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Ted C. Feigenbaum
Senior Vice President and
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NYN-92159

November 17, 1992

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) 92-21-00: Non-compliance with Technical Specification Surveillance Requirements

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 92-21-00 for Seabrook Station. This submittal documents an event which occurred on September 18, 1992 and is reported pursuant to 10CFR50.73(a)(2)(i)(B).

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,

Ted C. Feigenbaum

TCF:MDO/act

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cc: Mr. Thomas T. Martin
Regional Administrator
United States Nuclear Regulatory Commission
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475 Allendale Road
King of Prussia, PA 19406

Mr. Gordon Edison, Sr. Project Manager
Project Directorate I-3
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NRC Form 366
(5-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Seabrook Station	0 5 0 0 0 4 4 3	1 OF 0 12

TITLE (4)
Non-Compliance with Technical Specification Surveillance Requirement

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 5 0 0 0
1 0	1 8	9 2	9 2	— 0 2 1	— 0 0	1 1	1 8	9 2		0 5 0 0 0

OPERATING MODE (9)	5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 0	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)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 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)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Mr. James M. Peschel, Regulatory Compliance Manager, Ext. 3772	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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
X YES (If yes, complete EXPECTED SUBMISSION DATE)	NO		1 2	1 5	9 2

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

On October 18, 1992, while performing a centrifugal charging pump [BQ] (CCP) surveillance, the motor circuit breaker [BKR] for the non-operating CCP was connected to its electrical bus [EA] prior to closing and locking the pump discharge valve [ISV]. This is contrary to Technical Specification SURVEILLANCE REQUIREMENT 4.1.2.3.1 which states that the inoperable, i.e. non-operating, charging pump may be energized for testing only after the discharge of the pump has been isolated from the Reactor Coolant System (RCS) by a manual isolation valve secured in the closed position.

The procedure in use at the time of the event specified that the charging pump discharge valve be closed and locked prior to connecting the pump's motor circuit breaker to the electrical bus. A misunderstanding on the part of the control room operator resulted in the motor circuit breaker being connected to the bus before the discharge valve was locked closed.

Immediate corrective action was to close and lock the pump discharge valve. The root cause of this event is under investigation and will be provided in a follow up report which is expected to be submitted by December 15, 1992.

There were no adverse safety consequences as a result of this event. At the time of the event the plant was in Mode 5 with the RCS vented. This is the second occurrence of this type at Seabrook Station. A similar event was reported to the NRC in LER 89-015.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Seabrook Station	0 5 0 0 0 4 4 3	9 2	— 0 2 1	— 0 0	0 2 OF 0 2

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

On October 18, 1992, while performing a Centrifugal Charging Pump (CCP) [BQ] surveillance, the motor circuit breaker [BKR] for the non-operating CCP was connected to its electrical bus [EA] prior to closing and locking the pump discharge valve [ISV]. This is contrary to Technical Specification Surveillance Requirement 4.1.2.3.1 which states that the inoperable, i.e. non-operating, charging pump may be energized for testing only after the discharge of the pump has been isolated from the Reactor Coolant System [AB] (RCS) by a manual isolation valve secured in the closed position.

The centrifugal charging pumps are part of the Chemical and Volume Control System [CB]. These pumps are the motive force for the high head Emergency Core Cooling System. During normal operation, these pumps are used to inject water into the RCS and to supply water to the reactor coolant pump seals.

Technical Specification Surveillance Requirement 4.1.2.3.1 specifies that all charging pumps except the required OPERABLE pump, shall be demonstrated to be inoperable by verifying that the motor circuit breakers are secured in the open position. A noted exception to this requirement is that an inoperable, i.e., non-operating, pump may be energized for testing provided the discharge of the pump has been isolated from the RCS by a manual isolation valve secured in the closed position.

The surveillance procedure being used to conduct the testing, OX1456.01, Charging Pump A and B Quarterly Flow and Valve Stroke Test, specified that the pump discharge valve be closed and locked prior to racking the breaker in. A misunderstanding by the control room operator resulted in the motor circuit breaker being connected to the electrical bus before the pump discharge valve was locked closed.

ROOT CAUSE

The root cause is under investigation. The root cause and corrective actions will be provided to the NRC in a follow up report which is expected to be submitted by December 15, 1992.

CORRECTIVE ACTION

Immediate corrective action was to close and lock the pump discharge valve.

SAFETY CONSEQUENCES

There were no adverse safety consequences as a result of this event. The situation where the charging pump breaker was racked-in and the discharge valve open, existed for only five minutes. The charging pump being tested was not started and did not result in any additional flow into the RCS.

Adequate RCS overpressure protection was provided by the 1.53 square inch vent used to satisfy the requirements of Technical Specifications 3.4.9.3 and by the RHR suction relief valve on the RHR train in operation.

PLANT CONDITIONS

At the time of the event the plant was in MODE 5 with the RCS vented.

SIMILAR EVENTS

This is the second occurrence of this type at Seabrook Station. A similar event was reported to the NRC in LER 89-015.