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**INDIAN POINT 2 STEAM GENERATOR TUBE INSPECTION FINDINGS  
AND PRELIMINARY SIGNIFICANCE CHARACTERIZATION**

**EDO PRE-BRIEF FOR COMMISSION TECHNICAL ASSISTANT BRIEFING**

**AUGUST 23, 2000**

# **NRC Event Response and Special Inspection Team Findings**

**Wayne Schmidt, Team Leader, Region I**

# **Indian Point 2 - February 15, 2000 - SG Tube Failure August 23, 2000, Briefing**

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- Introduction - Brian Holian, Deputy Division Director, DRS, Region I
  - Special Steam Generator Team Inspection - Wayne Schmidt, Team Leader, DRS, Region I
  - Risk Analysis - Steve Long, Senior Risk Analyst, DSSA, NRR
  - Steam Generator Regulator Issue Summary - Ted Sullivan, Section Chief, DE, NRR
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## Introduction:

- Discussion of the February 15, 2000, event.
  - ▶ MD 8.3 - AIT focused on review of Con Edison's response.
    - Initial Event Risk Assessment
    - Event cause not reviewed by AIT
- SG Special Inspection exited July 20, 2000.
  - Con Edison disagreed with the findings and provided some additional information.
  - ▶ Team's preliminary findings issued July 27, 2000.
  - ▶ Report in final Regional and NRR review (to be issued 8/25 or 8/28).
    - Communication Plan
- Agency Focus Meeting 9/11 and Regulatory Conference 9/26.
- SDP and Safety Evaluation overview.

## Steam Generator Special Inspection:

- Reason for the Inspection
  - Team Composition
  - Inspection Phases
  - General Background (SG specifics and history, technical specifications)
  - Inspection Results
    - Performance Issues and Inspection Findings
  - Con Edison Disagreements with Inspection Findings
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## Team Composition

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Integrated NRC effort. Substantial coordination and cooperation between NRR and Region I in planning, conducting, and assessing findings.

- Inspection Support and Team Leader -Region I
  - Engineering and Part Time Eddy Current Support -NRR
  - Program Review Contractor Support -NRR
  - Finding Characterization - Region I and NRR
  - Significance Determination Process -NRR and Region I
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# Inspection Phases:

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Broken up into several phases:

- Initial NRR engineering and contractor support to gather information and review the beginning of the 2000 outage.
  - Assessment of 1997 Outage Performance
    - ▶ Steam Generator Visual and Eddy Current Inspection
    - ▶ Eddy Current Inspection Program
  - Significance Determination Process - Assessing the potential risk of the findings.
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## **Background:**

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### IP 2 Steam Generators

- Model 44 SGs - no chemical cleaning done.
- 3,260 tubes - 92 in each of the low-rows (rows 1-4)
- Row 1 plugged prior to operation
- Mill-annealed Alloy 600 - 0.875-inch OD 0.05-inch wall thickness
- Six tube support plates provide horizontal stability
  - Each tube support plated has six flow slots flame cut across their diameter (between row 1 tube legs).



## IP2 SG History

- Numerous degradation mechanisms prior to 1997
  - ▶ ODSCC
    - Crevice - between roll transition and the top of the tube sheet
    - Sludge pile
    - Dented areas
  - ▶ PWSCC
    - Tube roll transition
    - Dented tubes
    - None detected in U-bends
- 1997 Results
  - One PWSCC indication in the U-bend R2C67 in SG 24
  - Tube restrictions due to denting at the upper support plate
- February, 15, 2000 - tube failure
  - ▶ PWSCC at the apex of low-row U-bend (R2C5 in SG24).

## Technical Specifications

### ■ Eddy Current Testing

- ▶ 40-percent TW defect plugging limit. (U-bend indications plugged on detection due to sizing problems.)
- ▶ Report significant deformation of flow slots (hour-glassing).
  - Hour-glassing is the deformation of the flow slots, due to corrosion, to the point that the sides are forced towards the middle, making it look like an hour-glass.
  - Hour-glassing is significant because it moves the tube legs together putting stress at the tube apex.
  - Tube denting is a precursor to hour-glassing.

### ■ Primary to Secondary Leakage Monitoring

- ▶ Limited to 0.3 gpm
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# Inspection Results:

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## Initial Phase - 2000 Outage

- Observed use of the mid-range Plus Point probe and reviewed some 1997 data
    - ▶ Mid-range Plus Point U-bend technique not calibrated or setup in accordance with the EPRI qualification.
      - Technique changed to be correct
    - ▶ 2000 eddy current data was very noisy.
      - Con Edison did not have criteria for when the noise could be masking data.
      - Criteria developed - approximately 450 tubes exceeded the criteria. High frequency probe developed and used. Eight tubes with defects found out of the 450.
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## Second Phase - 1997 Outage Performance Issues

### **Steam Generator Inspection Results**

- The team reviewed the eight tubes identified by Con Edison as possibly having defects based on 1997 data.
  - ▶ Based on independent NRC review four defects were missed.
  - ▶ Included the one tube that failed (R2C5 in SG 24).
- Overall the team found that technical direction for the 1997 SG inspection program (eddy current and visual) was deficient in several respects. Con Ed did not address conditions that adversely affected the detection of, and increased the susceptibility, to PWSCC flaws in the low-row, small radius U-bend tubes.

- First instance of U-bend PWSCC defect (R2C67 in SG 24).
    - ▶ Significance not understood.
    - ▶ Apex flaws have been associated with through wall leakage and burst.
    - ▶ Noise was not a significant factor in R2C67 identification.
    - ▶ Noise in other tubes should have been evaluated relative to this tube.
    - ▶ No review for the possibility of hour-glassing.
    - ▶ No entry into the corrective action program.
    - ▶ Tube plugged on detection.
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- First instance of low-row (row 2) tube denting at the upper support plate.
    - ▶ Indicated a significant potential for hour-glassing.
    - ▶ 19 tubes identified, as U-bend restrictions. The team found that these were upper support plate restrictions due to denting. The tubes were plugged in accordance with TS.
    - ▶ No specific examination or criteria for significant hour-glassing.
    - ▶ No corrective action program review.
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## **Program Review Issues**

- Compared to Rev 4 of the EPRI Guidelines, technique qualification, data analysis guidelines, and analyst training reviewed.
  - Con Ed did not ensure that the mid-range Plus Point used in the U-bend area was calibrated and setup in accordance with the EPRI technique -had a marginal effect on the detection of small flaws.
  - Data analysis guidelines did not have any specifics on how to use the mid-range Plus Point in the U-bends.
  - Training documentation was incomplete.
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## **Inspection Findings:**

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- **Potential Red - Inadequate Corrective Actions** taken during 1997 outage inspection. Three significant conditions not identified and evaluated, resulting in four tubes not being removed from service.
  - ▶ First PWSCC U-bend indication not recognized for its significance. Not entered in Corrective Action System.
  - ▶ First upper TSP denting not recognized for its potential for hour-glassing and Con Edison did not have a method of ensuring that significant hour-glassing was not taking place. Not entered into Corrective Action System.
  - ▶ Eddy Current noise not evaluated and not corrected for. Not entered into Corrective Action System.



- **Green - NCV - Mid-range Plus Point probe not properly calibrated and setup for U-bend inspections - based on EPRI guidance.**
    - ▶ Found to not have a significant effect on flaws like those missed during the 1997 outage.
    - ▶ Would affect the ability to identify small flaws, but not those of the size that were missed during the 1997 inspection.
    - ▶ Con Ed corrected the issue during the 2000 exam.
  - **No color - Con Edison's root cause analysis did not address the performance issues identified by the team and was inadequate.**
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## **Con Edison Disagreements with Findings:**

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- The PWSCC indication was expected and no additional assessment was warranted after this discovery.
  - ▶ NRC Response
    - Based on SG Life Prediction PWSCC was a possibility and needed to be inspected for, but it was not clearly expected. The team believes this was a significant unrealized opportunity.
- There were no specific noise criteria relative to the probability of detection of flaws using eddy current examination in the EPRI Guidelines.
  - ▶ NRC Response
    - This is a true statement; however, the issue of noise masking signals is not new to eddy current inspection.
    - Several NRC documents discuss noise NUREG 1477 and IN 94-88.

- The root cause submitted was complete and accurate .
  - ▶ NRC Response
    - The finding stands based on the inspection results.
- The 2000 NRC Team's findings are not in agreement with NRC Team Inspection Report 50-247/97007, dated July 16, 1997.
  - ▶ NRC Response
    - The 1997 inspection was not a team, it was an integrated report with the SG inspection done by one inspector. Con Edison's SG inspection was deemed adequate.
    - It was a sampling process and not to the depth of the team inspection.
    - There was no specific review of the quality of the eddy current data or the analysis of the specific results.

■ All 1997 steam generator inspection requirements were met and the team had not identified any specific requirements, standards or guidelines that were not met.

► NRC Response

- The team identified 10 CFR 50, Appendix B, Criterion XVI Corrective Actions as a requirement that was not met.
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# **NRC Risk Assessment for Significance Characterization of Degraded SG Tubes**

**Steve Long, SPSB/DSSA/NRR**

Risk Assessment for IP2 SG Tube Degradation  
~~Leading to SG Tube Failure on February 14, 2000~~

For the SDP, risk is assessed for the *condition* of the tubes over the time that degradation exceeded allowable levels.

This is *different* from the ASP program analysis of the event that actually occurred.

The condition of the tube made it vulnerable to several potential causes for failure:

- spontaneous failure (with potential flows ranging from tenths to hundreds of gpm)

- steam system depressurization transients

- reactor coolant system over-pressurization transients

- core damage accidents (with steam system dry and depressurized but RCS not fully depressurized)

Each of these sequences would add to the frequency of core damage accidents with containment bypass (treated as LERF).

The risk assessment process considers the frequency of each of these challenges, the probability that the tube would fail given each, and the probability that the challenge with tube failure would lead to core damage.

Of these, the spontaneous rupture dominates the risk estimate at about  $1 \times 10^{-4}$ /RY averaged over the last year.

The steam system depressurization transients and the core damage accidents could add about  $1 \times 10^{-5}$ /RY each if the tubes were susceptible for a whole year, but it is not clear whether they were.

Although the frequency of each of these accident sequences could be subjected to more detailed analysis, it is not expected that the result would be to reduce the total core damage frequency increment to a value below  $1 \times 10^{-5}$ /RY.

Because the numerical threshold between "red" and "yellow" is  $1 \times 10^{-5}$ /RY for core damage accidents that would create large releases, it does not appear that more detailed analysis would change the "color" assessment.

## Spontaneous Rupture

$\Delta\text{LERF Contribution} = [\text{Tube Rupture Frequency}] \times [\text{Probability of Not Preventing Core Damage}]$

### Tube Rupture Frequency:

The condition of the tubes was allowed to deteriorate to the point that a substantial failure occurred before the end of the planned period of operation.

The flaw that failed was long enough to cause a full SGTR flow rate if remaining ligaments had failed.

Experience indicates that about half of the in-service tube failures are gross failures and half are leaks that result in shutdown before gross failure occurs.

So, probability of rupture is about 0.5.

The period of time to be used to make this a "frequency" is not determinate, because the failure occurs as soon as the tube is unable to withstand normal operating conditions. The practice is to average core damage frequency increments over a 1 year period.

So, frequency is estimated as about 0.5/RY.

### Probability of Not Preventing Core Damage:

The net probability can be derived from a PRA by dividing the core damage frequency contribution from tube ruptures by the tube rupture frequency.

Results vary with the PRA used:

The IP2 IPE gives  $7.7 \times 10^{-5}$

The NRC's SPAR model for IP2 gives  $3.3 \times 10^{-4}$

The NUREG-1150 model for Surry gives  $1.4 \times 10^{-4}$

Review of cutsets indicates that the dominant contributions are human errors, which are very uncertain.

Conclusion is that the non-mitigation probability is about  $10^{-4}$

### Contribution to SDP $\Delta\text{CDF}$ and $\Delta\text{LERF}$ :

Products of the above estimates range from  $1.7 \times 10^{-4}/\text{RY}$  to  $3.9 \times 10^{-5}/\text{RY}$

Geometric mean is about  $8 \times 10^{-5}/\text{RY}$

## Tube Ruptures Induced by Steam System Depressurization Events

$\Delta\text{LERF Contribution} = [\text{Frequency of Steam System Depressurization}]$   
 $\times [\text{Conditional Probability of Tube Rupture}]$   
 $\times [\text{Probability of Not Preventing Core Damage}]$

### Frequency of Steam System Depressurization:

This frequency is estimated from experience to be in the mid- $10^{-3}/\text{RY}$  for Westinghouse plants.

Estimates have ranged from  $7 \times 10^{-3}/\text{RY}$  to  $1 \times 10^{-3}/\text{RY}$ .

Assume value is  $5 \times 10^{-3}/\text{RY}$  for IP2

### Conditional Probability of Tube Rupture:

It is clear that the tube at R2C5 in SG 24 would have failed earlier if the  $\Delta P$  increased.

It is not clear for what period of time the tube was susceptible to rupture at the increased  $\Delta P$  that would result from a steam system depressurization event.

Most steam system depressurization events affect only one SG, so divide probability by 4 to account for number of SGs at IP2. (Assumes frequency per plant is independent of the number of SGs in the plant.)

Applying the increased probability to a default period of one year would give a conditional rupture probability of 0.25.

### Probability of Not Preventing Core Damage:

The probability of not preventing core damage for this sequence was estimated in NUREG-1570 at  $10^{-2}$ , based on extensive modeling of the thermal-hydraulic conditions and human error probabilities.

### Contribution to SDP $\Delta\text{CDF}$ and $\Delta\text{LERF}$ :

The product of these factors is about  $1 \times 10^{-5}/\text{RY}$ .



## Increased LERF Due to Tube Ruptures Induced by Core Damage

$\Delta\text{LERF Contribution} = [\text{"Hi/Dry" Part of the Core Damage Frequency}]$   
 $\times [\text{Probability that Tube Rupture Will Be Induced by Physical Phenomena}]$

### "High/Dry" Part of Core Damage Frequency:

Some core damage accident sequences involve increased  $\Delta P$ s across some or all SGs, which can induce rupture of flawed tubes, as discussed in the previous slide.

In addition, studies documented in NUREGs 1150 and 1570 demonstrated that, if the SGs were dry, core damage accidents could increase temperatures in SG tubes to the point that flawed tubes would fail by creep before other parts of the RCS pressure boundary, creating a large early release of radioactive materials for what would otherwise be a "contained" accident.

This part of the CDF is estimated to be between  $1$  and  $2 \times 10^{-5}/\text{RY}$  from other PRAs for Westinghouse plants

### Probability that Tube Rupture Will Be Induced by Physical Phenomena:

Challenges to the tubes during core damage accident conditions can arise from increased pressure differentials across the tubes caused by steam side depressurization, from increased tube temperatures that weaken the Inconel tube material, and from combinations of these effects.

There are a number of core damage sequences that present different levels of challenge to the tubes.

It is clear that, just before the tube failure on February 14<sup>th</sup>, any slight combination of these effects would have induced tube failure.

But it is not clear how long the periods of susceptibility lasted for each of the various challenging sequences.

### Contribution to SDP $\Delta\text{LERF}$ :

It is not possible without further detailed analysis to realistically estimate the contribution from this type of sequence.

If temperature effects alone would have induced tube failure during the last year, then the  $\Delta\text{LERF}$  would be in the range of the "high/dry" frequency, about  $10^{-5}/\text{RY}$ .

If a depressurized SG was necessary to induce the flawed tube to rupture during most of the year, then the  $\Delta\text{LERF}$  would depend on the probability of SG depressurization. (IP2 has some history of SG leakage while "isolated.")

It would be necessary to perform extensive analyses before concluding whether this contribution to  $\Delta\text{LERF}$  is sufficient to make the total  $\Delta\text{LERF}$  for the condition exceed  $1 \times 10^{-5}/\text{RY}$ .

## Staff Knowledge of Licensee's Risk Analysis

The staff has reviewed an analysis by the licensee that calculates a *conditional core damage probability* given the specifics of the event that actually occurred on February 14, 2000.

That analysis used the less-than-maximum potential flow rate to re-estimate the time available for operators to take mitigative actions and the human error probabilities associated with those actions.

This greatly reduced the estimated probability that core damage would occur, because the dominant cutsets in the risk analysis are those containing human errors.

The staff has three criticisms of the licensee's analysis:

Some of the human errors considered would result in the flawed tube experiencing high stress for an extended period or even experiencing higher stresses than actually encountered during the event. The staff does not believe that the flow rate can be assumed not to increase over extended exposures to such conditions, given the size of the flaw and the incomplete state of its failure.

The analysis does not take into account the potential for the flaw to have been initially revealed by a different degree of failure with a different flow rate.

The analysis does not take into account the risk associated with the exposure to other potential events that would have been complicated by induced tube rupture.

# **NRC SE/RIS and Related Initiatives Regarding SG Tube Technical Issues**

**Ted Sullivan, EMCB/DE/NRR**

## **SAFETY EVALUATION PROCESS**

- **IP-2 TECH SPECS REQUIRED NRC APPROVAL TO RESTART**
- **INFORMATION REVIEWED BY NRC STAFF DEALT WITH**
  - **2000 INSPECTION PROCESS**
  - **CONDITION MONITORING ASSESSMENT (WERE TUBE INTEGRITY CRITERIA MET, EXCEPT FOR R2C5)**
  - **OPERATIONAL ASSESSMENT (WOULD TUBE INTEGRITY CRITERIA BE SATISFIED UNTIL THE NEXT INSPECTION)**
- **SINCE CON ED REPLACING SGs, TS CONDITION REQUIRING RESTART APPROVAL NO LONGER APPLIES**
- **SE ESSENTIALLY COMPLETE BUT WILL NOT BE ISSUED**
- **INSTEAD, STAFF WILL DEVELOP RIS DISCUSSING MAJOR FINDINGS FROM THE IP-2 SE AND FINDINGS FROM RECENT ANO-2 EXPERIENCE**

## ISSUES - DRAFT SE

STAFF WAS UNABLE TO CONCLUDE THAT TUBE INTEGRITY CRITERIA COULD BE MET UPON PLANT RESTART AT TIME LICENSEE ELECTED TO PROCEED WITH SG REPLACEMENT.

UNRESOLVED ISSUES RELATING TO LICENSEE'S OPERATIONAL ASSESSMENT, INCLUDING:

- PROBABILITY OF DETECTION (POD) OF U-BEND CRACKS
- CRACK SIZE MEASUREMENT ERROR IN U-BENDS
- CRACK GROWTH RATES

COMMON DENOMINATOR: ASSUMED POD AND SIZING PERFORMANCE NOT VALIDATED BY DESTRUCTIVE EXAMINATION OF CRACKED TUBE SPECIMENS

- PREDICTIVE MODELS
- RELATIVE SUSCEPTIBILITY OF ROW 3 U-BENDS TO CRACKING COMPARED TO ROW 2

## **Planned Agency Actions and Approach for IP2**

**Brian Holian, Director, DRS, Region I**