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April 16, 1993

United States Nuclear Regulatory Commission  
Washington, D.C. 20555

Attention: Document Control Desk

Reference: Facility Operating License No. NPF-86, Docket No. 50-443

Subject: Licensee Event Report (LER) 93-005-00: Non-compliance With Technical  
Specification 3.5.1.1 and 3.5.2 Action Requirements

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 93-005-00 for Seabrook Station. This submittal documents an event that occurred on March 18, 1993. This event is being report pursuant to 10 CFR 50.73(a)(2)(i)(B) and 10 CFR 50.73(a)(2)(vii).

Should you require further information regarding this matter, please contact Mr. James M. Peschel, Regulatory Compliance Manager, at (603) 474-9521, extension 3772.

Very truly yours,

A handwritten signature in dark ink, appearing to read "Ted Feigenbaum", written over a horizontal line.

Ted C. Feigenbaum

TCF:EWM/act

Enclosures: NRC Forms 366, 366A

230014

TE22

United States Nuclear Regulatory Commission  
Attention: Document Control Desk

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cc: Mr. Thomas T. Martin  
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U. S. Nuclear Regulatory Commission  
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## LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Seabrook Station

DOCKET NUMBER (2)

05000443

PAGE (3)

1 OF 4

TITLE (4)

Noncompliance with Technical Specification 3.5.1.1 and 3.5.2 Action Requirements

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 NAME	DOCKET NUMBER	
03	18	93	93	05	00	04	16	93	FACILITY NAME	DOCKET NUMBER	
										05000	
										05000	
OPERATING MODE (9)		1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
POWER LEVEL (10)		100	20.402(b)			20.405(c)			50.73(a)(2)(iv)		73.71(b)
			20.405(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v)		73.71(c)
			20.405(a)(1)(ii)			50.36(c)(2)			X 50.73(a)(2)(vii)		OTHER
			20.405(a)(1)(iii)			X 50.73(a)(2)(i)			50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)
			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)(x)					

LICENSEE CONTACT FOR THIS LER (12)

NAME

Mr. James M. Peschel, Regulatory Compliance Mgr.

TELEPHONE NUMBER (Include Area Code)

(603) 474-9521 Ext 3772

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS

SUPPLEMENTAL REPORT EXPECTED (14)

YES  
(If yes, complete EXPECTED SUBMISSION DATE).

X NO

EXPECTED  
SUBMISSION  
DATE (15)

MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On March 18, 1993 while performing a Miscellaneous Valve Stroke surveillance, two accumulator isolation valves and selected ECCS valves had power restored to their operators. This resulted in a condition prohibited by Technical Specifications 3.5.1.1 and 3.5.2, which require power to be removed from the aforementioned valves in modes 1, 2, and 3. Additionally, with power available to two accumulator isolation valves the action statement for Technical Specification 3.5.1.1 no longer applies, requiring entry into Technical Specification 3.0.3. This constituted a condition prohibited by Technical Specifications.

There were no adverse safety consequences as a result of this event. At no time during the event were the accumulator isolation valves or the selected ECCS valves repositioned. The control room operator would have been alerted of this type condition, had it existed, through: audible alarms, visual alarms and changes in status lights on the main control board. The accumulators and ECCS systems would have performed normally, and as designed, had an event requiring them occurred.

The root cause for this event was determined to be personnel error. The control room operator performing the surveillance procedure missed the step directing the deenergization of MCC E522 and MCC E622.

Immediate corrective action was to deenergize the MCC, removing power from the valve operators. Actions to prevent reoccurrence of the event include: North Atlantic Management will discuss this event with operating crews to include alternate methods of procedural usage to prevent reoccurrence, the responsible individual involved will complete a critique in accordance with North Atlantic self checking (STAR) program, and the Operations Support Group will review industry events and practices relating to procedure interface and documentation.

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TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

Description of Event

On March 18, 1993 while performing a Miscellaneous Valve Stroke surveillance, two accumulator isolation valves and selected Emergency Core Cooling System (ECCS) valves had power restored to their operators. This resulted in a condition prohibited by Technical Specifications 3.5.1.1 and 3.5.2, which require power to be removed from the aforementioned valves in Modes 1, 2, and 3. In addition, with power available to two accumulator isolation valves the action statement for Technical Specification 3.5.1.1 no longer applies, requiring entry into Technical Specification 3.0.3. This constituted a condition prohibited by Technical Specifications.

The Safety Injection System accumulator tanks discharge borated water into the Reactor Coolant System (RCS) following a Loss of Coolant Accident (LOCA). When RCS pressure drops below the pressure of the four accumulator tanks, they discharge their contents into the RCS cold legs. During normal operation, check valves prevent reactor coolant from leaking back into these accumulator tanks.

Technical Specification 3.5.1.1a specifies that, "Each RCS accumulator shall be OPERABLE with the isolation valves open and power removed." Technical Specification Surveillance Requirement 4.5.2 specifies that, "Each ECCS subsystem shall be demonstrated OPERABLE by verifying selected ECCS valves are in the indicated positions with power to the valve operators removed." The specific circumstances regarding the noncompliance are described below.

The surveillance procedure being used to conduct the testing, OX1490.05, Miscellaneous Systems ASME Section XI Quarterly Valve Stroke Test, provides direction for stroking RC-FV-2894, RCS Loop 1 sample, and RC-FV-2896, RCS Loop 3 sample. These valves receive their power from Motor Control Centers (MCC) E522 and E622 respectively. These MCCs, which also provide power to accumulator isolation valves and selected Emergency Core Cooling System (ECCS) valve operators, are normally deenergized using control switches on the main control board.

Prior to energizing MCCs E522 and E622, the procedure directs the operator to open the circuit breakers for accumulator isolation valves and selected ECCS valve operators. This step ensures the requirements of Technical Specification 3.5.1.1 and 3.5.2 will be satisfied when MCCs E522 and E622 are energized. Additionally, the normally locked open circuit breakers for the previously mentioned RC sample valves had to be closed on the MCC. The MCCs were energized to allow the stroking of RC-FV-2894 and RC-FV-2896. After successful testing of the sample valves, the control room operator directed the auxiliary operator (locally at the MCC 622) to lock open the breaker for RC-FV-2896, and close the breakers for the accumulator isolations and selected ECCS valves supplied by MCC E622. With the breakers closed, power became available to the selected ECCS valves and accumulator isolation valve operators. After approximately

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(Continued)

5 minutes, the control room operator noticed that the white "power available" lights on the main control board for MCC E622 powered accumulator isolation valves were illuminated and immediately deenergized both MCC E522 and E622. A review of the procedure identified that a procedure step had been missed. The control room operators decided to enter Technical Specification 3.0.3 for the period of time power was available to both accumulator isolation valves because the action statements for Technical Specification 3.5.1.1 do not address the inoperability of two accumulator isolation valves.

Safety Consequences

There were no adverse safety consequences as a result of this event. At no time during the event were the accumulator isolation valves or the selected ECCS valves repositioned. The control room operator would have been alerted of this type condition, had it existed, through: audible alarms, visual alarms and changes in status lights on the main control board. The accumulators and ECCS systems would have performed their specified functions had they been called upon to do so.

Root Cause

The root cause for this event was determined to be personnel error. The control room operator performing the surveillance procedure missed the step directing the deenergization of MCC E522 and MCC E622.

Corrective Actions

Immediate corrective action was to deenergize the MCCs, to remove power from the valve operators. North Atlantic Management will review this LER with operators during their normal training cycle to discuss alternate methods of procedural usage to prevent reoccurrence. Additional actions to prevent reoccurrence of the event include:

1. The Unit Journal was updated to annotate the entrance in Technical Specification 3.0.3.
2. The responsible individual involved completed a critique in accordance with the North Atlantic self checking (STAR) program. This critique will stress the importance of self verification, and supply data for trending purposes. The STAR program is a human performance enhancement program.

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3. The Operations Support Group will review industry events and practices relating to procedure interface and documentation. This information will be evaluated and used to determine whether current station programs need enhancements.

Plant Conditions

At the time of the identification the plant was in MODE 1, 100% power.

Similar Events

There have been three previous similar events where the action requirements of Technical Specifications were not complied with. LER 89-015 documents an event which occurred on April 29, 1989 with the plant in MODE 5. While shifting from the "A" Centrifugal Charging Pump to the "B" Centrifugal Charging Pump, both pumps were operated for approximately eight seconds. The event was attributed to personnel error on the part of the control room operator. During the performance of the procedure the operator looked away from the procedure to acknowledge alarms, and upon resuming performance of the procedure inadvertently missed one step. LER 91-005 documents an event which occurred on May 29, 1991, involving the circuit breaker feeding the Rod Control Cluster Change Fixture being found open but unlocked, contrary to Technical Specification 3.8.4.1. The event was attributed to personnel error on the part of the Operations individual preparing the tagging order who failed to identify the circuit breaker as a locked component as required by Procedure MA 4.2, "Equipment Tagging and Isolation". LER 92-021 documents an event which occurred on October 18, 1992 with plant in MODE 5. While performing a Centrifugal Charging Pump (CCP) surveillance, the motor circuit breaker for the non-operating CCP was connected to its electrical bus prior to closing and locking the pump discharge valve. The event was attributed to personnel error on the part of the control room operator.

North Atlantic considers the previous events (LER 89-015, LER 91-005 and 92-021) and this event to be isolated instances of Technical Specification noncompliance. None of these events involved the same individual. The North Atlantic Operations Department has been effective in performing surveillances required by Technical Specifications.