CATEGORY 1

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FACIL:50-400 Shearon Harris Nuclear Power Plant, Unit 1, Carolina 05000400
AUTH.NAME AUTHOR AFFILIATION
EADS,J. Carolina Power & Light Co.
DONAHUE,J.W. Carolina Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 96-014-00:on 891127,identified condition of two Charging/Safety Injection Pumps connected to same emergency electrical bus.Caused by failure to follow operating procedures.Racked out 6.9 KV breaker.W/960909 ltr.

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TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:Application for permit renewal filed. 05000400

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Serial: HNP-96-150
10CFR50.73

SHEARON HARRIS NUCLEAR POWER PLANT UNIT 1
DOCKET NO. 50-400
LICENSE NO. NPF-63
LICENSEE EVENT REPORT 96-014-00

Dear Sir or Madam:

In accordance with Title 10 to the Code of Federal Regulations, the enclosed Licensee Event Report is submitted. This report concerns a condition outside of the design basis in which two Charging/Safety Injection Pumps (CSIPs) were inadvertently connected to the same emergency electrical bus.

Sincerely,

J. W. Donahue
Director of Site Operations
Harris Plant

JHE/jhe

Enclosure

c: Mr. J. B. Brady (NRC - HNP)
Mr. S. D. Ebneter (NRC - RII)
Mr. N. B. Le (NRC - PM/NRR)

9609170534 960906
PDR ADOCK 05000400
S PDR

NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Harris Nuclear Plant Unit-1	50-400	1 OF 3

TITLE (4)
Condition outside of design basis in which two Charging/Safety Injection Pumps (CSIPs) were inadvertently connected to the same emergency electrical bus.

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 NAME	DOCKET NUMBER
										05000
11	27	89	96	-- 014 --	00	09	06	96	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	6
POWER LEVEL (10)	000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.2201(b)		20.2203(a)(2)(v)		50.73(a)(2)(i)		50.73(a)(2)(viii)
	20.2203(a)(1)		20.2203(a)(3)(i)	X	50.73(a)(2)(ii)		50.73(a)(2)(x)
	20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
	20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
	20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Johnny Eads Project Engineer - Licensing	(919) 362-2646

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
YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO				

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

On November 27, 1989, with the plant shutdown in Mode-6, Operations personnel identified a condition in which two Charging/Safety Injection Pumps (CSIPs) were inadvertently connected to same emergency electrical bus. Specifically, the 6.9 KV breakers for both the "B" CSIP and the "C" CSIP were simultaneously racked into the B-SB 6.9 KV Emergency Bus for approximately 10 minutes. This condition was determined to be reportable on August 7, 1996 as a condition outside the plant design basis.

This condition was caused by a failure to follow operating procedures.

Immediate corrective actions in 1989 included racking out the breaker for the "B" CSIP. Additional corrective actions completed include placing clearance tags on the breakers to provide additional warning and revisions to operating procedures to provide additional caution. In addition, mechanical interlocks will be installed on CSIP breakers to inhibit racking in the breakers for the spare and dedicated pumps simultaneously.

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Shearon Harris Nuclear Plant - Unit #1	50-400	96	-- 014 --	00	2 OF 3

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

EVENT DESCRIPTION:

On November 27, 1989, with the plant shutdown in Mode-6, Operations personnel identified a condition in which two Charging/Safety Injection Pumps (CSIPs) were inadvertently connected to same emergency electrical bus. Specifically, the 6.9 KV breakers for both the "B" CSIP and the "C" CSIP (EIIS Code BQ-BKR) were simultaneously racked into the B-SB 6.9 KV Emergency Bus for approximately 10 minutes. This condition was determined to be reportable on August 7, 1996 as a condition outside the plant design basis. This condition was recognized as being outside the design basis while investigating an NRC identified concern related to interlocks for the spare and dedicated Component Cooling Water (CCW) pump breakers not being installed in the plant as described in the FSAR. This condition was determined to be not reportable in 1989 based on the fact that the plant remained in compliance with applicable Technical Specification Action requirements.

At 2:30 p.m. on November 27, 1989, while returning the "C" CSIP to service to support an operation surveillance test, (OST-1801, "ECCS Throttle Valve, CSIP and Check Valve Verification - 18 Month Interval - Mode 6"), the breaker for the "C" CSIP was racked into the B-SB 6.9 KV emergency electrical bus while the "B" CSIP was also racked into the same emergency bus. The plant was in Mode 6 in support of Refueling Outage No. 2 with core reload completed. The upper internals were installed and the reactor vessel head was removed.

Prior to the event the Senior Control Operator (SCO) in the control room contacted the Clearance Center and stated that he needed someone to rack in the "C" CSIP breaker. The SCO requested the Clearance Center personnel to find someone and have that person see him in the control room. The Clearance Center personnel dispatched an operator to go to the control room stating that they needed someone to rack in the "C" CSIP breaker. The operator went to the control room and asked, to no specific individual, which bus the "C" CSIP was being powered from. He received the answer from the Shift Technical Advisor (STA) and the Balance of Plant (BOP) Operator that it was wired to the B-SB bus. The operator then left the control room without speaking to the SCO and proceeded to rack the "C" CSIP breaker into the B-SB bus. The "CHARGING PUMPS B BOTH BKRS IN" annunciator in the control room lit and the Reactor Operator (RO) observed the control power indication for the "C" CSIP. The operator who racked in the "C" CSIP breaker returned to the control room to inform the SCO that the "C" CSIP breaker was racked in. The error was recognized and corrected. At 2:40 p.m., the "B" CSIP breaker was racked out and declared inoperable.

Operating Procedure, OP-107, "Chemical and Volume Control System," contains procedural steps to prevent the racking in the spare and dedicated CSIP breakers simultaneous into the same emergency bus. The procedure requires that the "B" CSIP breaker be racked out prior to the "C" CSIP breaker being racked in.

CAUSE:

This condition was caused by a failure to follow operating procedures.

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

SAFETY SIGNIFICANCE:

There were no safety consequences for this event. This condition occurred in November 1989 while the plant was in Mode 6. During this event, the annunciator in the control room lit, the operator observed the control power indication for the spare pump, and the error was recognized and corrected. Both the dedicated and spare CSIP breakers were racked in simultaneously for approximately 10 minutes. There were no adverse consequences as a result of this event and compliance with Technical Specifications were maintained.

This condition is reportable per 10CFR50.73(a)(2)(ii).

PREVIOUS SIMILAR EVENTS:

No similar plant events of simultaneously racking both the dedicated and spare CSIP breakers into the same emergency bus have been identified at the Harris Plant.

CORRECTIVE ACTIONS COMPLETED:

1. Racked out the 6.9 KV breaker for the "B" CSIP at 2:40 p.m.on November 27, 1989.
2. Clearance tags placed on breakers to provide additional warning.
3. Operating procedures enhanced to provide additional caution.

CORRECTIVE ACTIONS PLANNED:

1. Install mechanical interlocks on CSIP breakers to inhibit racking in the breakers for the spare and dedicated pumps simultaneously prior to completion of the Spring 1997 Refueling Outage currently scheduled to begin March 1997.