

FPL Energy Seabrook Station P.O. Box 300 Seabrook, NH 03874 (603) 773-7000

AUG 18 2003

Docket No. 50-443 <u>NYN-03063</u>

U. S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, DC 20555-0001

> Seabrook Station Licensee Event Report (LER) 2003-001-00 for Non-Compliance With Requirements of Technical Specification 3.8.1.1 Action b.

Enclosed is Licensee Event Report (LER) 2003-001-00. This LER reports an event that occurred at Seabrook Station on June 10, 2003. This event is being reported pursuant to the requirements of 10 CFR 50.73(a)(2)(i)(B).

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

Very truly yours,

FPL ENERGY SEABROOK, LLC

Mark E. Warner Site Vice President

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



# **ENCLOSURE TO NYN-03063**

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NRC FORM 366 (7-2001) U.S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)																	
1. FACILITY NAME Seabrook Station						2. DOCKET NUMBER 0500 - 0443					3. page 1 of 3						
4. TITLE	Non-C	omp	lian	ce v	with Requi	rer	nents	ofTo	echnic	al S	Specificat	ion 3.8	.1.1	Ac	tion b		
5. EVE	ENT DATE			6. LER NUMBER				7. REPORT DATE			8.	ACILITIES INVOLVED					
MO	DAY	YEAR	Y	EAR		rev No	мо	DAY	YEAR	FA	CILITY NAME N/A		DOCKET NUMBER				
06	10	2003	3 2	003		00	08	15	2003		CILITY NAME N/A		DOCKET NUMBER				
9. OPER	ATING	1								TO THE REQUIREMENTS OF 10 CFR : (Check all that apply)				t apply)			
MODE	MODE		1_		2201(b)	<u> </u>	t	3(a)(3)(ii)		50.73(a)(2)(ii)(B)		50.73(a)(2)(ix)(A)					
10. POWER		100	0 -		2201(d)				)3(a)(4)		50.73(a)(2)(iii)		50.73(a)(2)(x)			-	
LEVEL					2203(a)(1)		50.36(c)(1)(i)(A)			50.73(a)(2)(iv)(A)			73.71(a)(4)				
			<u> </u>				<u> </u>	6(c)(1)(ii)(A)			50.73(a)(2)(v)(A)			73.71(a)(5) OTHER			
					2203(a)(2)(ii)		50.36(			50.73(a)(2)(v)(B)			Specify in Abstract below or i			ct below or in	
			8—	_	2203(a)(2)(iii)	<u> </u>		a)(3)(ii)			50.73(a)(2)(v)(C)			NRC Form 366A			
			<b>-  </b>		2203(a)(2)(iv)	₩.	<u> </u>	a)(2)(i)(A)		50.73(a)(2)(v)(D)							
		n an i				a)(2)(i)(B) a)(2)(i)(C)		50.73(a)(2)(vii) 50.73(a)(2)(viii)(A)									
		- <b>1</b> 12-1	* <b> </b>			┨	i				50.73(a)(2)(v						
			<b>æ</b>	20.4	2203(a)(3)(i)			a)(2)(ii)	CT FOR T	-1110		10(0)					
NAME	•				12.		INSEE	CONTA	UT FOR I	_		RED /Inclu	da Area	Cod	<u></u>		
James M. Peschel, Regulatory Programs N					TELEPHONE NUMBER (Include Area Code)       (603)     773-7194					·							
		<u>13. C</u>	OMPI	ETE	ONE LINE FO	RE/	ACH CO	MPONE	ENT FAILI	JRE	DESCRIBED	IN THIS I	REPOR	Τ			
CAUSE	SYSTEM		MPON	ENT	MANU- FACTURER	RE	PORTABLI TO EPIX	E	CAUSE		SYSTEM	COMPON	ENT	FA	MANU-	REPORTABLE TO EPIX	
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14. SUPPLEMENTAL REPORT EXPECTED				<del></del>	CUDNIECION			DAY	YEAR								
YES (If yes, complete EXPECTED SUBMISSION DATE)			E)	XN	0	DATE N/A			۹	<u>_N/A</u>	N/A						
16. ABSTRAC	-				approximately			paced ty	pewritten	lines	s) farrad dara						

On June 10, 2003, due to a potential for a common mode failure found during preventive maintenance activities for the "A" Emergency Diesel Generator (EDG-1A), EDG-1B was started and run unloaded to satisfy the requirements of Technical Specification (TS) 3.8.1.1 action b.

A subsequent review conducted on June 18, 2003, determined that unloaded testing of EDG-1B did not adequately address the requirements of TS 3.8.1.1. EDG-1B was subsequently retested satisfactorily under loaded conditions. Failure to complete the loaded run within the required action statement time constitutes noncompliance with the requirements of the action statement and is reportable as a condition prohibited by TS pursuant to 10 CFR 50.73(a)(2)(i)(B). LER 02-002-00 identified a condition where plant operators failed to start the operable EDG unit within 24 hours after discovery as required by TS 3.8.1.1

The cause of this event was the failure of Licensee personnel to recognize the entire affect of a change to the Technical Specifications. Contributing causes include inadequate license amendment review process and an inadequate response to TS 3.8.1.1 questions. Corrective actions include enhancing the TS change review process, and providing additional training for the Operations Department and personnel involved in the event.

There were no adverse safety consequences as a result of this event.

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NRC FORM 366A U.S. NUCLEAR REGULATOR	Y COMMISSION	τι τη του	
	EE EVENT R	EPORT (LER)	
FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)	PAGE (3)
		SEQUENTIAL REVISION	
Seabrook Station	0500-0443	NUMBER	2 oF 3
		2003 - 001 - 00	
17. NARRATIVE (If more space is required, use additional cop I. <u>Description of Event</u>	pies of NRC Form 3	66A) (17)	
At approximately 0500 hours on June 10, 20 Emergency Diesel Generator (EDG) - 1A [E maintenance. During the preventive mainter #3 [ENG]. Due to a potential for a common on June 10, 2003 to meet the requirements A subsequent management review on June EDG-1B did not adequately address the foo therefore did not meet the requirements of T requirement 4.8.1.1.2a.5, TS 4.0.3 was enter The first sentence of the footnote (***) for SI 01-01 as a result of a comment received du the footnote was to provide additional clarific testing of the EDG units. However, the addi perform a loaded test of the operable EDG of c. Incorporation of the reviewer's comment change in intent was also not recognized by Committee (SORC) and Nuclear Safety Auc submittal and subsequent approval by the N	K] was declared nance, broken E mode failure, E of Technical Sp 18, 2003 (disco thote (***) for Si TS 3.8.1.1, actio ered at 1700 on R 4.8.1.1.2a.5 w ring the review of cation to plant o unit in accordan resulted in an u other licensee dit Review Comm	I inoperable in order to perform pre ielleville washers were discovered DG-1B [EK] was started and run un ecification (TS) 3.8.1.1, action b. wery date) determined that the union urveillance Requirement (SR) 4.8.1 n b. As a result of not completing June 18, 2003. vas added to License Amendment of the LAR. The intention of adding perators when performing the mon sentence unintentionally linked the ce with SR 4.8.1.1.2a.6 to TS 3.8.1 nintended material change to the for personnel, and the Station Operation	eventive on cylinder head nloaded at 1701 baded testing of 1.1.2a.5 and surveillance request (LAR) g the sentence to thly surveillance requirement to 1.1, actions b and ootnote. This ng Review
In response to a February 14, 2002 question loaded test of the diesel was not required will address the incorrect conclusion were misse action statement requirements.	hen TS 3.8.1.1,	action b or c are entered. Multiple	opportunities to
Failure to complete surveillance requiremen 3.8.1.1, action b, constitutes a noncomplian satisfactorily retested under loaded condition the time of discovery (1700, June 18, 2003) hours, 25 minutes. This event represents a reportable pursuant to 10 CFR 50.73(a)(2)(i	ce with the requins June 19, 200 until TS 3.8.1.1 condition prohit	irements of TS 3.8.1.1. EDG-1B w 3 at 0325. The duration of the non action b was satisfied (0325, June	vas subsequently acompliance from 19) was 10
II. <u>Cause of Event</u>			
The cause of this event (personnel error) wa entire affect of a change to the wording prop 01-01. This personnel error was made due initiated to support corrective actions associ the footnote were a very small part of a large	bosed in SR 4.8 to time pressur iated with the D	.1.1.2a.5, footnote (***), originally p e while developing the LAR. The L ecember 2000 failure of an EDG.	roposed in LAR AR was primarily
A contributing cause (management deficient review process had insufficient barriers, whi			
An additional contributing cause (manageme to questions on TS 3.8.1.1 by Regulatory Co questions were asked regarding the need Department personnel relied upon the initial	mpliance Depa to load the en	rtment personnel. There were thre gine. In each instance, the Regu	e occasions where latory Compliance
NRC FORM 366A (1-2001)	-		

## NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	U · · · ·	ER NUMBER (6)	PAGE (3)		
Cocharols Ctation	0500 0442	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 2	
Seabrook Station	0500-0443	2003 -	- 001 -	00	3 OF 3	

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

#### III. Analysis of Event

(1-2001)

There were no adverse safety consequences as a result of this event. Subsequent testing of EDG-1B on June 19, 2003 indicated that a common mode failure did not exist. EDG-1B remained operable and was capable of performing its intended safety function. This event is significant because plant operators did not correctly perform the actions required by TS 3.8.1.1, action b to run EDG-1B in a loaded condition.

As described in Seabrook Station – NRC Integrated Inspection Report 05000443/200303 issued on July 29, 2003, the finding associated with this event was determined to be of very low safety significance.

#### IV. Corrective Actions

#### Root Cause

An additional interdisciplinary review will be added to the LAR review process to address material changes that are made to the wording of a Technical Specification during the SORC, CNRB, and NRC review.

#### **Contributing Causes**

- Regulatory Compliance Department personnel will be briefed on the event and the lessons learned.
- Operations Department shift crews will be briefed by Regulatory Compliance supervision to address the lessons learned from this event.

# Extent of Condition

• A review of license submittals since LAR 01-01 will be performed to ensure that review comments did not materially change the intent of the Technical Specifications.

# V. Additional Information

None

# VI. Similar Events

LER 02-002-00 was issued by Seabrook Station on September 27, 2002. This LER identified a condition where one EDG unit was declared inoperable due to kVAR fluctuations. As a result of this event, plant operators failed to start the operable EDG unit as required by TS 3.8.1.1, action b within 24 hours after discovery. The cause of the event was the lack of formal training given to plant operators regarding the requirements of TS 3.8.1.1, action b.