December 9, 1998

Mr. T. C. Feigenbaum
Executive Vice President and Chief Nuclear Officer
Seabrook Station
North Atlantic Energy Service Corporation
c/o Mr. Terry L. Harpster
P. O. Box 300
Seabrook, NH 03874

SUBJECT: MID-YEAR INSPECTION RESOURCE PLANNING MEETING - SEABROOK STATION

Dear Mr. Feigenbaum:

On November 10, 1998, the NRC staff held an inspection resource planning meeting (IRPM). The IRPM provided a coordinated mechanism for Region I to adjust inspection schedules, as needed, prior to the conclusion of the Plant Performance Review cycle in May 1999.

This letter advises you of our planned inspection effort resulting from the Seabrook Station IRPM review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 1 details our inspection plan for the next 6 months. Resident inspections are not listed due to their ongoing and continuous nature.

Enclosure 2 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this IRPM process to arrive at an integrated view of licensee performance trends. The PIM includes only items from inspection reports or other docketed correspondence between the NRC and Seabrook Station. The IRPM may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the PDR as part of the normal issuance of NRC inspection reports and other correspondence.

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at 610-337-5233.

Sincerely,

Original Signed By:

Curtis J. Cowgill, III, Chief
Reactor Projects Branch 5
Division of Reactor Projects

Docket No. 50-443

Enclosures: 1) Inspection Plan
2) Plant Issues Matrix

Add: RES/DET

cc w/encl:
B. D. Kenyon, President - Nuclear Group
J. S. Streeter, Recovery Officer - Nuclear Oversight
W. A. DiProfio, Station Director - Seabrook Station
R. E. Hickok, Nuclear Training Manager - Seabrook Station
D. E. Carriere, Director, Production Services
L. M. Cuoco, Senior Nuclear Counsel
W. Fogg, Director, New Hampshire Office of Emergency Management
D. C. McElhinney, RAC Chairman, FEMA RI, Boston, Mass.
R. Backus, Esquire, Backus, Meyer and Solomon, New Hampshire
D. Brown-Couture, Director, Nuclear Safety, Massachusetts Emergency Management Agency
F. W. Getman, Jr., Vice President and General Counsel - Great Bay Power Corporation
R. Hallisey, Director, Dept. of Public Health, Commonwealth of Massachusetts
Seacoast Anti-Pollution League
D. Tefft, Administrator, Bureau of Radiological Health, State of New Hampshire
S. Comley, Executive Director, We the People of the United States
W. Meinert, Nuclear Engineer

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NAME	RSummers/CEO		CCowgill					
DATE	12/4/98		12/4/98					

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ENCLOSURE 1

SEABROOK INSPECTION PLAN FOR DECEMBER 1998 THROUGH MAY 1999

Inspection	Program Area/Title	Planned Dates	Inspection Type
37550	Engineering	03/08/99	Core
64704	Fire Protection Program	03/15/99	Core
83750	Occupational Radiation Exposure (Outage)	04/05/99	Core

Legend:

IP	-	Inspection Procedure Number
TI	-	Temporary Instruction Program / Sequence Number
Core	-	Minimum NRC Inspection Program (mandatory at all plants)
OA	-	Other Inspection Activity
RI	-	Additional Inspection Effort Planned by Region I
SI	-	Safety Initiative Inspection

ENCLOSURE 2

PLANT ISSUES MATRIX

United States Nuclear Regulatory Commission

PLANT ISSUE MATRIX

Region 1

SEABROOK

By Primary Functional Area

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
08/22/1998	05000443/	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	The operators performed routine reactor plant evolutions, including the ractor startup and an emergency feedwater pump surveillance test well.
08/22/1998	1998005	Pri: OPS Sec:	NRC	NEG	Pri: 5B Sec: 5C Ter:	A minor weakness was noted in that an adverse condition report (ACR) was not initially wirtten to evaluate improperly stored nitrogen bottles. Additionally, the ACR was subsequently approved without fully considering all the potential generic concerns.
08/22/1998	1998005	Pri: MAINT Sec:	NRC	MV	Pri: Sec: Ter:	The licensee identified failure to properly calibrate the power operated relief valve low temperature overpressure protection channels (LER 98-007) was considered a violation of minor significance
08/22/1998	1998005	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: 3B Ter: 5C	The corrective actions performed in response to an unexpected engineered safeguards feature (LER 98-008) actuation during surveillance testing were appropriate
08/22/1998	1998005	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 1C Ter:	Appropriate procedural guidelines were in place to manage the 12 week work planning process. The newly instituted work process was functioning as intended, however, final determination of its effectiveness remains to be determined.
08/22/1998	1998005	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Maintenance technicians performed several activities well druing the period including: installation of a freeze seal and replacement of a safety-related relief valve, installation of new spent fuel racks and testing of a pwoer range nuclear instrument rate circuit.
08/22/1998	1998005	Pri: MAINT Sec:	NRC	POS	Pri: 5C Sec: Ter:	Corrective actions taken following the maintenance rule baseline inspection were appropriate

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	NEG	Pri: 2B Sec: Ter:	The lubrication instruction sin both preventive maintenance and refurbishment procedures were not sufficiently specific to ensure consistent and appropriate breaker lubrication.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	NEG	Pri. 2B Sec: Ter:	Seabrook had large number of maintenance procedures for low voltage breakers making coordination among procedures cumbersome.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	NEG	Pri: 5B Sec Ter:	The licensee's operating experience review (OER) program to review industry events and problems was generally adequate, and their actrions in response to those events were appropriate. However, the licensee's OER reviews fro some information notices (IN) were narrowly focused, without considering the generic implication of the INs.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 2A Sec: 2B Ter:	The breakers at Seabrook had performed well during the past five years. The breaker refurbishment program at Seabrook Station was good.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 2A Sec: 3A Ter:	The physical condition of the switchgear was good. The breaker refurbishment room was well-equippped and provided a good environment for performing breaker refurbishment work. The technicians performing breaker refurbishment were knowledgeable and familiar with the refurbishment procedure.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 2B Sec: Ter:	The licensee's practice of using reduced-control-voltage testing was good. The preventive maintenance and refurbishment procedures for medium-voltage breakers was generally good.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 2B Sec: Ter:	The maintenance procedures for low voltage breakers were clear and detailed. Data sheets for completed maintenance provided a good record of the results of all measurements made and the breaker condition at time of maintenance.

United States Nuclear Regulatory Commission

PLANT ISSUE MATRIX

Region 1

SEABROOK

By Primary Functional Area

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 2B Sec: Ter:	The recently-developed circuit breaker tracking system (database) at Seabrook Station provided good information of the circuit breakers. This initiative was judged to be a program strength.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 5A Sec: 5B Ter: 5C	Work requests and Adverse Condition Reports (ACR) associated with breaker corrective maintenance were well documented. Corrective actions were appropriate and timely. Root cause and apparent cause evaluations were thorough, of good quality, and contained appropriate recommendation for corrective actions.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 5A Sec: 5B Ter: 5C	The licensee had completed a thorough, broad-in-scope self-assessment audit for the medium-voltage and low-voltage breakers, resulting in significant improvement in their breaker vendor interface program. The self-assessment audit report was of good quality. The self-assessment program was effective.
08/08/1998	1998007	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 5A Sec: 5C Ter:	The licensee's vendor interface program improved significantly as a result of licensee's self-assessment audit findings.
08/22/1998	1998005	Pri: ENG Sec: Ter:	NRC	POS	Pri: 4B Sec: 4A Ter:	Engineering design and documentation of the SFP rack safety evaluation was adequate. Engineering personnel provided good support during installation of the new SFP racks
08/08/1998	1998007	Pri: ENG Sec: Ter:	NRC	NEG	Pri: 2B Sec: 4C Ter:	Commercial-grade dedication at Seabrook for breaker maintenance was limited to breaker lubricant. There was inconsistency of critical characteristics and verification instructions in the breaker lubricant dedication package.
08/08/1998	1998007	Pri: ENG Sec: Ter:	NRC	POS	Pri: 4A Sec: Ter:	The control circuit voltage drop calculations were conservative and were generally thorough and of good quality. The input data and assumptions were technically sound.

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Region I

SEABROOK

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
08/22/1998	1998005	Pri: PLTSUP Sec: 	NRC	POS	Pri: 1C Sec: Ter:	The licensee was conducting security and safeguards activities in a manner that protected public health and safety in the areas of access authorization, alarm stations, communications, and protected area access control of personnel and packages
08/22/1998	1998005	Pri: PLTSUP Sec: 	NRC	POS	Pri: 1C Sec: Ter:	the level of management support was adequate to ensure effective implementation of the security program and was evidenced by adequate staffing levels and the allocations of resources to support programmatic needs
08/22/1998	1998005	Pri: PLTSUP Sec: 	NRC	POS	Pri: 1C Sec: Ter:	Performance in the radiation protection program was effective.
08/22/1998	1998005	Pri: PLTSUP Sec: 	NRC	POS	Pri: 1C Sec: 5B Ter: 5C	In recognition of the increased source term that may affect future radiological work, the licensee initiated actions to effect better ALARA performance and radiation protection implementation.
08/22/1998	1998005	Pri: PLTSUP Sec: 	NRC	POS	Pri: 2B Sec: Ter:	The licensee's security facilities and equipment in the areas of protected area assessment aids, protected area detection aids, and personnel search equipment were determined to be well maintained and reliable and were able to meet the licensee's commitments and NRC requirements.
08/22/1998	1998005	Pri: PLTSUP Sec: 	NRC	POS	Pri: 3A Sec: 3B Ter: 3C	The security force members demonstrated that they had the requisite knowledge necessary to effectively implment the duties and responsibilities associated with their position. Security force personnel were being trained in accordance with the requirements of the Training and Qualification Plan and training documentation was properly maintained and accurate
08/22/1998	1998005	Pri: PLTSUP Sec: 	NRC	POS	Pri: 3B Sec: Ter:	The training and qualification process for senior radiological control technicians was well proceduralized, detailed, and implemented.

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

Region I

SEABROOK

By Primary Functional Area

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
08/22/1998	1998005	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 3B Sec: 1C Ter:	Selected records for new senior technicians were properly documented in a detailed and thorough manner.
08/22/1998	1998005	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 5B Sec: 5C Ter:	Quality assurance and self-assessment activities, and the rpoblem idnetification process resulted in a thorough and programmatic evaluation of the radiation protection (RP) program and were instrumental in identifying a need for improvement in oversight of, and involvement in , RP by management and supervision from outside of the RP organization.
08/22/1998	1998005	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 5B Sec: 5C Ter: 5A	The security audits wre comprehensive in scope and depth that the audit findings were reported to the appropriate level of management, and that the program was bein properly administered.

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
P21	Part 21
POS	Positive
SGI	Safeguard Event Report

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
7/30/98 405	Negative	IR 98-04	N	1-OPS	1C 5B	The SORC review of an operability determination for a degraded compressor lubricating oil system pressure condition could have been more complete since it did not consider all available technical information.
7/30/98 395	Positive	IR 98-04	N	1-OPS	1C 5A 5B	The licensee implemented several initiatives to improve the effectiveness of the Nuclear Safety and Audit Review Committee.
7/30/98 394	Positive	IR 98-04	N	1-OPS	1A 2A	Safety-related systems and component material conditions were adequate.
7/30/98 393	Negative	IR 98-04	LP	1-OPS	1A 5B	The operators did not control a planned pressurizer level increase well which resulted in exceeding the allowable pressurizer cooldown limits. A subsequent evaluation indicated that the pressurizer integrity was not compromised by this event.
7/30/98 392	Positive	IR 98-04	N	1-OPS	1A 1B	Routine operations were performed well and operators wee knowledgeable of plant and equipment status. The plant shutdown and cooldown were performed well.
5/4/98 381	Violation	IR 98-02	N	1-OPS	5B 2A	Several performance deficiencies were noted during review of the steamline pressure channel calibrations. This issue remains unresolved pending resolution of the calibration methodology questions being investigated by the licensee. (Violation issued in IR 98-04).
5/16/98 380	Positive	IR 98-02	N	1-OPS	1A 1C 2A	The field walkdown program continued to be effective at identifying minor equipment issues as highlighted by the large number of equipment deficiencies tags generated.
5/16/98 379	Positive	IR 98-02	N	1-OPS	1A	Routine operations were performed in accordance with station procedures and plant evolutions were completed in a deliberate manner with clear communications and effective oversight by shift supervision.
10/4/97 298	Negative	IR 97-06	N	1-OPS		During a surveillance test of the "A" SI pump, the inspector observed boric acid accumulation at the pump's mechanical seal, in the seal basin, and the seal basin drain. Operator awareness and usage of the process to identify and clean boric acid leakage from the "A" safety injection pump mechanical seal was ineffective since boric acid was not being cleaned from the pump on a regular interval. The system engineer adequately assessed the pump's mechanical seal leakage, however, the inspector noted that the possible failure mode of increased leakage without drainage was not evaluated.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
10/4/97 297	Positive	IR 97-06	L	1-OPS		The control room operators noted oscillation of the "A" main feed pump governor control valve position and the steam flow indications to the MFP. Operators maintained control and stabilized the plant throughout the entire event. Operations management determined that neither the reactor nor the secondary plant was in jeopardy at any time and therefore did not initiate a plant trip.
10/4/97 296	Positive	IR 97-06	L	1-OPS		The conduct of operations was professional and focused on safety principles.
7/30/98 401	Positive	IR 98-04	N	2-MAINT	2B 1C	The forced outage was performed safely. The mode change controls implemented prior to start-up were appropriate.
7/30/98 400	Negative	IR 98-04	N	2-MAINT	3B 5C	The corrective actions for the RC-V-89 pipe leak involving prevention of wetting to insulation had not been completed as scheduled.
7/30/98 399	Positive	IR 98-04	N	2-MAINT	3A 3B	The licensee performed freeze seal activities well. Minor procedural weaknesses were noted regarding precautions for installing freeze seals near welded joints.
7/30/98 398	Positive	IR 98-04	N	2-MAINT	2A 4B	The licensee promptly identified and investigated an abnormal noise in the emergency feedwater pump room. The engineering evaluation and follow-up of this condition was sound. The decision to repair the leaking valves during the forced outage was appropriate, and the repair activities were effective.
7/30/98 397	Positive	IR 98-04	N	2-MAINT	5A 2B	The licensee's investigation into lead/lag card methodology issues was thorough.
7/30/98 396	Violation	IR 98-04	N	2-MAINT	5A 5C 2A	The licensee did not promptly initiate action to confirm the operability of the steam pressure protection channels on the A and D steam generators (NOV 98-04-01).
5/16/98 385	Positive	IR 98-02	N	2-MAINT	3A 2A	The licensee promptly initiated an investigation for a failed pressurizer sample valve position indication, and implemented appropriate corrective actions.
5/16/98 384	Positive	IR 98-02	N	2-MAINT	3A 2A	The electricians performed well during refurbishment of a safety battery breaker.
5/16/98 383	Positive	IR 98-02	N	2-MAINT	3A 2A	The licensee implemented an aggressive inspection criteria for detecting sparking emergency diesel generator brushes. Upon identification of minor sparking, the licensee promptly evaluated the condition, determined that operability of the EDG was not affected, and conservatively decided to replace the affected brushes.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
5/16/98 382	Positive	IR 98-02	N	2- MAINT	3A 2A	The troubleshooting of the personnel access hatch hydraulic control valves and replacement of the mechanical interlock cable were performed well. Excellent briefings were observed, and the mechanics were well prepared to perform the planned evolutions.
3/28/98 369	NCV	IR 98-01 NCV 98-01-01	L	2- MAINT	2B 4B 5A	The licensee reported several examples of failure to develop adequate surveillance test procedures. The licensee subsequently revised the test procedures and properly tested each component. This licensee identified violation of failure to develop adequate test procedures is being treated as a non-cited violation.
3/28/98 368	Positive	IR 98-01	N	2- MAINT	3A 2B 2A	Safety-related degraded voltage bus testing was performed well, and the test results satisfied technical specification requirements.
3/28/98 367	Positive	IR 98-01	N	2- MAINT	2B	The licensee performed the planned freeze seal activities well. The work package, and associated on-line maintenance and freeze seal evaluations and management oversight were effective.
3/28/98 366	Positive	IR 98-01	N	2- MAINT	5A 3A 2B	An electrician demonstrated excellent attention to detail and a questioning attitude, to detect and identify the incorrect installation of two operating mechanism springs on a safety-related breaker.
1/21/98 362	VIO	IR 97-09 VIO 97-09-02	N	2- MAINT	2B	Measuring and testing devices were not properly controlled to maintain accuracy within necessary limits. This was a violation of 10CFR 50, Appendix B, Criterion XII.
1/21/98 361	VIO	IR 97-09 VIO 97-09-01	N	2- MAINT	2B	On March 13, 1997 the licensee changed procedures as described in the UFSAR and failed to perform a written safety evaluation to determine that the change did not involve an unreviewed safety question (USQ).This was a violation of 50.59.
1/21/98 360	Positive	IR 97-09	N	2- MAINT	3A 1C	The instrumentation and control (I&C) technician's use of procedure and equipment to perform calibrations of M&TE is acceptable. Also, the M&TE morning meetings are useful for discussing current and future M&TE issues.
1/31/98 351	URI	IR 97-08 URI 97-08	N	2- MAINT	3A 5B	The apparent cause evaluation report for six loose service water valve flange nuts did not document an apparent root cause. The failure to properly document apparent cause findings could affect the identification and correction of the underlying causes for deficiencies. This issue will remain unresolved.
1/31/98 350	Positive	IR 97-08	N	2- MAINT	3A	The emergency feedwater (EFW) surveillance activities were performed well.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
1/31/98 349	Negative	IR 97-08	N	2-MAINT	3A 5C	Foreign material exclusion controls during the control building air conditioning (CBA) system modifications were poor, and the actions taken to improve performance in this area were not fully effective.
1/31/98 348	Positive	IR 97-08	N	2-MAINT	3A	The residual heat removal (RHR) system pipe replacement activities were performed well
12/6/97 344	LER	IR 98-01 LER 97-17-00	L	2-MAINT	2B	North Atlantic Energy Service Corporation (North Atlantic) determined that the current Solid State Protection System (SSPS) surveillance testing did not adequately test certain logic circuits.
12/6/97 343	Negative LER	IR 97-07 LER 97-14-00	L	2-MAINT	2B	A licensee review of the Reactor Coolant System (RCS) wide range pressure channel calibration procedures concluded that the Residual Heat Removal System (RHR) Low Pressure Interlocks (LPI) reset on increasing pressure such that the RHR isolation valves can be opened with an RCS pressure above the TS limit.
12/6/97 329	Negative	IR 97-07	N	2-MAINT	3A 2B	Minor weaknesses were noted in the program guidance for evaluating fluctuating gage indications, and scheduling EDG preventive maintenance activities. The licensee identified appropriate measures to address these concerns.
12/6/97 328	Positive	IR 97-07	N	2-MAINT	2A 2B 3A	The emergency feedwater (EFW) and emergency diesel generator (EDG) surveillance activities were performed well. Troubleshooting activities to correct an adverse EDG start time trend were effective.
12/6/97 327	Positive	IR 97-07	N	2-MAINT	2A 2B 3A	The repair of a failed hot leg temperature instrument was well controlled and prompt. A good initiative was identified to enhance instrument and technician procedural guidance.
10/4/97 319	VIO	IR 97-06 VIO 97-06-05	N	2-MAINT	2A 3A	Several performance problems occurred during the troubleshooting and repair activities for the A Main Feedwater Pump (MFP) that collectively resulted in the A MFP failing to trip during the post-maintenance trip test. A lack of self-check and questioning attitude on the part of supervision and technicians resulted in the use of an inadequate procedure, poor configuration control (failure to document lifting electrical leads) during corrective maintenance, and adherence to procedures. This was a violation of Technical Specification 6.8.1 for failure to follow procedure.
10/4/97 318	Positive	IR 97-06	N	2-MAINT	2B 2A	The installation of the makeup totalizer modification was well coordinated. Good inter-departmental cooperation was demonstrated. Station and operations management demonstrated a conservative approach to conducting the on-line maintenance by establishing contingency plans for addressing a rapid power reduction scenario.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
10/4/97 301	VIO	IR 97-06 VIO 97-06-??	N	2- MAINT	2A 3A	Several performance problems occurred during the troubleshooting and repair activities for the A MFP that collectively resulted in the A MFP failing to trip during the post-maintenance trip test. A lack of self-check and questioning attitude on the part of supervision and technicians resulted in the use of an inadequate procedure, the lack of configuration control during corrective maintenance, and adherence to procedures.
7/30/98 404	Positive	IR 98-04	N	3-ENG	2A 4A 4B	The licensee's actions to improve the reliability of the control building air conditioning system were extensive.
7/30/98 403	Positive	IR 98-04	N	3-ENG	2A 4B	The licensee responded well to investigate the temporary loss of the normal reactor coolant pump seal cooling flow. The identified causes and corrective actions for this event were adequate.
7/30/98 402	Positive	IR 98-04	N	3-ENG	4B 5B	The evaluation of an evaporator coil over pressurization event was good. A weakness was noted involving the initial estimate of the maximum coil pressure.
5/16/98 389	Positive	IR 98-02	N	3-ENG	4B 2A	The licensee performed well by identifying and investigating questions pertaining to their previous lead/lag card calibration methodology. This issue will remain unresolved pending review of the impact of the initial method on the channel operability.
5/16/98 388	Positive	IR 98-02	N	3-ENG	4B 3A	The system engineer provided good support and analysis of a degraded charging pump drive pin/bushing. The licensee's actions to replace the components and continue with the inspection program were appropriate.
5/16/98 387	Negative	IR 98-02	N	3-ENG	4B 4C 2A	The inspector noted some weaknesses in the licensee's method to evaluate the long term reliability of the EDG exhaust piping.
5/16/98 386	Positive	IR 98-02	N	3-ENG	5B 2A	The licensee promptly and adequately evaluated the inspector's concerns, and determined that no immediate concern regarding degradation of the EDG exhaust piping existed.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
1/15/98 378	VIO L-III	IR 97-08 EA 98-073- 02013	L	3-ENG	2A 4A 4B	The control room air conditioning system had inherent design deficiencies and performance problems dating back to initial plant startup and testing. Past actions taken to correct the system performance were primarily focused on the component level to address symptoms associated with the inherent design. These changes were made without a complete understanding of the full effect on the integrated system. A design change to improve the system performance had been developed, however, it was not implemented in a timely manner. Additionally, the corrective action program did not result in the prompt correction of the design deficiencies that were significant conditions adverse to quality. This resulted in a severity level III violation (no civil penalty) for failure to promptly correct a degraded condition.
3/28/98 374	Positive	IR 98-01	N	3-ENG	2A 4B	The licensee determined that incorrectly installed coupling hubs caused a degraded EFW motor outboard bearing condition. The pump remained operable in this condition and the licensee implemented appropriate corrective actions to address this deficiency.
3/28/98 373	Positive	IR 98-01	N	3-ENG	1A 5A 4B	Operations personnel performed well by identifying the safety injection accumulator nitrogen leaks. The licensee promptly investigated the leakage and implemented appropriate repairs to reduce the leakage. Engineering properly assessed the impact of this minor leakage on the accumulator operability.
3/28/98 372	Negative	IR 98-01	N	3-ENG	5B	The inspector noted that the licensee's response to a previous condition involving four minor pipe leaks did not include identification of the other plant areas potentially susceptible to periodic wetting. The licensee implemented appropriate actions to address this concern.
3/28/98 371	Positive	IR 98-01	N	3-ENG	1A 4B	The licensee promptly reviewed and evaluated the identification of boric acid accumulation on a RHR drain line. The identification of this condition reflected positively on the licensee's new system walkdown program.
3/28/98 370	VIO	IR 98-01 VIO 98-01-02	N	3-ENG	4B 3A	The licensee failed to implement adequate design controls to ensure that the safety-related components within the residual heat removal system pump room would remain within their required temperature limits prior to modifying the room ventilation system. A subsequent licensee analysis, performed after the NRC identified this deficiency, indicated that the modification reduced the room ventilation flow by about 50% however, the room temperature limits would not have been exceeded.
1/31/98 356	URI	IR 97-08 URI 97-08-05	N	3-ENG	4C	Several performance weaknesses were identified regarding the implementation of the oil analysis program. Incorrect information was provided to the shift manager which formed the basis for the decision to delay sampling the 2B charging pump motor bearing oil. The motor oil was subsequently sampled and found not to adversely affect the pump operability, and the oil sampling frequency was increased to better monitor the oil condition.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
1/31/98 354	VIO L-III	IR 97-08 EA 97-073- 01013	L	3-ENG	4B 3A 5A	The licensee did not promptly investigate potential pressure boundary leakage from RHR pipe located below the RC-V-89 relief valve. This resulted in a severity level III violation (no civil penalty) for failure to take prompt corrective action.
1/31/98 353	Positive	IR 97-08	N	3-ENG	5B 4B	The inspector did not identify any factors that would provide a basis for disagreeing with the event team finding that the RHR pipe leaks were a result of stress corrosion cracking initiated from the outside of the pipe from chlorides leached on to the pipe from the heat insulating material.
1/31/98 342	Positive LER	IR 97-07 LER 97-015-00	L	3-ENG	4A 4B	Westinghouse informed North Atlantic Energy Service Corporation that a developmental fuel rod performance model could calculate reduced fuel rod internal pressure margins when compared to the previously licensed computer code. Westinghouse has determined that in very limiting cases for high power, high burnup Integral Fuel Burnable Absorber fuel rods, calculated pressures are in excess of the fuel rod design criterion that the fuel rod pellet to clad gap shall not reopen.
12/6/97 340	Positive	IR 97-07	N	3-ENG	4A 4B 4C	The licensee was taking appropriate actions to improve the content of the Seabrook design basis. The EFW system was installed and operational consistent with the design requirements as described in the UFSAR.
12/6/97 333	Negative	IR 97-07	N	3-ENG	4B 4C	Weaknesses were noted in the control of temporary equipment in that some nonpermanent components were connected to or located near plant systems without a formal evaluation. There were no immediate operability concerns with the temporary equipment, and noted that the licensee initiated an ACR to review the program.
12/6/97 332	Positive	IR 97-07	N	3-ENG	4B	The licensee took appropriate steps to evaluate and correct plant problems regarding the potential for high primary component cooling water temperatures during post-accident conditions and high vibrations in the steam piping for the steam generator feed pump turbines.
12/6/97 330	Positive	IR 97-07	N	3-ENG	4A 4B 4C	The licensee was taking appropriate actions to improve the content of the Seabrook design basis. The EFW system was installed and operational consistent with the design requirements as described in the UFSAR.
10/4/97 321	VIO	IR 97-06 VIO 97-06-05	N	3-ENG	4B 3A	A weakness existed in the maintenance/procurement engineering (PE) interface, such that a barrier to ensuring the use of the correct replacement component broke down. Personnel performing the work identified the wrong component in the field, but that information was never related to PE contrary to the guidance in MA 3.0. This resulted in a severity level IV violation for failure to adhere to procedures.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
10/4/97 320	Positive	IR 97-06	N	3-ENG	4B 3A	Overall, Seabrook performed the fuel inspection activities well. The inspector observed adequate reactor engineering supervisory and vendor oversight on the job. Further, there was excellent HP coverage and radiation controls, good FME program implementation, adequate operations support, and adequate self-assessment by the QA department.
7/30/98 409	Positive	IR 98-04	N	4-PS	3A 1C	Security activities were performed well. The licensee implemented a detailed plan to ensure proper vital area access controls were maintained during a planned demonstration.
7/30/98 408	Negative	IR 98-04	N	4-PS	5B 5C	The licensee did not implement interim corrective actions to enhance the control of cleaning boron from remotely operated valves following an event where a valve was unexpectedly positioned during a cleaning activity.
7/30/98 407	Negative	IR 98-04	N	4-PS	3A 3B	The inspector identified a poor practice involving a health physics technician who performed an activity on a potentially contaminated system without wearing protective gloves. The licensee's corrective actions for this event were adequate.
7/30/98 406	Positive	IR 98-04	N	4-PS	3A 1C	The radiological control technicians at the radiological controlled area (RCA) check point and in the field were generally attentive, knowledgeable, and provided high quality assistance to ensure proper radiological work practices. The RCA access turnstile installation as a good initiative to ensure that radiation workers comply with RCA access control requirements.
5/16/98 391	Positive	IR 98-02	N	4-PS	3A	The inspectors observed good security force performance during inspection activities. Protected area access controls were found to be properly implemented during random observations. Proper escort control of visitors was observed. Security officers were alert and attentive to their duties.
5/16/98 390	Positive	IR 98-02	N	4-PS	3A	The radiological controls technicians were observed to be attentive and provided high quality assistance to plant workers. Plant workers were observed to be following proper radiological work practices including use of dosimetry and protective equipment. Personnel briefings prior to containment entries were thorough and informative.
3/28/98 375	VIO	IR 98-01 VIO 98-01-03	N	4-PS	1C 3A	The inspector that identified four workers were performing maintenance on the "B" containment spray pump in a posted contaminated area without wearing any protective clothing as required by the radiation work permit and posted instructions.
1/31/98 359	Positive	IR 97-08	N	4-PS	3A 5B	The inspector concluded that the licensee's actions in response to a positive test result were consistent with the fitness for duty program.

SEABROOK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
1/31/98 358	Positive	IR 97-08	N	4-PS	3A 1C	The radiological controls technicians at the Radiological Control Area (RCA) check point and in the field provided high quality assistance to ensure proper radiological work practices. All personnel observed were properly wearing dosimetry and protective clothing as required. The licensee began to report the daily work group exposures at the station management meeting to heighten personnel exposure awareness.
12/6/97 338	Positive	IR 97-07	N	4-PS	1C 3A	The licensee maintained an effective security program. Management support was evident based on the implementation of the security program as documented in this report. Audits were thorough and in-depth, alarm station operators were knowledgeable of their duties and responsibilities, communications requirements were being performed in accordance with the NRC-approved physical security plan (the Plan) and assessment aids had adequate picture quality. Security equipment was being tested and maintained in accordance with the Plan and security training was being performed in accordance with the training and qualification plan. The licensee's provisions for land vehicle control measures satisfied regulatory requirements and licensee commitments.
12/6/97 337	Negative	IR 97-07	N	4-PS	1C	Chapter 11, Radioactive Waste Management, of the Updated Final Safety Analysis Report (UFSAR) does not accurately reflect the current status of plant equipment and of methods used for radioactive waste processing.
12/6/97 336	Negative	IR 97-07	N	4-PS	1C	Weak attributes were noted in the scope of the Process Control Program document, in the documentation of the technical rationale for changes to the PCP, and in the procedure for updating scaling factors for radioactive waste streams.
12/6/97 335	Positive	IR 97-07	N	4-PS	1C 3A	The management of solid radioactive waste and of transportation of radioactive materials was generally effective. The volume of low level radioactive dry active waste which was being generated continued to be low as the result of effective management in this area.
10/4/97 323	Positive	IR 97-06	N	4-PS	4A	The fire suppression system configuration in the main control room meets the requirements of the station's fire protection program. Seabrook Station's fire suppression systems meet General Design Criterion 3 with respect to inadvertent operation of fire suppression systems.
10/4/97 322	Positive	IR 97-06	N	4-PS	3A	Security personnel properly responded to alarms caused by card readers inaccurately reading security access cards. The security staff adequately demonstrated that the security system appropriately alarmed and identified errors in access control.

ABBREVIATIONS USED IN PIM TABLE

CBA	Control Building Air Conditioning System
EDG	Emergency Diesel Generator
EFW	Emergency Feedwater
MFP	Main Feedwater Pump
NRC	Nuclear Regulatory Commission
RCA	Radiological Control Area
RCS	Reactor Coolant System
RHR	Residual Heat Removal
SI	Safety Injection
SSPS	Solid State Protection System
UFSAR	Updated Final Safety Analysis Report

GENERAL DESCRIPTION OF PIM TABLE COLUMNS

Date	The actual date of an event or significant issue for those items that have a clear date of occurrence (mainly **LERs**), the date the source of the information was issued (such as for **EALs**), or the last date of the inspection period (for **IRs**).
Type	The categorization of the item or finding - see the Type / Findings Type Code table, below.
Source	The document that describes the findings: **LER** for Licensee Event Reports, **EAL** for Enforcement Action Letters, or **IR** for NRC Inspection Reports.
ID	Identification of who discovered issue: **N** for NRC; **L** for Licensee; or **S** for Self Identifying (events).
SFA	SALP Functional Area Codes: **OPS** for Operations; **MAINT** for Maintenance; **ENG** for Engineering; and **PS** for Plant Support.
Code	Template Code - see table below.
Item Description	Details of NRC findings on LERs that have safety significance (as stated in IRs), findings described in IR Executive Summaries, and amplifying information contained in EALs.

TYPE / FINDINGS CODES

ED	Enforcement Discretion - No Civil Penalty
Strength	Overall Strong Licensee Performance
Weakness	Overall Weak Licensee Performance
EEI *	Escalated Enforcement Item - Waiting Final NRC Action
VIO	Violation Level I, II, III, or IV
NCV	Non-Cited Violation
DEV	Deviation from Licensee Commitment to NRC
Positive	Individual Good Inspection Finding
Negative	Individual Poor Inspection Finding
LER	Licensee Event Report to the NRC
URI **	Unresolved Item from Inspection Report
Licensing	Licensing Issue from NRR
MISC	Miscellaneous - Emergency Preparedness Finding (EP), Declared Emergency, Nonconformance Issue, etc. The type of all MISC findings are to be put in the Item Description column.

TEMPLATE CODES

1	Operational Performance: **A** - Normal Operations; **B** - Operations During Transients; and **C** - Programs and Processes
2	Material Condition: **A** - Equipment Condition or **B** - Programs and Processes
3	Human Performance: **A** - Work Performance; **B** - Knowledge, Skills, and Abilities / Training; **C** - Work Environment
4	Engineering/Design: **A** - Design; **B** - Engineering Support; **C** - Programs and Processes
5	Problem Identification and Resolution: **A** - Identification; **B** - Analysis; and **C** - Resolution

NOTES:

* EEIs are apparent violations of NRC requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.

** URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.