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December 10, 1992

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

Attention: Document Control Desk

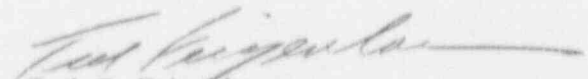
References: Facility Operating License No. NPF-86, Docket No. 50-443

Subject: Licensee Event Report (LER) 92-022-00: Non-Compliance With Technical
Specification Surveillance Interval for Containment Air Locks

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 92-022-00 for Seabrook
Station. This submittal documents an event that was discovered on November 10, 1992. This
event is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B).

Very truly yours,


Ted C. Feigenbaum

TCF:JES/jes

Enclosures: NRC Forms 366, 366A

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

APPROVED OMB NO. 2950-0106

EXPIRES 8/31/88

FACILITY NAME (1) SEABROOK STATION										DOCKET NUMBER (2) 0 5 0 0 0 4 4 3				PAGE (3) 1 OF 0 3							
TITLE (4) NON-COMPLIANCE WITH TECHNICAL SPECIFICATION SURVEILLANCE INTERVAL FOR 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)								
1	1	0	9	2	9	2	0	2	2	0	0	1	2	1	0	9	2	0 5 0 0 0 0 0 0			
OPERATING MODE (9) 3			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 50.71 (Check one or more of the following) (11)																		
POWER LEVEL (10) 1 0			20.402(b)			20.405(a)			50.73(a)(2)(iv)			73.71(b)									
			20.405(a)(1)(i)			50.73(a)(1)			50.73(a)(2)(iv)			73.71(a)									
			20.405(a)(1)(ii)			50.73(a)(2)			50.73(a)(2)(v)			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)(vi)(A)												
			20.405(a)(1)(iv)			50.73(a)(2)(ii)			50.73(a)(2)(vi)(B)												
20.405(a)(1)(v)			50.73(a)(2)(iii)			50.73(a)(2)(v)															
LICENSEE CONTACT FOR THIS LER (12)																					
NAME Mr. James M. Peschel, Regulatory Compliance Manager, ext. 3772										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					
YES (If yes, complete EXPECTED SUBMISSION DATE)												X NO									

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

On November 10, 1992, while returning to power operation from a refueling outage, it was determined that the containment personnel hatch air lock [BD] seal leakage surveillance was not performed at the frequency required by Technical Specification 4.6.1.3. This surveillance, which demonstrates operability of the containment air locks, requires the air lock seal leakage be measured to be less than 0.01 L_a at least once every 72 hours, during periods of multiple containment entries. This specification applies only in Modes 1 through 4. On November 10, 1992, at 2200, during a review of other surveillances, it was discovered that the personnel hatch surveillance was last completed on November 5, 1992 at 2156. This surveillance was performed in Mode 5, just prior to entering Mode 4, which took place on November 6, 1992 at 0047. Since the resultant surveillance interval exceeded 72 hours, the personnel hatch air lock was immediately declared inoperable. This surveillance was subsequently successfully completed on November 10, 1992 at 22:44, and the personnel hatch air lock was declared operable. In total, the Technical Specification 4.6.1.3 surveillance interval of 72 hours was exceeded by 45 hours and 57 minutes, as measured from the entry into Mode 4.

There were no adverse safety consequences as a result of this event. A subsequent leak test demonstrated that containment integrity was never in question.

The root cause for this event was determined to be the lack of an administrative mechanism to alert operations staff to perform the air lock seal surveillance at the completion of long term outages when containment integrity has been set.

Corrective actions include the automatic generation of the airlock seal test surveillance package every 48 hours during Modes 2, 3, and 4. Additionally, Operations management discussed this event with the Control Room operating crews.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES 8/31/96

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

TEXT (IF MORE SPACE IS REQUIRED USE ADDITIONAL NRC Form 366A (1/77))

Description of Event

On November 10, 1992, while returning to power operation from a refueling outage, it was determined that the containment personnel hatch air lock [BD] seal leakage surveillance was not performed at the frequency required by Technical Specification 4.6.1.3. This surveillance, which demonstrates operability of the containment air locks, requires the air lock seal leakage be measured to be less than 0.01 L_a at least once every 72 hours, during periods of multiple containment entries. This specification applies only in Modes 1 through 4. On November 10, 1992, at 2200, during a review of other surveillances, it was discovered that the personnel hatch surveillance was last completed on November 5, 1992 at 2156. This surveillance was performed in Mode 5, just prior to entering Mode 4, which took place on November 6, 1992 at 0047. Since the resultant surveillance interval exceeded 72 hours, the personnel hatch air lock was immediately declared inoperable. This surveillance was subsequently successfully completed on November 10, 1992 at 22:44, and the personnel hatch air lock was declared operable. In total, the Technical Specification 4.6.1.3 surveillance interval of 72 hours was exceeded by 45 hours and 57 minutes, as measured from the entry into Mode 4.

Safety Consequences

There were no adverse safety consequences as a result of this event. The requisite personnel air lock leakage test was immediately performed upon determination that the surveillance interval had been exceeded. This test demonstrated that the seal leakage was less than the Technical Specification requirements for the same. Based on this, it is concluded that the personnel hatch air lock was always capable of ensuring containment integrity, and therefore, 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 for this event was determined to be the lack of an administrative mechanism to alert operations staff to perform the air lock seal surveillance at the completion of long term outages when containment integrity has been set. Note that procedure ON1090.04, "Containment Entry," provides an adequate administrative mechanism to ensure that this surveillance is performed during all phases of power operation and for initial entry following reactor shutdown. This procedure does not apply, however, when multiple containment entries are being made during outages. It should also be noted the routine surveillance 1-MM-OT001, procedure OX1460.01, "Airlock Seal Test Containment," is normally generated on a weekly basis during power operation, or when specifically required for a containment entry. While this frequency is adequate for power operation where containment entries are typically made every two weeks, it is not adequate for periods of multiple containment entries at the completion of an outage.

Corrective Actions

Upon determination that the Technical Specification 4.6.1.3 surveillance interval had been exceeded, a leak test was immediately performed on the personnel hatch. This test demonstrated that containment integrity was never in question. Additionally, North Atlantic also initiated a Human Performance Enhancement System evaluation for this event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/96

FACILITY NAME (1) SEABROOK STATION	DOCKET NUMBER (2) 0500044392	LER NUMBER (8)			PAGE (3) 03 OF 03
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		92	022	00	

TEXT (If more space is required, use additional NRC Form 366A 1/11)

As corrective action to prevent recurrence the airlock seal test surveillance package 1-MM-OT001 will be automatically computer generated every 48 hours during Modes 2, 3, and 4. This will ensure that the air lock seal surveillance is performed at least every 72 hours whenever containment entries are made while in these modes. It is anticipated that this action will be completed by January 15, 1993.

Additionally, Operations management reviewed this event, the root cause, and the corrective actions with the Control Room operating crews on November 11, 1992.

A status board will also be installed in the work control area in the Control Room to remind operators of the containment hatch status and the containment air lock surveillance status. It is anticipated that the aforementioned status board will be in place by December 11, 1992.

A Training Development Request (TDR) will be initiated to ensure that this event is reviewed with Operations shift crews during pre-outage training sessions. It is anticipated that this TDR will be issued by January 15, 1993.

The personnel air lock is equipped with a system that will automatically determine the air lock leak rate after each air lock usage. This system is not currently in service. North Atlantic will evaluate the return of this system to service.

Plant Conditions

This event took place at the completion of a refueling outage while the plant was in Mode 3, Hot Standby, at 0 percent power, with a Reactor Coolant System [AB] Temperature of 557 degrees Fahrenheit and a pressure of 2235 psig.

Previous Occurrences

This is the second occurrence where the surveillance requirements of Technical Specification 4.6.1.3a were not performed at the required frequency. This previous event was reported in LER 90-09, and it pertained to an exceedance of the surveillance interval for the equipment hatch personnel air lock.