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Ted C. Feigenbaum
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February 17, 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) 93-004-00: Non-compliance With Technical Specification Actions for Inoperable Radioactive Effluent Monitoring Instrumentation

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 93-004-00 for Seabrook Station. This submittal documents an event that occurred on January 18, 1993. This event is being report pursuant to 10 CFR 50.73(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:EWM/act

Enclosures: NRC Forms 366, 366A

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cc: Mr. Thomas T. Martin
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U. S. Nuclear Regulatory Commission
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NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

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 (MNBB 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.

LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Seabrook Station	05000443	1 OF 3

TITLE (4) Non Compliance with Technical Specification Actions for Inoperable Radioactive Effluent Monitoring Instrumentation

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
										05000
01	18	93	93	04	00	02	12	93	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)					
POWER LEVEL (10)	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
		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	TELEPHONE NUMBER (Include Area Code)
Mr. James M. Peschel, Regulatory Compliance Mgr.	(603) 474-9521 Ext 3372

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
YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO				

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

On January 18, 1993 a Steam Generator Blowdown Flush Release Permit was generated to allow the rinsing of a recently regenerated steam generator blowdown demineralizer to the ocean. The flowmeter in this discharge path is not designed for the low conductivities (less than 5 micromhos) which were expected during this evolution. Technical Specification Table 3.3-12 Action 31, allows the continuation of effluent releases with the flowmeter inoperable provided the flow rate is estimated at least once per four hours. On January 18, 1993 at 2135, it was determined that the 4 hour flow estimate was exceeded by 35 minutes. This constituted a condition prohibited by the Technical Specifications.

There were no adverse safety consequences as a result of this event. No radioactive liquid effluent limits were exceeded.

The root cause for this event was determined to be personnel error on the part of the chemistry technician responsible for obtaining the radioactive liquid effluent flow estimation. The technician became involved in other duties and failed to obtain the flow estimate required by Technical Specifications.

The chemistry technician who was responsible for the event was counseled by supervision on his failure to take the proper action. Additionally, this event is scheduled to be discussed with each operating crew by the end of February 1993. The discussion will stress the importance of using the Non-routine Surveillance Log, to assist shift technicians in ensuring timely performance of Technical Specification activities.

DESCRIPTION OF EVENT

On January 18, 1993 a Steam Generator Blowdown Flush Release Permit was generated to allow rinsing the steam generator blowdown demineralizer to the ocean. Demineralized water is used to rinse the steam generator blowdown demineralizer, directing the effluent flow to the ocean. This flow is measured by a magnetic type flow instrument, WL-FT-1458, which relies on ions in the flowstream to determine flow. The demineralized water, used to rinse the steam generator blowdown demineralizer, has a conductivity too low for this flow instrument to work properly. It has been determined that the flow instrument is not designed for water with conductivities less than 5 μmhos.

Technical Specification 3.3.3.9 provides the operability requirements for radioactive liquid effluent monitoring instrumentation channels. Action b requires implementation of the actions stated in Table 3.3-12 when less than the minimum number of monitoring instrumentation channels are inoperable. For the Liquid Radwaste Test Tank Discharge Flow Rate Measuring Devices (Item 2a.), if no flow rate measuring devices are operable, Action 31 requires that the flow rate be estimated once per 4 hours. For this Steam Generator Blowdown demineralizer rinse, flow rates were scheduled to be taken at 3 hour intervals to ensure compliance with the 4 hour equirement. The specific circumstances regarding the noncompliance are described below.

The flow estimate was first taken on January 18, 1993 at 1700. The chemistry technician's supervisor discussed the flow estimate requirement intervals with the technician to ensure the flow estimates would be taken every three hours, so as not to exceed the four hour requirement. The next scheduled flow estimate was to be taken at 2000. However, the technician became involved with other duties and when returning to the laboratory at 2130 realized the missed flow estimate. The technician immediately notified the Control Room of the error and obtained the flow estimate, which was logged at 2135. A total of 4 hours and 35 minutes elapsed between flow estimates. This exceeded the required 4 hour flow estimate interval by 35 minutes and therefore constitutes a condition prohibited by Technical Specifications.

SAFETY CONSEQUENCES

There were no adverse safety consequences as a result of this event. No radioactive liquid effluent limits were exceeded. The worst case scenario that could occur as a result of this non-compliance is that the radioactive effluent discharging to the ocean could have been flowing at a rate higher than was permitted in the Steam Generator Blowdown Flush Release Permit during the missed surveillance period and the effluent release could have been underestimated. The scenario of an increase in flow above the limit stated in the Steam Generator Blowdown Flush Release Permit is possible during any planned release if the flow is adjusted during the evolution. The adjusted flow would be discovered during the 4 hour flow determination and the flow readjusted or the effluent release recalculated. The impact of exceeding the flow determination by 35 minutes (other than violating Technical Specifications) is not significant unless the flow increase was so substantial so as to cause an effluent limit to be violated. An audible alarm in the Control Room would sound in the event of a high effluent flow condition. The high flow alarm setpoint was set at the maximum flow stated in the Steam Generator Blowdown Flush Release Permit. During the missed surveillance period this alarm did not sound.

ROOT CAUSE

The root cause for this event was determined to be personnel error on the part of the chemistry technician responsible for obtaining the radioactive liquid effluent flow estimation. The technician became involved in other duties and failed to obtain the flow estimate required by Technical Specifications.

It is noted, that this event might have been avoided had Control Room operators contacted the chemistry technician to verify the flow estimate had been obtained.

CORRECTIVE ACTIONS

The chemistry technician who was responsible for the event was counseled by supervision on his failure to take the proper action. This LER will be shared with all Chemistry Department personnel as part of the routine review of Station operating experience.

Additionally, this event is scheduled to be discussed with each operating crew by the end February 1993. The discussion will stress the importance of using the Non-routine Surveillance Log, to assist shift technicians ensuring timely performance of Technical Specification activities.

PLANT CONDITIONS

At the time of the identification the plant was in MODE 3.

There have been two previous similar events where the action requirements of Technical Specification 3.3.3.9 were not complied with. LER 92-20 documents an event which occurred on September 24, 1992, involving a missed grab sample on the Primary Component Cooling Water System (PCCW), when the PCCW radiation monitor was inoperable. The event was attributed to personnel error on the part of the technician responsible for missing the grab sample. The individual was counselled and all Chemistry Department personnel were informed of the event. LER 89-09 documents an event which occurred on August 10, 1989, involving a PCCW grab sample which was obtained in a timely manner when the PCCW head tank rate of change alarm was inoperable, however, the sample was not properly analyzed for radioactivity content. The event was attributed to personnel error on the part of the technician responsible for performing the sample analysis. The individual was counselled and all Chemistry Department Personnel were informed of the event.

North Atlantic considers the previous events (LER 92-20 and LER 89-09) and this event to be isolated instances of Technical Specification non-compliance. None of these events involved the same individual. The North Atlantic Chemistry Department has been effective in performing the extensive sampling and analysis required by Technical Specifications.