

Seabrook 1

4Q/2008 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Tagging Procedure Caused Inadvertant Drain of 200 Gallons From RCS

A self-revealing non-cited violation of Technical Specification 6.7.1.a was identified for the failure to implement written procedures governing safety-related activities. Specifically, on April 20, 2008, FPLE failed to implement tagging and configuration control procedures, resulting in the loss of configuration control during shutdown operations when flow was established through a partially disassembled charging system valve. This resulted in a 200 gallon leak of reactor cavity water onto the floor of the Primary Auxiliary Building (PAB). The letdown flow path was established while work was in progress on valve CS-V-299. A clearance boundary was modified with the incorrect assumption that CS-V-299 was intact.

This finding was more than minor because it was associated with the configuration control attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of plant events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the loss of configuration control in the charging system unintentionally drained 200 gallons from the reactor cavity, which affected the shutdown critical safety function of maintaining adequate reactor inventory, and caused an uncontrolled leak of radioactively contaminated water to a work area. The finding was determined to be of very low safety significance (Green) using the SDP Appendix G assessment, since the finding did not result in a loss of control of shutdown operations and adequate mitigation capabilities remained available.

The finding has a cross-cutting aspect in the area of human performance, work control, since FPL Energy did not plan and coordinate work activities consistent with nuclear safety (H.3(b)). Specifically, FPLE revised a clearance tagging boundary without verifying the status of affected work activities in accordance with site procedures.

Inspection Report# : [2008003](#) (*pdf*)

Significance:  Jun 30, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Corrective Actions to Prevent Recurrence of Mispositioned Stow-Operated Valves Caused Inadvertant Drain of 2000 Gallons From RCS

A self-revealing non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," was identified because FPLE did not implement corrective actions to prevent recurrence of mispositioned valves caused by difficult to operate stow-operator reach rods. Specifically, on April 20, 2008, a mispositioned (partially open), stow-operated filter drain valve, CS-V-1190, resulted in the inadvertent draining of 2000 gallons of water from the reactor cavity while operators placed the reactor letdown system into service. The drain valve was partially open because it was difficult to operate when positioned with its stow-operator. The mispositioning of a stow-operated valve in a safety system was a repeat occurrence of a similar event in October 2007.

This finding was more than minor because it was associated with the configuration control attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of plant events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the loss of configuration control in the charging system unintentionally drained 2000 gallons from the reactor cavity, which affected the shutdown critical safety function of maintaining adequate reactor inventory. The finding was determined to be of very low safety significance (Green) using the SDP Phase 1 assessment, since the finding did not

result in a loss of control of shutdown operations and adequate mitigation capabilities remained available.

The finding has a cross-cutting aspect in the area of problem identification and resolution because FPL Energy did not take appropriate corrective actions to address safety issues in a timely manner commensurate with their safety significance and complexity (P.1.d). Specifically FPL Energy did not take adequate corrective actions to assure the correct positioning of stow-operated safety system valves and thereby prevent recurrence of a significant condition adverse to quality.

Inspection Report# : [2008003](#) (*pdf*)

Mitigating Systems

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Control a High Radiation Area as a Locked High Radiation Area.

A self-revealing non cited violation of Technical Specification 6.11.2 was identified. Specifically, on May 1, 2008, FPLE failed to identify and control an existing high radiation area with dose rates greater than 1000 millirems per hour in the reactor containment building. A worker was exposed to higher than expected radiation levels of approximately 2,270 mrems per hour. The worker received a dose of 4 millirem.

The finding is more than minor because it is associated with the occupational radiation safety cornerstone attribute of exposure control and affected the cornerstone objective, because not controlling the locked high radiation areas could increase personal exposure. The finding was determined to be of very low safety significance (Green) using the SDP assessment because it did not involve ALARA planning and controls, an overexposure, a substantial potential for overexposure, or an impaired ability to assess dose.

The finding had a cross-cutting aspect in the area of human performance, work control, because FPLE did not adequately assess changing area dose rates caused by operating activities, and thus did not adequately plan a work task with due consideration of the actual radiological conditions at the job site (H.3(a)).

Inspection Report# : [2008003](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Dec 05, 2008

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The inspectors concluded that FPLE was effective in identifying, evaluating, and resolving problems. Seabrook personnel generally identified problems and entered them into the Corrective Action Program (CAP) at a low threshold, and had taken actions to address previous NRC findings. The inspectors determined that FPLE appropriately screened issues for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Causal analyses appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors determined that corrective actions addressed the identified causes and were typically implemented in a timely manner. However, the inspectors noted several examples of minor material condition issues that had not been identified by FPLE. Corrective actions were initiated for all issues identified by the NRC inspectors.

FPLE's audits and self-assessments were generally thorough and probing. The inspectors concluded that FPLE adequately identified, reviewed, and applied relevant industry operating experience. Based on interviews, observations of plant activities, and reviews of the CAP and the Employees Concerns Program (ECP), the inspectors determined that site personnel were willing to raise safety issues and to document them in the CAP.

Inspection Report# : [2008009](#) (*pdf*)

Significance: N/A Oct 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Conduct an Adequate Dry Run

The NRC identified a violation of Condition 8.b of the CoC for not performing a fully effective pre-operational demonstration of the welding of the inner top cover of the dry shielded canister (DSC). Specifically, the equipment configuration during the initial processing of spent fuel included a shield bell that was not installed during the pre-operational demonstration. In addition, significant differences in the personnel used to complete the welding activities were observed between the pre-operational demonstration and the initial spent fuel processing activities. This led to a delay in completing the processing of the initial DSC. The finding was determined to be a Severity Level IV violation consistent with Supplement I.D.3 of the NRC's Enforcement Policy. However, the finding was dispositioned as a Non-cited Violation (NCV), consistent with Section VI.A.1 of the NRC's Enforcement Policy.

Inspection Report# : [2008006](#) (*pdf*)

Last modified : April 07, 2009