

NMC

Point Beach Nuclear Plant

Regulatory Conference Concerning Auxiliary
Feedwater Orifice Issue



June 6, 2003



Agenda

Purpose/Objective	Mano Nazar
Overview	Fred Cayia
Root Cause Analyses	Fred Cayia
Significance Determination	Mark Reddemann
Closing Remarks	Mano Nazar



Purpose

- Provide Overview of Auxiliary Feedwater System Orifice Issue
- Discuss Root Cause Evaluation of the AFW Orifice Issue
- Present Methodology and Conclusion of the NMC/Point Beach Significance Determination Process for AFW Orifice Issue



Objective

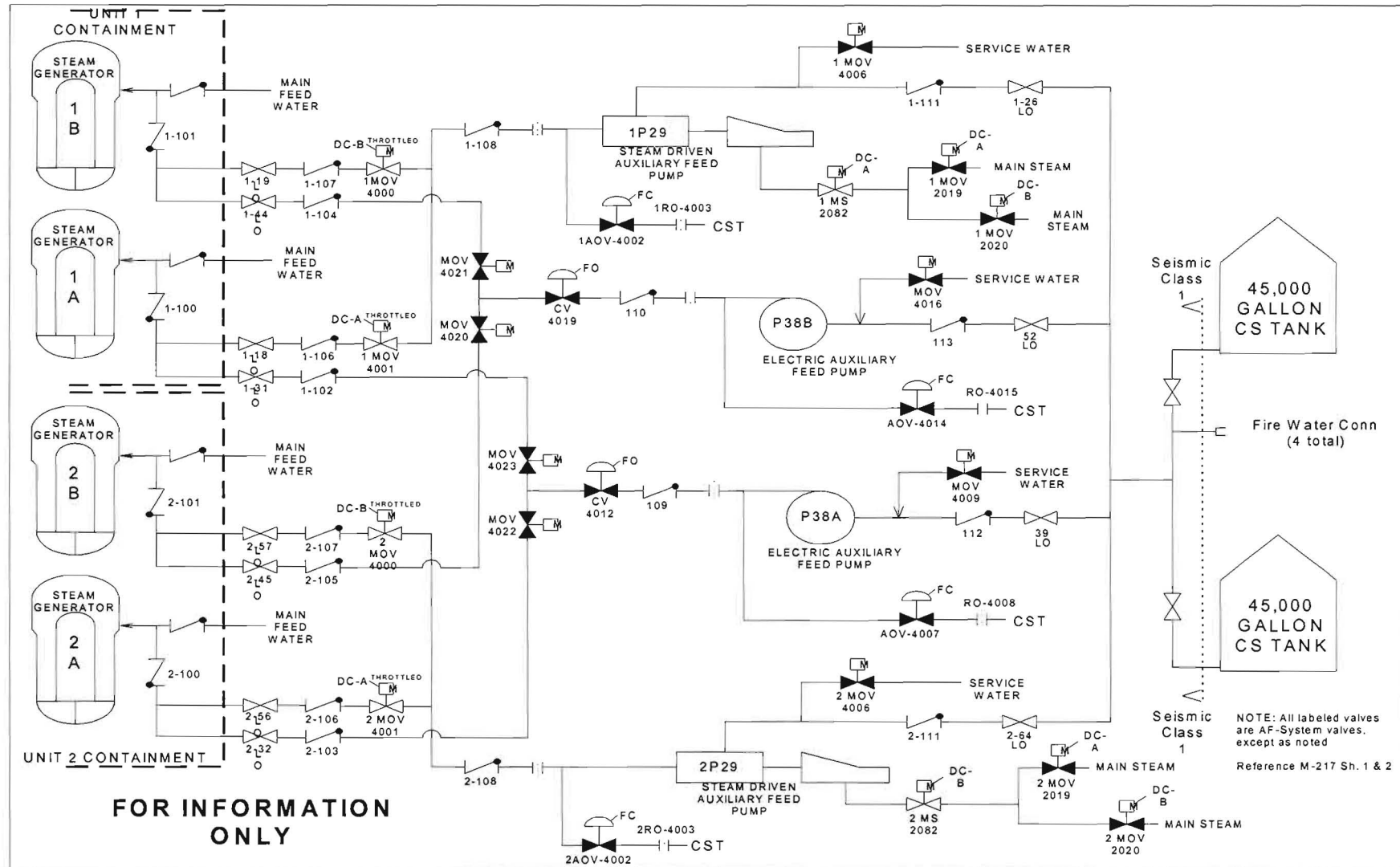
- Present New Information and Considerations Concerning Issue Significance
- Provide NMC's Position on the Characterization of the Apparent Violation of 10 CFR 50, Appendix B, Criterion III "Design Control"



Overview

Overview

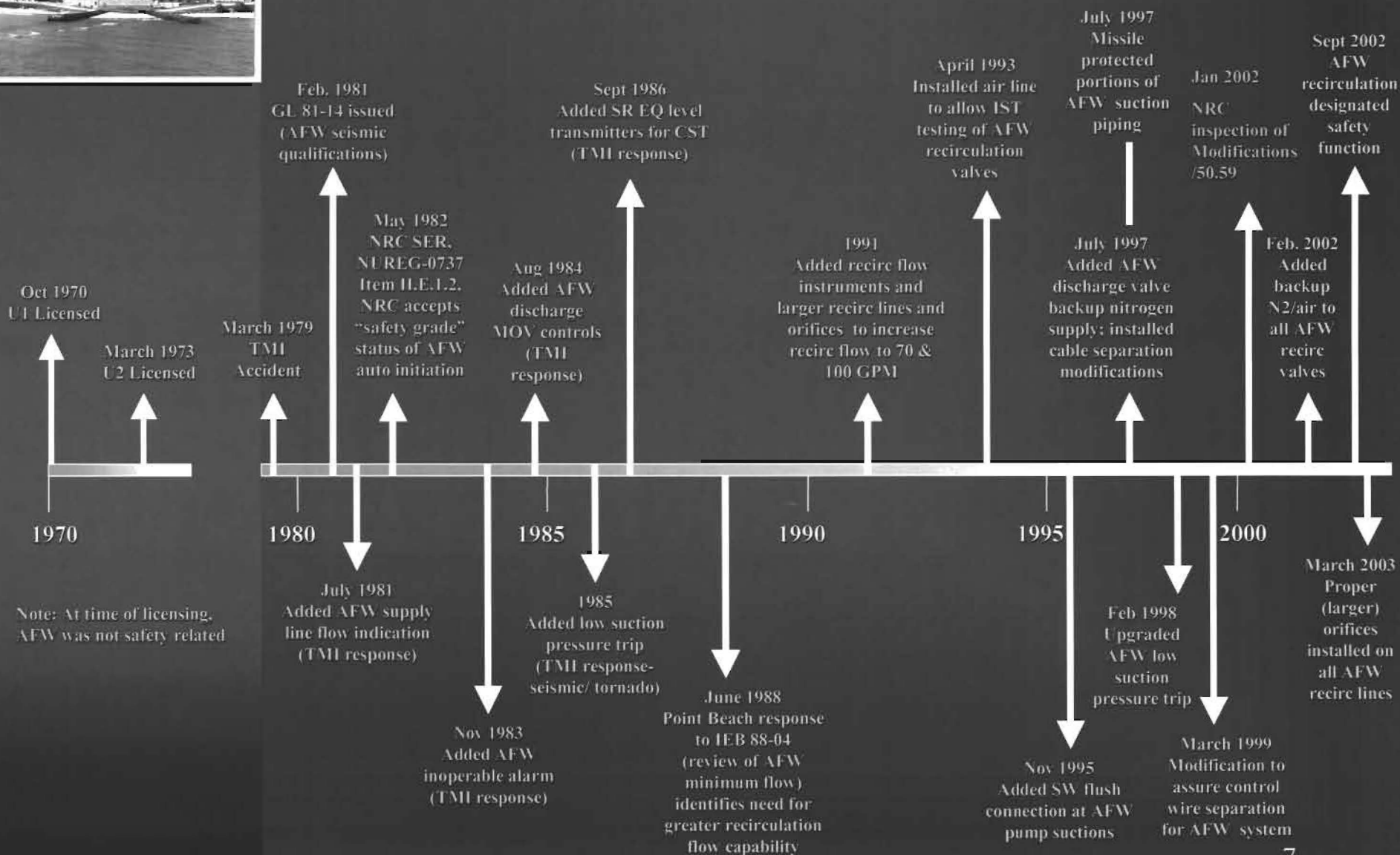
Auxiliary Feedwater System





Overview

Timeline of AFW System Improvements





Overview

Recirculation Line Orifice

Discussion:

- Orifice Modification Developed in 2000 to Reduce Recirculation Line Cavitation
- Recirculation Line Orifices- Modification History

	Unit 1	Unit 2
Motor Driven AFW Pumps (MDAFP) Modification issued	June 2000	June 2000
MDAFP Modification Installed	March 2001	November 2000
Turbine Driven Auxiliary Feedwater Pump (TDAFP) Modification Issued	March 2002	December 2001
TDAFP Modification Installed	October 2002	May 2002



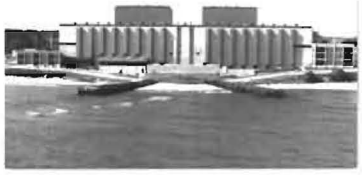
Overview

Recirculation Line Orifice

Description:

Potential for Fouling of Recirculation Line Coincident with Procedurally-Directed Operator Action to Secure AFW Forward Flow.

- Identified by NMC Following System Testing of the Motor Driven AFW Pump
- Orifice Plugging Could Occur When AFW Pumps Were Aligned to Service Water Resulting in Potential Common Mode Failure
- Prompt Corrective Actions
 - All Four AFW Pumps Declared Out-of-Service Due to Potential Recirculation Orifice Common Mode Failure
 - Compensatory Actions Established to Direct Operators to Secure AFW Pumps in the Event Minimum Recirculation Flow Cannot be Maintained



Root Cause Analyses



Root Cause Analyses

AFW Recirculation Orifice

- Root Cause-Orifice Issue (RCE000191)
 - Failure to Properly Evaluate the Potential for Orifice Plugging Within the Design Process
- Contributing Causes
 - Use of Unverified Information and the Omission of Key Design Information in the Safety Evaluation for the Orifice Modification



Root Cause Analyses

AFW Recirculation Orifice

➤ Corrective Actions- Complete

- Increased Engineering Management Involvement in Approval and Oversight of Modifications
- Implemented Periodic Review of Engineering Products by a Quality Review Team
- Presented Lessons Learned to Engineering Personnel Stressing the Use of the Design Process
- Revised Training Materials to Accurately Reflect AFW Recirculation Line Design Functions
- Orifice Redesigned, Tested and Installed on all Four Pumps in March 2003



Root Cause Analyses

AFW Air Operated Valve Finding

Missed Opportunity (RCE 01-069)

- The Root Cause Problem Statement Focused on Emergency Operating Procedure (EOP) Limitations Related to a Loss of Instrument air event.
- The Root Cause Problem Statement should have Focused on the Potential Loss of Recirculation Flow.
- The Extent of Condition Evaluation would then have Investigated Conditions in Addition to a Failed Closed AFW AOV recirculation valve.
- Examples of Possible Loss of Recirculation Failures would have Included:
 - Orifice Plugging
 - Electrical/ Control System Failures
 - Indication Failures



Root Cause Analyses

Comprehensive AFW Evaluation

➤ Root Cause-Comprehensive AFW Evaluation (RCE000202)

- Failure to Consider the Integration of AFW System Design and Accident Progression (RC-1)
- Less than Adequate Knowledge of the Safety Significance of the AFW Recirculation Line in Protecting the Pumps (RC-2)

➤ Contributing Causes

- Lack of Problem and Issue Ownership (CC-1)
 - Corrective Action Program Weaknesses
- Less than Adequate Engineering / Operations Interface (CC-2)
- Less than Adequate Management of the Inter-Relationship of Documents (CC-3)



Root Cause Analyses

Comprehensive AFW Evaluation

- Prompt Corrective Actions- Complete
 - Placed Modifications Developed using “Old Process” on Installation Hold Pending Accident Progression Review
 - Implemented Multi-Discipline Review of Proposed Modifications by Management Team
- Interim Corrective Actions- Complete
 - Implemented New Fleet Modification Process
 - Implemented Design Review Board
 - Assigned Issue Managers for Significant Station Issues
 - Conducted Detailed Review of AFW Design and Licensing Bases (RC-2)
 - Implemented the Corrective Action Program Improvements



Root Cause Analyses

Comprehensive AFW Evaluation

Additional Corrective Actions:

- Enhance Understanding of System Design and Accident Progression (RC-1)
 - Upgrade Modification Process and EOP/AOP change process
 - Develop and conduct training for Engineering and Operations
- Resolve Remaining Issues from AFW Design and Licensing Bases (RC-2)
- Develop and Conduct Training on AFW Design Bases (RC-2)
- Strengthen the Role of Engineering in the Development/Revision of Operations Procedures (CC-2)
- Upgrade Electronic Document Management System (CC-3)
- Continue Implementation of Corrective Action Program Improvements

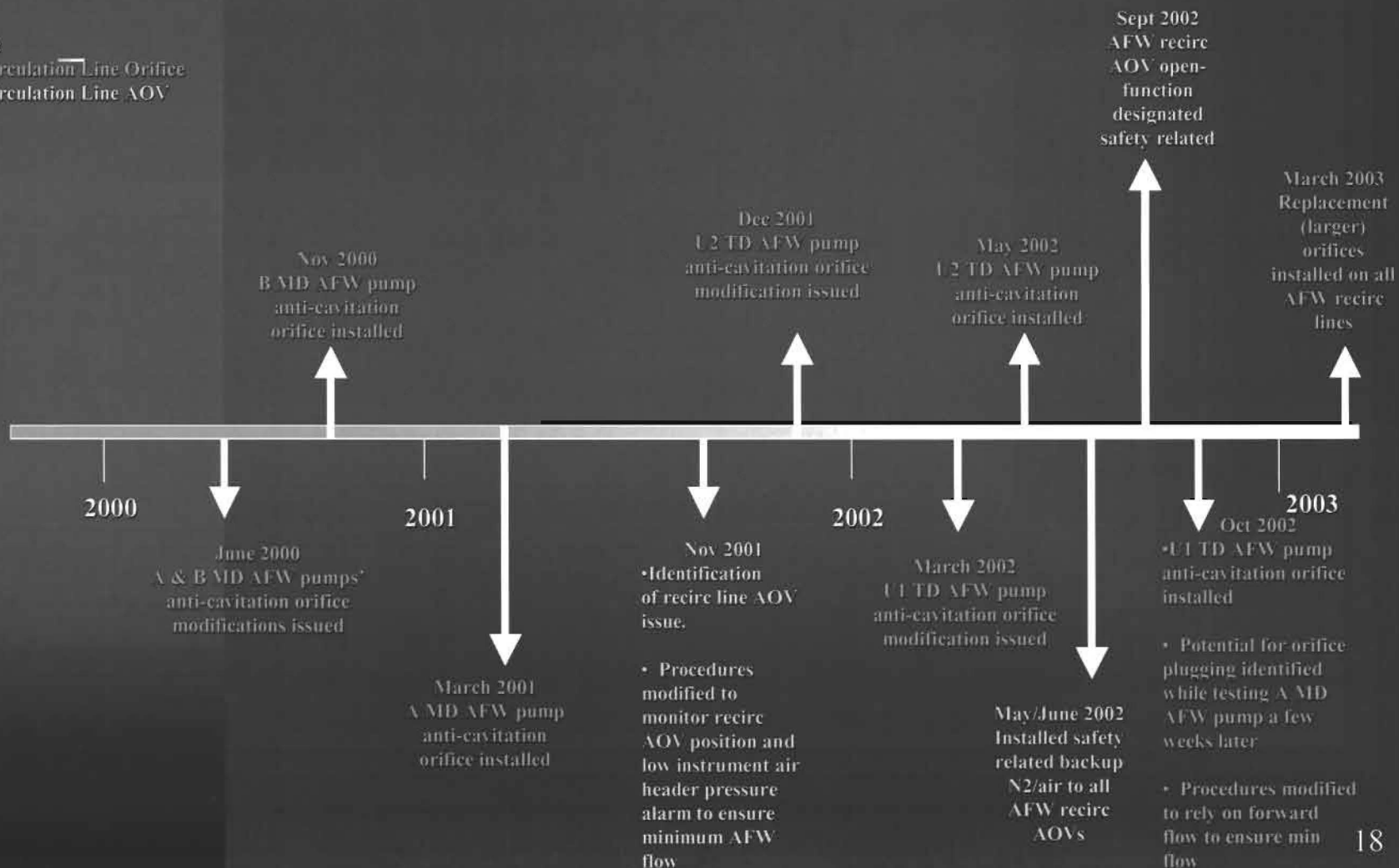


Significance Determination



Significance Determination Historical Timeline

Key:
Recirculation Line Orifice
Recirculation Line AOV





Significance Determination Events Affected by Orifices

Dual Unit Events

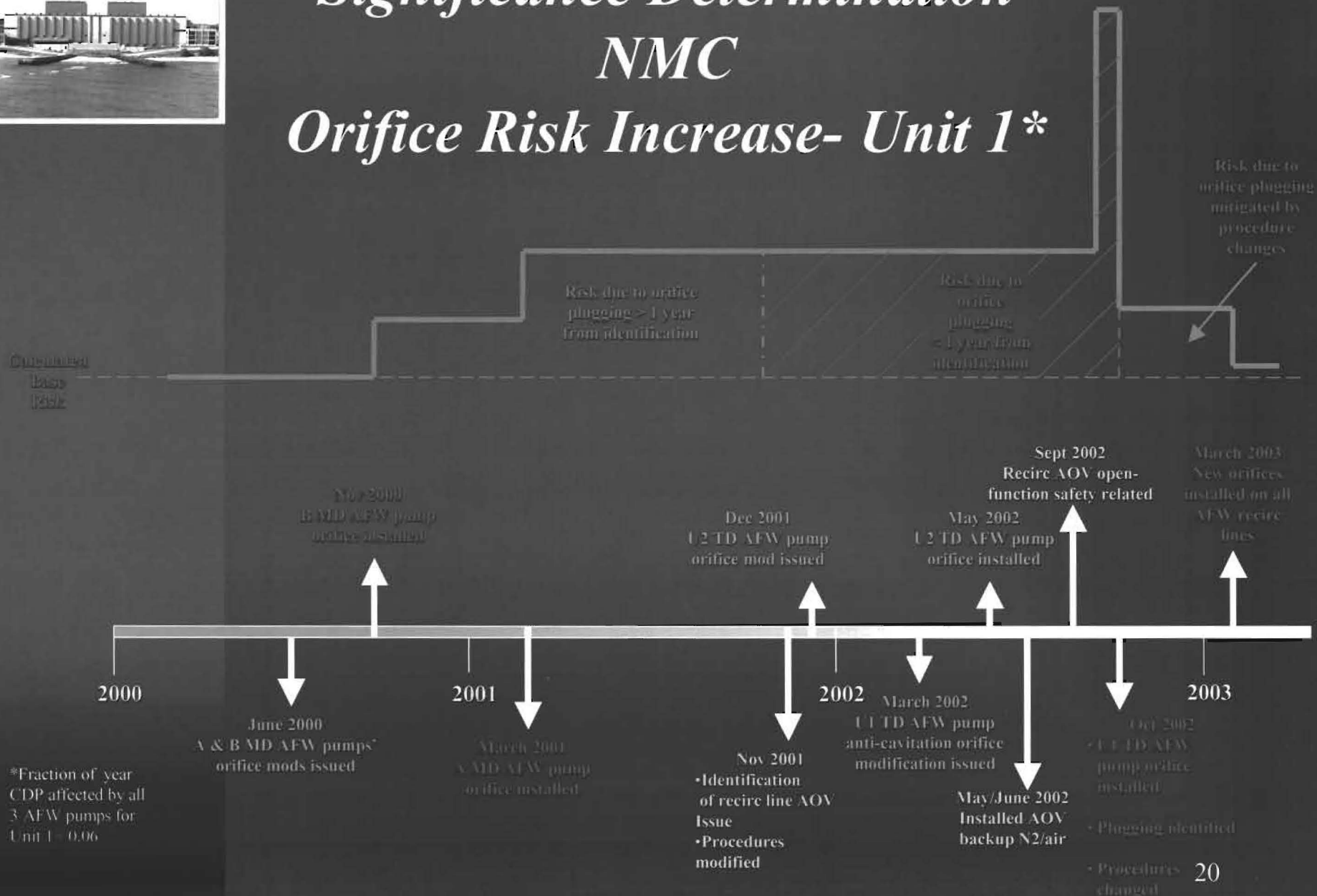
- Loss of Offsite Power
- Loss of Service Water
- Loss of Instrument Air (Minor)
- Loss of DC Bus D02

Single Unit

- Transient (Minor)
- Transient without Heat Sink
- Steam / Feed Line Break (Minor)
- Loss of Component Cooling Water (Minor)



Significance Determination NMC Orifice Risk Increase- Unit 1*

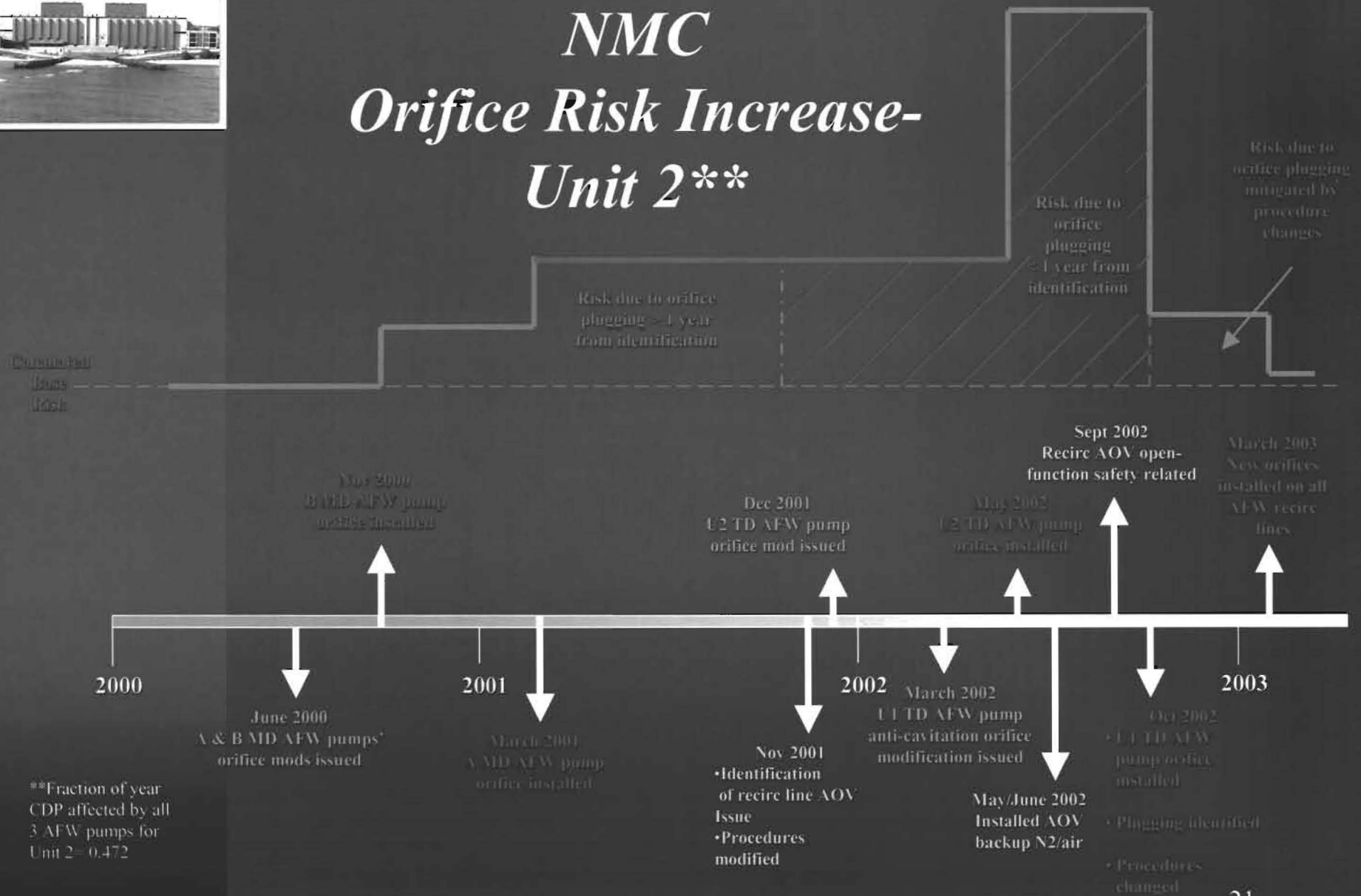




Significance Determination

NMC

Orifice Risk Increase- Unit 2**



Significance Determination- Event Timelines

Events	Time to CST Low-Low Level	With Water Treatment System Clearwell	Time to Initiate Feed & Bleed (If Required)	Notes
<u>Dual Unit Events</u>				
•Loss of Offsite Power, Loss of Instrument Air, Loss of DC Bus D02, Loss of Service Water	1.6 Hrs	System Not Available	4.8 Hrs	
<u>Single Unit Events</u>				
•Transients without Heat Sink	Not Required	Not Required	Not Required	Normal CST Makeup Available
•Transient without Heat Sink and No Water Treatment	2.1 Hrs	System Not Available	5.5 Hrs	
•Small LOCA	5.1 Hrs (0.5" Break Only)	Not Required	Not Applicable	Three break sizes, with and without safety injection. Only smallest break reaches CST Low-Low Level
•Steam Generator Tube Rupture	3 Hrs	9.7 Hrs	Not Applicable	
•Main Steam Line Break (Inside Containment)	3.3 Hrs	12 Hrs	15 Hrs	
•Main Steam Line Break (Outside Containment)	1.6 Hrs	Not Required	Not Required	RHR conditions reached on CST inventory at ~2.2 hrs- prior to reaching SG level requiring feed & bleed.



Significance Determination Differences for Plugged Orifice

- AFW Swap-Over Occurs Hours After Reactor Trip
 - Decay Heat Lower
 - Charging Successful for Feed and Bleed
 - Shutdown Cooling Credited
 - Steam Generator Depressurization and Service Water /Fire Water Addition Possible
 - Emergency Response Facilities Staffed
 - More Time for Troubleshooting and Recovery



Significance Determination

NRC

- Preliminary Evaluation of Risk Increase Based on Phase 2 Analysis
- Assumed AFW Failure Probability of 1.0
- No Credit for:
 - Initial Cooling by AFW
 - Charging Feed and Bleed
 - Transition to Shutdown Cooling
 - Service / Fire Water Addition



Significance Determination

NMC

- Internal Events Evaluated Probabilistic Risk Assessment
 - MAAP (Modular Accident Analysis Program) used to Demonstrate Success and Determine Timeline of Recovery Actions
 - Human Reliability Analysis for Credited Recovery Actions
- Seismic Events Evaluated using Seismic PRA
- Fire Event Analysis in Progress



Significance Determination NMC Risk Mitigating Factors Incorporated

- Water Treatment System
 - Makeup to Condensate Storage Tank
 - Clearwell Tank Makeup to CST
 - Recovery Following Restoration of Off-Site Power
- Service/Fire Water through Disabled AFW Pump
- Charging for Feed and Bleed



Significance Determination NMC Risk Mitigating Factors Incorporated (cont'd)

- Changes to HEPs for Feed and Bleed
- Recovery of SI/ RHR Valves Left in Incorrect Position
- Operators Starting/Stopping AFW Pumps to Avoid Failure of 2nd and/or 3rd Pump



Significance Determination NMC Risk Mitigating Factors Not Incorporated

- Available 14,000 Gallons of Water Left in Each CST at Low Low Level
- Increase Charging to Maximum While in Loss of Heat Sink Procedure
- Likely AFW Pump Survival Time Following Swap-Over to Service Water
 - Valve Leakage
 - Packing Leakage
- Alignment of N₂ to Pressurizer PORVs Following Loss of IA



Significance Determination Largest Contributors to Risk

Largest Contributors

Recovery Credited

Initiator	Water Treatment	Service / Fire Water	Charging Feed & Bleed	Shutdown Cooling
Loss of Offsite Power-Dual and Single Unit	x	x	x	x
Transient w/o Heat Sink	x	x		x
Loss of DC Bus 2		x	x	x
Loss of SW		x		



Significance Determination Sensitivity Analysis

Factor	Contribution to CDP Reduction (%)
Water Treatment System Impacts	91
Service Water/Fire Water through AFW Pump	48
Feed and Bleed HEP Change	48
Charging for Feed and Bleed	19
SI / RHR Valve Recovery HEP	10
Start / Stop AFWPs	5



Significance Determination Results

Internal Events

- Increase in Internal Events Core Damage Probability
 - Unit 1: High White
 - Unit 2: Mid Yellow



Significance Determination Results

External Events- Seismic

- Fragility Analysis Performed
- Charging, CST, and Service Water Addition Credited Following Safe Shutdown Earthquake
- Increase in Seismic Initiated Core Damage Probability
 - Unit 1: Green
 - Unit 2: Green



Significance Determination Results

Increase in Internal Event and Seismic Initiated Core Damage Probability

- Unit 1: High White
- Unit 2: Mid Yellow



Significance Determination Results

External Events- Fire

- Fire PRA Model Not Developed
- Development is in Progress
- Method Includes:
 - Fire Initiation Frequency
 - Detection Probability
 - Automatic and Manual Suppression Probability
 - Identification of Cables and Determination of Equipment Affected
 - Credit for Mitigating Factors
 - Consequences of Unsuppressed Fires
- Completion Targeted in August

Summary



- Installation of Inappropriate Orifice Design was Risk Significant
- NMC Significance Determination Preliminary Results (Internal and Seismic)
 - Unit 1: High White
 - Unit 2: Mid Yellow
 - Final Results, Including Fire, Targeted in August 2003
- Further AFW System Modifications
 - Electrical Modifications in Progress
 - Margin Recover Study
- Engineering Excellence Plan



Closing Remarks

- AFW Orifice Issue Self-Identified and Resolved in Timely Manner.
- AFW System Today is more Reliable.
- NMC Understands the Importance of the AFW Orifice Issue.
- NMC Significance Determination Preliminary Results (Internal and Seismic)
 - Unit 1: High White
 - Unit 2: Mid Yellow
- SDP for Fire Events Remains a Work in Progress.
- NMC Concurs with the Characterization of the Apparent Violation of 10 CFR 50 Appendix B.