November 14, 2002

Mr. Mark E. Warner
Site Vice President
c/o James M. Peschel
Seabrook Station
P.O. Box 300
Seabrook, NH 03874

SUBJECT: SEABROOK STATION - NRC PROBLEM IDENTIFICATION & RESOLUTION INSPECTION REPORT NO. 50-443/02-011

Dear Mr. Warner:

On October 4, 2002, the NRC completed the biennial problem identification and resolution team inspection at your Seabrook Station. The enclosed report documents the inspection findings which were discussed at an exit meeting on October 4, 2002, with Mr. G. St. Pierre and other members of the Seabrook Station staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations, and the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, the corrective action program at Seabrook was adequate. Overall your staff identified problems at an appropriate threshold, conducted proper evaluations, and implemented appropriate corrective actions.

One Green finding was identified during the inspection regarding inadequate calculations used to determine the acceptability of voids in the suction piping to safety-related pumps. This Green finding was determined to be a violation of NRC requirements. However, because of its very low safety significance and because it is being addressed within your corrective action process, the NRC is treating this as a non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violations, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN.: Document Control Desk, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Seabrook facility.

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Sincerely,

/RA/

David C. Lew, Chief
Performance Evaluation Branch
Division of Reactor Safety

Docket No. 50-443
License No. NPF-86

Enclosure: NRC Inspection Report 50-443/02-011

cc w/encl:
J. A. Stall, FPL Senior Vice President, Nuclear & CNO
J. M. Peschel, Manager - Regulatory Programs
G. F. St. Pierre, Station Director - Seabrook Station
R. S. Kundalkar, FPL Vice President - Nuclear Engineering
D. G. Roy, Nuclear Training Manager - Seabrook Station
D. Bliss, Director, New Hampshire Office of Emergency Management
D. 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
S. McGrail, Director, Massachusetts Emergency Management Agency
R. Hallisey, Director, Dept. of Public Health, Commonwealth of Massachusetts
M. Metcalf, 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, Massachusetts Municipal Wholesale Electric company
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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No:	50-443
License No:	NPF-86
Report No:	50-443/02-011
Licensee:	FPL Energy Seabrook
Facility:	Seabrook Station
Location:	P.O. Box 300 Seabrook, NH 03874
Dates:	September 16 - October 4, 2002
Inspectors:	W. Schmidt, Sr. Reactor Inspector, DRS M. Gray, Sr. Reactor Inspector, DRS D. Schroeder, Reactor Inspector, DRS C. Jones, contractor
Approved By:	David C. Lew, Chief Performance Evaluation Branch Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000443/02-011; 9/16-10/4/02; Seabrook Station; biennial inspection of the identification and resolution of problems.

The inspection was conducted by two regional inspectors and one contractor. The team identified one Green finding of very low safety significance during the inspection and classified it as a non-cited violation. The significance of most findings is indicated by their color (green, white, yellow, red) using Inspection Manual Chapter 0609, "Significance Determination Process (SDP)." Findings for which the SDP does not apply may be "green" or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

Overall, the team concluded that the licensee identified problems at an appropriate threshold, conducted proper evaluations, and implemented appropriate corrective actions within the corrective action program (CAP). The daily condition review team meeting provided good coordination and review of issues entered into the system. Operability determinations and extent of condition reviews were appropriate. CAP performance indicators, audits, self-assessments, and cause code trending provided good information on program performance, areas for improvement, and potential trends. Corrective actions were effective and properly documented including resource intensive projects such as modifications.

Cornerstone: Mitigating Systems

Green. A non-cited violation of 10 CFR Appendix B, Criterion III, "Design Control," for failure to identify calculation errors regarding air void acceptance criteria for emergency core cooling piping.

The calculation errors resulted in an incorrect conclusion that air voids in charging and safety injection pump suction piping high points would not likely be entrained in system flow. This issue was more than minor because the incorrect conclusion could reasonably be viewed as a precursor to a more significant event affecting the mitigating systems cornerstone. Specifically, the void limits were based on engineering judgement rather than a technical assessment of charging and safety injection pump performance with void entrainment in the system flow. However, the issue was determined to have very low safety significance in accordance with Phase I of the SDP. The availability of the pumps was never affected because the procedural acceptance criteria limited the detectable air void volumes to a point that performance would not have been degraded. (Section 4OA2.b).

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

a. Effectiveness of Problem Identification

(1) Inspection Scope

The team reviewed the Seabrook corrective action program (CAP); items entered into this process are referred to as condition reports (CRs). The team reviewed CRs and other documents, identified in Attachment 1, to determine the licensee's threshold for identifying problems and entering them into the CAP.

The team reviewed items from the licensee's operating, maintenance, quality assurance (QA) audit, and departmental self-assessment processes to determine if personnel initiated CRs after identifying problems. The team also reviewed a sample of work requests (WR), system health reports, surveillance test (ST) results, and operating experience information.

The team attended the licensee's daily condition review team (CRT) meeting to assess the type of issues identified during the inspection. The team also conducted a plant walk-down of safety-related, risk significant areas to verify that observable system equipment and plant material adverse conditions were entered into the CAP. Additionally, the team interviewed plant personnel to discuss technical issues and the use of the CAP.

(2) Findings

Overall the team concluded the licensee identified problems at an appropriate threshold and entering them into the CAP for resolution. The identification of repetitive trends appeared proper. Reviews of equipment condition during plant tours did not identify any adverse conditions that were not previously identified. People interviewed appeared to understand the expectations for initiating CRs. Licensee audits and self-assessments were comprehensive and were effective. Also, the team did not identify any conditions adverse to quality being handled outside the CAP.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The CR process required that each issue be assigned a significance level; level A, the most significant, receive a root cause determination; level B receive an apparent cause determination; and level C, the least significant, require only correcting the condition, without a specific causal analysis. The program considers level A, B, and C CRs to be conditions adverse to quality relative to 10 CFR 50, Appendix B, Criterion XVI. The program has a fourth significance level, level D, which is used to document conditions that are not adverse to quality.

The team screened CRs issued since the previous problem identification and resolution inspection and selected those listed in Attachment 1 of this report for detailed review to determine whether the issues were properly evaluated and resolved. The sampled CRs

included issues in risk significant systems including: auxiliary feed water (AFW), service water (SW), instrument air, alternating current (AC) and direct current (DC) electrical systems, and several issues related to non-cited violations (NCVs) and Licensee Event Reports (LERs). For the selected CRs, the team reviewed the licensee reportability and operability determination (OD); the assignment of significance and priority; and the technical adequacy, scope, and depth of the root or apparent cause evaluation.

In addition to reviewing more than 200 selected CRs, the team attended several of the daily CRT meetings and interviewed engineers and managers responsible for assigning significance levels, prioritizing, and conducting evaluations. The team also attended a joint corrective action review board (CARB) and management review team (MRT) meeting where the root cause assessment for a level A CR concerning a security guard performance issue was discussed.

(2) Findings

The team found that issues were properly prioritized and evaluated. The CRT provided good coordination and review of the day-to-day input to the CAP. The CRT was cognizant of recurring issues and trends. The MRT and CARB provided appropriate oversight. CAP performance indicator appeared to be providing good information on program performance and areas for improvement. The team noted that the backlog of open corrective actions was reduced over the last year. Cause code trending was in use and appeared effective, along with audits and self-assessments, at identifying areas for improvement. Extent of condition reviews were appropriate. The team reviewed several ODs and did not identify any issues.

The team identified one finding and several minor issues concerning evaluations and prioritizations. The finding, discussed below, concerned an inadequate engineering calculation leading to an incorrect evaluation of potential pipe voiding in safety-related piping. The team discussed several minor issues with licensee management, including: an improper significance level characterization for a repeated loose parts monitor alarm during feedwater isolation valve testing; CRs that were closed to lower level CR actions without clear transfer of action responsibility; and examples where evaluations could have been more complete.

Green. A non-cited violation of 10 CFR Appendix B, Criterion III, “Design Control,” for failure to identify calculation errors regarding air void acceptance criteria for emergency core cooling system (ECCS) piping.

The inspectors reviewed significance level D CR 02-12558, initiated in August 2002, which identified a small air void in an eight inch diameter pipe segment from the outlet of the reactor water storage tank to the “A” charging pump inlet. The void was detected, using ultrasonic testing, during routine technical specification (TS) required ST to ensure that ECCS system piping is full. The CR indicated the void did not present an operability concern since the size was less than the procedural acceptance criteria, and the CR was closed to trending.

The inspectors reviewed the acceptance criteria contained in ST OX1456.02, and the supporting calculation C-S-1-84104, developed and implemented based on industry experience in 1999. The calculation addressed five high points in charging and safety injection pump suction piping that could not be vented. The calculation used the non-dimensional fluid hydraulic Froude number to characterize whether an air void would likely be entrained and

carried to the suction of a safety-related pump. For safety injection and charging pump suction piping, the calculation presented a relatively low Froude number and concluded that a void would not likely be drawn as an air pocket into the downstream pumps. However, based on engineering judgement, the ST limited the voids in these piping high points to 25% of the cross section of the piping.

In reviewing the calculation the inspectors identified errors including use of inappropriate units for pipe diameter and incorrect assumptions for pipe area, based on the reduction of available pipe area due to the void. Both of these errors would increase the calculated Froude numbers and increase the potential that a void would be entrained and pass though a safety-related pump. In response to inspector questions, Seabrook personnel initiated CR 02-14102, re-calculated the Froude numbers, and concluded that air voids in the charging pump and safety injection suction piping high points would likely be swept into the downstream pumps.

The licensee then evaluated the possible volume of an air void that could be present based on the ST acceptance criteria of 25% of the pipe cross section, determining that pump performance would not have been degraded. Seabrook personnel indicated they planned to revise the calculation to indicate air voids would likely be swept along with system flow. Additionally, they planned to revise ST OX1456.02 to provide void acceptance criteria in terms of pipe volume.

The inspectors reviewed published pump voiding limits and similar analyses and tests performed by other licensees, and concluded the procedural void limits had been sufficient to reasonably ensure pump performance would not be degraded by air voids. The issue, however, was more than minor since the calculation errors resulted in an incorrect conclusion that air voids in charging and safety injection pump suction piping high points would not likely be entrained in system flow. This incorrect conclusion could reasonably be viewed as a precursor to a more significant event since the void limits were based on engineering judgement rather than a technical assessment of charging and safety injection pump performance with void entrainment in the system flow. The issue affected the mitigating systems cornerstone because the charging and safety injection pumps provide high and intermediate pressure injection flow for core cooling during postulated accident conditions. The issue was determined to have very low safety significance using Phase I of the NRC significance determination process described in NRC IMC 0609, Appendix A, because, notwithstanding the calculation errors, the procedural acceptance criteria adequately limited detectable air pocket volumes to ensure that pump performance would not be degraded. Therefore the charging and safety injection systems remained operable and the issue does not represent an actual loss of system function.

10 CFR Appendix B, Criterion III, “Design Control,” requires, in part, that design control measures shall provide for verifying or checking the adequacy of design, including hydraulic analyses. Contrary to this requirement, in December 1999, design control measures did not ensure the adequacy of Calculation C-S-1-84104, Revision 0, calculation errors led to incorrect conclusions regarding the likelihood of air void entrainment in charging system pipe flow. However, because of the very low safety significance of this issue and because it was entered into the CAP as CR 02-14102, the issue is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy. **(NCV 50-443/02-11-01)**

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The team reviewed the corrective actions associated with selected CRs to determine whether the identified causes were appropriately addressed and completed or scheduled to be completed in a timely fashion. The team reviewed CRs for repetitive problems to determine the effectiveness of previous corrective actions. In addition the team reviewed the Equipment Reliability Budget Committee (EBRC), which is responsible for prioritizing and dispositioning long-term corrective actions, such as plant modifications. This included reviewing evaluation and prioritization listing and a sample of project summary description and interviewing the EBRC chairman.

(2) Findings

The team found that corrective actions were effective and properly documented within the CR system. The effectiveness reviews and audits selected were appropriate, including several where the reviewers identified and took actions to correct inadequate corrective actions. The inspection team determined that the corrective actions for resource intensive projects such as modifications were adequate and timely.

d. Assessment of Safety Conscious Work Environment

(1) Inspection Scope

During the inspection, the team interviewed plant staff to determine if conditions existed at the site which would result in personnel being hesitant to raise safety concerns to Seabrook management and/or the NRC.

(2) Findings

No findings of significance were identified.

e. Selected Issue Follow-up

(1) Inspection Scope

A team member conducted a detailed review of Limitorque valve actuator issues in accordance with the guidance provided for sample inspections in IP 71152. The inspector reviewed licensee corrective actions for two Limitorque MOV failures. In one instance, SW-V-74 failed to close, and SW-V-76 failed to open, both used SMB-0 actuators. CR 02-08565 identified concerns that actuator spring packs were incorrectly assembled during valve actuators modifications. The associated Apparent Cause Evaluation identified that incorrect assembly allowed the bearing cartridge cap to unthread from the bearing cartridge stem. Misalignment of these components caused premature actuation of the torque switch and prevented further movement of the valve. The unthreading of the cartridge cap was apparently caused by not properly using Loctite on the threads during reassembly following modification DCR 97-021.

The apparent cause determination was reviewed to ensure that the full extent of the issues was identified, that appropriate evaluations were performed, and that appropriate corrective actions were specified and prioritized. The inspector also reviewed selected work orders (WOs), and procedure changes and performed a system walk down to ensure that proper corrective maintenance had been completed. CRs for other Limitorque actuators were reviewed to identify additional valve actuator problems. The training facility was toured and appropriate people were interviewed for additional insight into the problem.

The inspector reviewed the extent of condition analysis performed by the licensee, after detection of the potential common mode failure in the two SMB-O actuators. Maintenance and Plant Engineers developed a list of valves that could experience a similar failure. Valve sizes other than SMB-0 do not use Loctite for spring pack assembly. The licensee inspected all size SMB-0 MOVs in the service water (SW) system, finding no similar problems. The inspector reviewed actions taken to prevent reoccurrence. Maintenance Procedure LS 0569.02 was changed to identify the application of Loctite as a critical step, and to add a place-keeping box to this step. The licensee also improved the Loctite used on these components.

(2) Findings

No findings of significance were identified.

The inspector found that the apparent cause evaluation, the extent of condition review, and the corrective actions following two service water valve failures were appropriate. The inspector found that there have been no additional failures of SMB-0 valve actuators and no other CR's with assembly related problems that affected MOV operability.

4OA6 Meetings, Including Exit

a. Exit Meeting Summary

On October 4, 2002, the team presented the inspection results to Mr. G. St. Pierre and other members of Seabrook management at the conclusion of the inspection. The licensee acknowledged the issues and finding presented.

The inspectors asked the licensee whether any material examined during this inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT 1 - SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

North Atlantic Energy Service Company

G. St. Pierre, Station Director
J. Peschel, Regulatory Programs Manager
V. Pascucci, assistant Oversight Manager
R. LeGrand, Work Control and Outage Manager
M. Lewis, Modifications and projects Manager
R. Hickok, NRC Coordinator
M. Carmichael, Performance Improvement Manager
C. Berry, Corrective Action and Human Performance Program Manager
R. Badge, Modifications Supervisor
B. Brown, Engineering Supervisor
R. Distefano, Maintenance Supervisor
J. Hill, Operations Engineering
E. Lent, Corrective Action/Lead CR Coordinator
E. Metcalf, Assistant Pant Engineering Manager
R. Parry, Engineering Supervisor
R. White, Nuclear Design Engineering Manager and Chairman ERBC

Nuclear Regulatory Commission

G. Dentel, Senior Resident inspector
J. Brand, Resident Inspector

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000443/2002-11-01	NCV	Failure to perform an adequate calculation of ECCS pump suction piping void migration, because of mathematical and assumption errors.

LIST OF ACRONYMS USED

CAP	corrective action program
CARB	corrective action review board
CR	condition report
CRT	condition review team
EBRC	Equipment Reliability Budget Committee
ECCS	emergency core cooling system
EDG	Emergency Diesel Generator
MRT	management review team
NAESCo	North Atlantic Energy Service Company
NCV	non-cited violation
NRC	Nuclear Regulatory Commission
OD	operability determination
QA	Quality Assurance
SDP	Significance Determination Process
ST	surveillance test
SW	service water
TS	technical specifications

LIST OF DOCUMENTS REVIEWED

ADMINISTRATIVE PROCEDURES AND MANUALS

OE 3.1 Initiating a Condition Report
OE 3.5 Condition Report Process and Evaluation
OE 4.3 Root Cause Evaluation
OE 4.5 Operability Determination
OE 4.8 Apparent Cause Evaluation
ES0815.001, Weld Procedure Qualification & Welder/Brazer Performance Qualification Program for Seabrook Station, Rev. 00, Chg. 03
ES0815.002, General Welding Procedure, Rev. 00, Chg. 13
ES0815.029, Weld Traveler Preparation and Completion, Rev.00, Chg. 06
ES1807.030, Nondestructive Examination (NDE) Personnel Certification Program, Rev.01, Chg. 01
MA 10.1, Station Leakage Program, Rev. 00, 8/20/2002
MA 10.2, Online Repairs of Non-Isolable Leaks, Rev. 00, 8/8/2002
MA 4.2, Equipment Tagging and Isolation, Rev. 19, Chg. 04, 8/7/2002
MA 4.5, Configuration Control During Maintenance and Troubleshooting, Rev. 10, Chg, 02, 4/26/2002
MA 5.1, Special Process Control, Rev. 07, Chg. 02
MA 5.2, Welding Material Control, Rev. 11, Chg. 13
MS0517.03, Piping Installation and Maintenance, Rev. 07, Chg. 02
Seabrook Self-Assessment Manual, Revision 00, effective 3/31/2000
SM 7.8, Equipment Reliability Budget Committee, Rev. 04, Chg. 01, effective 8/12/2002
Work Management Manual, Revision 17

Condition Reports

96-31993	01-13369	02-06552	02-09752
99-13530	01-13460	02-06581	02-10024
99-15330	01-13487	02-06608	02-10082
99-17536	01-13598	02-06727	02-10224
00-06672	01-13600	02-06828	02-10262
00-06962	02-00119	02-06872	02-10378
01-00747	02-00134	02-06883	02-10463
01-01023	02-00513	02-06922	02-10486
01-05638	02-00533	02-06973	02-10538
01-06822	02-00669	02-07007	02-10593
01-09888	02-00863	02-07015	02-10598
01-09900	02-00915	02-07028	02-10662
01-10089	02-01069	02-07037	02-10834
01-10090	02-01080	02-07118	02-10859
01-10144	02-01243	02-07181	02-10904
01-10206	02-01387	02-07182	02-10912
01-10235	02-01442	02-07212	02-10921
01-10347	02-01716	02-07356	02-10962
01-10348	02-02219	02-07412	02-11060
01-10463	02-02321	02-07479	02-11097
01-10553	02-02571	02-07549	02-11149
01-10575	02-02680	02-07572	02-11395
01-10770	02-02743	02-07580	02-11438
01-10800	02-03528	02-07597	02-11440
01-10843	02-03655	02-07642	02-11631
01-10901	02-03754	02-07685	02-11792
01-10919	02-04029	02-07699	02-11823
01-11039	02-04117	02-07871	02-11827
01-11109	02-04253	02-08104	02-11865
01-11121	02-04591	02-08106	02-12132
01-11130	02-04605	02-08112	02-12140
01-11134	02-04832	02-08234	02-12220
01-12010	02-05038	02-08488	02-12353
01-12373	02-05134	02-08565	02-12419
01-12697	02-05318	02-08592	02-12558
01-12746	02-05573	02-08788	02-12888
01-12847	02-05740	02-08956	02-12905
01-12888	02-05772	02-09097	02-12923
01-12924	02-05849	02-09258	02-13459
01-12926	02-05902	02-09299	02-13946
01-13034	02-05986	02-09300	02-13975
01-13041	02-06021	02-09365	02-13976
01-13095	02-06147	02-09561	02-14066
01-13183	02-06389	02-09622	02-14102
01-13203	02-06488	02-09723	02-14111
01-13262	02-06507	02-09743	

Work Orders

98W000982	0100409	0202137	0215122
98W000983	013609	0207425	0215123
99W003292	01B9139	0210221	02A3869
WO0216659	01W002962	0214200	
98C7508			

Other

Calculation C-S-1-20812, EFW Mounting Bolt Evaluation, 1/24/2002
DG System Performance Report, March 2002
EBRC Scoping Summary/Funding Request 02-0538,
EBRC Scoping Summary/Funding Request 02DCR013,
EBRC Scoping Summary/Funding Request 02DCR013m
EBRC Scoping Summary/Funding Request 02DCR021,
Equipment Operational Issues List, Plant Engineering (as of 9/18/2002)
Maintenance Leadership Expectations, 9/3/2002
MM-0060, Job Performance Worksheet, Torquing, Training Department, 1/21/1991, Rev. 0
MMOD 99-0628, Limit Switch Actuation Arm Modification, DCN 00, 2/13/2002
Residual Heat Removal (RH) System Performance Report Post OR08, 9/25/2002
Residual Heat Removal (RH) System Performance Report, 3/2002
Seabrook Station Equipment Reliability Review Summary Report, Revision 0, May 16, 2001
Self Assessment 01-0256, Work management Self Assessment
Self Assessment 01-0280, Equipment Reliability, Revision 0
Self Assessment 01-0514, Vendor Document Process Improvement, 12/11/2001
Self Assessment 01-0560, MM Work Package Quality
Self Assessment 01-0566, Mechanical Engineering Design Standards, 6/27/2002
Self Assessment 02-0244, Overall Work Management Process Effectiveness, 6/11/2002
Self Assessment 02-0313, Effectiveness of Generic Letter 89-13 Monitoring, 8/1/2002
Self Assessment 02-0353, CR Disposition and Completion Documentation, 8/20/2002
SMRC Scoping Summary/Funding Request 01-0001
SMRC Scoping Summary/Funding Request 01-0004
SMRC Scoping Summary/Funding Request 01DCR022
Welding program training lesson plans and handouts, some dated 1992
Work Order WO 0207877, Replace 1-DG-E-42B heat exchange tube bundle
Calculation C-S-1-23903, Revision 0
Calculation C-S-1-84104, Revision 0
DCR 02-008
DCR 01-0017
DCR 99-036
Diesel Air handling System Health Reports, 2002
Diesel Generator System Health Reports, 2002
Engineering Evaluation EE-99032, Revision 1
Engineering Evaluation EE-98002, Revision 1
Minor Modification 99-0618
Procedure MS0519.65, Revision 5
Procedure OX1456.02, Revision 6, change 34
Self Assessment 01-0129
Technical Clarification TS-208, Revision 1
Temporary Modification 02TMOD0002-01

Temporary Modification 02TMOD0014-00
Vendor Manual W030-1
Nuclear Oversight Audit 02-A02-01- Corrective Action