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SUBJECT: Responds to NRC 960927 ltr re violations noted in insp rept 50-400/96-07.C/As:CO responsible for monitoring wrong gauge during performance of OST-1214 was counselled on use of self-checking 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

OCT 28 1996

SERIAL: HNP-96-179
10CFR2.201

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 VIOLATION (NRC INSPECTION REPORT NO. 50-400/96-07)

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 September 27, 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)

IE01 1/1

REPLY TO NOTICE OF VIOLATIONS
NRC INSPECTION REPORT NO. 50-400/96-07

Reported Violation:

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)."

Regulatory Guide 1.33, Appendix A, Section 8.b, includes specific procedures for surveillance tests listed in technical specifications.

1. Licensee surveillance test procedure OST-1214, Emergency Service Water System Operability Train A, Revision 7, Step 7.7.17 directed the operator to obtain a screenwash pump flowrate between 31-33 inches water column (150-155 gpm) on the installed differential pressure gauge by throttling pump discharge isolation valve 1CS-23.

   Contrary to the above, on August 9, 1996, an operator referred to the wrong instrument gauge while throttling emergency service water screenwash pump discharge flow during the performance of procedure OST-1214, resulting in the pump running with nearly no flow for approximately two minutes. This affected the pump such that the impeller had to be readjusted prior to putting the pump in service.

2. Licensee surveillance test procedure OST-1045, ESFAS Train B Slave Relay Test, Quarterly Interval, Revision 9, Step 7.20.5 directed the operator to turn Test Switch S938 clockwise and momentarily depress it to test circuitry associated with containment ventilation system isolation.

   Contrary to the above, on August 12, 1996, an operator depressed the wrong switch (S931) while performing procedure OST-1045. This resulted in an inadvertent engineered safety features actuation causing three main steam drain valves to shut.

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 and the Shift Technical Advisor (STA) involved in example 2 failed to use self checking techniques to verify they were using the correct gauge and switch respectively.

Reason for the Violation: (continued)

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 most problems. These poor work practices and standards are resultant 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 monitoring the wrong gauge during performance of OST-1214 was counselled on the use of self-checking techniques. The screenwash pump impeller was adjusted and a successful post maintenance test completed on August 10, 1996.

Example 2:

The STA responsible for actuating the wrong switch during performance of OST-1045 was counselled on the use of self-checking techniques. After verifying that the appropriate automatic actuations had functioned, the applicable portions of OST-1045 were used to reset the main steam line drain isolation signal and realign the system on August 12, 1996. LER 96-015 was submitted on September 11, 1996 due to this event.

The following directives were issued on September 13, 1996 to Operations Unit Supervisors and Superintendents as interim corrective actions until the common cause analysis corrective actions are completed:

1. Enforce formality in all activities, not just the high focus evolutions.

2. Perform tasks covered by reference use procedures as if they were continuous use procedures.

3. Use the Job Performance Checklist. This checklist provides generic expectations and basic reminders for preparation, performance, and review of tasks.

4. Hold a brief shift update meeting or conference call at a time frame of approximately mid-shift to review progress and plans for the remainder of the shift.

5. Preplan schedules to ensure adequate coverage for all watch stations.

As a result of the common cause analysis, a directive was issued on September 26, 1996 as an additional interim action. Operations Unit Supervisors were directed to perform daily in-field observations to ensure standards and expectations are understood and followed.

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 comprised of the following:

1. Existing strategies and initiatives in place for improving performance.

2. Focus Team initiatives. The Focus Team has been formed and is comprised of operators in various working level positions. The team is responsible for identifying critical improvement opportunities that will result in a near-term step change in performance, and will position the organization for future advances to "world class" levels of 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 owership of problems and solutions at all levels in the organization.

3. Establishing 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.

The Near Term Improvement Plan will be issued by December 31, 1996.

Date When Full Compliance Was Achieved:

Full compliance was achieved on August 10, 1996 for Example 1 and on August 12, 1996 for Example 2.