CATEGORY 1

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Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 961107 ltr re violations noted in insp rept 50-400/96-09.Corrective Actions:CO responsible for inadvertent filling & resultant dilution of RWST,was counseled on use of error prevention techniques.

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NOTES:Application for permit renewal filed. 05000400

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CP&L

Carolina Power & Light Company
PO Box 165
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William R. Robinson
Vice President
Harris Nuclear Plant

DEC 9 1996

SERIAL: HNP-96-200
10 CFR 2.201

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 VIOLATIONS (NRC INSPECTION REPORT NO. 50-400/96-09)

Dear Sir or Madam:

Attached is Carolina Power & Light Company's reply to the Notice of Violations described in Enclosure 1 of your letter dated November 7, 1996.

Questions regarding this matter may be referred to Ms. D. B. Alexander at (919) 362-3190.

Sincerely,

W R Robinson

MGW

Attachment

c: Mr. J. B. Brady (NRC Resident Inspector, HNP)
Mr. S. D. Ebneter (NRC Regional Administrator, Region II)
Mr. N. B. Le (NRR Project Manager, HNP)

130011

REPLY TO NOTICE OF VIOLATIONS
NRC INSPECTION REPORT NO. 50-400/96-09

Reported Violation A:

Technical Specification 6.8.1.a requires, in part, that procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, "Quality Assurance Program Requirements (Operations)."

1. Regulatory Guide 1.33, Appendix A, Section 3.1, includes specific procedures for the auxiliary feedwater system, for which the Condensate Storage Tank (CST) is a safety-related water source.

   Licensee operating procedure OP-134, Condensate System, Revision 7, contains in Section 8.3.2 specific steps for filling the CST. These steps include options to manipulate either valve 1CE-23 (Step 2) or valves 1DW-490 and 1DW-486 (Step 3).

   Contrary to the above, on September 6, 1996, an operator manipulated the wrong valve, 1DW-5, while attempting to fill the CST. This error caused the subsequent filling and dilution of the refueling water storage tank, and contributed to the simultaneous short-term inoperability of the boration flow paths required by Technical Specification 3.1.2.2.

2. Regulatory Guide 1.33, Appendix A, Section 3 requires procedures for startup, operation, and shutdown of safety-related PWR systems. This requirement is further implemented by the licensee's operations management manual procedure OMM-001, Operations - Conduct of Operations, Revision 16.

   Procedure OMM-001 requires, in part, that instructions for energizing, filling, draining, starting up, shutting down, and other instructions appropriate for operations of systems related to safety shall be delineated in system operating procedures. Step 5.2.2.3.c directed personnel to use Attachment 2 of the procedure to document small changes to completed lineups (contained in system operating procedures).

   Contrary to the above, on September 29. 1996, operators and shift management failed to comply with the direction in OMM-001 by relying on an unreviewed and unapproved list of "spare" breakers to be turned off. This resulted in the de-energization of a live circuit feeding a safety-related radiation monitor and the subsequent actuation of fuel handling emergency exhaust fan E-13B.

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

Denial or Admission of Violation:

The violation is admitted.

Reason for the Violation:

Both examples of the above cited violation occurred due to personnel error. The Control Operator (CO) involved in example 1 failed to use error prevention techniques to verify that he was opening the correct valve. The Control Room Supervisor (CRS) involved in example 2 allowed the use of an informal, unapproved list to operate the circuit breakers.

A common cause analysis was performed to address an adverse trend in personnel errors by operations personnel. Substandard work practices and work standards have been the major contributor to the adverse trend. These poor work practices and standards result from fundamental attitudes and beliefs (culture) not being at a level required to support excellence in all aspects of operator performance.

Corrective Steps Taken and Results Achieved:

Example 1:

The CO responsible for the inadvertent filling and resultant dilution of the Refueling Water Storage Tank (RWST), was counseled on the use of error prevention techniques. The RWST was borated to within Technical Specification limits on September 7, 1996. LER 96-020-00 was submitted on October 7, 1996 due to this event.

Example 2:

The breaker was returned to its normally closed position promptly after it was opened. The responsible CRS was counseled on the use of formality and procedural compliance when directing the operation of plant components.

Directives are in place to Operations Unit Supervisors and Superintendents as interim corrective actions until the common cause analysis corrective actions are completed. These directives were included in CP&L's reply to notice of violation (NRC Inspection Report No. 50-400/96-07) dated October 28, 1996 and address formality, use of procedures, generic job performance, expectations, shift briefings, shift staffing, and daily in-field observations by supervisors.

Corrective Steps That Will Be Taken to Avoid Further Violations:

Additional actions are being developed to address the attitudes and beliefs (culture) within the Operations Unit. A Near Term Improvement Plan is being developed and will establish the framework for sustained, improved performance in Operations. This plan will be issued by December 31, 1996 and will include the following:

1. Existing strategies and initiatives for performance improvement.

Corrective Steps That Will Be Taken to Avoid Further Violations: (continued)

2. Focus Team initiatives. A Focus Team has been established and is comprised of operators in various working level positions. The team is responsible for identifying critical improvement opportunities to effect a near-term step change in performance and position the organization for advancement to "world class" performance. The team will provide Operations management continuing feedback on the effectiveness of these initiatives. The Focus Team is an essential link to improving the culture in Operations because it will build ownership of problems and solutions at all levels in the organization.

3. A plan for benchmarking work practices and culture with the best practices and behaviors within the Harris Plant, CP&L, and as opportunity allows, neighboring utilities.

This plan will be periodically assessed and revised as necessary.

Date When Full Compliance Was Achieved:

Full compliance was achieved on September 7, 1996 for Example 1 and on September 29, 1996 for Example 2.

Reported Violation B:

Technical Specification 6.8.1.c requires that written procedures shall be established, implemented, and maintained covering Security Plan implementation.

Licensee procedure SP-005, Security Search and Contraband Denial, Revision 5 partially implements activities covered by the licensee's corporate security plan. Procedure section 7.0, Vehicle Searches, Step 7 specified that, following access by the vehicle, the gate and the vehicle barrier system active barrier shall be closed and returned to the blocking position.

Contrary to the above, on September 13, 1996, an officer failed to ensure complete closure of protected area gate 1B following access by a vehicle. This resulted in a short-term protected area opening (of which security personnel were unaware) in excess of the requirements specified in the licensee's corporate security plan, Physical Security and Safeguards Contingency Plan, Revision 0.

This is a Severity Level IV Violation (Supplement III).

Denial or Admission of Violation:

The violation is admitted.

Reason for the Violation:

The reason for the violation was human error, failure to comply with a procedural requirement. The assigned Nuclear Security Officer failed to ensure that an electrically operated Protected Area gate was properly closed before turning his attention, and his view, to a different task.

Corrective Steps Taken and Results Achieved:

The gate was secured immediately following discovery on September 13, 1996. A Security Incident/Complaint Report was prepared documenting the circumstances surrounding the incident. A Condition Report (CR) was written. Investigation determined the cause of the event to be human error. The event was documented in the HNP Safeguards Event Log in accordance with the provisions of 10 CFR 73.71.

The Nuclear Security Officer involved in the procedural noncompliance has received disciplinary counseling and corrective instruction.

A training document was prepared and addressed with members of each of the four Security Platoons to reiterate procedural requirements related to the integrity of Protected Area gates. The training document [Training Topic "Operation and Opening Protected Area Barrier Gates"] provided an overview of the circumstances involved in the incident and contained extracts from applicable security procedures including:

1. Monitoring Protected Area gate activity from an alarm station.

2. Integrity of the Vehicle Barrier System (VBS).

3. Responsibility assignment for maintaining the integrity of the Protected Area barrier.

4. Maximum permissible size of openings within the Protected Area barrier.

5. Method of securing the Protected Area gate when it is not attended by a Security Officer.

6. Prerequisite security manning before a Protected Area gate may be opened.

Corrective Steps That Will Be Taken to Avoid Further Violations:

No further actions required.

Date When Full Compliance Was Achieved:

Full compliance was achieved on September 13, 1996 when Protected Area gate 1B was secured following discovery.

Reported Violation C:

10 CFR 50.65 (b) establishes that the scope of the maintenance rule monitoring program shall include safety-related structures, systems, or components that are relied upon to remain functional during and following design basis events to ensure the integrity of the reactor coolant pressure boundary, the capability to shut down the reactor and maintain it in a safe shutdown condition, and the capability to prevent or mitigate the consequences of accidents that could result in potential offsite exposure comparable to the 10 CFR Part 100 guidelines; and non-safety related structures, systems or components that are relied upon to mitigate accidents or transients or are used in the plant emergency operating procedures, or whose failure could cause a reactor scram or actuation of a safety-related system.

Procedure ADM-NGGC-0101, Maintenance Rule Program, Revision 3, implements 10 CFR 50.65 and provides maintenance rule implementation instructions. Section 9.3.1, under scoping, directed personnel to obtain systems lists from the Equipment Data Base System (EDBS) and supply to the Expert Panel for evaluation. Attachment 1, List of CP&L Maintenance Rule Systems, lists the EDBS system name, system number, and the expert panel determination. The expert panel system determinations were loaded into EDBS with all components in each system receiving the determination for the system.

Contrary to the above, as of August 16, 1996, the licensee had not included all systems and components within the scope of the rule as required. Boric Acid filter isolation valve 1CS-559 was designated in EDBS as not within the scope of the maintenance rule, even though it is in the emergency boration flow path which is used to mitigate accidents. The component had been listed in EDBS under a system that was not scoped within the maintenance rule. The licensee's review also found multiple components in each of nine systems that were not scoped correctly in EDBS because they were listed in incorrect systems.

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

Denial or Admission of Violation:

The violation is admitted.

Reason for the Violation:

The violation resulted from a failure to identify that specific components in maintenance rule (MR) systems were loaded in the EDBS under other non-MR systems. This occurred due to an oversight during development of a site-wide action item list to track MR implementation actions and inappropiate use of EDBS as a MR tool.

EDBS was developed using system boundaries from initial system startup. A MR Expert Panel determined MR scoping using guidance in NUMARC 93-01. Although the scoping was performed at the "EDBS system" level, it was recognized that there might be quality class "A" components in non-MR systems which could impact a MR function and would need to be included. Quality class "A" is the designator used for safety related components in EDBS. However, no formal action item was created to ensure that such components were identified.

Corrective Steps Taken and Results Achieved:

On August 8, 1996, quality class "A" components listed under non-MR systems were re-coded in EDBS to be identified as within the scope of the MR. Although some class "A" components do not serve a safety related function, this was completed as an interim corrective action to ensure these components (approximately 1200) will be treated as MR for maintenance purposes until further evaluation can be completed.

Further review of these 1200 items revealed that 152 (41 components, 111 piping segments) should be relocated to specific MR systems in the EDBS database. These changes were completed on October 30, 1996.

Based on this violation and the preliminary results of initial NRC MR baseline inspections at other plants, Harris Nuclear Plant conducted a MR self assessment. The assessment was completed on December 5, 1996. Preliminary results of the assessment indicate other items which need further review to ensure full compliance with the MR.

Corrective Steps That Will Be Taken to Avoid Further Violations:

Some of the 1200 items were listed correctly under non-MR systems, but could potentially impact MR functions. These components' functions will be validated and presented to the Expert Panel for formal MR inclusion by February 28, 1997.

Additional guidance will be provided regarding the use and limitations of EDBS as a MR tool by February 28, 1997.

Components which were re-coded as MR on August 8, 1996 which are determined by further evaluation to have no impact on MR functions will be returned to non-MR designation in EDBS by March 31, 1997.

Date When Full Compliance Will Be Achieved:

Items from the MR self assessment discussed above which could result in noncompliance will be resolved prior to February 28, 1997 or a supplemental response to this violation will be provided with an updated schedule for resolution.