

Seabrook 1

2Q/2004 Plant Inspection Findings

Initiating Events

Significance: TBD Jun 26, 2004

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Properly Conduct a 10 CFR 50.59 Evaluation for Removal of Turbine Building Scuppers.

The inspectors identified an apparent violation of 10 CFR 50.59 for implementing a change in the facility that resulted in a more than a minimal increase in the likelihood of occurrence of a malfunction of a structure, system, or component important to safety without obtaining NRC approval pursuant to 10 CFR 50.90. In 1997, Seabrook identified that turbine building scuppers had not been installed in the plant as described in the Final Safety Analysis Report and the NRC's Safety Evaluation Report. Seabrook failed to properly evaluate the change to the facility in accordance with 10 CFR 50.59. The licensee also had two additional opportunities to identify this failure in 2000.

The issue affected both the Initiating Events and Mitigating System Cornerstones. The turbine building scuppers were designed to mitigate the consequences of a circulating water failure. The circulating water failure would create a flood in the turbine building, which if not addressed, could impact both offsite power sources and onsite power sources (emergency switchgear rooms). The change (removal of the scuppers) resulted in greater reliance on operator action to mitigate the event and thus increased the risk to more than minimal. The risk remains TBD pending a SERP.

Inspection Report# : [2004003\(pdf\)](#)

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Significance: Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Implement Procedure for RCS Draining to Mid-loop

The inspectors identified a non-cited violation of Technical Specification 6.7.1.a, "Procedures and Programs." Seabrook failed to properly implement the procedure for draining the reactor coolant system to a mid-loop condition. Specifically, operators failed to stop draining when the deviation between level instruments did not meet procedural limits. This finding, which involved operators failure to implement a procedure, was associated with the cross cutting area of human performance.

This finding is greater than minor because it affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown. The procedural limit was established to ensure operators had accurate level indication to prevent challenging residual heat removal pump performance which could upset plant stability. The finding is of very low safety significance since no actual impact on pumps occurred.

Inspection Report# : [2003006\(pdf\)](#)

Mitigating Systems

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Significance: Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Turbine Vibration Abnormal Operating Procedure

The inspectors identified a non-cited violation of Technical Specification 6.7.1.a, "Procedures and Programs." Seabrook failed to properly implement the abnormal operating procedure during high turbine vibrations. The high turbine vibrations occurred following replacement of the "C" low pressure turbine during the ninth refueling outage. This finding, which involved operators failure to implement a procedure, was associated with the cross cutting area of human performance.

This finding is greater than minor because it affected the Mitigating Systems cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. The operators failure to properly implement abnormal operating procedures could impact the plant's ability to respond to an initiating event. The finding is of very low safety significance since failure to implement the procedure did not result in a loss of the safety function of a train or system.

Inspection Report# : [2003006\(pdf\)](#)

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Significance: Jul 09, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish a Test Program to Demonstrate Satisfactory Performance of the Enclosure Air Handling to Cool Safety-Related

Equipment

The inspector identified a non-cited violation of 10 CFR 50, Appendix "B," Criteria XI, "Test Control." The licensee failed to develop a test program for routine performance monitoring of the enclosure air handling (EAH) system, which is designed to maintain the area temperatures of engineered safety function equipment within design limits during normal and accident conditions. Such testing is required since the EAH system cools the charging pumps, safety injection pumps, the residual heat removal pumps and heat exchangers, and the containment spray pumps and heat exchangers.

The finding is more than minor because it affected the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding was of very low safety significance because the EAH-supported equipment remained operable and there was no loss of safety function.

Inspection Report# : [2003003\(pdf\)](#)

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Significance: Jul 09, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate the Cause of the Failure of Diodes associated with Safety-Related 4kV Breakers

The inspectors identified a non-cited violation of 10 CFR 50, Appendix "B", Criterion XVI, "Corrective Action." Seabrook did not perform a cause analyses for two failures of diodes associated with 4kV safety-related breakers and in one case did not take corrective actions to prevent recurrence.

The finding is more than minor because it affected the Mitigating Systems cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. The reliability of 4kV breakers was reduced based on the multiple failures that occurred and the potential for additional failures. The inspectors determined that the finding was of very low safety significance since the failures in 2002 and 2003 would not have resulted in loss of function for the mitigating system or train.

Inspection Report# : [2003003\(pdf\)](#)

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Significance: Jul 09, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Test the Emergency Diesel Generator in Accordance with Technical Specifications for a Potential Common Cause Issue

The inspectors identified a non-cited violation of technical specification 3.8.1.1, for failure to properly test the redundant "B" emergency diesel generator (EDG) for a potential common cause issue on the "A" EDG. On June 10, Seabrook had identified a defective condition on one exhaust valve assembly of the "A" EDG, which could have affected operability and/or ability to perform its intended safety function. Although not characterized as a corrective action violation, this was the 2nd violation for TS required testing of the redundant EDG for common cause potential.

The finding is considered more than minor because if the condition had existed on the remaining EDG and was left uncorrected, it could have degraded and impacted the operability and availability of the remaining EDG. The finding was determined to be of very low safety significance because: 1) a fully loaded operation of the "B" EDG was demonstrated subsequent to this finding on June 19; 2) an extent of condition evaluation was accomplished by Seabrook; and 3) two operability determinations were performed that found the "B" EDG to be operable.

Inspection Report# : [2003003\(pdf\)](#)

Barrier Integrity**Emergency Preparedness****G**

Significance: Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Declaration of an Unusual Event caused by a Flammable Concentration of Hydrogen in the Turbine Building

The inspectors identified a non-cited violation of 10 CFR 50.54(q) and 50.47(b)(4). Seabrook failed to make a prompt declaration of a Notification of Unusual Event in accordance with the Seabrook Station Radiological Emergency Plan following a main generator hydrogen gas leak. This finding, which involved operators failure to implement a procedure, was associated with the cross cutting area of human performance.

The finding was determined to be greater than minor because it affected the Emergency Preparedness Cornerstone objective of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The finding was determined to be of very low safety significance because Seabrook failed to properly comply with NRC requirements while in the lowest level of the event classifications.

Inspection Report# : [2003006\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : September 08, 2004