DCS No: 50433940410
Date: April 11, 1994

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PN1-9424

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region I staff on this date.

Facility:
Seabrook Station
Seabrook, New Hampshire

Docket No.: 50-443
License No.: NPF-86
Event No.: 27073
Event Location Code: PWR

Licensee Emergency Classification:
___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

Subject: Media Interest in Personnel Injuries Upon Opening Containment Hatch in Mode 5

At approximately 2:30 pm on Sunday, April 10, an industrial safety accident occurred at Seabrook Station; however, no adverse consequences relative to the health and safety of the public resulted. Some licensee personnel suffered minor injuries when the outer containment personnel hatch door was forced open by a differential pressure (approximately 0.5 psig) and the resultant air flow was of sufficient velocity to cause flying debris and knocked people down. This occurred shortly after the plant entered mode 5 (cold shutdown) as part of the cooldown for Seabrook's third refueling outage. Eleven plant workers were treated onsite for minor injuries, two of which were transported to a local hospital for further treatment and later released that day.

The licensee was in the process of opening both containment personnel hatch doors in accordance with a maintenance procedure, which defeats the normal door interlocks. In higher modes of operation, when containment integrity is required by the Technical Specifications, the door interlocks prevent more than one door from being opened. However, in mode 5, both doors can be opened to facilitate the movement of personnel and equipment into containment.

The two personnel transported to the local (< 10 miles) hospital were treated for minor injuries (i.e., debris in the eye and a banged knee) and released. No radiological concerns or personnel contamination issues are evident. The outer personnel hatch door sustained some damage to hardware that will require repair. The air lock hatch inner and outer doors will be inspected and tested to ensure no other damage is present. The licensee has established an event evaluation team to review this incident. At this time, it appears that the maintenance procedural steps for blocking the inner door slightly open, to gradually relieve any differential pressure, were not performed before the outer door was opened.

No OSHA notification is required by plant procedures, but the NRC informed OSHA of this event. The licensee issued a press release on April 11 on this event, as well as an ENS call. Region I has responded to media inquires. The State of New Hampshire has been notified.

The resident inspectors were inspecting the shutdown activities at the time and were informed of the incident. Further resident followup is planned.

Contact: J. Rogge (610) 337-5146

0/1
IE-34

DCS No: 50433940410
Date: April 11, 1994

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNI-9424

DISTRIBUTION:

OWFN	MNBB	L-St.	NL	Mail:	ADM:DMB
Chairman Selin	AEOD	PDR	RES		DOT:Trans only**
Comm. Rogers	IRM				
Comm. Remick	OIG			NRC Ops Ctr _____	
Comm. de Planque					
OCAA				INPO** 3:00	
OIP				NSAC** 3:05	

		Phillips		
OCA	EDO	ACRS		
OGC	NMSS			
OPA	NRR** (Phone Verif: A. Byrdsong 964-1168 or 964-1166)			
	OE			
	OSP	Regional Offices _____	RI Resident Office 3:25	
		EWW		
		OIG	Licensee: 4:25	
			(Reactor Licensees)	

** General list for sending PNs by FAX

Region I Form 83
(Rev. August 1993)