

8.15

North Atlantic

North Atlantic Energy Service Corporation P.O. Box 300 Seabrook, NH 03874 (603) 474-9521, Fax (603) 474-2987

The Northeast Utilities System

Ted C. Feigenbaum Senior Vice President & Chief Nuclear Officer

NYN -94037

April 8, 1994

United States Nuclear Regulatory Commission Washington, D.C. 20555

Attention: Document Control Desk

References: (a) Facility Operating License No. NPF-86, Docket No. 50-443

(b) North Atlantic Letter NYN-94025, dated March 11, 1994, "Licensee Event Report (LER) 94-02-00: Inadequate Slave Relay Testing," T.C. Feigenbaum to USNRC

Subject: Licensee Event Report (LER) 94-02-01, "Inadequate Slave Relay Testing"

Gentlemen:

Enclosed is Licensee Event Report (LER) 94-02-01 for Seabrook Station. This submittal provides supplemental information regarding corrective actions.

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, 8 p Ted C. Feigenbaum

TCF:MDO

Enclosures: NRC Forms 366/366A

9404150247 9404 PDR ADOCK 050 00443

1622

United States Nuclear Regulatory Commission Attention: Document Control Desk

April 4, 1994 Page two

 cc: Mr. Thomas T. Martin Regional Administrator
U.S. Nuclear Regulatory Commission Region I
475 Allendale Road King of Prussia, PA 19406

> Mr. Albert W. De Agazio, Sr. Project Manager Project Directorate I-4 Division of Reactor Projects U.S. Nuclear Regulatory Commission Washington, DC 20555

Mr. Antone C. Cerne NRC Senior Resident Inspector P.O. Box 1149 Seabrook, NH 03874

INPO Records Center 700 Galleria Parkway Atlanta, GA 30339-5957

NRC FOR (5-92)				U.S	NUCLEAR	REGULATO	RY COM	MISSION	1	APPROVED B EXP	Y OMB NO. IRES 5/31	3150-0 /95	104	
(Se	e rever	•		EVENT REP			ich bli	ock)	THIS FORWA THE I (MNBB WASHI REDUC	ATED BURDEN PI INFORMATION CC RD COMMENTS RI NFORMATION ANI 7714), U.S. HU NGTON, DC 2055 TION PROJECT EMENT AND BUDGE	EGARDING CRECORDS CLEAR REG 5-0001, AU (3150-0	REQUEST BURDEN MANAGI ULATORY ND TO T 104).	1: 50.0 HRS ESTIMATE T EMENT BRANC COMMISSION HE PAPERWOR OFFICE O	
FACILITY NAME (1) Seabrook Station							DOCKET NUMBER (2) 05000443			1	PAGE (3) OF 3			
TITLE (4)	İı	nadequ	uate Slave	Relay	Test	ing		Al			Meneral		
EVE	NT DATE	(5)	I	LER NUMBER (6		REPORT DATE (7)			Γ	OTHER FACI	TTIES INV	VOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY		FACILI	TY NAME		DOCKET NUMBER		
02	10	94	94	02	01	04	08	94	FACILI	TY NAME		DOCKET NUMBER		
OPER	TING	5	THIS RE	PORT IS SUBMITTE	D PURSUANT	TO THE	REQUI	REMENTS	OF 10 (FR S: (Check	one or mo	re) (11)	
MODE	(9)	2		402(b)		20,405(50.73(a)(2)(71(b)	
POV	VER	0	20.	405(a)(1)(i)	50.36(c)(1)			50.73(a)(2)(v)			73.	71(c)		
LEVEL	(10)	0	20.405(a)(1)(ii)			50.36(c)(2)			X 50.73(a)(2)(vii)			OTHER		
			20.405(a)(1)(iii)			X 50.73(a)(2)(i)				50.73(a)(2)((Specify in	
			20.405(a)(1)(iv)			50.73(a)(2)(ii)			50.73(a)((VIII)(B) and in		ct below	
			20.405(a)(1)(v)			50.73(a)(2)(iii)			50.73(a)(2)(x)		x)	NRC Form 366A)		
				an a	LICENSEE (CONTACT P	OR TH	IS LER	(12)					
NAME Mr.	Jame	s M.		hel, Regul						(603)47	4-9521		and the second se	
CAUSE SYSTEM C		TMOTNENT I MANILACTIDED		REPORTAB	TABLE		SYSTEM COMPONENT		(3) MANUFACTURER		REPORTABLE			
UTIO DE					TO NPRD	S	-		D. D. L.	T NOT MENT		- ONER	TO NPRDS	
			SUPPLEME	NTAL REPORT EXPE	CTED (14)	ar an free grow	and the second			EXPECTED	MONTH	DA	Y YEAR	
YES (1f yes, complete EXPECTED SUBMISSION DATE).					X NO			SUBMISSION DATE (15)						

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

On February 10, 1994, while conducting a Solid State Protection System (SSPS) procedure review, it was determined that the method for performing Slave Relay Testing on three Charging System valves did not completely satisfy the Technical Specification Definition of a Slave Relay Test. Specifically, a continuity check was not performed on some testable actuation devices.

Changes made to the procedures for performing slave relay testing revised the method by which the valves were prevented from closing. The procedure change verified slave relay closure but did not verify continuity of the associated testable actuation devices.

The cause of the event is the omission of relevent information from surveillance procedures. Immediate corrective actions were to change procedures to correctly perform a Slave Relay Test and to retest the subject valves.

NRC FORM 366A (5-92)	U.S. NUCL	LEAR REGULATORY COMMISSION	APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95					
	EVENT REPORT CONTINUATIO		ESTIMATED BURDEN PER RESPONSE TO COMPLY WI THIS INFORMATION COLLECTION REQUEST: 50.0 HE FORWARD COMMENTS REGARDING BURDEN ESTIMATE THE INFORMATION AND RECORDS MANAGEMENT BRAN (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSIC WASHINGTON, DC 20555-0001, AND TO THE PAPERWO REDUCTION PROJECT (3150-0104), OFFICE MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.					
FACILITY NA	ME (1)	DOCKET NUMBER (2)	1	LER NUMBER (6	PAGE (3)			
Seabrook Stat	ion		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
the server and do not built the server set to		05000443	94	002	01	2 OF 3		

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

On February 10, 1994, while conducting a Solid State Protection System (SSPS) [JE] procedure review, it was determined that the method for performing Slave Relay Testing on three Charging System [CB] valves did not completely satisfy the Technical Specification Definition of a Slave Relay Test. Specifically, a continuity check was not performed on some testable actuation Jevices. Regulatory Guide 1.22 "Periodic Testing of Protection System Actuation Functions" defines an *Actuation Device* as a component or assembly of components that directly controls the motive power for actuated equipment.

The subject valves are containment isolation motor operated valves. Two valves close automatically on a Safety Injection signal to isolate the charging flow path to the regenerative heat exchanger [CB]. The remaining valve closes automatically on a containment Phase A isolation signal to isolate the letdown flowpath out of the letdown heat exchanger [CB].

These three valves are included in the Updated Final Safety Analysis Report (UFSAR) list of plant equipment which cannot be tested while the plant is at power so as not to damage plant equipment or upset plant operation. The original method for performing a Slave Relay Test of these valves was changed due to the potential for valve damage as a result of stroking the valves. Since it is not desirable for the valves to close while the plant is at power, the revised slave relay test is done in a manner which does not energize the motor operator on the valves. In the past, the motor thermal overload heaters were removed prior to slave relay actuation. Testing the valves in this manner demonstrated OPERABILITY of the associated slave relay and also performed a continuity check of the associated testable actuation devices.

Subsequent changes made to the procedures for performing slave relay testing revised the method by which the valves were prevented from closing. The changes replaced the steps which removed the motor thermal overload heaters with steps which opened slide links in the control circuits. This method verified slave relay closure but did not verify continuity of the associated testable actuation devices.

Safety Consequences

There were no adverse safety consequences as a result of this event. Subsequent surveillance testing demonstrated that the subject valves were OPERABLE in the as found condition. Given that the valves were found to be OPERABLE, there is no reason to believe that the valves were not capable of performing their intended safety function. Therefore, the inadequate surveillance testing notwithstanding, the plant response to an accident was unchanged and there were no adverse safety consequences as a result of the event.

NRC FORM 366A (5-92)	U.S	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.					
LI	CENSEE EVENT REI TEXT CONTINUZ						
	FACILITY NAME (1) DOC				LER NUMBER (6)	PAGE (3)
Seabro	brook Station			YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		050	05000443		002	01	3 OF 3

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

Root Cause

The cause of the event is the omission of relevant information from the surveillance procedures. Due to the unique method for testing the subject valves, the original procedure changes should have contained information which would alert personnel to the specific surveillance requirements. Due to the lack of relevant information, a satisfactory slave relay test was interpreted to be only a verification of proper slave relay operation. This definition does not include a continuity check of associated testable actuation devices and is thus not in agreement with the Technical Specification definition of a Slave Relay Test.

Corrective Action

1. Procedure changes were implemented to revise the method for performing Slave Relay Testing on the affected procedures. The revised method tests the associated testable actuation devices.

2. Surveillance Procedures which perform Slave Relay Testing were reviewed. No additional Slave Relay Testing issues were discovered.

3. The test methodology in the affected procedures will be administratively controlled to ensure that the Slave Relay Test incorporates the attributes of Technical Specification Definition 1.34 Slave Relay Test.

4. Guidance on overlap testing methodology will be included in the Operations Department Procedure Writers Guide.

Plant Conditions

At the time of the event the plant was in Mode 5 with Reactor Coolant System (RCS) temperature at 195 degrees Fahrenheit and RCS pressure at 335 psig.

Previous Occurrences

There are seven previous similar events involving general surveillance procedure inadequacies. These events were reported to the NRC in LER 93-15, LER 93-13, LER 92-09, LER 92-08, LER 89-002, LER 87-17, and LER 88-06. The event being reported in this LER differs from the previous events in that the root cause involves the omission of relevent information from a procedure change.