

Harris 1

Initiating Events

Significance: N/A Nov 15, 2002

Identified By: NRC

Item Type: FIN Finding

95001 SUPPLEMENTAL INSPECTION FOR WHITE PERFORMANCE INDICATOR

Supplemental inspection was conducted to assess the licensee's evaluation associated with a White performance indicator in the initiating events cornerstone. The White performance indicator involved crossing the threshold from Green to White for the Unplanned Scrams per 7,000 Critical Hours Performance Indicator for the third quarter of calendar year 2002. Specifically, the licensee experienced three reactor trips during the first three quarters of 2002. The first reactor trip, which occurred on January 2, 2002, was a manual trip from approximately 7 percent reactor power caused by an equipment failure associated with the main feedwater regulating valve bypass valve for the C steam generator. The second reactor trip, which occurred on July 13, 2002, was a manual trip from approximately 85 percent reactor power caused by an equipment failure associated with the digital electro-hydraulic control system. The third reactor trip, which occurred on August 15, 2002, was an automatic trip from approximately 100 percent reactor power caused by a momentary grid undervoltage condition. The licensee's problem identification, root cause and extent-of-condition evaluations, and corrective actions for the three reactor trips were adequate. Common cause aspects linking the three reactor trips from a risk perspective were not evident.

Inspection Report# : [2002012\(pdf\)](#)

Mitigating Systems



Significance: G Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY THAT THE RWST LEVEL TRANSMITTERS WERE SUSCEPTIBLE TO FLOODING

Green. A non-cited violation (NCV) of 10 CFR 50 Appendix B Criterion XVI was identified for failing to identify that the 4 refueling water storage tank level transmitters did not meet General Design Criteria 2 for protection from flooding when, on two occasions (July and August 2001), 1 of 4 transmitters was affected by rain water accumulation and declared inoperable. This issue was of very low risk significance because of the low probability of the flooding condition that would cause Refueling Water Storage Tank (RWST) transmitter failure coinciding with the need for the RWST contents, and because operator action in the mitigating system cornerstone would negate any equipment damage, and because another multi-train containment heat removal system was available in the barrier integrity cornerstone.

Inspection Report# : [2002004\(pdf\)](#)



Significance: W Jun 21, 2002

Identified By: NRC

Item Type: VIO Violation

FOREIGN MATERIAL IN A RESIDUAL HEAT REMOVAL SYSTEM CONTAINMENT SUMP SUCTION PIPING

A violation of Technical Specification 6.8, Procedures and Programs, Section 6.8.1 was identified concerning the implementation of Maintenance Management Manual Procedure MMM-011, Cleanliness and Housekeeping, Section 5.3, Preventing Contamination During Maintenance, which contains requirements to prevent the entry of foreign objects into plant systems and components. Adequate foreign material exclusion controls were not implemented for the residual heat removal (RHR) system when on October 8, 2001, foreign material of a size to affect pump performance (greater than the containment sump screen openings) was identified in the containment sump suction piping to the A RHR pump. As a result, during the operating cycle from April 15, 2000, to September 22, 2001, Unit 1 was operating in Modes 1, 2 and 3 on numerous occasions and the A RHR pump was inoperable for greater than 72 hours and the licensee did not satisfy the requirements of TS 3/4.5.2, Emergency Core Cooling Subsystems. Using the significance determination process, this finding was determined to be White because the foreign material would affect train A of low pressure and high pressure recirculation. [95002 supplemental inspection performed July 8-12, 2002 concluded that problem identification, root cause, extent of condition and corrective actions were acceptable. The White finding was closed.]

Inspection Report# : [2002009\(pdf\)](#)

Inspection Report# : [2002010\(pdf\)](#)



Significance: G Apr 12, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE EMERGENCY CORE COOLING SYSTEM (ECCS) VENTING PROCEDURES

A non-cited violation of Technical Specification 6.8.1, with two examples of inadequate operations procedures for the venting of safety-related systems was identified. The first example resulted in operation of Shearon Harris with a significant quantity of gas in the common refueling water storage tank suction supply line to the ECCS high head injection pumps. This condition adverse to quality existed for approximately 45 days beginning in February 2002. Operating Procedure OP-111, Residual Heat Removal System, failed to provide adequate instructions such that the timing of ECCS filling and venting, specifically for the residual heat removal (RHR) system and heat exchangers, was not performed when system conditions warranted sweeping and venting of gas due to changing plant conditions. The licensee's procedures and risk assessments for returning the RHR system to operable status did not incorporate the potential for gas accumulation in the RHR system once the system was depressurized. The finding was of very low safety significance because mitigation systems were concluded to be operable based on the engineering analysis performed. Further, the gas accumulation did not result in any adverse consequences. The second example of the above non-cited violation was identified for an inadequate maintenance restoration procedure, which resulted in the potential movement of an unknown quantity of gas into the suction flowpath of an operating charging/safety injection pump (CSIP) in February 2002 and on other occasions during previous on-line CSIP maintenance restoration activities. Operating Procedure OP-107, Chemical Volume Control System, used to perform venting of the C CSIP, incorrectly assumed that gas vented from the CSIP casing and suction supply piping would be vented from the system through the VCT supply line. The Special Inspection Team determined that there was a probability that the licensee's on-line process of venting the pump would result in all or a portion of the gas being swept to the operating CSIP due to flow out of the VCT supply line, location of the operating CSIP, and the buoyancy effects of the gas. The finding was of very low safety significance because mitigation systems, specifically the CSIPs, have not currently exhibited a known adverse effect from this condition.

Inspection Report# : [2002006\(pdf\)](#)



Significance: Mar 30, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY TERMINATE A LUG IN THE CONTROL CIRCUIT OF MOTOR OPERATED VALVE 1RH-39

The failure to properly terminate a lug in the control circuit of motor operated valve 1RH-39 during performance of modification PCR 7167 (work order 94-AJLP1) was considered a violation of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings.

Inspection Report# : [2001006\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety



Significance: Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT CALIBRATION PROCEDURES USED TO ENSURE ACCURATE RADIONUCLIDE ANALYSES OF AIRBORNE EFFLUENT PARTICULATE SAMPLES IN ACCORDANCE WITH ODCM REQUIREMENTS

Green. An NCV of Technical Specification (TS) 6.8.1 was identified for the failure to properly implement calibration procedures used to ensure accurate radionuclide analyses of airborne effluent particulate samples required by the Offsite Dose Calculation Manual (ODCM) Table 4.11-2. The finding was of very low safety significance because it involved the failure to meet a regulatory requirement but did not significantly impair the licensee's ability to assess results of gaseous effluent particulate releases to the offsite environs.

Inspection Report# : [2002004\(pdf\)](#)

G

Significance: Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE REMP AIR AIRBORNE MONITORING PROGRAM IN ACCORDANCE WITH THE ODCM REQUIREMENTS

Green. An NCV of TS 6.8.1 was identified for the failure to properly implement Radiological Environmental Monitoring Program continuous airborne monitoring activities specified in the ODCM Table 3.12-1. The finding was of very low safety significance because it involved the failure to meet a regulatory requirement but did not significantly impair the licensee's ability to corroborate results of effluent releases to the offsite environs.

Inspection Report# : [2002004\(pdf\)](#)

Physical Protection

Miscellaneous

Last modified : March 25, 2003