

New Hampshire Yankee

Ted C. Feigenbaum
President and
Chief Executive Officer

NYN-91078

May 15, 1991

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

Attention: Document Control Desk

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

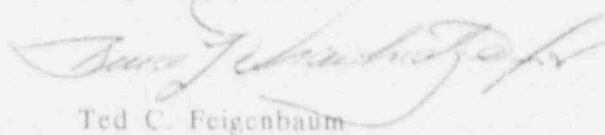
Subject: Licensee Event Report (LER) No. 91-003-00: Noncompliance with Technical Specifications - Mispositioned Valve

Gentlemen:

Enclosed please find Licensee Event Report (LER) No. 91-003-00 for Seabrook Station. This submittal documents an event which was discovered on April 16, 1991 and is being reported pursuant to 10CFR 50.73(a)(2)(i).

Should you require further information regarding this matter, please contact Mr. Allen L. Legendre, Lead Engineer - Compliance, at (603) 474-9521, extension 2372.

Very truly yours,



Ted C. Feigenbaum

Enclosures: NRC Forms 366, 366A

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May 15, 1991
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cc: Mr. Thomas T. Martin
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United States Nuclear Regulatory Commission
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Atlanta, GA 30339

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Seabrook Station	DOCKET NUMBER (2) 0 5 0 0 0 4 4 3 1	PAGE (3) 1 OF 0 3
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TITLE (4)
Noncompliance with Technical Specifications - Mispositioned Valve

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)
04	16	91	91	0013	000	05	15	91			0 5 0 0 0
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5 (Check one or more of the following) (71)											

OPERATING MODE (9) 1	POWER LEVEL (10) 11010	20 402(b)	20 406(c)	50 73(a)(2)(iv)	73.71(b)
		20 405(a)(1)(i)	50 38(c)(1)	50 73(a)(2)(v)	73.71(c)
		20 405(a)(1)(ii)	50 38(c)(2)	50 73(a)(2)(vi)	OTHER (Specify in Abstract Below and in Text NRC Form 366A)
		20 405(a)(1)(iii)	50 73(a)(2)(i)	50 73(a)(2)(vii)(A)	
		20 406(a)(1)(i)	50 73(a)(2)(ii)	50 73(a)(2)(vii)(B)	
		20 406(a)(1)(ii)	50 73(a)(2)(iii)	50 73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Allen L. Legendre, Lead Engineer - Compliance, Extension 2373	TELEPHONE NUMBER AREA CODE: 6 0 3 4 7 4 - 9 5 2 1
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On April 16, 1991 at 9:45 p.m., EDT, while in MODE 1 at 100% reactor power, it was discovered that an instrument root isolation valve (SI-V61) for two non-safety class pressure instruments 7-2491 and 1-SI-PI-929) was unlocked and open, contrary to its required position of locked closed. This instrument root isolation valve is located outside the primary containment building, between the two containment isolation valves (SI-V70-inside, and SI-V62-outside) for containment penetration X-35A. During the time that SI-V61 was in the open position, and contrary to Seabrook Station Technical Specification 3.6.3, the inside containment isolation valve (SI-V70) for penetration X-35A was not deactivated in the isolation position. When discovered to be open, SI-V61 was immediately locked closed.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

TEXT (if more space is required, use additional NRC Form 365A z/117)

Description of Event

On April 16, 1991 at 9:45 p.m., EDT, while in MODE 1 at 100% reactor power, it was discovered that an instrument root isolation valve (SI-V61) for two non-safety class pressure instruments (1-SI-PT-2491 and 1-SI-PI-929) was unlocked and open, contrary to its required position of locked closed. This instrument root isolation valve is located outside the primary containment building, between the two containment isolation valves (SI-V70-inside, and SI-V62-outside) for containment penetration X-35A. During the time that SI-V61 was in the open position, and contrary to Seabrook Station Technical Specification 3.6.3, the inside containment isolation valve (SI-V70) for penetration X-35A was not deactivated in the isolation position. When discovered to be open, SI-V61 was immediately locked closed.

SI-V61 was inadvertently left in the open and unlocked position during the performance of a Safety Injection/Residual Heat Removal (SI/RHR) check valve seating operation which is contained within operating procedure OS1005.05, SI System Operation. The SI/RHR check valve seating operations were performed on April 5, 1991.

Prior to this event, on June 15, 1990, it was determined that SI-V61 was incorrectly identified as a normally open valve as required by design drawings, procedures, and the FSAR. Upon discovery of this condition, SI-V61 was immediately locked and danger tagged closed until an evaluation was completed.

As a result of the evaluation, changes to the engineering documents and station procedures were implemented. However, the procedure change to operating procedure OS1005.05 did not utilize the standard format which requires that locked components, which require unlocking and locking whenever manipulated, be identified within the body of the procedure. The required valve position was only identified in the system lineup attached to the procedure. The failure to fully incorporate the necessary changes to OS1005.05 is a direct contributor to the April 16, 1991 event.

Additionally, an inappropriate determination was made in June of 1990 that the June 15, 1990 event was not reportable pursuant to 10CFR50.73.

Safety Consequences

There were no adverse safety consequences as a result of this event. Both containment isolation valves (SI-V70 and SI-V62), which automatically close on an ESFAS Phase A isolation signal remained operable. With SI-V61 open, the pressure boundary integrity remained intact for containment penetration

X-35A by means of the non-safety class instrument piping and instruments. The SI test line header is not required to be available to mitigate an accident. In the unlikely event that the inside containment isolation valve SI-V70 failed to close and the instrument piping or instrument integrity was breached, any egress of radioactive materials through the SI test line header piping from the primary containment would be contained within the secondary containment boundary. The SI test line instruments are located within the secondary containment boundary.

At no time during this event was there any impact on the health and safety of plant employees or the public.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Seabrook Station	DOCKET NUMBER (2) 0500044391	LER NUMBER (6)			PAGE (3) 03 OF 03
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		00	03	00	

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

Root Cause

The root cause of this event has been determined to be an inadequate procedure. Operating procedure OS1005.05, SI System Operation, which controls the manipulation of SI-V61 during SI/RHR check valve seating operations was inadequate in identifying SI-V61 as a normally locked closed valve. This procedural inadequacy contributed to the failure of control room personnel to recognize that SI-V61 was a locked closed component. If SI-V61 had been identified as a locked closed component within the body of the procedure, additional administrative measures/controls would have been taken (i.e., entering SI-V61 in the locked component log of the component configuration control procedure OS1090.05). The locked component log entry, had it been made, would have ensured that SI-V61 was returned to its locked closed position once check valve seating operations were complete.

The root cause of the failure to report the June 15, 1990 event has been determined to be an inadequate reporting procedure and a misinterpretation of Technical Specification 3.6.3, Containment Isolation Valves, by the engineer performing the reportability review.

Corrective Actions

Upon discovery that SI-V61 was open, it was immediately locked closed and an evaluation was initiated. A Human Performance Evaluation System (HPES) analysis was also initiated.

Appropriate procedure changes were made to OS1005.05 and a review of other operating procedures will be conducted during the normal review cycle to determine the existence of and to correct similar problems. These procedure reviews will be conducted during the normal procedure review cycle. A design change is also being evaluated which will relocate or upgrade 1-SI-PT-2491 and 1-SI-P-929.

The NHY process for determining 10CFR50.72 and 50.73 reportability will be revised to include additional guidance. This revision is currently scheduled to be completed by July 31, 1991.

Additionally, technical guidance will be issued to address the appropriate actions to be taken when manipulating valves (e.g. test, vent and drain valves) within the containment penetration pressure boundary. This guidance is expected to be issued by June 30, 1991.

Plant Conditions

At the discovery time of this event the plant was in MODE 1, Power Operation at 100% with and RCS temperature of 587.5 F and pressure of 2,235 psig.

This is the second event at Seabrook Station involving pressure boundary integrity of containment penetration X-35A when SI-V61 is open.