

New Hampshire Yankee

Ted C. Feigenbaum
President and
Chief Executive Officer

NYN- 91175

October 25, 1991

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

Attention: Document Control Desk

References: Facility Operating License No. NPF-86, Document No. 50-443

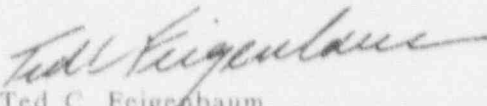
Subject: Licensee Event Report (LER) No. 91-012-00: Engineered Safety Features
Actuation Due to an Inadvertent Safety Injection Signal

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 91-012-00 for Seabrook Station. This submittal documents an event which occurred on September 27, 1991, and is being reported pursuant to 10CFR50.73(a)(2)(iv).

Should you require further information regarding this matter, please contact Mr. Allen L. Legendre, Lead Engineer - Compliance, at (603) 474-9521, extension 2373.

Very truly yours,


Ted C. Feigenbaum

TCF:WJT/ss

Enclosures: NRC Forms 366, 366A

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PDR ADDCK 05000443
S PDR

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United States Nuclear Regulatory Commission
Attention: Document Control Desk

October 25, 1991
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cc: Mr. Thomas T. Martin
Regional Administrator
United States Nuclear Regulatory Commission
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King of Prussia, PA 19406

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Project Directorate I-3
Division of Reactor Projects
U.S. Nuclear Regulatory Commission
Washington, DC 20555

Mr. Noel Dudley
NRC Senior Resident Inspector
P.O. Box 1149
Seabrook, NH 03874

INPO
Records Center
1100 Circle 75 Parkway
Atlanta, GA 30339

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Seabrook Station										DOCKET NUMBER (2) 0 5 0 0 3 4 4 3 1										PAGE (3) 1 OF 0 2	
TITLE (4) Engineered Safety Features Actuation Due to an Inadvertent Safety Injection Signal																					
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)											
MONTH	DAY	YEAR	YEAR	SEQUENCE NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES						DOCKET NUMBER(S)						
0	9	27	91	91	012	00	10	25	91							0 5 0 0 0					
OPERATING MODE (9) 5			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																		
POWER LEVEL (10) 10		20.402(b)				20.406(e)				X 50.73(a)(2)(iv)				73.71(b)							
		20.406(a)(1)(i)				50.36(e)(1)				50.73(a)(2)(v)				73.71(c)							
		20.406(a)(1)(ii)				50.36(e)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 766A)							
		20.406(-)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(vii)(A)											
		20.406(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)											
		20.406(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)											
LICENSEE CONTACT FOR THIS LER (12)																					
NAME										TELEPHONE NUMBER											
Allen L. Legendre, Lead Engineer - Compliance, Extension 2373										610 134 7141-191521											
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)											
YES (If yes, complete EXPECTED SUBMISSION DATE)										X NO											
ABSTRACT (Limit to 1400 words, i.e., approximately fifteen single-space typewritten lines) (16)																					

On September 27, 1991, at 2:09 p.m., while in MODE 5, multiple Engineered Safety Features (ESF) associated with Train A actuated upon receipt of an inadvertent Safety Injection (SI) signal for Train A. The inadvertent SI signal was generated during the performance of a Train B ESF test.

Once the inadvertent SI signal was generated for Train A, all Train A related equipment operated as designed. Specifically, Emergency Diesel Generator (EDG) 1A started, the Train A Phase A Containment Isolation occurred, a Train A Containment Ventilation Isolation signal was generated and the Control Room Normal Makeup Air Subsystem transferred to the Control Room Emergency Air Cleanup and Filtration Subsystem. The EDG start was an unloaded start with no actuation of the Emergency Power Sequencer (EPS). Additionally, no Emergency Core Cooling System (ECCS) pumps started and no ECCS water was injected into the Reactor Coolant System (RCS).

The root cause of this event has been determined to be personnel error. A contributing cause was determined to be an indistinct procedure step. Specifically, two separate operator actions were contained within one procedure step.

Each Shift Superintendent will discuss this event and the lessons learned with their respective operating crews by October 31, 1991.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Seabrook Station	DOCKET NUMBER (2) 05000443	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		91	012	00	02	OF	02

TEXT (If more space is required, use additional NRC Form 388A's) (17)

Description of Event

On September 27, 1991, at 2:09 p.m., EDT, while in MODE 5 (Cold Shutdown), multiple Engineered Safety Features (ESF) [JE] associated with Train A actuated upon receipt of an inadvertent Safety Injection (SI) signal. The inadvertent SI signal for Train A was generated during the performance of procedure EX1804.015, "Diesel Generator 1B 18-Month Operability and Engineered Safeguards Pump and Valve Response Time Testing Surveillance". This procedure is associated with the Testing of Train B Engineered Safety features.

Once the inadvertent SI signal was generated for Train A, all Train A related equipment operated as designed. Specifically, Emergency Diesel Generator (EDG) 1A started, the Train A Phase A Containment Isolation occurred, a Train A Containment Ventilation Isolation signal was generated and the Control Room Normal Makeup Air Subsystem transferred to the Control Room Emergency Air Cleanup and Filtration Subsystem. The EDG start was an unloaded start with no actuation of the Emergency Power Sequencer (EPS). Additionally, no Emergency Core Cooling system (ECCS) pumps started since they were removed from service and no ECCS water was injected into the Reactor Coolant System (RCS).

Safety Consequences

There were no adverse safety consequences as a result of this event. All equipment operated as designed, thus fulfilling the Engineered Safety Features (ESF) function. At no time during this event was there any impact on the health and safety of plant employees or the public.

Root Cause

The root cause of this event has been determined to be personnel error. The individual involved misread the procedure step and incorrectly placed the Train A Solid State Protection System (SSPS) in "operate" rather than in "test". A contributing cause was determined to be an indistinct procedure step. Specifically, two separate operator actions were contained within one procedure step.

Corrective Actions

Each Shift Superintendent will discuss this event and the lessons learned with their respective operating crews by October 31, 1991.

Appropriate procedure changes have been made to this and other ESF actuation testing procedures to clarify dual train operation. In addition, Operations' Department procedures related to Solid State Protection System (SSPS) testing will be reviewed and revised as necessary to clarify dual train operation. These procedure changes will ensure that each operator action is distinct and discernible. Specifically, procedure steps which direct separate actions from the two SSPS cabinets will be separated into two steps. It is anticipated that these reviews will be completed by January 31, 1992.

Plant Conditions

At the time of this event, the plant was in MODE 5, Cold Shutdown, with a Reactor Coolant System [AB] temperature of 135 degrees Fahrenheit and pressure of 260 psig.

This is the second event of this type at Seabrook Station. The previous similar event was reported by LER 86-002-01.