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SUBJECT: Responds to NRC 880401 ltr re violations noted in Insp Rept 50-400/88-06. Corrective actions: 871216 change to Procedure EOP-EPP-010 & 880106 change to Procedure EOP-EPP-003 issued & changes made re control of plant design changes.

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Carolina Power & Light Company

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APR 29 1988

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United States Nuclear Regulatory Commission
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 April 1, 1988, referring to I.E. Report RII: 50-400/88-06, the attached is Carolina Power & Light Company's reply to the violation identified in Enclosure 1.

It is considered that the corrective actions taken are satisfactory for resolution of the item.

Thank you for your consideration in this matter.

Very truly yours,

R A Watson

R. A. Watson
Vice President
Harris Nuclear Project

MGW:dj

Attachment

cc: Messrs. B. C. Buckley (NRC)
G. Maxwell (NRC-SHNPP)
Dr. J. Nelson Grace (NRC)

IE01
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Attachment to CP&L Letter of Response to NRC I.E. Report RII:
50-400/88-06 Violation

Reported Violation:

Technical Specification 6.8.1a requires that written procedures be implemented covering the procedures outlined in Appendix A of Regulatory Guide 1.33, Rev. 2, February 1978. Administrative Procedures are identified in Appendix A of the Regulatory Guide. An Administrative Procedure titled "Procedure Review and Approval," AP-006, Rev. 7, Sections 5.7 and 5.8, requires that Emergency Operating Procedures must be technically accurate to safely perform their intended function.

Contrary to the above, from September 24, 1986, until December 10, 1987, AP-006 was not implemented in that an Emergency Operating Procedure EOP-EPP-010, titled "Transfer to Cold Leg Recirculation" was not revised to include the valve configuration described in FSAR Table 6.3.2-6. Failure to revise the EOP to ensure that a single RHR pump would perform its intended function while operating in the recirculation configuration could have resulted in a total loss of RHR during a LOCA condition. This is a Severity Level IV violation (Supplement I).

Denial or Admission and Reason for The Violation:

The violation is correct as stated.

In September 1985 and August 1986, Westinghouse recommended changes to the procedure described in FSAR Table 6.3.2-6 for the transfer of the Emergency Core Cooling System (ECCS) from the injection to the recirculation phase.

Westinghouse recommended deletion of the procedure steps which separated the two ECCS trains, since these steps did not provide complete passive failure protection, and since their elimination would allow a single Residual Heat Removal Pump (RHRP) to supply both Charging Safety Injection Pumps (CSIPs). These proposed changes were approved for implementation at SHNPP.

An FSAR change (serial HPOS-845) was initiated to incorporate these changes. As part of the review of these changes, the on-site Technical Support Unit determined that a single RHRP could not supply two CSIPs and both low pressure ECCS injection headers, as the proposed recirculation lineup required. However, by isolating one of the two low pressure safety injection (LPSI) header containment isolation valves, an acceptable configuration

was created. (It was subsequently demonstrated that with this revised lineup the RHRP would not run out, Preoperational Test 2085-P-05, completed October 5, 1986.) Therefore, the FSAR change included the new requirement to close one of the two LPSI containment isolation valves to ensure that runout of the RHRP would not occur during recirculation if the other RHRP failed.

This change was incorporated into the FSAR change which was approved on September 24, 1986. This change was not incorporated into EOP-EPP-010 as required.

There is no single reason as to why this procedure deficiency came into existence, but the following contributed to the error.

1. Personnel responsible for the EOPs were aware of the Westinghouse proposals to revise the ECCS recirculation lineup, and when the FSAR was changed to implement this new lineup the additional requirement to close the LPSI isolation valve was not noted. The modification to close one of the two LPSI containment isolation valves affected only one page of a change package which was 32 pages in length, and the majority of this package discussed containment isolation valve design, not ECCS recirculation procedures.

2. Changes made to the FSAR, which would require changes to plant procedures, were not routinely identified and tracked prior to licensing of the plant due to the significant number of changes and due to the fact that procedures were being revised prior to initial use in preparation for the operation of the plant.

3. FSAR changes are not immediately made available in the copies of the FSAR, since updates are only required annually by regulations.

The discrepancy between the FSAR and EOPs was identified by many groups during 1987. However, the technical issue as to which document was accurate was not obvious. Investigation of the discrepancy was not given appropriate urgency, given the potential consequences of the discrepancy. When the investigation was completed, the problem was corrected within a reasonable period of time.

Corrective Steps Taken and Results Achieved:

On December 3, 1987, the ONS unit contacted Operations and made them aware of the serious nature of the deficiency. A change to procedure EOP-EPP-010 was issued on December 16, 1987, correcting the error and making the procedure consistent with the FSAR. In addition, a change to procedure EOP-EPP-003, Loss of All AC Power Recovery with Safety Injection Required, which also addresses the recirculation lineup, was issued on January 6, 1988.

Corrective Steps Taken to Avoid Further Noncompliancce:

The events which led to this procedure deficiency occurred prior to licensing of the plant. Upon issuance of the operating license, many changes went into effect regarding how plant design changes are controlled. These changes are considered sufficient to preclude further noncompliance.

- Changes to the plant components which require a Plant Change Request (PCR) receive a complete safety analysis in accordance with 10CFR50.59.

- PCRs are reviewed by the appropriate units to determine the impact on plant procedures for which they are responsible.

- FSAR changes now follow, rather than precede, the changes made to the plant and/or procedures.

The following additional measures have been taken:

- Changes to the FSAR approved in 1986 have been reviewed to verify that those changes which alter procedures described in the FSAR were properly implemented in the plant. No similar situations were discovered.

- Members of the Plant Nuclear Safety Committee have been informed of this event and reminded of their responsibility to ensure potentially reportable items are brought to the attention of management.

Date When Full Compliance Was Achieved:

Full compliance was achieved on February 9, 1988.