C/A:Event Revent Team was assigned to perform root cause investigation of event.

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TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:Application for permit renewal filed. 05000400

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CATEGORY 1 DOCUMENT

CP&L

Carolina Power & Light Company
PO Box 165
New Hill NC 27562

William R. Robinson
Vice President
Harris Nuclear Plant

JUN 18 1996

SERIAL: HNP-96-105

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 NOTICE OF VIOLATION (NRC INSPECTION REPORT NO. 50-400/96-04)

Dear Sir or Madam:

Attached is Carolina Power & Light Company's reply to the Notice of Violation described in Enclosure 1 of your letter dated May 20, 1996.

Questions regarding this matter may be referred to Mr. T. D. Walt at (919) 362-2711.

Sincerely,

for WRR

MGW

Attachment

c: Mr. J. B. Brady
Mr. S. D. Ebneter
Mr. N. B. Le

210043

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1/1

REPLY TO NOTICE OF VIOLATIONS
NRC INSPECTION REPORT NO. 50-400/96-04

Reported Violation:

10 CFR 50, Appendix B, Criterion XVI requires that measures be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. These requirements are further delineated in Section 12 of the licensee's Corporate Quality Assurance Program Manual, Revision 18.

1. Contrary to the above, prior to April 10, 1996, the licensee failed to correct the cause of a January 4, 1995 identified condition adverse to quality related to the spread of contamination from the waste processing building floor drain system in that the event recurred on April 10, 1996. The spread was caused by venting the waste processing demineralizer skid to the floor drain system which blew contamination and resin out the floor drains in the waste processing building and contaminated two persons.

2. Contrary to the above, on April 2, 1996, the licensee failed to correct a documented deficiency (WR/JO AAQY1) with the installed reactor switchgear voltmeter switch prior to using the voltmeter switch for reactor protection system surveillance test MST-I0320. This caused inaccurate readings when testing the P-4 permissive which contributed to entry into two Technical Specification Limiting Conditions for Operation.

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

Denial or Admission of Violation:

The violation is admitted.

Reason for the Violation:

Example 1:

The investigation of the January 4, 1995 event failed to adequately identify the specific activities and factors that contributed to the event. Corrective actions were not effective in precluding recurrence. The corrective action proposed was to eliminate the use of the pressure vessel vent valves, however, no alternative method of venting was proposed. This corrective action was subsequently deemed unreasonable. A night order was issued instead to use caution when venting the vessels to prevent carryover of resin to the floor drains.

Example 2:

The Train B P4 Contact Verification Switch experienced a problem in February 1996 during performance of surveillance test MST-I0320. Section 7.5.28 of the test expected a reading of 48 VDC with the switch in the BY position, but 0 VDC was initially read on the P4 voltmeter.

When the switch was taken to OFF and back to BY position, the proper voltage was obtained. WR/JO 96-AAQY1 was initiated to document the switch problem. The symptoms pointed to dirty contacts as the most likely cause of failure to obtain the expected voltmeter reading. The WR/JO was coded to be worked during an outage since it was initially believed to involve unnecessary risk if worked at power.

The system engineer's decision to not complete WR/JO AAQY1 during the March 1996 forced outage and prior to performance of MST-I0320 on April 2, 1996 was based on (1) the non-safety function of the test voltmeter, (2) the preliminary conclusion that the problem was due to dirty contacts, (3) an alternate method of performing the test was available, and (4) assumed significant post maintenance testing. On April 2, 1996 compensatory actions for the "suspect" P4 voltmeter switch were discussed by the system engineer and the maintenance I&C supervisor prior to the start of the test, but these actions were not added to the procedure.

Corrective Steps Taken and Results Achieved:

Example 1:

1. An Event Review Team (ERT) was assigned to perform a root cause investigation of the event, including why the previous actions where not sufficient to preclude recurrence. This root cause investigation was completed and approved by plant management on May 29, 1996.

2. The venting and admission of resin to the floor drain header from the demineralizer pressure vessel vent valves was eliminated by removing the vent header tail pipe hose from the floor drain and rerouting it to the spent resin header. This action was completed on May 30, 1996.

3. Operating procedure OP-120.09.05, Radwaste Demineralizer Skid, was revised (Rev. 8) to accommodate the hose rerouting discussed in corrective step #2 above and to ensure that post transfer cleaning of system hoses is directed to the Spent Resin System or the Treated Laundry and Hot Shower Tanks if the hoses are to be removed or rerouted due to resin bed replacement. OP-120.09.05, Revision 8 was approved on June 3, 1996.

Example 2:

1. During troubleshooting and review of the voltmeter switch failure on April 2, 1996, the system engineer discovered that MST-I0320 alone could be used to provide the required post maintenance testing, in Mode 1, following switch replacement. The switch was replaced and tested with satisfactory voltage readings per MST-I0320 on April 2, 1996. The plastic covering for two contacts on the removed switch were broken. This condition is believed to have interfered with the contact closure, resulting in the failure to obtain voltage readings in the BY position.

2. A sample survey of shift operators, work coordinators, and maintenance technicians confirmed that there is a general understanding that when a worker encounters a deficiency

tag on instrumentation needed to support a test that the individual will evaluate the potential impact on the test.

Corrective Steps That Will Be Taken to Avoid Further Violations:

Example 1:

A "Training Brief" will be distributed to plant management personnel (first-line supervisors and above) involved with Condition Report investigation and approval. This brief will stress the importance of proper adverse condition investigation, corrective action assignment, approval and implementation. Distribution of this brief will be made by September 1, 1996. Individuals not available due to training, vacation, sickness, etc., will receive the brief upon their return to work.

Example 2:

1. As an additional measure, PLP-103, Surveillance and Periodic Test Program will be revised to include a statement that the test performer is to verify instrumentation needed for performance of the test is free from deficiencies that may affect the test performance. This revision will be completed by July 31, 1996.

2. The expectation stated in corrective step #1 above will be communicated by memorandum to applicable plant personnel by September 1, 1996.

3. Training will be provided to applicable engineering personnel on the P4 switch incident. The need to include compensatory actions in a surveillance procedure when they are expected and would be in conflict with existing procedure requirements, as in the case of the P4 switch, will be emphasized. This training will be completed for applicable engineering personnel by June 30, 1996. Training of individuals not available due to other training, vacation, sickness, etc., will be accomplished upon their return to work.

Date When Full Compliance Was Achieved:

Full compliance was achieved on June 3, 1996.