

# Seabrook 1

## 3Q/2004 Plant Inspection Findings

---

### Initiating Events

**Significance:**  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to take prompt corrective actions for a trip circuit relay**

Green. The inspectors identified a non-cited violation of 10 CFR 50, Appendix B Criterion XVI "Corrective Action." Seabrook failed to promptly identify and correct a deficiency of a safety-related trip circuit relay. This failed safety-related trip circuit relay was identified to be degraded approximately 15 months before corrective actions were taken. This finding, which involved Seabrook's failure to promptly identify and correct a deficiency, was associated with the cross-cutting area of PI&R.

This finding is more than minor because it affected the Mitigating Events cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. Seabrook's failure to promptly identify and correct a deficiency of a safety-related trip circuit relay for DC Bus 11C could impact the plant's ability to respond to an initiating event. The finding is of very low significance since the delayed time response of the trip circuit relay did not result in an actual loss of the safety function of a train or system. Inspection Report# : [2004004\(pdf\)](#)

**Significance:**  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to properly implement dig safe procedure**

Green. The inspectors identified a non-cited violation of Technical Specification (TS) 6.7.1.a, "Procedures and Programs." Seabrook failed to properly implement their "Dig Safe" procedure which resulted in three incidents where underground utilities were damaged during site excavations. This finding, which involved Seabrook's failure to properly implement a procedure on multiple occasions, was associated with the cross-cutting areas of human performance and problem identification and resolution (PI&R).

The finding was more than minor because if left uncorrected the potential exists that an underground utility could be damaged and result in an initiating event. The finding is of very low safety significance since the damaged utilities did not actually impact plant operations. Inspection Report# : [2004004\(pdf\)](#)

**Significance:**  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to prevent repetitive failures of the pressurizer level recorder**

Green. The inspectors identified a non-cited violation of 10 CFR 50, Appendix B Criterion XVI "Corrective Action." Seabrook failed to take adequate corrective actions following pressurizer level recorder failures on June 7, and July 27, to preclude a repeat failure on September 20, 2004. The pressurizer level recorder was determined to have failed more than 10 times since 2002. This finding, which involved Seabrook's failure to take adequate corrective actions, was associated with the cross-cutting area of PI&R.

This finding is more than minor because it affected the Mitigating Events cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. To ensure the reliability of systems, operators must take the preplanned manual actions that are required for safety systems to accomplish their safety function. The pressurizer level recorder is an instrument that is used by control room operators to take the preplanned manual actions. The finding is of very low significance since additional instrumentation was available to allow operators to take the appropriate preplanned manual actions. Inspection Report# : [2004004\(pdf\)](#)

**Significance:**  Jun 28, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Non-Timely Corrective Actions for Degraded Instrument Tubing Adapter to Transmitter Connecting Bolts**

Green. The inspector identified a Green, non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action" for failure to implement prompt corrective actions for a condition adverse to quality involving the torque of instrument tubing adapter to transmitter connection bolts.

This finding is more than minor because the licensee failed to promptly evaluate (or correct) an adverse condition that had the potential to result in a RCS leak. The significance of this problem was evaluated using the "Significance Determination of Reactor Inspection Findings for At Power Situations" (SDP) Phase I worksheet and determined to be of very low significance (Green) since a loss of the instrument bolt integrity would not result in a primary or secondary system loss of coolant accident (LOCA), contribute to the likelihood of a reactor trip combined with the loss of a mitigating equipment function and did not increase the likelihood of a fire or flood.

Inspection Report# : [2004006\(pdf\)](#)

**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

**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\(pdf\)](#)

---

## Barrier Integrity

## Emergency Preparedness

**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 : December 29, 2004