FPL Energy
Seabrook Station

FPL Energy Seabrook Station
P.O. Box 300
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April 12, 2007

Docket No. 50-443

SBK-L-07069

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

Seabrook Station
Licensee Event Report (LER) 2007-001-00
Noncompliance with the Requirements of Technical Specification 3.6.3

Enclosed is Licensee Event Report (LER) 2007-001-00. This LER reports an event that occurred at Seabrook Station on February 14, 2007. 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

Gene St. Pierre
Site Vice President

cc: S. J. Collins, NRC Region I Administrator
G. E. Miller, NRC Project Manager, Project Directorate I-2
G. T. Dentel, NRC Senior Resident Inspector

IE22

ENCLOSURE TO SBK-L-07069

NRC FORM 366 (6-2004) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB: NO. 3150-0104 EXPIRES: 06/30/2007

Estimated burden per response to comply with this mandatory 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 and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@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 an 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)

1. FACILITY NAME	2. DOCKET NUMBER	3. PAGE
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4. TITLE

Noncompliance with the Requirements of Technical Specification 3.6.3

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
									N/A	05000
02	14	2007	2007	- 001 -	00	04	12	2007	FACILITY NAME: N/A	DOCKET NUMBER: 05000

9. OPERATING MODE

1

10. POWER LEVEL

100

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: *(Check all that apply)*

- ☐ 20.2201(b)
- ☐ 20.2201(d)
- ☐ 20.2203(a)(1)
- ☐ 20.2203(a)(2)(i)
- ☐ 20.2203(a)(2)(ii)
- ☐ 20.2203(a)(2)(iii)
- ☐ 20.2203(a)(2)(iv)
- ☐ 20.2203(a)(2)(v)
- ☐ 20.2203(a)(2)(vi)
- ☐ 20.2203(a)(3)(i)
- ☐ 20.2203(a)(3)(ii)
- ☐ 20.2203(a)(4)
- ☐ 50.36(c)(1)(i)(A)
- ☐ 50.36(c)(1)(ii)(A)
- ☐ 50.36(c)(2)
- ☐ 50.46(a)(3)(ii)
- ☐ 50.73(a)(2)(i)(A)
- ☒ 50.73(a)(2)(i)(B)
- ☐ 50.73(a)(2)(i)(C)
- ☐ 50.73(a)(2)(ii)(A)
- ☐ 50.73(a)(2)(ii)(B)
- ☐ 50.73(a)(2)(iii)
- ☐ 50.73(a)(2)(iv)(A)
- ☐ 50.73(a)(2)(v)(A)
- ☐ 50.73(a)(2)(v)(B)
- ☐ 50.73(a)(2)(v)(C)
- ☐ 50.73(a)(2)(v)(D)
- ☐ 50.73(a)(2)(vii)
- ☐ 50.73(a)(2)(viii)(A)
- ☐ 50.73(a)(2)(viii)(B)
- ☐ 50.73(a)(2)(ix)(A)
- ☐ 50.73(a)(2)(x)
- ☐ 73.71(a)(4)
- ☐ 73.71(a)(5)
- ☐ OTHER

Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME	TELEPHONE NUMBER (Include Area Code)
James M. Peschel, Regulatory Programs Manager	603-773-7194

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

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

14. SUPPLEMENTAL REPORT EXPECTED

☐ YES *(If yes, complete 15. EXPECTED SUBMISSION DATE)* ☒ NO

15. EXPECTED SUBMISSION DATE

MONTH	DAY	YEAR

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

On February 14, 2007 at 1725, with the plant in Mode 1 at 100% power, Operations personnel identified a failure to comply with the actions of Technical Specification (TS) 3.6.3, Containment Isolation Valves. Preventative maintenance on a 120-volt circuit breaker, which commenced on February 13, 2007, de-energized and, consequently, rendered inoperable two containment isolation valves, RC-V2840 and RC-V2876. In preparation for the work, the containment penetration with RC-FV-2840 was isolated by deactivated automatic valves secured in the isolation position as required by TS 3.6.3. However, personnel failed to recognize that maintenance on the circuit breaker also rendered inoperable a second valve, RC-FV2876. As a result, the containment penetration associated with RC-FV-2876 was not isolated within 4 hours as stipulated by TS 3.6.3. Following discovery of this condition on February 14, 2007, Operations personnel promptly isolated the containment penetration containing RC-FV2876 to meet the action of TS 3.6.3. The direct cause of the event was inadequate preparation and review of the clearance order for work on the 120-volt circuit breaker. RC-FV-2876 remained closed for the duration of the event and no safety consequences resulted from the condition. However, this event is of regulatory significance because it resulted in a condition prohibited by the TS.

LICENSEE EVENT REPORT (LER)

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

I. Description of Event

On February 14, 2007 at 1725, with the plant in Mode 1 at 100% power, Operations personnel identified a failure to comply with the actions of Technical Specification (TS) 3.6.3, Containment Isolation Valves. Preventative maintenance on a 120-volt circuit breaker [52], which commenced on February 13, 2007, de-energized and, consequently, rendered inoperable two containment isolation valves, RC-FV-2840 and RC-FV-2876 [AB,20]. These solenoid-operated valves automatically close on a containment isolation signal ("T" signal) to isolate the sample lines from the reactor coolant system and the pressurizer. In preparation for the work on the circuit breaker, the containment penetration [PEN] containing RC-FV-2840 was isolated by deactivated automatic valves secured in the isolation position as required by TS 3.6.3. However, personnel failed to recognize that maintenance on the circuit breaker also rendered inoperable a second valve, RC-FV-2876, which is in a different containment penetration than RC-FV-2840. As a result, the containment penetration associated with RC-FV-2876 was not isolated within 4 hours by a deactivated automatic valve secured in the isolation position as stipulated by TS 3.6.3. Following discovery of this condition on February 14, 2007, Operations personnel promptly isolated the containment penetration containing RC-FV-2876 to meet the action of TS 3.6.3.

II. Cause of Event

The direct cause of the event was inadequate preparation and review of the clearance order for work on the 120-volt circuit breaker that supplies RC-FV-2840 and RC-FV-2876. An evaluation of the event identified two root causes: (1) There was no independent review of the clearance order used to ensure compliance with TS 3.6.3 during the maintenance activity, and (2) roles and responsibilities for the review, preparation and implementation of on-line work affecting T.S. 3.6.3 are fragmented and not well understood.

III. Analysis of Event

Containment isolation valves RC-FV-2840 and RC-FV-2876 were rendered inoperable at 0225 on February 13, 2007 in preparation for preventative maintenance on the 120-volt feeder breaker that supplies power to the two containment isolation valves. With the feeder breaker out of service for maintenance, the valves would remain inoperable until the circuit was restored to service and surveillance testing required by TS 4.6.3.1 demonstrated operability of the valves. With one or more containment isolation valves inoperable, TS 3.6.3 includes an action to isolate the affected penetration by the use of a deactivated automatic valve secured in the isolation position. Station personnel complied with the action of TS 3.6.3 for the containment penetration with RC-FV-2840 by installing a clearance order that closed, deactivated, and secured the remaining solenoid-operated isolation valves in the penetration. Because the valves fail closed upon de-energization, locking open the circuit breakers was the mechanism used to secure the valves in the isolation position. However, the failure to recognize that RC-FV-2876, which is in a different containment penetration than RC-FV-2840, was also inoperable resulted in noncompliance with TS 3.6.3 because the isolation valve in the penetration was not secured in the isolation position. Although RC-FV-2876 remained closed for the duration of the maintenance on its feeder breaker, the valve was not secured in its isolation position as required by the action in TS 3.6.3.

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

During a walk down of the main control board [MCBD] on February 14 at 1725, Operations personnel observed the absence of illuminated position indication lamps on RC-FV-2876. A subsequent review determined that the valve was inoperable due to maintenance on the valve's supply breaker. As a result, at 1739 on February 14, the operators isolated the penetration containing RC-FV-2876 as specified by TS 3.6.3.

RC-FV-2876 remained closed for the duration of the event, from 0225 on February 13 when the valve was rendered inoperable until the penetration was isolated in accordance with TS 3.6.3 at 1739 on February 14. While the containment penetration was not isolated as stipulated in TS 3.6.3 within the four-hour completion time, no adverse safety consequences resulted from the condition. However, this event is of regulatory significance because it resulted in a condition prohibited by the TS.

A review of the risk and consequences for this event found that there was no increase in core damage frequency or large early release frequency as a result of the noncompliance with TS 3.6.3. RC-FV-2876 does not have a core damage mitigation function and has only a minimal potential impact on releases to the environment. This valve is in series with another containment isolation valve (RC-FV-2833) which was not impacted by this event and remained in the closed position. Further, RC-FV-2876 represents a very small leakage path and was also closed for the duration that the valve's supply breaker was out of service for maintenance.

IV. Corrective Actions

The planned corrective actions that will address the root causes of this event include:

1. Establishing administrative controls that require an independent review of clearance orders by a Senior Reactor Operator, after the preparer and reviewer have completed their actions, to verify that the clearance boundary is adequate and that the TS requirements are correctly implemented.
2. Revising the work management process to ensure that the roles and responsibilities for on-line work affecting TS 3.6.3 are clearly defined.

V. Similar Events

LER 2005-001, submitted on March 15, 2005 reported that containment isolation valve CC-V-1095 had been inoperable for a period of time longer than allowed by the technical specifications following maintenance on the valve's power supply.