

Seabrook 1

4Q/2004 Plant Inspection Findings

Initiating Events

Significance: N/A Dec 17, 2004

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The team determined that Seabrook was generally effective at identifying problems and placing them in the corrective action program. Once entered into the system, these items were screened and prioritized in a timely manner using established criteria, and they were properly evaluated commensurate with their safety significance. Overall, the evaluations reasonably identified the causes of the problem, assessed the extent of condition, and developed appropriate corrective actions. However, the team did identify some minor instances where problem evaluation could have been strengthened. Corrective actions were typically implemented in a timely manner, but the team found that in some cases, corrective actions were not effectively used to resolve and prevent recurrent problems. The inspectors found that Seabrook's self-assessments and audits were self-critical and consistent with the team's observations.

Inspection Report# : [2004008\(pdf\)](#)

G

Significance: Dec 17, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Effective Corrective Action for Underground Utility and Equipment Damage During Excavation

The team identified a non-cited violation of 10CFR 50, Appendix B, Criterion XVI, "Corrective Action," because Seabrook failed to take adequate corrective actions to prevent damage to underground utilities and equipment during site excavations. Following a series of issues where contract personnel hit buried cables and pipes while excavating, Seabrook failed to take effective corrective actions and later hit a safety-related control building ventilation line. This finding was associated with the cross-cutting area of problem identification and resolution.

This finding was more than minor because it affected the Initiating Events Cornerstone objective of limiting events that upset plant stability and challenge critical safety functions. Specifically, an underground utility or buried equipment could be damaged and result in an initiating event. The finding was determined to be of very low safety significance since it did not contribute to both an increased likelihood of a reactor trip and an increased likelihood that mitigating equipment would be unavailable.

Inspection Report# : [2004008\(pdf\)](#)

G

Significance: Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Implement Dig Safe Procedure

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\(pdf\)](#)

G

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

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\(pdf\)](#)

Mitigating Systems

Significance:  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Prompt Corrective Actions for a Trip Circuit Relay

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 Prevent Repetitive Failures of the Pressurizer Level Recorder

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\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Last modified : March 09, 2005