New Hampshire
Yankee

Ted C. Feigenbaum
Senior Vice President and
Chief Operating Officer

NYN-90045

February 22, 1990

United States Nuclear Regulatory Commission
Washington, DC 20555

Attention: Document Control Desk

Reference: Facility Operating License NPF-67, Docket No. 50-443

Subject: Licensee Event Report (LER) No. 90-004-00: Noncompliance with Technical Specifications - Wide Range Gas Monitor Inoperable

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 90-004-00 for Seabrook Station. This submittal documents an event which was identified on January 24, 1990, and is being reported pursuant to 10CFR50.73(a)(2)(i).

Should you require further information regarding this matter, please contact Mr. Richard R. Belanger at (603) 474-9521, extension 4048.

Very truly yours,

Ted C. Feigenbaum

Enclosures: NRC Forms 366, 366A

cc: Mr. William T. Russell
Regional Administrator
United States Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406

Mr. Victor Nerses, Project Manager
Project Directorate I-3
United States Nuclear Regulatory Commission
Division of Reactor Projects
Washington, DC 20555

INPO
Records Center
1100 Circle 75 Parkway
Atlanta, GA 30339

IE22
1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Seabrook Station	0 5 0 0 0 4 4 3	1 OF 0 3

TITLE (4)

Noncompliance with Technical Specification - Wide Range Gas Monitor Inoperable

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)
										0 5 0 0 0
0 1 2 3	9 0	9 0	— 0 0 4	— 0 0	0 2	2 2	9 0			0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 0 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 (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)(viii)(A)	
		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
Richard R. Belanger, Lead Engineer - Compliance, Extension 4048	AREA CODE 6 0 3 4 7 4 1 - 9 5 2 1

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 fifteen single-space typewritten lines) (16)

On January 24, 1990, at 1:40 a.m. EST, the Wide Range Gas Monitor (WRGM) process flow rate value used to obtain the proper setpoint for the plant vent radiation monitor was identified to be at the default value, not the actual value. Therefore the plant vent radiation monitor setpoint was not based on the actual value, contrary to the requirements of Technical Specification 3.3.3.10.

On January 23, 1990, a Chemistry Technician was requested to close out the Repetitive Task Sheet (RTS) used for the LCO action statement for the plant vent radiation monitor. This monitor had been out of service to implement a design change. The Technician obtained a copy of the RTS but he did not obtain the procedure required for a complete task description. As a result, the task was not properly accomplished.

The root cause of this event has been determined to be personnel error.

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

Corrective actions included restoring WGRM process flow, counseling the Technician and enhancing the RTS.

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

TEXT (If more space is required, use additional NRC Form 366A's) (17)

On January 24, 1990, at 1:40 a.m. EST, the Wide Range Gas Monitor (WRGM) process flow rate value used to obtain the proper setpoint for the plant vent radiation monitor was identified to be at the default value, not the actual value. Therefore, the plant vent radiation monitor setpoint was not based on the actual value, contrary to the requirements of Technical Specification 3.3.3.10.

Background

The Wide Range Gas Monitor process flow monitor had been out of service for approximately six months for the implementation of Design Coordination Report (DCR) 88-012. On January 23, 1990, a Chemistry Technician was informed by the Control Room that this monitor was ready to become operational and requested that the Repetitive Task Sheet (RTS) used for the Limiting Condition of Operation (LCO) action statement be cleared.

The Technician obtained a copy of the RTS and began the closeout process. The RTS references Chemistry procedure CX0901.12, "Plant Vent Flow Rate Monitor (1-RM-FT-6577) Out of Service", and specifically directs the Technician to the procedure for "a complete task description". However, this procedure was not obtained by the Technician.

As a result, the task was not properly accomplished. Procedure Step 8.1.3 was not performed to update the WGRM data base for correct WGRM operation. Therefore, the process flow remained at the default value, not the actual process flow value.

Root Cause

The root cause of this event has been determined to be personnel error. The Technician did not obtain or use the procedure referenced on the RTS while restoring the WRGM to service.

Safety Consequences

There were no adverse safety consequences as a result of this event. The Wide Range Gas Monitor does not perform any safety functions and the event did not interfere or inhibit any safety-related equipment from performing its function.

In addition, the WGRM was still capable of detection and alarm functions but it was using a default flow value rather than actual process flow.

Corrective Actions

The WGRM process flow was restored per procedure CX0901.12 at 2:46 a.m., on January 24, 1990. A Channel Check per Technical Specification 3.3.3.10 was performed, and the WGRM was declared operable.

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

TEXT (If more space is required, use additional NRC Form 366A's) (17)

The Technician was counseled by department supervision and appropriate disciplinary action was taken. To preclude this event from recurring, the RTS has been enhanced to add a step to verify that the monitor items are set properly. This additional step incorporates the existing procedure requirements.

Plant Conditions

At the time of this event, the plant was in MODE 5.

Previous events involving the WGRM have been reported via Seabrook Station LERs 90-001, 90-002, and 90-003.