

U. S. NUCLEAR REGULATORY COMMISSION
REGION I

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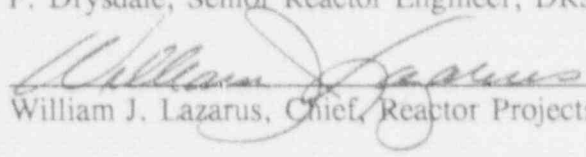
Licensee: Public Service Company of New Hampshire,
New Hampshire Yankee (NHY) Division

Facility: Seabrook Station, Seabrook, New Hampshire

Dates: April 7 - May 11, 1992

Inspectors: N. Dudley, Senior Resident Inspector
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Approved By:


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Date

OVERVIEW

The Operations Department continued to operate the reactor plant safely and competently responded to minor plant events. Routine Radiological Controls, Security, Maintenance, and Surveillance activities were procedurally controlled and properly documented.

During an emergency drill, the inspector noted weaknesses in the post accident sampling procedure and in radiological practices. The weaknesses were being addressed by the licensee.

The purchase of a battery tester and construction of a sulfur hexafluoride testing facility will improve plant safety by reducing the time equipment is unavailable due to testing. Self-identified problems with 18 month diesel generator testing, calibration procedure tolerances, and testing of the reactor head vent solenoid valve were resolved.

The recertification of remedial auxiliary operators (AO) was completed after a comprehensive training program. Revised AO log sheets were of an improved format.

The Nuclear Quality Group monthly surveillance procedure developed to evaluate personnel integrity was useful but the relationship between the procedure and the existing surveillance program was not clearly established.

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DETAILS

1.0 SUMMARY OF ACTIVITIES

1.1 NRC Activities [94702]

Two resident inspectors were assigned. Backshift inspections were conducted on 4/11 and 4/30. Deep backshift inspections were conducted on 4/12, 4/26, 4/27, 4/29 and 5/3.

On April 30, Chairman I. Selin and Mr. T. Martin, Regional Administrator, RI, toured the facility and held discussions with plant management and Mr. R. Grossi, Chairman of the Joint Owners Executive Committee. Slides of New Hampshire Yankee's presentation are provided as Attachment 1.

1.2 Plant Activities

The plant was operated at 100% power throughout the report period.

2.0 OPERATIONS [71707]

The inspectors conducted daily control room tours, observed shift turnovers, and attended plan-of-the-day meetings. The inspectors reviewed plant staffing, safety tagging orders, safety system valve lineups, and compliance with Technical Specification requirements. Routine tours were conducted of safety related equipment, the turbine building, the waste handling building, the circulating water building, and the pipe chases.

On April 26, during performance of surveillance procedure OS 1412.09, "PCCW Monthly Flow Check," the primary component cooling water (PCCW) heat exchanger bypass valve CC-TCV-2171-2 did not indicate fully closed while receiving a closure signal from the temperature controller. The operators performed surveillance procedure OX 1456.81, "Operability Testing of IST Valves," to establish valve operability. A two position switch was used to cycle CC-TCV-2171-2. In the "full flow" position, signals open CC-TCV-2171-1, the PCCW heat exchanger outlet valve, and shut CC-TCV-2171-2. In the "normal flow" position, the temperature controller demand signals normally shut CC-TCV-2171-1 and open CC-TCV-2171-2.

The inspector observed the performance of OX 1456-81 locally at the valve, discussed plant response with the Unit Shift Supervisor and reviewed the Operational Information Report. When the control switch was placed in "full flow," both valves cycled properly, and valve CC-TCV-2171-2 indicated fully closed. When the control switch was placed in "normal flow", CC-TCV-2171-1 closed but CC-TCV-2171-2 did not open. Flow in the PCCW system decreased to 2500 gpm and low flow alarms were received for reactor coolant pump cooling flow and for two containment structure cooling units. The Senior Control Room Operator (SCRO) placed the control switch in "full flow" and CC-TCV-2171-1 opened to restore system flow. The SCRO verified the proper demand signal from the temperature controller and placed the switch to "normal flow." The valves responded as expected. The

SCRO's attempt to reproduce the failure was unsuccessful. The operators prepared work requests to investigate the causes of the lack of valve closed indication and the failure of the bypass valve to open. The Technical Support Department was conducting an evaluation to determine the causes of the problems.

On May 5, the diesel generator "A" air compressor motor insulation failed resulting in smoke which actuated a fire alarm in the diesel building. The fire brigade responded and the motor was deenergized. While the motor was being replaced the air receivers were charged using compressed air bottles. The air compressor was restored to service the next day.

The inspector concluded that the operators competently responded to minor plant events.

3.0 RADIOLOGICAL CONTROLS

3.1 Plant Tours [71707]

The inspector toured the fuel storage building, waste disposal building, primary auxiliary building, circulating water building, cooling tower, and turbine building. The inspector reviewed the postings at the Health Physics Control Point, witnessed job planning discussions between health physics and maintenance personnel, and verified the status of radiation and contamination controls. Local radiation monitoring equipment was calibrated and source checked. Postings were well controlled. Health Physics supervisors initiated reviews and corrected minor discrepancies.

The inspector accompanied a health physics technician during a scheduled surveillance of the fuel pool building and the affiliated instrumentation and controls(I&C) work area. The inspector observed the gathering of air samples and smears. The limitations on equipment allowed into the I&C work area were clearly stated on permanent postings on the entrance to the area. The security force provided controlled access to the I&C work area in support of the radiological surveillance.

The inspector concluded that radiological controls were effective in ensuring a safe working environment and were implemented with ALARA consideration.

3.2 Labeling of Radioactive Shipments [83750]

On April 7, Receiving personnel called Health Physics personnel when they discovered an otherwise unmarked package containing smoke detectors, labeled with the radioactive symbol. Health Physics personnel surveyed the package and measured a contact reading of 20 mrem/hr (200 uSv/hr) in one location. The Department of Transportation (DOT) requires that any limited quantity, non-exclusive use package which exceeds 0.5 mrem (5uSv/hr) be indicated as radioactive.

The inspector reviewed the initial Station Information Report and held discussions with the Radwaste Department Supervisor. New Hampshire Yankee (NHY) contacted the distributor of the PerkinElmer fire detectors in Norwood, Massachusetts, who recognized the labeling error, and requested that the package be returned. The Health Physics Department identified the source of the activity as two fire detectors containing radium-226 which were packaged with 34 less radioactive americium fire detectors. The event was not reportable to the NRC since the radioactive material was non-exclusive use and no DOT report was required.

The inspector concluded that appropriate actions were being taken by NHY.

3.3 Radiological Controls During Drill [82301]

During observation of the performance of a post accident sample during an emergency preparedness drill, the inspector noted poor contamination control practices. After drawing an actual primary sample, a Chemist, in full anti-contamination clothing and a respirator, used a telephone without removing or frisking his gloves. A Health Physics technician, who was observing the sample without any protective clothing, later used the same phone. Subsequently, the phone was surveyed and determined to be clean. Also, the post accident sampling team failed to remove their rubber booties prior to exiting the sample room as the Health Physics department had requested. The poor practices were included on the list of drill weaknesses and assigned to the Health Physics department for corrective action.

4.0 MAINTENANCE/SURVEILLANCE

4.1 Maintenance [62703, 71707]

The inspector attended some of the daily planning meetings for each maintenance department and a Maintenance Manager's morning meeting. During plant tours, the inspector noted performance of maintenance activities.

During replacement of cracked insulators in the sulfur hexafluoride (SF_6) electrical ducting for the offsite Scobie line, the inspector toured the newly established SF_6 testing facility and held discussions with the Electrical Department Supervisor. The testing facility was used to verify the leak tightness and insulating capability of repaired SF_6 ducting. Testing was previously performed by an offsite facility. As a result, the time that the offsite line was unavailable due to repairing the SF_6 ducting was reduced.

The inspector observed portions of the repairs conducted on CS-V-125, vent valve for reactor coolant pump seal return line fitter, CS-F-4A and reviewed work package 92W1646. The maintenance worker performed the removal of the disk assembly in full anti-contamination clothing and respirator. The work was monitored by a Health Physics technician. The valve disk and seat were both eroded. The erosion on the seat was repaired and the disk was replaced. The work package contained the forms, procedures, and tagout required to safely

complete the valve repair. The issue ticket for the disk assembly matched the work order and welding sheets for tack welding the bonnet were complete. The inspector concluded that the maintenance was well-planned, procedurally controlled, and properly documented.

4.2 Surveillance [61726]

The inspector observed the performance of surveillance procedure OX1410.02, "Monthly Rod Operability Check." The test was sequenced so that maintenance inside the containment was completed prior to initiating the test. The operators performing the test were knowledgeable of test procedures and expected results. Technical representatives from I&C and reactor engineering were available in the main control room for support. The procedure was performed successfully with no discrepancies identified.

The monthly operability test of the turbine driven emergency feedwater pump was successfully completed. The inspector observed the pump start locally. An auxiliary operator was in communication with the main control room during the test and monitored the local equipment response. Repetitive Task Sheet 92R03602B03 documented the test data and included applicable approvals and reviews.

The inspector observed portions of surveillance procedure MX0506.04, "Station Battery Service Test." The battery capacity tester used is shared by several New England utilities. The equipment was calibrated on site prior to use in the surveillance. Upon initiating the battery discharge test, the expected response was not indicated on the test equipment; the technician immediately halted the discharge test. The batteries were realigned to the normal configuration pending resolution of the test equipment concern. The test equipment was repaired and the test was completed successfully.

The inspector observed good prestaging and coordination of the work activity. Prior to initiating the test, the applicable Technical Specification action statements were entered. Because of the problems encountered, the licensee plans to purchase battery testing equipment for use at the site.

The inspector concluded that knowledgeable personnel were involved in the surveillance test and a strong safety focus was maintained. The inspector noted that procurement of battery testing equipment that can be more closely controlled and maintained represented a positive initiative and illustrated the licensee's recognition of the significance of reliable testing equipment.

Maintenance workers used steps of surveillance procedure MX 0539.05, "Diesel Generator Engine Annual/Refuel PM and Inspection," to measure cylinder pressures and temperatures. The acceptance criteria for the steps were not met. The Technical Support Group determined that the failure to meet the acceptance criteria did not constitute an inoperable diesel since diesel operability was established by the monthly and semi-annual operability surveillances.

The inspector reviewed the Technical Support Group General Evaluation Sheet and held discussions with Operations Department personnel. Exceeding the cylinder pressure and temperature criteria had occurred previously, due to known diesel exhaust leaks. The diesel manufacturer, Coltec Industries, concurred with the system engineer that under existing conditions the diesel could satisfy all its safety related functions. A copy of the evaluation sheet was provided to the main control room and all shift supervisors were instructed to refer to the evaluation during future diesel tests.

The inspector concluded surveillance tests were controlled and effectively implemented and the operability determination was proper.

4.3 Diesel Generator Testing [92701]

During discussion with the NRC, New Hampshire Yankee determined that the performance of Technical Specification Surveillance requirement 4.8.1.2.f.6) for 18-month testing of the diesel generators may not have met the intent of Regulatory Guide 1.108, "Periodic Testing of Diesel Generator Units Used as Onsite Electrical Power Systems at Nuclear Power Plants." Specifically, NHY did not perform the Loss-of-Offsite Power in conjunction with Safety Injection (LOP/SI) Generator Start Test at ambient temperatures. However, NHY reviewed the testing that was performed on the emergency diesel generators and determined that the attributes that would have been tested during the "ambient" LOP/SI test were verified through other testing.

NHY concluded that the diesel generators were operable based on the completion of all required Technical Specification surveillance tests. NHY committed in a letter (NHY 920540) issued April 24, 1992, to conduct the "ambient" LOP/SI test during the second refueling outage and to supplement Licensee Amendment Request 91-10 to clarify that TS 4.8.1.2.f.6) be performed at ambient temperature.

The inspector reviewed the NHY letter, NRC Regulatory Guide 1.108, and supporting surveillance data. Based on the document review and discussions with NRR technical reviewers, the inspector concluded that NHY position was acceptable.

5.0 SECURITY [71707]

The inspector toured the protected area, noted that compensatory measures were in place, observed guards on patrol and monitored equipment status in the secondary alarm station. The inspector witnessed the security force implementation of a security drill scenario. The inspector observed portions of the activities associated with coordinating and implementing security for a large tour group within the protected area. Prompt repairs were made to several access control doors with degraded latches during this inspection period.

The inspector determined that security personal were knowledgeable of job responsibilities, aware of equipment status, and performed duties effectively. The inspector concluded that security controls were being maintained.

6.0 EMERGENCY PREPAREDNESS [82301, 82302]

A dress rehearsal for the June 4, 1992, Emergency Preparedness Drill was conducted on May 6, 1992. State and local organizations participated with the exception of South Hampton and East Kingston townships. The inspector observed the collection of a post accident system sample (PASS), reviewed a draft revision of chemistry procedure CS 0925.01, "Post Accident Liquid Sampling," held discussions with a chemistry supervisor, and attended the post drill critique in the Technical Support Center. The scenario involved failed fuel, a 70 gpm loss of coolant accident, and a breach of the containment.

The Health Physics technician and Chemist, who composed the PASS team, were briefed prior to leaving the Operations Support Center. Both wore full anti-contamination clothing and respirators while performing the sampling activity. The chemist successfully collected the required reactor coolant samples in accordance with procedure CS 0925.01, Rev.4, even though the procedure was difficult to follow. Communications with the Main Control Room were good. The chemist delivered the samples to a second chemist who performed boron, hydrogen, and activity analysis with equipment that had been setup and calibrated. The inspector concluded that the chemists demonstrated the ability to obtain and analyze post-accident primary coolant samples within a three hour period.

The inspector noted problems during the collection of the PASS sample including procedural weaknesses, lack of administrative control of SS-V-2857, a containment isolation valve, an unexpected pressure decrease in a sample flask, and a contamination control issue discussed in Section 5.3. The inspector reviewed a draft of a revision to procedure OS 0925.01 which incorporated human factor considerations such as use of simple action verbs and use of a step for each action. The Chemistry Supervisor committed to incorporate a requirement in procedure OS 0925.01 to notify the Main Control Room of the final position of SS-V-2857. The Chemistry Supervisor verified the unexpected pressure drop was due to a leaking valve and prepared a work request to repair the valve. The inspector had no further questions.

The post drill critique of the Technical Support Center by the drill coordinators noted good command and control, good communications, a low noise level, and a setting of priorities by the Emergency Director. Areas for improvement were noted locating the containment breach and establishing consistency between post LOCA data sheets and status boards. The inspector concluded the dress rehearsal provided good training and identified areas for improvement.

7.0 ENGINEERING/TECHNICAL SUPPORT

7.1 Motor Operated Valve Grease Leaks [92701]

The Motor Operated Valve Inspection Team noted oil leakage on the motor operator for AS-V-176, an auxiliary steam valve associated with the high energy line break isolation system. The inspector noted oil leakage on the motor operator for CS-V-475, a cross connect valve between the Safety Injection and Chemical and Volume Control Systems. The inspector discussed the oil leakage with the System Support Manager and his staff.

In response to industry recommendations, the Technical Support staff implemented a surveillance program in January 1991, which included inspection of the grease in safety related motor operated valves every other refueling outage and in non-safety related motor operated valves every third refueling outage.

The inspector reviewed the inservice test data and the preventive maintenance history for AS-V-176 and CS-V-475. The inservice testing of the closing times of AS-V-176 were measured quarterly since June 1986, and showed no trend. Based on a visual inspection of the housing cover gasket in February 1992, the system engineer determined that the oil leakage was not excessive. A grease sample was removed from the main gear box upper access plug and visually evaluated in April 1992. The grease level was above the worm gear and no contamination or separation of the grease was apparent.

The inservice testing of the opening and closing times for CS-V-475 were measured quarterly since June 1986 and showed no trend. The maintenance supervisor responsible for motor operated valve testing conducted a visual inspection of the oil leakage in March 1992, determined the leakage was not excessive, and prepared a work request to repair the leakage during the next refueling outage. Grease was removed from the main gear box upper access plug and visually evaluated in April 1992. The grease was above the worm gear and no contamination or separation of the grease was apparent.

The inspector concluded that AS-W-176 and CS-V-475 were operable based on maintenance and inservice test data.

7.2 Calibration Tolerances [61701]

During performance of a calibration on the cooling tower pool level transmitter, SW-LT-6929, the system engineer noted that the allowable tolerance provided in the calibration procedure of $\pm 1.0\%$ was greater than the assumed tolerance of $\pm 0.25\%$ used in calculation 5-SP-1F "Error Analysis for Safety Related Instrument Loops." An engineering review of the 110 safety related instrument loops covered by calculation 5-SP-1F identified 60 instruments that had calibration procedural tolerances which were less conservative than the assumed tolerances used in the setpoint calculations.

The inspector reviewed Station Information Report 92-19 calculation 5-SP-1F, and New Hampshire Yankee (NHY) meeting report CEM-92-270. The inspector also held discussions with the I&C Engineering Supervisor and the Maintenance Support Supervisor. Engineers reviewed the affected setpoint calculation for the 60 identified instrument loops and determined there was sufficient margin to account for the less conservative calibration surveillance tolerances except for three of the loops. Further evaluation determined that the instrument loop setpoints were never exceeded. The evaluation was based on the maintenance practice of calibrating instruments to within half of the specified tolerances, the minimal effect of sensor error accuracy on the calculation, and the unnecessary addition of an error for environmental conditions.

NHY determined that the root cause of the problem was inadequate communication between Engineering, I&C Maintenance, and Procurement personnel during plant construction. The present plant design change program requires an interdisciplinary review and identifies operational and maintenance concerns. A meeting was held on April 21, 1992, between I&C supervisors, I&C Technical Support engineers, I&C engineers, and procedure writers to discuss and heighten awareness of the interface between safety related setpoint calculations and the maintenance procedures. The meeting included discussions of the assumptions concerning the frequency, accuracy, and methods of calibrating of equipment.

The Engineering staff planned to review and revise, as necessary, safety related setpoint calculations and surveillance calibration procedures to insure consistency. The I&C maintenance staff planned to revise calibration procedures for SW-LT-6929 and the refueling water storage tank level transmitters CBS-LB-930 through 933 to reflect the assumptions of the setpoint calculations. The I&C maintenance staff planned to revise the calibration guideline procedure to reflect the calibration accuracy and the method of calibrating safety related instruments.

The inspector concluded that the self identified inconsistencies between engineering and surveillance documents were evaluated to assure safe plant conditions had existed and that actions were taken to eliminate the inconsistencies. The inspector had no further questions.

7.3 Inoperability of Reactor Head Vent - Unresolved Item 92-05-02 (Closed) (LER 92-04 Closed) [92701]

The Technical Support staff identified a discrepancy in the stroke time testing of twenty solenoid valve operators. The licensee successfully tested nineteen of the valves by using status monitoring lights to verify the closed position of the valves. The reactor vessel head vent valve RC-FV-2881 could not be tested.

In a letter issued April 6, 1992, the licensee requested interim relief from inservice testing of RC-FV-2881 since the installed instrumentation did not provide remote indication of closed valve position. On April 9, 1992, the NRC issued a letter which granted the interim relief request provided that the licensee performed alternative testing until the instrumentation could

be modified during the second refueling outage to provide remote position indication. The granting of the interim relief was pursuant to 10 CFR 50.55a(3)(ii) since imposition of the Code would require a plant shutdown without a compensating increase in the level of safety.

The inspector reviewed plant procedure, EX1804.058, "IST Testing of Reactor Vessel Head Vent Valves," and repetitive task sheet 92RE0031901 which documented the successful completion of the alternative testing. The valve was exercised, the opening time was measured, and the valve was verified closed by monitoring downstream temperature. The inspector concluded that the testing performed satisfied the alternative testing proposed by the relief request.

Licensee Event Report (LER) 92-04 documented the stroke time issue and was issued on time. The root cause was attributed to design and testing inadequacies on solenoid valves with respect to the actuation logic for the "closed" position indicating light. The licensee verified the wiring design was consistent with the generic wiring guidance provided for the Valcor solenoid valves during plant construction. The licensee indicated in their LER that they planned to evaluate the current design requirements for all solenoid operated valves in the inservice testing program and, if necessary, initiate design changes. NHY also committed to modify the design for the closed position indication for the reactor vessel head vent during the next refueling outage.

The inspector determined that the licensee's identification of the discrepancy represented good self assessment. This item is closed.

8.0 SAFETY ASSESSMENT/QUALITY VERIFICATION

8.1 Auxiliary Operator Log Discrepancies [92701]

On April 10, 1992, The President and Chief Executive Officer submitted the New Hampshire Yankee (NHY) report of its assessment of the Auxiliary Operator watchstander (AO) performance concerns to the NRC. A Summary Report by the Executive Director-Nuclear Production, the Station Manager's Evaluation, and the report of the NHY Independent Review Team were included in the submittal.

The inspector reviewed NHY's report. NHY initiated the self assessment process promptly. The assessment team was independent from the line organization and was composed of experienced personnel. NHY used various methods including Barrier Analysis and Kepner-Tregoe Problem Analysis to determine root causes. NHY conducted an evaluation to determine whether performance concerns existed in other departments, and concluded that no other departments were affected. A representative cross section of licensee personnel were involved in the data collection and interviewing process.

The NHY independent Review Team identified "failure to follow procedures" as the root cause of the performance concerns. A secondary root cause was identified as "management systems" due to the procedural compliance policy not being uniformly applied to document routine rounds. Contributing factors included ineffectiveness of On-the-Job Training, an inadequate policy concerning explicit management expectations for routine tasks, and inadequate supervision of AO watchstanding practices. The licensee developed short and long term corrective actions primarily in the areas of management expectations, communications, and training.

The inspector attended a sample of the classroom training provided to the remedial AOs and reviewed the schedule of the classroom training and selected lesson plans. The training observed was lecture style. The remedial AOs were attentive and participated through questioning and discussion of the material presented. The training included program guidance, findings of the Attention-to-Detail task force, industrial experience, regulatory requirements, and presentations from senior management. The lesson plan included learning objectives and material compiled by the remedial AOs. The Training Department planned to include portions of the two weeks of classroom training in the requalification program. The inspector determined that classroom training was well organized, comprehensive, and supported by Senior Managers.

The inspector observed the evaluation of a remedial AO during the conduct of a primary round and held discussions with the evaluator. The round was conducted by the remedial AO and evaluated by a certified AO who had received training for conducting on-the-job training and evaluations. The remedial AO was asked questions at several places in his round and a brief discussion of areas for improvement was conducted at the end of the tour. The certified AO evaluated performance using an objective set of criteria based on management expectations of job performance contained in station procedures. All remedial AOs were recertified, following interviews with senior management, and were required to perform four hours of parallel watchstanding with ten different AOs over the next several months.

The inspector reviewed one of the five revised AO watch station logs. The logs were printed on 8½ x 11 inch sheets instead of the former larger log sheets. The instructions for conducting area inspections, the parameters being monitored, and the requirements for logging a satisfactory observation were explicitly stated. Technical Specification surveillance requirements were highlighted. The revised periodicity of approximately half the observations was increased from four hours to eight hours. The log provided a relief checklist for each shift change and instructions for AO response to a reactor trip. The Assistant Operations Manager required the AOs to carry the log sheets during rounds. The inspector concluded the revised log sheets defined the inspections expected by operations management and were of an improved format.

The inspector determined that the actions taken and planned by the licensee provided reasonable assurance that personnel performance standards would be maintained.

8.2 Quality Assurance Surveillance [61726]

The Nuclear Quality Group (NQG) developed a monthly quality assurance surveillance, 013-02-001, which included accountability checks of production personnel, observation of individuals conducting tasks, and reviews of documentation accuracy. The surveillance included fourteen check sheets that contained some redundancy to existing surveillances. The NQG considered surveillance 013-02-001 to be in addition to the established surveillance program. Even though the conduct of the surveillance required significant resources, the NQG intended to complete the established surveillance program. Depending on the finding generated by surveillance 013-02-001, the NQG may extend the frequency of the surveillance or use portions of the surveillance to meet some of the requirements of the present program.

The inspector questioned one attribute on the check sheet for auxiliary operators which read "Auxiliary Operators who are under remedial instruction DO NOT perform any component manipulations." After discussions with the Operations and Training Departments, the NQG revised the attribute to allow component manipulations under the direction of a qualified operator. The inspector noted that the attribute was only applicable for the one week period between issuance of the surveillance and the certification of the remedial auxiliary operators, and was never used in a surveillance inspection.

The inspector concluded that quality assurance surveillance 013-02-001 was useful. However, the need for long term implementation of this surveillance has not been determined.

8.3 Nonconforming Molded Case Circuit Breakers, Bulletin No. 88-10 (Closed) [92701]

NRC Bulletin No. 88-10 was issued on November 22, 1988, to request that licensees take actions to provide reasonable assurance that molded-case circuit breakers purchased for use in safety related equipment perform their safety function. Supplement 1 to the bulletin issued on August 3, 1989, requested that licensees review previous written submittals and verify that responses met the bulletin provisions as clarified by the supplement.

New Hampshire Yankee responded to the bulletin and supplement in letters No. NYN-89035, dated March 31, 1989, No. NYN-8907, dated May 31, 1989, No. NYN-89103, dated August 11, 1989, and No. NYN-90119, dated May 31, 1990. The NRC review of NHY submittals and closure of the bulletin were documented in a letter dated April 10, 1992.

The inspector discussed the disposition of 76 uncertified molded case circuit breakers with the responsible engineer. The circuit breakers were deleted from the station inventory, physically segregated, and labeled, however final disposition of the breakers had not occurred.

This bulletin is closed.

8.4 Safety Evaluations to Modify Radiologically Controlled Boundaries - Unresolved Item 91-80-02 (Closed) [40500]

During the Maintenance Team Inspection in early 1991, the team noted that a comprehensive safety evaluation for the Instrument and Control (I&C) hot shop adjacent to the Fuel Handling Building was in progress and indicated that more information was needed to evaluate the licensee's review. The inspector reviewed: 1) completed safety evaluations for the I&C hot shop and the alternate access to the radiologically controlled area used during outage conditions, 2) station procedure HD0958.36, Revision 4 Change 1, "Radioactive Material Storage Area Control," and 3) station memos which addressed the I&C hot shop. The inspector toured the I&C hot shop and discussed the use, monitoring, and controls involving the facility with personnel from the health physics, chemistry, and maintenance departments.

The station procedure required Health Physics supervision to evaluate whether a 10CFR50.59 evaluation was needed for planned extensions to the existing radiologically controlled area boundary. Safety evaluations were available for review. The licensee's evaluation of the I&C hot shop included consideration of electrical power supplies, radiation protection, ventilation, effluent monitoring, fire protection, structural, operating license and access control. Guidance delineating security, water use, and general policies was posted near the entrance to the facility.

Following a tour of the I&C hot shop, the inspector requested an explanation of the standard ventilation lineup for the area. The inspector noted that there was not a clear understanding by workers of the controls for the ventilation system in the I&C hot shop. The inspector determined that there was no radiological hazard associated with the observed ventilation system operation, but questioned the application of controls referenced in the initial safety assessment. The licensee reviewed the issue and clarified the responsibilities of the I&C and health physics departments for the I&C hot shop and described the method for communicating this information to employees.

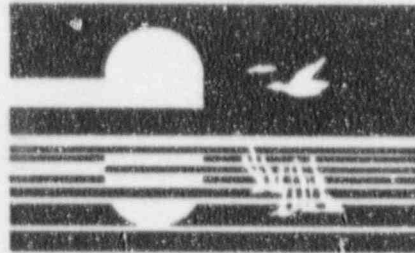
The inspector determined that the safety evaluations for the I&C hot shop and the alternate radiologically controlled area access were comprehensive and detailed. The inspector concluded that procedural guidance was adequate to ensure the necessary reviews prior to any long term extension of the radiologically controlled area boundaries. The actions initiated by the licensee for control of the I&C hot shop provide reasonable assurance that the controls specified in the safety evaluations are implemented. This item is closed.

9.0 MEETINGS

The scope and findings of the inspection were discussed periodically throughout the inspection period. An oral summary of the inspection findings was provided to the Station Manager and his staff at the conclusion of the inspection period.

ATTACHMENT

NRC INSPECTION
REPORT 50-443/92-09



SEABROOK STATION
PRESENTATION TO U.S. NRC CHAIRMAN
IVAN SELIN

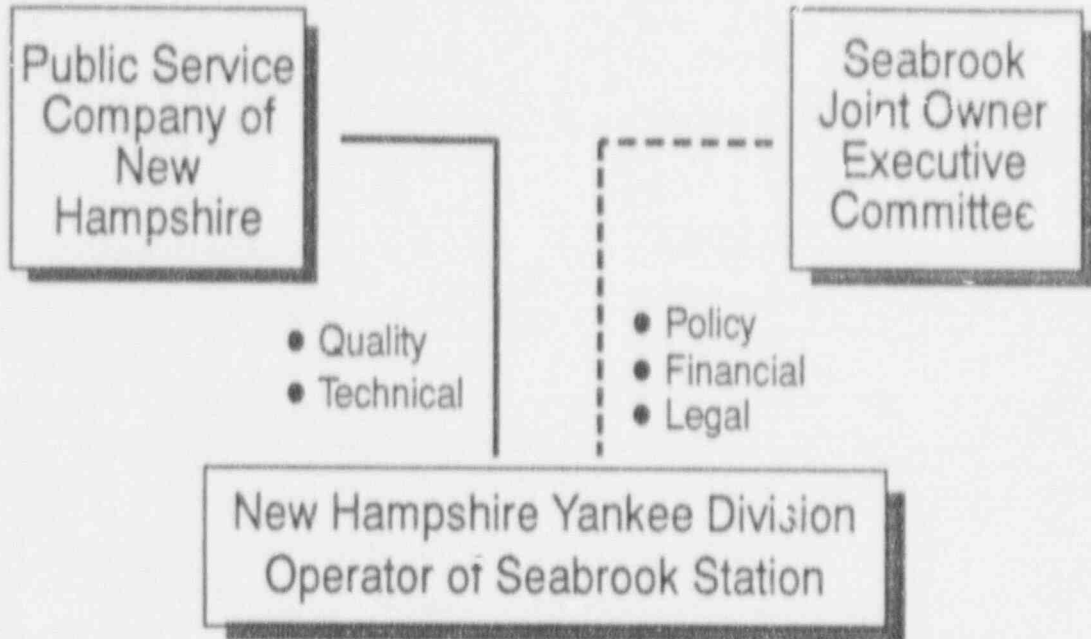
April 30, 1992

AGENDA

April 30, 1992

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|--|-------------------|
| 1. SEABROOK STATION OVERVIEW | – T.C. Feigenbaum |
| 2. JOINT OWNERS OVERVIEW | – R.J. Grossi |
| 3. NHY STAFFING AND BUDGET | – T.C. Feigenbaum |
| 4. NHY SELF ASSESSMENTS AND INITIATIVES | – B.L. Drawbridge |
| 5. AUXILIARY OPERATOR PERFORMANCE CONCERNS | – B.L. Drawbridge |
| 6. COMMUNITY OUTREACH AND STATE REGULATOR
RELATIONSHIPS | – T.C. Feigenbaum |
| 7. MASSACHUSETTS EMERGENCY PLAN TRANSITION | – G.R. Gram |
| 8. CONCLUDING REMARKS | – T.C. Feigenbaum |

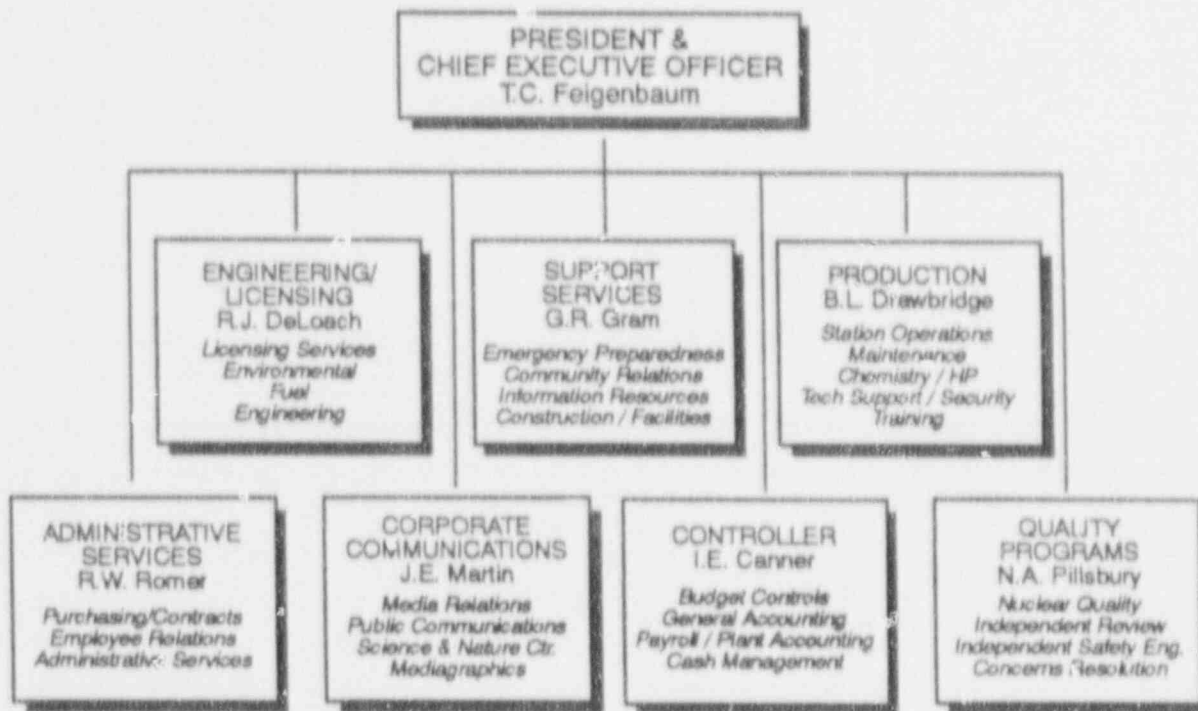
SEABROOK STATION MANAGEMENT



Created in 1984

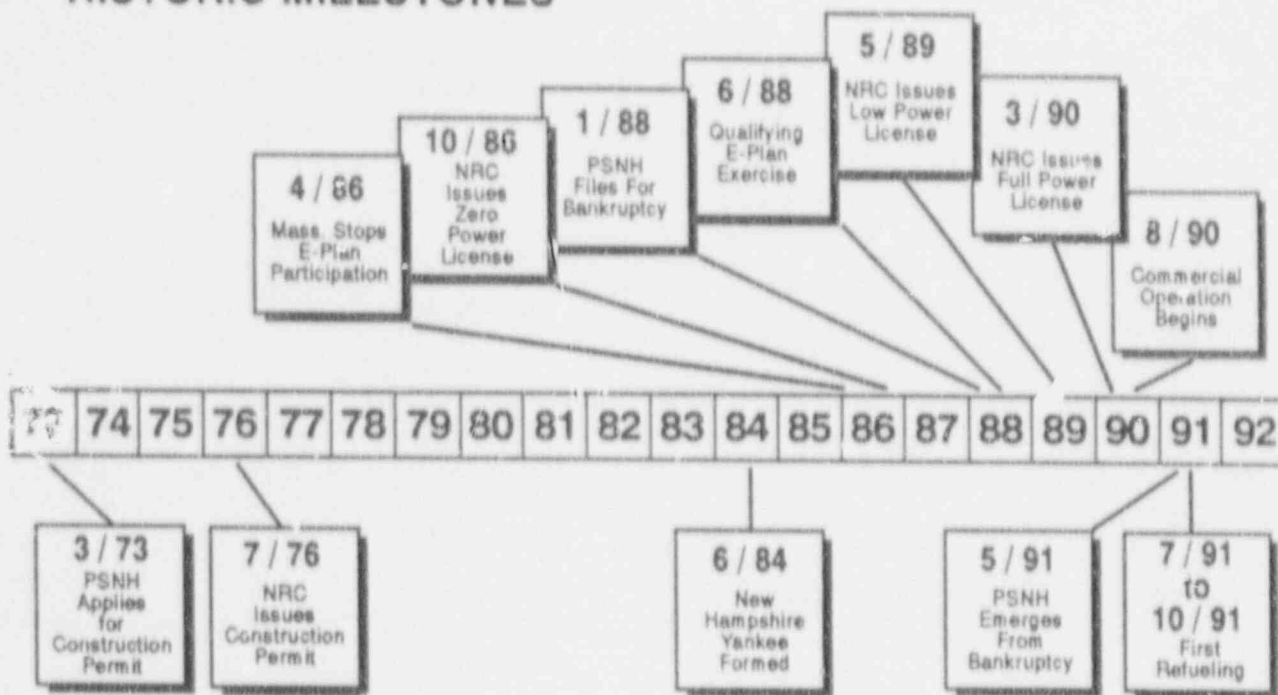
Sole Function is to Operate and Maintain Seabrook Station

NEW HAMPSHIRE YANKEE ORGANIZATION

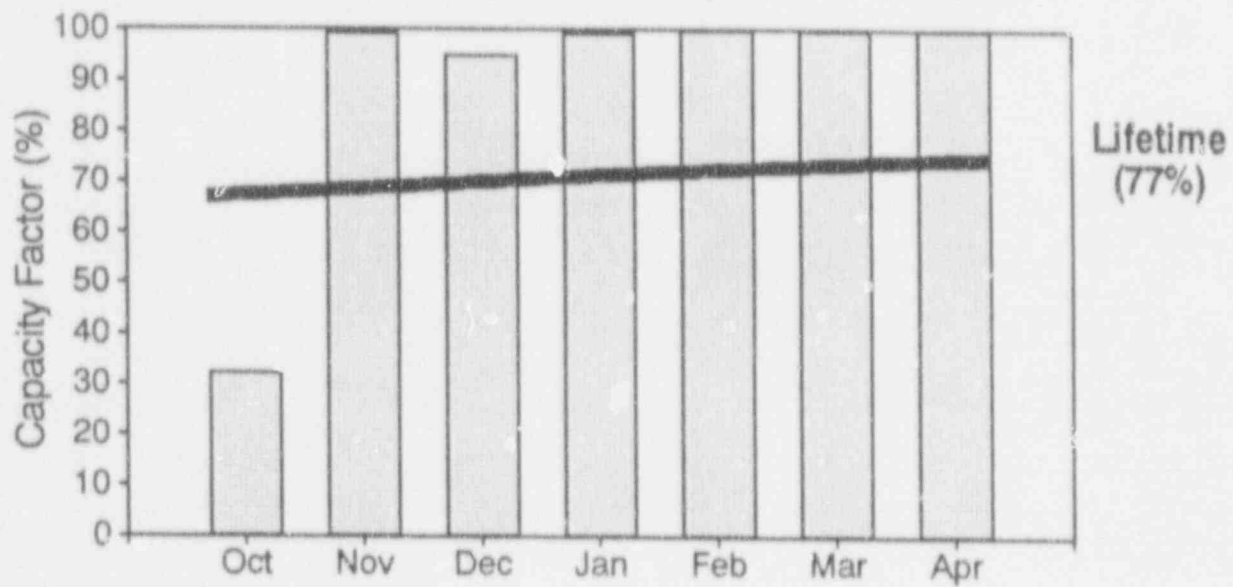


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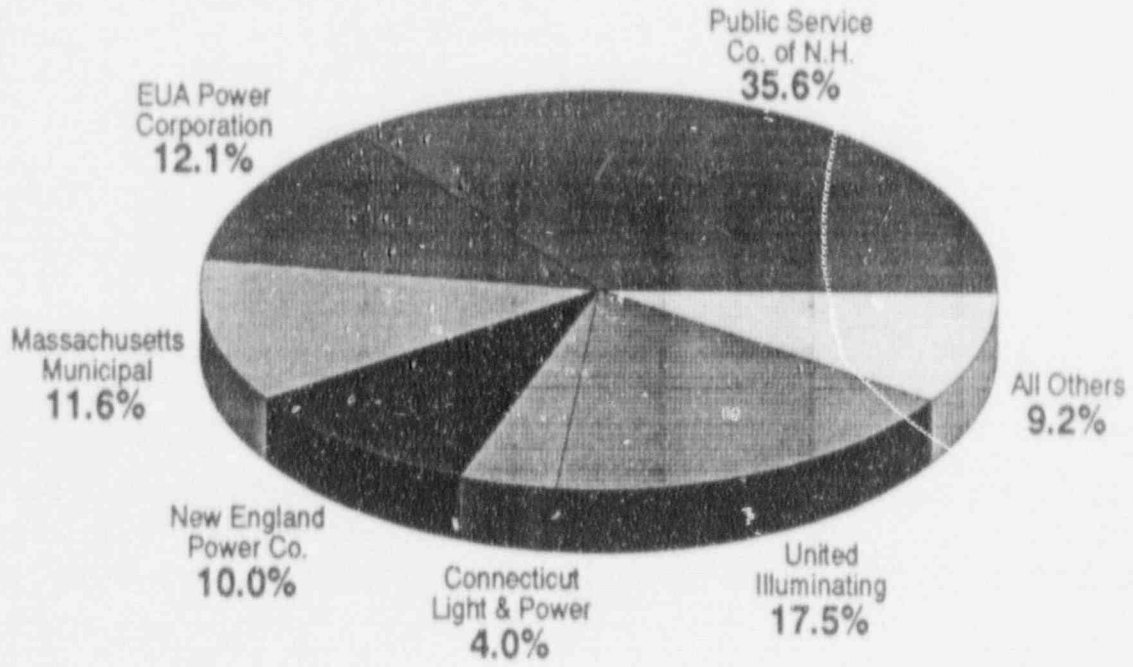
Seabrook Station HISTORIC MILESTONES



Seabrook Station
SECOND CYCLE CAPACITY FACTOR
(as of 4/30/92)



SEABROOK JOINT OWNERS



**EXECUTIVE COMMITTEE OF SEABROOK STATION
JOINT OWNERS**

The United Illuminating Company

Chairman/CEO Richard Grossi

Public Service Company of New Hampshire

President/CEO Leon Maglathin

EUA Power Corporation / Montaup Electric Company

Chairman/CEO Donald Pardus

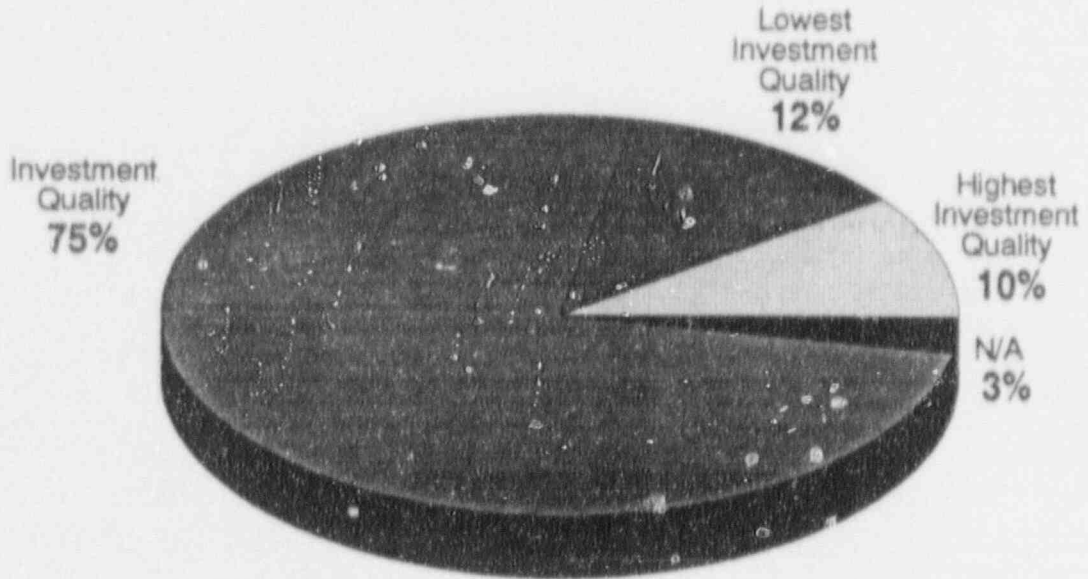
Massachusetts Municipal Wholesale Electric Company

General Manager David Sjosten

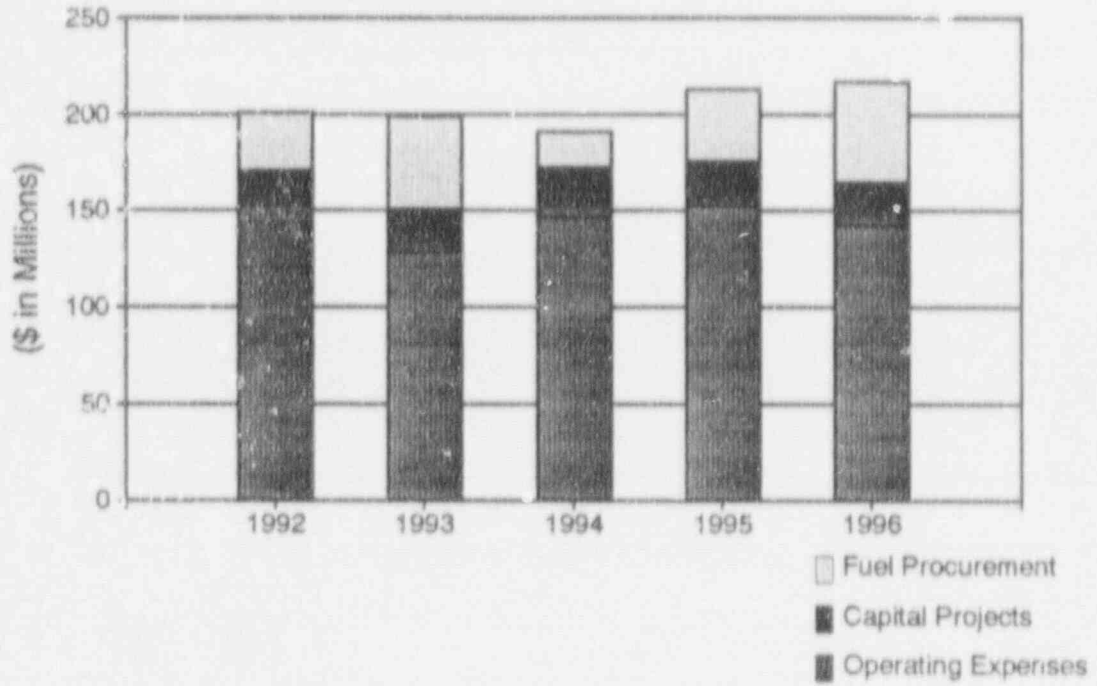
New England Power Company

Sr Vice President/General Counsel Frederic Greenman

**SEABROOK JOINT OWNERS
CURRENT MOODY'S INVESTORS SERVICE RATINGS
(By Ownership Share)**

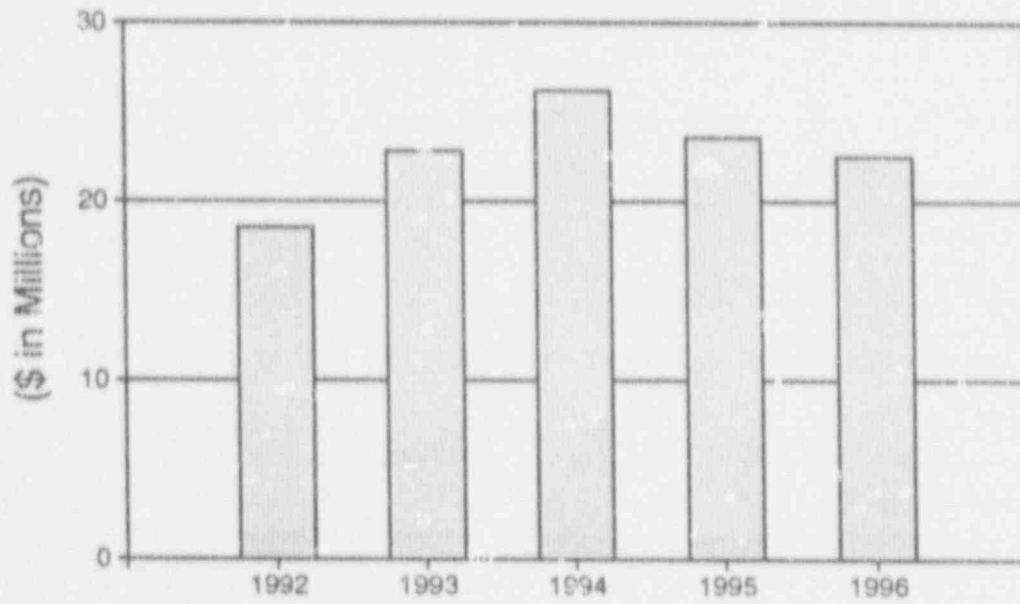


Seabrook Station
FIVE YEAR BUDGET FORECAST
(ESCALATED)



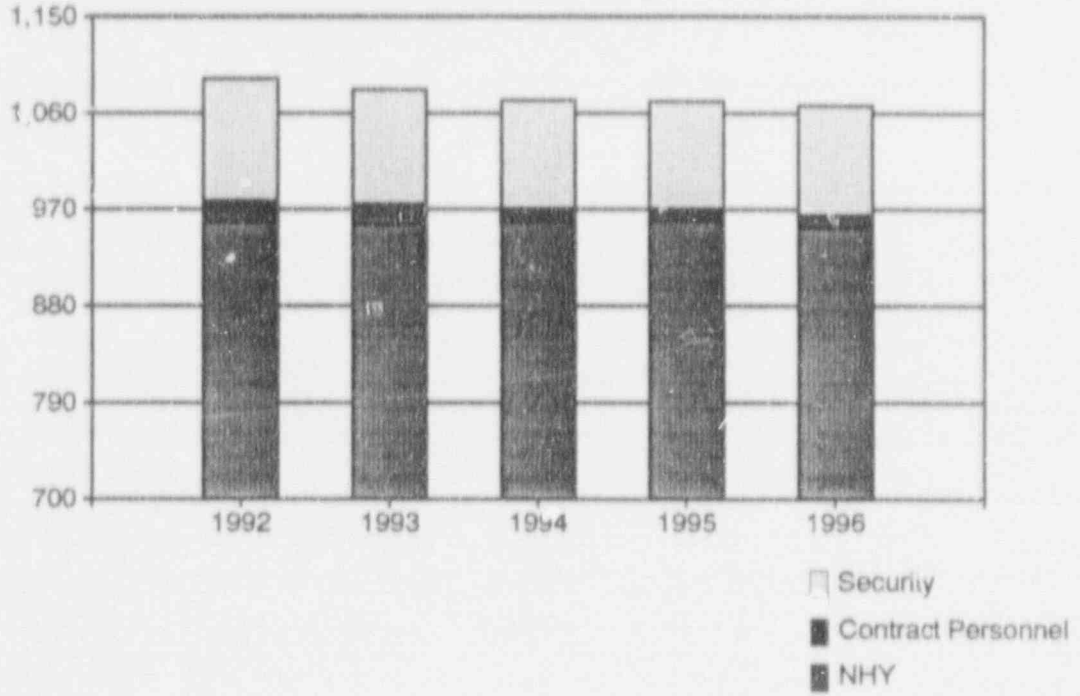
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Seabrook Station
CAPITAL PROGRAM
(ESCALATED)



MS-CAPITAL

Seabrook Station FIVE YEAR STAFFING FORECAST



INITIATIVES

- Trip Avoidance Program
Focused on balance of plant components to improve overall plant reliability
- Attention to Detail Task Force
Developed recommendations to:
 - Improve communications
 - Increase supervisor field time
 - Improve awareness of attention to detail
- Configuration Control Task Force
Developed recommendations to improve:
 - Policies
 - Procedures
 - Training
- Maintenance Improvement Plan
Implementing the following:
 - Formed Maintenance Support Department
 - Issued maintenance management manual
 - Reliability Centered Maintenance

AUXILIARY OPERATOR PERFORMANCE CONCERNS

Summary Letter to NRC

- Summary Report by Executive Director of Nuclear Production
 - Summarizes other two reports
- Station Manager's Evaluation
 - Summarizes Station actions and disciplinary process
- Independent Review Team Report
 - Findings:
 - Plant Safety not compromised
 - Six Technical Specification Surveillances missed
 - Certain AOs knowingly misrepresented log entries
 - Problem not pervasive in the NHY organization

CORRECTIVE ACTIONS

Short Term

- 13 Auxiliary Operators suspended without pay
- 4 Auxiliary Operators separated from the Company
- Independent Review Team established to determine scope and causes of recordkeeping discrepancies
- Briefings of all operations personnel by Executive Director of Nuclear Production & Station Manager

Long Term

- Executive Director - Nuclear Production provided four long-term corrective actions in the areas of communications, hiring practices, team building and industry lessons learned
- Independent Review Team provided 21 specific recommendations
- Executive Director-Nuclear Production has assigned responsibility/due dates for all recommendations

AUXILIARY OPERATOR PERFORMANCE CONCERNS RESULTS OF INDEPENDENT REVIEW TEAM INVESTIGATION

Root and Secondary Causes

- Failure to follow procedures
- Procedure compliance policy not uniformly applied

Contributing Factors

- Ineffective on-the-job training program for AO round taking
- Inadequate policy concerning explicit management expectations for routine tasks
- Inadequate supervision of AO watchstanding practices

COMMUNITY OUTREACH / STATE REGULATORY RELATIONSHIPS

- Community Involvement
- NH Business of the Year
- Media Relations
- "Good Neighbor" Activities
- State Agency / Gov't Interface

MASSACHUSETTS EMERGENCY PLANNING AND TRANSITION

- Utility Solutions
 - Seabrook Plan for Massachusetts Communities
 - Vehicular Alert Notification System (VANS)
- Massachusetts Transition Project

MASSACHUSETTS TRANSITION PROJECT GOALS

- Strong commitment and participation by local and state organizations
- Comprehensive local and state plans
- Installation of pole mounted sirens/elimination of VANS
- Transition to Commonwealth plan and response organization in 1992
- Elimination of utility Offsite Response Organization - (ORO)

MASSACHUSETTS TRANSITION PROJECT STRATEGIES

- Strong financial commitment
- First class community relations
- Active local and state government affairs
- Overall project manager & individual community project managers
- Significant local and state facility upgrades

MASSACHUSETTS TRANSITION PROJECT PROGRESS & STATUS

- Gov. executive order on planning-participation-sirens
- Town meeting approval in communities to plan & participate
- State and local plans submitted to FEMA on 9/24/91
- FEMA graded exercise to test plans scheduled for June 4th
- VANS have been eliminated in four towns
All sirens should be erected by June & VANS eliminated by September
- FEMA commitment for plan and exercise review by August
- Finding of adequacy to protect health and safety of public will trigger 50.54Q review by licensee
- Transition to Commonwealth control by the end of 3rd quarter

SUMMARY: KEY CHALLENGES AND INITIATIVES

- Complete Massachusetts emergency preparedness transition
- Address self-assessment findings
- Technical interchange with Northeast Utilities
- Well planned and executed 2nd Refueling Outage
- Refine Business Plan and master planning tools
- Continue positive relationship with the public and government agencies