



**North  
Atlantic**

North Atlantic Energy Service Corporation  
P.O. Box 300  
Seabrook, NH 03874  
(603) 474-9521

The Northeast Utilities System

March 29, 2001

Docket No. 50-443

NYN-01027

United States Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, DC 20555

Seabrook Station  
Licensee Event Report (LER) 01-001-00 for  
Non-Compliance with Technical Specifications  
Due To Installation Of Unqualified Test Equipment

Enclosed is Licensee Event Report (LER) 01-001-00 for an event that occurred at Seabrook Station on February 1, 2001. This event is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B).

Should you require further information regarding this matter, please contact Mr. James M. Peschel, Manager-Regulatory Programs at (603) 773-7194.

Very truly yours,

NORTH ATLANTIC ENERGY SERVICE CORP.

Ted C. Feigenbaum  
Executive Vice President and  
Chief Nuclear Officer

cc: H. J. Miller, NRC Region I Administrator  
V. Nerses, NRC Project Manager, Project Directorate I-2  
NRC Senior Resident Inspector

JE22

**ENCLOSURE 1 TO NYN-01027**

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

# LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1) <b>Seabrook Station</b>	DOCKET NUMBER (2) <b>05000443</b>	PAGE (3) <b>1 of 3</b>
--	--------------------------------------	---------------------------

TITLE (4)  
**Non-Compliance With Technical Specifications Due to Installation of Unqualified Test Equipment**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
02	01	01	01	- 001 -	00	03	29	01		
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9) <b>1</b>	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)				
	20.2201(b)		20.2203(a)(3)(ii)	50.73(a)(2)(ii)(B)	50.73(a)(2)(ix)(A)
POWER LEVEL (10) <b>100</b>	20.2201(d)		20.2203(a)(4)	50.73(a)(2)(iii)	50.73(a)(2)(x)
	20.2203(a)(1)		50.36(c)(1)(i)(A)	50.73(a)(2)(iv)(A)	73.71(a)(4)
	20.2203(a)(2)(i)		50.36(c)(1)(ii)(A)	50.73(a)(2)(v)(A)	73.71(a)(5)
	20.2203(a)(2)(ii)		50.36(c)(2)	50.73(a)(2)(v)(B)	OTHER Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iii)		50.46(a)(3)(ii)	50.73(a)(2)(v)(C)	
	20.2203(a)(2)(iv)		50.73(a)(2)(i)(A)	50.73(a)(2)(v)(D)	
	20.2203(a)(2)(v)	X	50.73(a)(2)(i)(B)	50.73(a)(2)(vii)	
	20.2203(a)(2)(vi)		50.73(a)(2)(i)(C)	50.73(a)(2)(viii)(A)	
	20.2203(a)(3)(i)		50.73(a)(2)(ii)(A)	50.73(a)(2)(viii)(B)	

LICENSEE CONTACT FOR THIS LER (12)

NAME <b>James M. Peschel</b>	TELEPHONE NUMBER (Include Area Code) <b>(603) 773-7194</b>
---------------------------------	---

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

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
N/A									

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 February 1, 2001, with the plant operating at 100% power, two non-safety related chart recorders were discovered installed and connected across the coils of solenoid valves which provide the safety-related functions for opening and closing the "D" main steam [SB] line atmospheric steam dump valve (1MS-PV3004). The subject recorders were not qualified for use in safety-related applications and no qualified isolation devices were used to provide the necessary separation from the safety-related equipment. The installation of the subject recorders caused 1MS-PV3004 to be inoperable. The subject recorders were subsequently removed. 1MS-PV3004 was required to be operable by Technical Specifications (TS) 3.6.3 and 3.7.1.6 during operational modes 1, 2, 3, and 4. Seabrook Station entered Mode 4 on January 24, 2001. Additionally, TS 3.0.4 requires that entry into an operational mode or another specified condition shall not be made when the conditions for the limiting conditions for operation are not met and the associated action requires a shutdown if they are not met within a specified time interval. Since these requirements were not met, this is a condition prohibited by the Technical Specifications and is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B).

The cause of this event is human error. There were no adverse consequences as a result of this event. During the period that the subject recorders were installed, 1MS-PV3004 was capable of operation. Corrective action has been initiated to prevent recurrence. This is the first event of this type reported by Seabrook Station.

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Seabrook Station	05000443	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		01	- 001	- 00	

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

**I. Description of Event**

On February 1, 2001, with the plant operating at 100% power (operational mode 1), two non-safety related chart recorders were discovered by plant personnel installed and connected across the coils of solenoid valves which provide the safety-related functions for opening and closing the "D" main steam [SB] line atmospheric steam dump valve (1MS-PV3004). One chart recorder was found on the floor behind the "B" remote safe shutdown cabinet. The second chart recorder was found installed inside the Main Control Board. These recorders were installed to troubleshoot the operation of the subject solenoid valves. The subject recorders were not qualified for use in safety-related applications and no qualified isolation devices were used to provide the necessary separation from the safety-related equipment. If the recorders or associated leads shorted or grounded due to a failure or seismic event, it may have caused the subject solenoids to short or would have tripped the supply breaker causing the solenoid vales to go to their fail-safe position rendering 1MS-PV3004 inoperable. The subject recorders were subsequently removed.

These recorders were installed on November 28, 2000, during refueling outage 07 when the valves were not required to be operable. Technical Specification (TS) 3.7.1.6 specifies that four atmospheric relief valves and associated manual controls including the safety-related gas supply systems shall be operable during operational modes 1, 2, 3 and 4. Entry into mode 3 and 4 is permitted for up to 24 hours to perform post-modification or post-maintenance testing to verify operability of components. Additionally, since 1MS-PV3004 is a containment isolation valve, the requirements of TS 3.6.3 apply, which requires the subject valve to be operable during operational modes 1, 2, 3, and 4. Seabrook Station entered Mode 4 on January 24, 2001. TS 3.0.4 requires that entry into an operational mode or another specified condition shall not be made when the conditions for the limiting conditions for operation are not met and the associated action requires a shutdown if they are not met within a specified time interval. Since the requirements of TS 3.0.4, 3.6.3 and 3.7.1.6 were not met, this is a condition prohibited by the Technical Specifications and is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B).

**II. Cause of Event**

The cause of this event is human error.

**III. Analysis of Event**

There were no adverse consequences as a result of this event. This event is significant because either a failure of the recorders or a seismic event may have adversely affected the ability of 1MS-PV3004 to operate if required. During the period that the subject recorders were installed, 1MS-PV3004 was capable of operation. The subject valve was successfully full-stroke exercised on December 1, 2000 after the recorders were installed. The potential that the recorders could physically interact with other safety-related equipment was also reviewed. It was determined that no adverse consequences would have resulted with respect to the seismic interaction between the recorder and nearby safety-related structures, systems, or components.

The subject valve is one of four power operated relief valves located in the 30-inch main steam line from each steam generator. The subject valves provide for controlled removal of reactor decay heat during reactor cooldown, plant startup, and after a turbine trip, when the condenser and/or the turbine bypass system are not available. When available, the atmospheric relief valves can be used to reduce main steam pressure for both hot and cold shutdown conditions. Operation of the subject valves can be either automatic pressure control or manual position from the main control board. The subject valves can also be operated from the remote safe shutdown panel and locally.

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Seabrook Station	05000443	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 3
		01	- 001	- 00	

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

**IV. Corrective Actions**

1. The subject recorders were removed.
2. A review was performed to determine if the recorders could physically interact with other safety-related equipment in the event of a seismic event. This review concluded that no adverse consequences would have resulted between the recorder and nearby safety-related structures, systems, or components.
3. The individuals involved with this event were coached and counseled on their responsibilities associated with work package ownership.
4. Maintenance Department personnel were briefed on this event and the lessons learned were reinforced.

**V. Additional Information**

None.

**Similar Events**

This is the first event of this type reported by Seabrook Station.

**Manufacturer Data**

None.