

# New Hampshire Yankee

Ted C. Feigenbaum  
Senior Vice President and  
Chief Operating Officer

NYN-90093

April 13, 1990

United States Nuclear Regulatory Commission  
Washington, DC 20555

Attention: Document Control Desk

References: (a) Facility Operating License No. NPF-67, Docket No. 50-443  
(b) Facility Operating License No. NPF-86, Docket No. 50-443

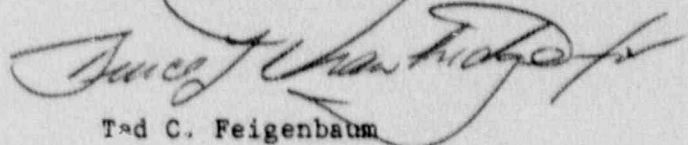
Subject: Licensee Event Report (LER) No. 90-009-00: Missed Surveillance,  
Technical Specification 3.6.1.3 - Containment Air Locks

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 90-009-00 for Seabrook Station. This submittal documents an event which was identified on March 14, 1990, and is being reported pursuant to 10CFR50.73(a)(2)(i).

Should you require further information regarding this matter, please contact Mr. Richard R. Belanger at (603) 474-9521, extension 4048.

Very truly yours,



Ted C. Feigenbaum

Enclosure: NRC Forms 365, 366A

cc: Mr. Thomas T. Martin  
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## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Seabrook Station										DOCKET NUMBER (2) 0 5 0 0 0 4 4 3 1				PAGE (3) OF 0 2	
TITLE (4) Missed Surveillance, Technical Specification 3.6.1.3 - Containment Air Locks															
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 NAMES				DOCKET NUMBER(S)		
0	2	1	3	9	0	9	0	0	0	9	0	0	0	0	0
OPERATING MODE (9) 3			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)												
POWER LEVEL (10) 0 0 1 0		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)	
		20.405(a)(1)(i)				50.38(c)(1)				50.73(a)(2)(v)				73.71(c)	
		20.405(a)(1)(ii)				50.38(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
		20.405(a)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(viii)(A)					
		20.405(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)					
		20.405(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)					
LICENSEE CONTACT FOR THIS LER (12)															
NAME Richard R. Belanger, Lead Engineer - Compliance - Extension 4048										TELEPHONE NUMBER AREA CODE 6 0 3 4 7 4 - 9 5 2 1					
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)															
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC					
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO			

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

On March 14, 1990, it was determined that a seal leak test surveillance was not performed as required by the technical specifications. A containment entry was made on February 13, 1990 by an Auxiliary Operator through the personnel hatch air lock. Once inside containment, the Auxiliary Operator opened the inner door to the equipment hatch air lock. The outer door to the equipment hatch air lock remained closed during this event. A seal leak test was not performed within the required surveillance period.

The containment equipment hatch air lock was tested satisfactory on March 9, 1990, following equipment hatch entry. Signs will be placed on the containment hatches to remind personnel that a retest is required after containment hatch use and to notify the Control Room.

The Security Department will notify the Control Room daily of any containment air lock opening. Training of Auxiliary and Licensed Operators has been initiated on this event.

The Control Room was notified that the Auxiliary Operator was going into the equipment hatch air lock, but the operator in the Control Room misunderstood the information given and thought that the personnel hatch air lock was being used. Due to the miscommunication, the required surveillance on the equipment hatch air lock was not initiated.

There were no adverse safety consequences as the result of this event.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/88

FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (6)

PAGE (3)

Seabrook Station

0 5 0 0 0 4 4 3 9 0 - 0 0 9 - 0 0 0 2 OF 0 2

TEXT (If more space is required, use additional NRC Form 306A's) (17)

On March 14, 1990, it was determined that a seal leak test surveillance was not performed as required by the technical specifications. A containment entry was made on February 13, 1990 at approximately 1:20 a.m. EST. This entry was made by an Auxiliary Operator through the personnel hatch air lock. Once inside containment, the Auxiliary Operator opened the inner door to the equipment hatch air lock in order to verify valve positions within that air lock. The outer door to the equipment hatch air lock remained closed during this event. Since the inner door to the equipment hatch air lock was exercised, a seal leak test is required per the Technical Specification. A seal leak test was not performed within the required surveillance period. Technical Specification Surveillance 4.6.1.3 requires that each containment air lock be demonstrated OPERABLE within 72 hours following each closing by verifying that the seal leakage is less than 0.01 L<sub>a</sub>. This operability demonstration was not performed until March 9, 1990.

CORRECTIVE ACTION

The containment equipment hatch air lock was tested satisfactory on March 9, 1990, following equipment hatch entry. This action was performed prior to the discovery of the missed surveillance. Signs will be placed on the containment hatches to remind personnel that a retest is required after containment hatch use and to notify the Control Room.

The Security Department will notify the Control Room daily of any containment air lock opening. Training of Auxiliary and Licensed Operators has been initiated on this missed surveillance and the related corrective action.

SAFETY CONSEQUENCES

There were no adverse safety consequences as the result of this event. The containment equipment hatch air lock passed the surveillance requirement on March 9, 1990, therefore, the hatch was capable of performing its intended function.

ROOT CAUSE

The on-shift Auxiliary Operator was not aware that a leak test was required following the opening of the equipment hatch air lock. The Control Room was notified that the Auxiliary Operator was going into the equipment hatch air lock, but the operator in the Control Room misunderstood the information given and thought that the personnel hatch air lock was being used. Due to the miscommunication, the required surveillance on the equipment hatch air lock was not initiated. The required surveillance on the personnel hatch air lock was being performed every forty-eight hours.

PLANT CONDITIONS

At the time of this event, the plant was in MODE 3, Hot Standby, with a Reactor Coolant System temperature of 558°F and pressure of 2,235 psig.

This is the first event of this type at Seabrook Station.