

# Auxiliary Feedwater System Risk-Based Inspection Guide for the Point Beach Nuclear Power Plant

---

Prepared by  
R. C. Lloyd, N. E. Moffitt, B. F. Gore, T. V. Vo, T. A. Vehec

Pacific Northwest Laboratory  
Operated by  
Battelle Memorial Institute

Prepared for  
U.S. Nuclear Regulatory Commission

## AVAILABILITY NOTICE

### Availability of Reference Materials Cited in NRC Publications

Most documents cited in NRC publications will be available from one of the following sources:

1. The NRC Public Document Room, 2120 L Street, NW., Lower Level, Washington, DC 20555
2. The Superintendent of Documents, U.S. Government Printing Office, P.O. Box 37082, Washington, DC 20013-7082
3. The National Technical Information Service, Springfield, VA 22161

Although the listing that follows represents the majority of documents cited in NRC publications, it is not intended to be exhaustive.

Referenced documents available for inspection and copying for a fee from the NRC Public Document Room include NRC correspondence and internal NRC memoranda; NRC bulletins, circulars, information notices, inspection and investigation notices; licensee event reports; vendor reports and correspondence; Commission papers; and applicant and licensee documents and correspondence.

The following documents in the NUREG series are available for purchase from the GPO Sales Program: formal NRC staff and contractor reports, NRC-sponsored conference proceedings, international agreement reports, grant publications, and NRC booklets and brochures. Also available are regulatory guides, NRC regulations in the *Code of Federal Regulations*, and *Nuclear Regulatory Commission Issuances*.

Documents available from the National Technical Information Service include NUREG-series reports and technical reports prepared by other Federal agencies and reports prepared by the Atomic Energy Commission, forerunner agency to the Nuclear Regulatory Commission.

Documents available from public and special technical libraries include all open literature items, such as books, journal articles, and transactions. *Federal Register* notices, Federal and State legislation, and congressional reports can usually be obtained from these libraries.

Documents such as theses, dissertations, foreign reports and translations, and non-NRC conference proceedings are available for purchase from the organization sponsoring the publication cited.

Single copies of NRC draft reports are available free, to the extent of supply, upon written request to the Office of Administration, Distribution and Mail Services Section, U.S. Nuclear Regulatory Commission, Washington, DC 20555.

Copies of industry codes and standards used in a substantive manner in the NRC regulatory process are maintained at the NRC Library, 7920 Norfolk Avenue, Bethesda, Maryland, for use by the public. Codes and standards are usually copyrighted and may be purchased from the originating organization or, if they are American National Standards, from the American National Standards Institute, 1430 Broadway, New York, NY 10018.

## DISCLAIMER NOTICE

This report was prepared as an account of work sponsored by an agency of the United States Government. Neither the United States Government nor any agency thereof, or any of their employees, makes any warranty, expressed or implied, or assumes any legal liability of responsibility for any third party's use, or the results of such use, of any information, apparatus, product or process disclosed in this report, or represents that its use by such third party would not infringe privately owned rights.

---

# Auxiliary Feedwater System Risk-Based Inspection Guide for the Point Beach Nuclear Power Plant

---

Prepared by  
R. C. Lloyd, N. E. Moffitt, B. F. Gore, T. V. Vo, T. A. Vehec

Pacific Northwest Laboratory  
Operated by  
Battelle Memorial Institute

Prepared for  
U.S. Nuclear Regulatory Commission

#### AVAILABILITY NOTICE

##### Availability of Reference Materials Cited in NRC Publications

Most documents cited in NRC publications will be available from one of the following sources:

1. The NRC Public Document Room, 2120 L Street, NW., Lower Level, Washington, DC 20555
2. The Superintendent of Documents, U.S. Government Printing Office, P.O. Box 37082, Washington, DC 20013-7082
3. The National Technical Information Service, Springfield, VA 22161

Although the listing that follows represents the majority of documents cited in NRC publications, it is not intended to be exhaustive.

Referenced documents available for inspection and copying for a fee from the NRC Public Document Room include NRC correspondence and internal NRC memoranda; NRC bulletins, circulars, information notices, inspection and investigation notices; licensee event reports; vendor reports and correspondence; Commission papers; and applicant and licensee documents and correspondence.

The following documents in the NUREG series are available for purchase from the GPO Sales Program: formal NRC staff and contractor reports, NRC-sponsored conference proceedings, international agreement reports, grant publications, and NRC booklets and brochures. Also available are regulatory guides, NRC regulations in the *Code of Federal Regulations*, and *Nuclear Regulatory Commission Issuances*.

Documents available from the National Technical Information Service include NUREG-series reports and technical reports prepared by other Federal agencies and reports prepared by the Atomic Energy Commission, forerunner agency to the Nuclear Regulatory Commission.

Documents available from public and special technical libraries include all open literature items, such as books, journal articles, and transactions. *Federal Register* notices, Federal and State legislation, and congressional reports can usually be obtained from these libraries.

Documents such as theses, dissertations, foreign reports and translations, and non-NRC conference proceedings are available for purchase from the organization sponsoring the publication cited.

Single copies of NRC draft reports are available free, to the extent of supply, upon written request to the Office of Administration, Distribution and Mail Services Section, U.S. Nuclear Regulatory Commission, Washington, DC 20555.

Copies of industry codes and standards used in a substantive manner in the NRC regulatory process are maintained at the NRC Library, 7920 Norfolk Avenue, Bethesda, Maryland, for use by the public. Codes and standards are usually copyrighted and may be purchased from the originating organization or, if they are American National Standards, from the American National Standards Institute, 1430 Broadway, New York, NY 10018.

#### DISCLAIMER NOTICE

This report was prepared as an account of work sponsored by an agency of the United States Government. Neither the United States Government nor any agency thereof, or any of their employees, makes any warranty, expressed or implied, or assumes any legal liability of responsibility for any third party's use, or the results of such use, of any information, apparatus, product or process disclosed in this report, or represents that its use by such third party would not infringe privately owned rights.

---

---

# Auxiliary Feedwater System Risk-Based Inspection Guide for the Point Beach Nuclear Power Plant

---

---

Manuscript Completed: January 1993  
Date Published: February 1993

Prepared by  
R. C. Lloyd, N. E. Moffitt, B. F. Gore, T. V. Vo, T. A. Vehec

Pacific Northwest Laboratory  
Richland, WA 99352

Prepared for  
Division of Systems Safety and Analysis  
Office of Nuclear Reactor Regulation  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555  
NRC FIN L1310

## Abstract

In a study sponsored by the U.S. Nuclear Regulatory Commission (NRC), Pacific Northwest Laboratory has developed and applied a methodology for deriving plant-specific risk-based inspection guidance for the auxiliary feedwater (AFW) system at pressurized water reactors that have not undergone probabilistic risk assessment (PRA). This methodology uses existing PRA results and plant operating experience information. Existing PRA-based inspection guidance information recently developed for the NRC for various plants was used to identify generic component failure modes. This information was then combined with plant-specific and industry-wide component information and failure data to identify failure modes and failure mechanisms for the AFW system at the selected plants. Point Beach was selected as one of a series of plants for study. The product of this effort is a prioritized listing of AFW failures which have occurred at the plant and at other PWRs. This listing is intended for use by NRC inspectors in the preparation of inspection plans addressing AFW risk-important components at the Point Beach plant.



## Contents

Abstract .....	iii
Summary .....	vii
1 Introduction .....	1.1
2 Point Beach AFW System .....	2.1
2.1 System Description .....	2.1
2.2 Success Criterion .....	2.3
2.3 System Dependencies .....	2.3
2.4 Operational Constraints .....	2.3
3 Inspection Guidance for the Point Beach AFW System .....	3.1
3.1 Risk Important AFW Components and Failure Modes .....	3.1
3.1.1 Multiple Pump Failures Due to Common Cause .....	3.1
3.1.2 Turbine Driven Pumps 1P-29 or 2P-29 Fails to Start or Run .....	3.2
3.1.3 Motor Driven Pump P-38A or P-38B Fails to Start or Run .....	3.3
3.1.4 Pump(s) Unavailable Due to Maintenance or Surveillance .....	3.4
3.1.5 Motor Operated Isolation Valves Fail Closed .....	3.4
3.1.6 Air Operated Flow Valves Fail Closed .....	3.5
3.1.7 Manual Suction or Discharge Valves Fail Closed .....	3.5
3.1.8 Leakage of Hot Feedwater Through Check Valves .....	3.6
3.2 Risk Important AFW System Walkdown Table .....	3.6
4 Generic Risk Insights from PRAs .....	4.1
4.1 Risk Important Accident Sequences Involving AFW System Failure .....	4.1
4.2 Risk Important Component Failure Modes .....	4.1
5 Failure Modes Determined from Operating Experience .....	5.1
5.1 Point Beach Experience .....	5.1
5.1.1 Motor Driven Pump Failures .....	5.1
5.1.2 Turbine Driven Pump Failures .....	5.1
5.1.3 Flow Control and Isolation Valve Failures .....	5.1
5.1.4 Check Valve Failures .....	5.1
5.1.5 Human Errors .....	5.1
5.2 Industry Wide Experience .....	5.1

5.2.1 Common Cause Failures .....	5.2
5.2.2 Human Errors .....	5.3
5.2.3 Design/Engineering Problems and Errors .....	5.4
5.2.4 Component Failures .....	5.5
6 References .....	6.1

## Figures

2.1 Point Beach auxiliary feedwater system .....	2.2
--	-----

## Tables

3.1 Risk important walkdown table for Point Beach AFW system components .....	3.7
---	-----



## Summary

This document presents a compilation of auxiliary feedwater (AFW) system failure information which has been screened for risk significance in terms of failure frequency and degradation of system performance. It is a risk-prioritized listing of failure events and their causes that are significant enough to warrant consideration in inspection planning at the Point Beach plant. This information is presented to provide inspectors with increased resources for inspection planning at Point Beach.

The risk importance of various component failure modes was identified by analysis of the results of probabilistic risk assessments (PRAs) for many pressurized water reactors (PWRs). However, the component failure categories identified in PRAs are rather broad, because the failure data used in the PRAs is an aggregate of many individual failures having a variety of root causes. In order to help inspectors focus on specific aspects of component operation, maintenance and design which might cause these failures, an extensive review of component failure information was performed to identify and rank the root causes of these component failures. Both Point Beach and industry-wide failure information was analyzed. Failure causes were sorted on the basis of frequency of occurrence and seriousness of consequence, and categorized as common cause failures, human errors, design problems, or component failures.

This information is presented in the body of this document. Section 3.0 provide brief descriptions of these risk-important failure causes, and Section 5.0 presents more extensive discussions, with specific examples and references. The entries in the two sections are cross-referenced.

An abbreviated system walkdown table is presented in Section 3.2 which includes only components identified as risk important. This table lists the system lineup for normal, standby system operation.

This information permits an inspector to concentrate on components important to the prevention of core damage. However, it is important to note that inspections should not focus exclusively on these components. Other components which perform essential functions, but which are not included because of high reliability or redundancy, must also be addressed to ensure that degradation does not increase their failure probabilities, and hence their risk importance.

# 1 Introduction

This document is one of a series providing plant-specific inspection guidance for auxiliary feedwater (AFW) systems at pressurized water reactors (PWRs). This guidance is based on information from probabilistic risk assessments (PRAs) for similar PWRs, industry-wide operating experience with AFW systems, plant-specific AFW system descriptions, and plant-specific operating experience. It is not a detailed inspection plan, but rather a compilation of AFW system failure information which has been screened for risk significance in terms of failure frequency and degradation of system performance. The result is a risk-prioritized listing of failure events and the causes that are significant enough to warrant consideration in inspection planning at Point Beach.

This inspection guidance is presented in Section 3.0, following a description of the Point Beach AFW system in Section 2.0. Section 3.0 identifies the risk important system components by Point Beach identification number, followed by brief descriptions of each of the various failure causes of that component. These include specific human errors, design deficiencies, and hardware failures. The discussions also identify where common cause failures have affected multiple, redundant components. These brief discussions identify specific aspects of system or component design, operation, maintenance, or testing for inspection by observation, records review, training observation, procedures review, or by observation of the implementation of procedures. An AFW system walkdown table identifying risk important components and their lineup for normal, standby system operation is also provided.

The remainder of the document describes and discusses the information used in compiling this inspection guidance. Section 4.0 describes the risk important information which has been derived from PRAs and its sources. As review of that section will show, the failure events identified in PRAs are rather broad (e.g., pump fails to start or run, valve fails closed). Section 5.0 addresses the specific failure causes which have been combined under these broad events.

AFW system operating history was studied to identify the various specific failures which have been aggregated into the PRA failure events. Section 5.1 presents a summary of Point Beach failure information, and Section 5.2 presents a review of industry-wide failure information. The industry-wide information was compiled from a variety of NRC sources, including AEOD analyses and reports, information notices, inspection and enforcement bulletins, and generic letters, and from a variety of INPO reports as well. Some Licensee Event Reports and NPRDS event descriptions were also reviewed. Finally, information was included from reports of NRC-sponsored studies of the effects of plant aging, which include quantitative analyses of reported AFW system failures. This industry-wide information was then combined with the plant-specific failure information to identify the various root causes of the broad failure events used in PRAs, which are identified in Section 3.0.

## 2 Point Beach AFW System

This section presents an overview description of the Point Beach AFW system (Westinghouse 2 loop plant), including a simplified schematic system diagram. In addition, the system success criterion, system dependencies, and administrative operational constraints are also presented.

### 2.1 System Description

The AFW system provides feedwater to the steam generators (SG) to allow secondary-side heat removal from the primary system when main feedwater is unavailable. The system is capable of functioning for extended periods, which allows time to restore main feedwater flow or to proceed with an orderly cooldown of the plant to where the RHR System can remove decay heat. A simplified schematic diagram of the Point Beach AFW system is shown in Figure 2.1.

The AFW system consists of two motor-driven (MDAFW) pumps, two turbine-driven (TDAFW) pumps, two Condensate Storage Tanks (CSTs) and associated piping and controls for operation. It is designed utilizing two pumping systems and two different sources of water supply to the pumps, thus providing redundancy to ensure that a single fault will not obstruct the system function. The AFW pumps normally take suction from two 45,000 gallon capacity CSTs via a common normally cross-tied suction header. The CSTs supply water to the suction of each AFW pump through a ten inch suction line containing manual gate valves and a check valve. The CSTs must contain a minimum volume of 13,000 gallons per operating unit for use by the AFW System to ensure a sufficient quantity of water is available to maintain the RCS at hot shutdown for 90 minutes with steam discharge to atmosphere. A backup water supply is available from the Service Water (SW) System. It can be manually aligned to the suction of the AFW pumps via normally closed MOVs. All four pumps can take suction from either or both of the North and South service water headers, however, one MDAFWP and one TDAFWP are normally aligned to take suction from each header.

The system is designed to start up and establish full rated flow within 30 seconds of an automatic start signal. The MDAFWP pumps start on the following conditions: low-low S/G level in any S/G, a trip of both main feedwater pumps in either unit, or a safety injection signal. The TDAFW pumps will start automatically on a low-low S/G level in both associated S/Gs or on a loss of both 4.16 kv buses that supply the main feedwater pumps.

The TDAFW pumps provide feedwater only to the S/G of the associated unit. Each pump discharges through a check valve into a common 4 inch header from which the auxiliary feed is delivered through individual 3 inch lines, each containing a normally open MOV, to the main feedwater line inside the containment near each S/G. Two check valves, one at the connection to the main feedwater line and one just downstream of the motor operated valve, prevent backflow from the main feed line when the pump is not in service. Manual valves are also provided for isolation of the individual feed lines.

The MDAFW pumps are common to both units with the discharge of each pump lined up to provide feed to one S/G on each unit, (P38A is normally aligned to supply the "A" S/G on each unit and P38B is normally aligned to supply the "B" S/Gs on each unit). Each pump discharges through a check valve and an air-operated pressure control valve into a common 3 inch header. The auxiliary feedwater is then directed to the associated steam generator in each unit through individual 3 inch lines, each containing a normally open motor-operated valve and a check valve. The individual lines join the discharge from the steam-driven pump downstream of the respective motor-operated valves outside of the containment structures such that only one auxiliary feed line penetration is required per steam generator. As with the steam-driven pumps, the double check valve arrangement prevents backflow when the pumps are not in service. Manual valves are also provided for isolation of the individual feed lines.

The common discharge headers from each motor-driven auxiliary feedwater pump can be cross-connected

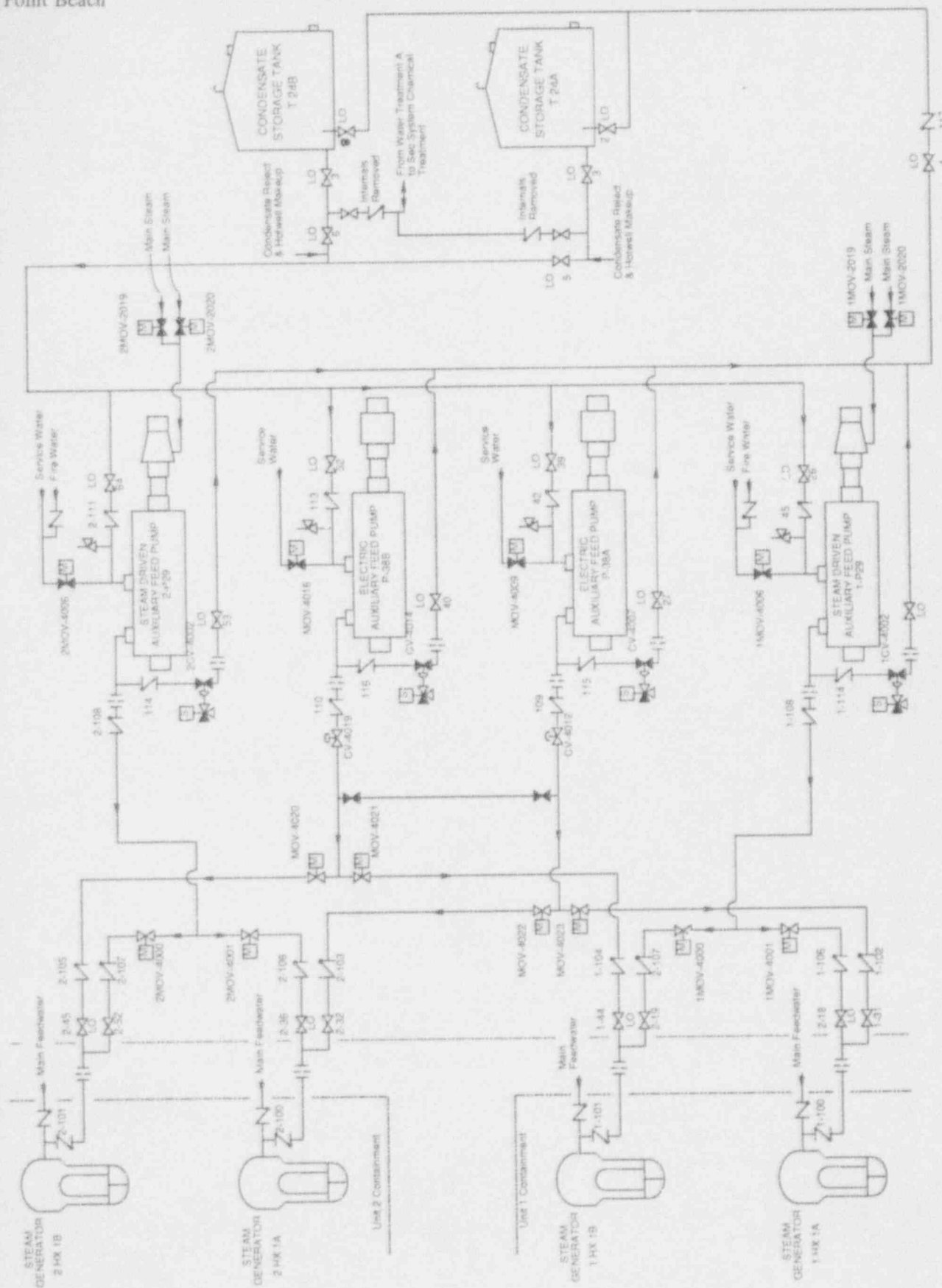


Figure 2.1. Point Beach auxiliary feedwater system

downstream of the air-operated control valves. Normal system alignment, however, requires that both valves in the cross-connection be locked in the shut position. To protect the auxiliary feedwater pumps from excessive temperature rise during low flow conditions, each pump is equipped with an orificed recirculation line which provides the required minimum flow through the pumps by returning feedwater to the condensate storage tanks. An air-operated valve in the recirculation line interrupts flow when adequate discharge flow is sensed.

Steam for the TDAFW pumps is provided from one or both of the associated steam generators from points upstream of the main steam isolation valves.

## 2.2 Success Criterion

System success requires the operation of at least one pump supplying rated flow to at least one of the two steam generators.

## 2.3 System Dependencies

The AFW system depends on AC power for motor-driven pumps, SW and MS motor operated valves, DC power for control power to valves, and instrument air for control valves. In addition, the turbine-driven pump also requires steam availability.

## 2.4 Operational Constraints

When the reactor coolant is heated above 350°F, the Point Beach Technical Specifications require that the reactor shall not be taken critical unless the following conditions are satisfied:

- (1) For two-unit operation, all four auxiliary feedwater pumps, together with their associated flow paths and essential instrumentation, shall be operable.
- (2) For single-unit operation, both motor-driven auxiliary feedwater pumps and the turbine-driven auxiliary feedwater pump associated with that unit, together with their associated flow paths and essential instrumentation, shall be operable.
- (3) A minimum of 10,000 gallons of water per operating unit in the condensate storage tanks and an unlimited supply from the lake via either leg of the plant service water system.

During two unit power operation, one of the four auxiliary feedwater pumps may be out-of-service as follows:

- (1) A turbine-driven auxiliary feedwater pump may be out-of-service for up to 72 hours. If not restored to service within the 72 hour time period, the associated reactor shall be shut down and in hot shutdown within the next 12 hours.
- (2) A motor-driven auxiliary feed pump may be out-of-service for up to 7 days. If not restored to service within the 7-day period, both reactors shall be shut down and in hot shutdown within the next 12 hours.

During single-unit operation, the turbine-driven auxiliary feedwater pump may be out-of-service for up to 72 hours. If not restored to service within the 72-hour time period, the reactor shall be placed in hot shutdown within the next 12 hours.

During single-unit operation, either one of the motor-driven auxiliary feedwater pumps may be out-of-service for up to 7 days. If not restored to service within the 7-day time period, the operating unit shall be placed in hot shutdown within the next 12 hours.



### 3 Inspection Guidance for the Point Beach AFW System

In this section the risk important components of the Point Beach AFW system are identified, and the important failure modes for these components are briefly described. These failure modes include specific human errors, design deficiencies, and types of hardware failures which have been observed to occur for these components, both at Point Beach and at PWRs throughout the nuclear industry. The discussions also identify where common cause failures have affected multiple, redundant components. These brief discussions identify specific aspects of system or component design, operation, maintenance, or testing for inspection activities. These activities include; observation, records review, training observation, procedures review, or by observation of the implementation of procedures.

Table 3.1 is an abbreviated AFW system walkdown table which identifies risk-important components. This table lists the system lineup for normal (standby) system operation. Inspection of the components identified in the AFW walkdown table addresses essentially all of the risk associated with AFW system operation.

#### 3.1 Risk Important AFW Components and Failure Modes

Common cause failures of multiple pumps are the most risk-important failure modes of AFW system components. These are followed in importance by single pump failures, level control valve failures, and individual check valve leakage failures.

The following sections address each of these failure modes, in decreasing order of risk-importance. They present the important root causes of these component failure modes which have been distilled from historical records. Each item is keyed with a three digit code to discussions in Section 5.2 where additional information on historical events is presented.

##### 3.1.1 Multiple Pump Failures Due to Common Cause

The following listing summarizes the most important multiple-pump failure modes identified in Section 5.2.1, Common Cause Failures, and each item is keyed with a 3 digit code to entries in that section.

- Incorrect operator intervention into automatic system functioning, including improper manual starting and securing of pumps, has caused failure of all pumps, including overspeed trip on startup, and inability to restart prematurely secured pumps. CC1.

*Inspection Suggestion* - Observe Abnormal and Emergency Operating Procedure (AOP/EOP) simulator training exercises to verify that the operators comply with procedures during observed evolutions. Observe surveillance testing on the AFW system to verify it is in strict compliance with the surveillance test procedure.

- Valve mispositioning has caused failure of all pumps. Pump suction, steam supply, and instrument isolation valves have been involved. CC2.

*Inspection Suggestion* - Verify that the system valve alignment, air operated valve control and valve actuating air pressures are correct using 3.1 Walkdown Table, the system operating procedures, and operator rounds logsheet. Review surveillance procedures that alter the standby alignment of the AFW system. Ensure that an adequate return to normal section exists.

- Steam binding has caused failure of multiple pumps. This resulted from leakage of hot feedwater past check valves and a motor-operated valve into a common discharge header. CC10. Multiple-pump steam binding has also resulted from improper valve lineups, and from running a pump deadheaded. CC3.



*Inspection Suggestion* - Verify that the pump discharge temperature is within the limits specified on the operator rounds logsheet. Assure any instruments used to verify the temperature by the utility are of an appropriate range and included in a calibration program. Verify affected pumps have been vented, and corrective actions taken per procedure. AOP-2C.

- Pump control circuit deficiencies or design modification errors have caused failures of multiple pumps to auto start, spurious pump trips during operation, and failures to restart after pump shutdown. CC4. Incorrect setpoints and control circuit calibrations have also prevented proper operation of multiple pumps. CC5.

*Inspection Suggestion* - Review design change implementation documents for the post maintenance testing required prior to returning the equipment to service. Assure the testing verifies that all potentially impacted functions operate correctly, and includes repeating any plant start-up or hot functional testing that may be affected by the design change.

- Loss of a vital power bus has failed both the turbine-driven and one motor-driven pump due to loss of control power to steam admission valves or to turbine controls, and to motor controls powered from the same bus. CC6.

*Inspection Suggestion* - The material condition of the electrical equipment is an indicator of probable reliability. Review the Preventative Maintenance (PM) records to assure the equipment is maintained on an appropriate frequency for the environment it is in and that the PMs are actually being performed as required by the program. Review the outstanding Corrective Maintenance records to assure the deficiencies found on the equipment are promptly corrected.

- Simultaneous startup of multiple pumps has caused oscillations of pump suction pressure causing multiple-pump trips on low suction pressure, despite the existence of adequate static net positive suction head (NPSH). CC7. At H.B. Robinson, design reviews have identified inadequately sized suction piping which could have yielded insufficient NPSH to support operation of more than one pump. CC8.

*Inspection Suggestion* - Assure that plant conditions which could result in the blockage or degradation of the suction flow path are addressed by system maintenance and test procedures. Examples include, if the AFW system has an emergency source from a water system with the potential for bio-fouling, then the system should be periodically treated to prevent buildup and routinely tested to assure an adequate flow can be achieved to support operation of all pumps, or inspected to assure that bio-fouling is not occurring. Design changes that affect the suction flow path should repeat testing that verified an adequate suction source for simultaneous operation of all pumps. Verify that testing has, at sometime, demonstrated simultaneous operation of all pumps. Verify that surveillances adequately test all aspects of the system design functions, for example, demonstrate that the AFW pumps will trip on low suction pressure.

### 3.1.2 Turbine Driven Pumps 1P-29 or 2P-29 Fails to Start or Run

- Improperly adjusted and inadequately maintained turbine governors have caused pump failures. HE2. Problems include worn or loosened nuts, set screws, linkages or cable connections, oil leaks and/or contamination, and electrical failures of resistors, transistors, diodes and circuit cards, and erroneous grounds and connections. CF5. Governor malfunction and control, bearing wear and oil supply problems have occurred at Point Beach.

*Inspection Suggestion* - Review PM records to assure the governor oil is being replaced within the designated frequency. During plant walkdowns carefully inspect the governor and linkages for loose fasteners, leaks, and unsecured or degraded conduit. Review vendor manuals to ensure PM procedures are performed according to manufacturer's recommendations and good maintenance practices.

- Turbines with Woodward Model PG-PL governors have tripped on overspeed when restarted shortly after shutdown, unless an operator has locally exercised the speed setting knob to drain oil from the governor speed setting cylinder (per procedure). Automatic oil dump valves are now available through Terry. DE4.

*Inspection Suggestion* - Observe the operation of the turbine driven Aux Feed pump and assure that the governor is reset per procedure. Assure the turbine is not coasting over, which can result in refill of the speed setting cylinder.

- Condensate slugs in steam lines have caused turbine speed control problems. Tests repeated right after such occurrences may fail to indicate the problem due to warming and clearing of the steam lines. Surveillances should exercise all steam supply connections. DE2.

*Inspection Suggestion* - Verify that the steam traps are valved in on the steam supply line. For steam traps that are on a pressurized portion of the steam line, check the steam trap temperature (if unlagged) to assure it is warmer than ambient (otherwise it may be stuck or have a plugged line). If the steam trap discharge is visible, assure there is evidence of liquid discharge.

- Trip and throttle valve (TTV) problems which have failed the turbine driven pump include physically bumping it, failure to reset it following testing, and failures to verify control room indication of reset. HE2. Whether either the overspeed trip or TTV trip can be reset without

resetting the other, and unambiguity of control room and local indication of TTV position and overspeed trip linkage reset status, all affect the likelihood of these errors. DE3.

*Inspection Suggestion* - Carefully inspect the TTV overspeed trip linkage and assure it is reset and in good physical condition. Assure that there is a good steam isolation to the turbine, otherwise continued turbine high temperature can result in degradation of the oil in the turbine, interfering with proper overspeed trip operation. Review training procedures to ensure operator training on resetting the TTV is current.

### 3.1.3 Motor Driven Pump P-38A or P-38B Fails to Start or Run

- Control circuits used for automatic and manual pump starting are an important cause of motor driven pump failures, as are circuit breaker failures. CF7. Control circuit and electric power failures have prevented automatic pump starts at Point Beach.

*Inspection Suggestion* - Review corrective maintenance records when control circuit problems occur to determine if a trend exists. Every time a breaker is racked in a PMT should be performed to start the pump, assuring no control circuit problems have occurred as a result of the manipulation of the breaker. (Control circuit stabs have to make up upon racking the breaker, as well as cell switch damage can occur upon removal and reinstallation of the breaker.)

- Mispositioning of handswitches and procedural deficiencies have prevented automatic pump start. HE3.

*Inspection Suggestion* - Confirm switch position using Table 3.1. Review administrative procedures concerning documentation of procedural deficiencies. Ensure operator training on procedural changes is current.

### 3.1.4 Pump(s) Unavailable Due to Maintenance or Surveillance

- Both scheduled and unscheduled maintenance remove pumps from operability. Surveillance requires operation with an altered line-up. A pump train is declared inoperable during testing. Prompt scheduling and performance of maintenance and surveillance minimize this unavailability.

*Inspection Suggestion* - Review the time the AFW system and components are inoperable. Assure all maintenance is being performed that can be performed during a single outage time frame, avoiding multiple equipment outages. The maintenance should be scheduled before the routine surveillance test, so credit can be taken for both post maintenance testing and surveillance testing, avoiding excessive testing. Review surveillance schedule for frequency and adequacy to verify system operability requirements per Technical Specifications.

### 3.1.5 Motor Operated Isolation Valves Fail Closed

MD Pump Service Water Suction Valves: 4009, 4016

TD Pump Service Water Suction Valves: 1-4006, 2-4006

TD Pump to "A" SG Isolation Valve: 1-4001, 2-4001

TD Pump to "B" SG Isolation Valve: 1-4000, 2-4001

Steam Supply TD Pumps: 1-2019, 1-2020, 2-2019, 2-2020

MD Pump Discharge to SG "A": 4022, 4023

MD Pump Discharge to SG "B": 4020, 4021

The MDAFW pump discharge valves are normally open MOVs. Steam supply lines to the turbine driven AFW pumps contain normally closed motor operated steam isolation valves. The service water suction isolation MOVs are normally closed. All these MOVs fail as-is on loss of power.

- Common cause failure of MOVs has resulted from failure to use electrical signature tracing equipment to determine proper settings of torque switch and

torque switch bypass switches. Failure to calibrate switch settings for high torques necessary under design basis accident conditions has also been involved. CC11. Torque switch adjustment and dirty contacts has prevented proper MOV operation at Point Beach.

*Inspection Suggestion* - Review the MOV test records to assure the testing and settings are based on dynamic system conditions. Overtorquing of the valve operator can result in valve damage such as cracking of the seat or disc. Review the program to assure overtorquing is identified and corrective actions are taken to assure valve operability following an overtorque condition. Review the program to assure EQ seals are renewed as required during the restoration from testing to maintain the EQ rating of the MOV.

- Valve motors have been failed due to lack of, or improper sizing or use of thermal overload protective devices. Bypassing and oversizing should be based on proper engineering for design basis conditions. CF4. Overload and valve operator adjustment have caused failure of MOVs at Point Beach.

*Inspection Suggestion* - Review the administrative controls for documenting and changing the settings of thermal overload protective devices. Assure the information is available to the maintenance planners.

- Grease trapped in the torque switch spring pack of Limitorque SMB motor operators has caused motor burnout or thermal overload trip by preventing torque switch actuation. CF8.

*Inspection Suggestion* - Review this only if the MOV testing program reveals deficiencies in this area.

- Manually reversing the direction of motion of operating MOVs has overloaded the motor circuit. Operating procedures should provide cautions, and circuit designs may prevent reversal before each stroke is finished. DE7.

*Inspection Suggestion* - Verify procedures and training address reversal of valve direction midstroke.

- Space heaters designed for preoperation storage have been found wired in parallel with valve motors which had not been environmentally qualified with them present. DE8.

*Inspection Suggestion* - Spot check MOVs during MOV testing to assure the space heaters are physically removed or disconnected.

### 3.1.6 Air Operated Flow Valves Fail Closed

MD Pump Flow Control: 4012, 4019

MD Pump Recirculation Control: 4007, 4014

TD Pump Recirculation Control: 1-4002, 2-4002

These air operated valves (AOVs) control flow to the steam generators and recirculation flow back to the CST. The flow control valves fail open and the recirculation valves fail closed on loss of instrument air.

- Control circuit problems have been a primary cause of failures, both at Point Beach and elsewhere. CF9. Valve failures have resulted from blown fuses, failure of control components (such as current/pneumatic convertors), diaphragm failure, broken and dirty contacts, misaligned or broken limit switches, control power loss, and calibration problems. Degraded operation has also resulted from improper air pressure due to air regulator failure or leaking air lines.

*Inspection Suggestion* - Check for control air system alignment and air leaks during plant walkdowns. (Regulators may have a small amount of external bleed to maintain downstream pressure.) Check for cleanliness and physical condition of visible circuit elements. Review valve stroke time surveillance for adverse trends, especially those valves on reduced testing frequency. Review air system surveillances moisture content of air is within established limits.

- Leakage of hot feedwater through check valves has caused thermal binding of flow control MOVs. AOVs may be similarly susceptible. CF2.

*Inspection Suggestion* - Covered by 3.1.1 bullet 3.

- Multiple flow control valves have been plugged by clams when suction switched automatically to an alternate, untreated source. CC9.

*Inspection Suggestion* - Covered by 3.1.1 bullet 6.

### 3.1.7 Manual Suction or Discharge Valves Fail Closed

MD Pump Suction Valves: 39, 52

MD Pump Discharge Valves: 31, 32, 44, 45

TD Pump Suction Valves: 64, 26

TD Pump Discharge Valves: 18, 19, 56, 57

CSTs Main Supply Valves: 3, 5, 6, 8

Recirculation Valves: 1, 2, 3, 27, 40, 53

These manual valves are normally locked open. Manual valves that could reduce flow in any AFW train are normally locked in the proper position for emergency use.

- Valve mispositioning has resulted in failures of multiple trains of AFW. CC2. It has also been the dominant cause of problems identified during operational readiness inspections. HE1. Events have occurred most often during maintenance, calibration, or system modifications. Important causes of mispositioning include:
  - Failure to provide complete, clear, and specific procedures for tasks and system restoration
  - Failure to promptly revise and validate procedures, training, and diagrams following system modifications
  - Failure to complete all steps in a procedure
  - Failure to adequately review uncompleted procedural steps after task completion
  - Failure to verify support functions after restoration



- Failure to adhere scrupulously to administrative procedures regarding tagging, control and tracking of valve operations
- Failure to log the manipulation of sealed valves
- Failure to follow good practices of written task assignment and feedback of task completion information
- Failure to provide easily read system drawings, legible valve labels corresponding to drawings and procedures, and labeled indications of local valve position

*Inspection Suggestion* - Review the administrative controls that relate to valve positioning and sealing, system restoration following maintenance, valve labeling, system drawing updating, and procedure revision, for proper implementation.

### 3.1.8 Leakage of Hot Feedwater Through Check Valves

SG Check Valves: 1-100,1-101,1-102,1-104,1-106,

1-107,2-100,2-101,2-103, 2-105,2-106,2-107

AFW Pump Discharge Check Valves:

1-108,2-108,109, 110

AFW Pump Suction Check Valves: 111,112,113,115

- Leakage of hot feedwater through several check valves in series has caused steam binding of

multiple pumps. Leakage through a closed level control valve in series with check valves has also occurred at Point Beach, as would be required for leakage to reach the motor driven pumps A and B. CC10.

*Inspection Suggestion* - Covered by 3.1.1 bullet 3.

- Slow leakage past the final check valve of a series may not force the check valve closed. Other check valves in series may leak similarly. Piping orientation and valve design are important factors in achieving true series protection. CF1.

*Inspection Suggestion* - Covered by 3.1.1 bullet 3.

## 3.2 Risk Important AFW System Walk-down Table

Table 3.1 presents an AFW system walkdown table including only components identified as risk important. This information allows inspectors to concentrate their efforts on components important to prevention of core damage. However, it is essential to note that inspections should not focus exclusively on these components. Other components which perform essential functions, but which are absent from this table because of high reliability or redundancy, must also be addressed to ensure that their risk importance are not increased. Examples include the (open) steam lead isolation valves (235 and 237) upstream of 2019 and 2020, and an adequate water level in the CSTs.

Table 3.1 Risk important walkdown table for Point Beach AFW system components

Component #	Component Name	Required Position	Actual
<b>Electrical</b>			
P-38A	Motor-Driven Pump	Racked In/Closed	_____
P-38B	Motor-Driven Pump	Racked In/Closed	_____
<b>Valves</b>			
AF 3	CST "A" Isolation Valve	Locked Open	_____
AF 5	CST "A" Isolation Valve	Locked Open	_____
AF 6	CST "B" Isolation Valve	Locked Open	_____
AF 8	CST "B" Isolation Valve	Locked Open	_____
AF 52	P-38B MDP Suction Valve	Locked Open	_____
AF 39	P-38A MDP Suction Valve	Locked Open	_____
AF 64	2-P29 TDP Suction Valve	Locked Open	_____
AF 26	1-P29 TDP Suction Valve	Locked Open	_____
1AF 4006	1P-29 TDP Service Water Supply	Closed	_____
2AF 4006	2P-29 TDP Service Water Supply	Closed	_____
AF 4016	P-38B MDP Service Water Supply	Closed	_____
AF 4009	P-38A MDP Service Water Supply	Closed	_____
AF 4014	P-38B MDP Recirculation Valve	Closed	_____
AF 4007	P-38A MDP Recirculation Valve	Closed	_____
2AF 4002	2-P29 TDP Recirculation Valve	Closed	_____



Table 3.1 (Continued)

Component #	Component Name	Required Position	Actual
<b>Valves</b>			
1AF 4002	1-P29 TDP Recirculation Valve	Closed	_____
AF 4019	P-38B MDP to SG "B" Flow Control	Open	_____
AF 4012	P-38A MDP to SG "A" Flow Control	Open	_____
AF 4020	P-38B MDP to SG 2-1B Discharge Iso	Open	_____
AF 402121	P-38B MDP to SG 1-1B Discharge Iso	Open	_____
AF 4022	P-38A MDP to SG 2-1A Discharge Iso	Open	_____
AF 4023	P-38A MDP to SG 1-1A Discharge Iso	Open	_____
2AF 4000	2P-29 TDP to SG 2-1B Discharge Iso	Open	_____
2AF 4001	2P-29 TDP to SG 2-1A Discharge Iso	Open	_____
1AF 4000	1P-29 TDP to SG 1-1B Discharge Iso	Open	_____
1AF 4001	1P-29 TDP to SG 1-1A Discharge Iso	Open	_____
2AF 2019	SG-2 M Steam Supply to TDP 2-P29	Closed	_____
2AF 2020	SG-2 M Steam Supply to TDP 2-P29	Closed	_____
1AF 2019	SG-1 M Steam Supply to TDP 1-P29	Closed	_____
1AF 2020	SG-1 M Steam Supply to TDP 1-P29	Closed	_____
AF 1-100	Piping Upstream of Check Valve	Cool	_____
AF 1-101	Piping Upstream of Check Valve	Cool	_____
AF 2-100	Piping Upstream of Check Valve	Cool	_____
AF 2-101	Piping Upstream of Check Valve	Cool	_____

Table 3.1 (Continued)

Component #	Component Name	Required Position	Actual
<b>Valves</b>			
AF 1-102	Piping Upstream of Check Valve	Cool	_____
AF 2-103	Piping Upstream of Check Valve	Cool	_____
AF 1-104	Piping Upstream of Check Valve	Cool	_____
AF 2-105	Piping Upstream of Check Valve	Cool	_____
AF 1-106	Piping Upstream of Check Valve	Cool	_____
AF 2-106	Piping Upstream of Check Valve	Cool	_____
AF 1-107	Piping Upstream of Check Valve	Cool	_____
AF 2-107	Piping Upstream of Check Valve	Cool	_____
AF 1-108	Piping Upstream of Check Valve	Cool	_____
AF 2-108	Piping Upstream of Check Valve	Cool	_____
AF 109	Piping Upstream of Check Valve	Cool	_____
AF 110	Piping Upstream of Check Valve	Cool	_____

## 4 Generic Risk Insights from PRAs

PRAs for 13 PWRs were analyzed to identify risk-important accident sequences involving loss of AFW, and to identify and risk-prioritize the component failure modes involved. The results of this analysis are described in this section. They are consistent with results reported by INEL and BNL (Gregg et al. 1988, and Travis et al. 1988).

### 4.1 Risk Important Accident Sequences Involving AFW System Failure

#### Loss of Power System

- A loss of offsite power is followed by failure of AFW and failure of feed and bleed, resulting in core damage.
- A station blackout fails all AC power except Vital AC from DC invertors, and all decay heat removal systems except the turbine-driven AFW pump. AFW system operation is subsequently impacted by loss of instrumentation or hardware failures, resulting in core damage.
- A DC bus fails, causing a trip and failure of the power conversion system. One AFW motor-driven pump is failed by the bus loss, AFW is subsequently lost completely due to other failures. Feed-and-bleed cooling fails, resulting in core damage.

#### Transient-Caused Reactor or Turbine Trip

- A transient-caused trip is followed by a loss of MFW and AFW. Feed-and-bleed cooling fails either due to failure of the operator to initiate it, or due to hardware failures, resulting in core damage.

#### Loss of Main Feedwater

- A feedwater line break drains the common water source for MFW and AFW. The operators fail to provide feedwater from other

sources, and fail to initiate feed-and-bleed cooling, resulting in core damage.

- A loss of main feedwater trips the plant, and AFW fails due to operator error and hardware failures. The operators fail to initiate feed-and-bleed cooling, resulting in core damage.

#### Steam Generator Tube Rupture (SGTR)

- An SGTR is followed by failure of AFW. Coolant is lost from the primary until the refueling water storage tank (RWST) is depleted. High pressure injection (HPI) fails since recirculation cannot be established from the empty sump, and core damage results.

### 4.2 Risk Important Component Failure Modes

The generic component failure modes identified from PRA analyses as important to AFW system failure are listed below in decreasing order of risk importance.

- (1) Turbine-Driven Pump Failure to Start or Run.
- (2) Motor-Driven Pump Failure to Start or Run.
- (3) TDP or MDP Unavailable due to Test or Maintenance.
- (4) AFW System Valve Failures
  - steam admission valves
  - trip and throttle valve
  - flow control valves
  - pump discharge valves
  - pump suction valves
  - valves in testing or maintenance.

(5) Supply/Suction Sources

- condensate storage tank stop valves
- hot well inventory
- suction valves
- Service Water System.

In addition to individual hardware, circuit, or instrument failures, each of these failure modes may result

from common causes and human errors. Common cause failures of AFW pumps are particularly risk important. Valve failures are somewhat less important due to the multiplicity of steam generators and connection paths. Human errors of greatest risk importance involve: failures to initiate or control system operation when required; failure to restore proper system lineup after maintenance or testing; and failure to switch to alternate sources when required.

## 5 Failure Modes Determined from Operating Experience

This section describes the primary root causes of AFW system component failures, as determined from a review of operating histories at Point Beach and at other PWRs throughout the nuclear industry. Section 5.1 describes experience at Point Beach, from 1974 to 1991. Section 5.2 summarizes information compiled from a variety of NRC sources, including AEOD analyses and reports, information notices, inspection and enforcement bulletins, and generic letters, and from a variety of INPO reports as well. Some LERs and NPRDS event descriptions were also reviewed. Finally, information was included from reports of NRC-sponsored studies of the effects of plant aging, which include quantitative analysis of AFW system failure reports. This information was used to identify the various root causes expected for the broad PRA-based failure events identified in Section 4.0, resulting in the inspection guidelines presented in Section 3.0.

### 5.1 Point Beach Experience

The AFW system at Point Beach has experienced failures of the AFW pumps, pump discharge flow control valves, the turbine steam admission and supply valves, turbine trip and throttle valve, pump discharge isolation valves, service water backup supply valves, and numerous system check valves. Failure modes include electrical, instrumentation and control, hardware failures, and human errors.

#### 5.1.1 Motor Driven Pump Failures

There have been five events from 1974-1991 which involved failure of the motor-driven pumps. Failure modes involved instrument and control circuit failure, human error during maintenance activities and circuit breaker failure.

#### 5.1.2 Turbine Driven Pump Failures

There have been ten events from 1974-1991 that have resulted in failures of the turbine driven pump. Failure modes involved failures in instrumentation and control circuits, system hardware failures, and human errors.

The turbine driven pump has tripped or failed to reach proper speed or output as a result of governor control problems, worn o-rings, and worn bearings and oil supply problems.

#### 5.1.3 Flow Control and Isolation Valve Failures

More than twenty events from 1974-1991 have resulted in failures of the motor operated isolation valves, steam control valves and air operated flow control valves. Principal failure causes were equipment wear, instrumentation and control circuit failures, valve hardware failures, and human errors. Valves have failed to operate properly due to failure of control components, broken or dirty contacts, misaligned or broken limit switches, control power loss, and valve operator calibration problems.

#### 5.1.4 Check Valve Failures

There have been two cases of check valve failure at Point Beach from 1974-1991. The failure modes cited were normal wear and aging.

#### 5.1.5 Human Errors

Human errors have caused several problems affecting the AFW system from 1974-1991. Personnel have inadvertently actuated the AFW pumps during testing, failed to calibrate equipment or improperly adjusted valves. Personnel error, inadequate training, and inadequate procedures have been involved.

### 5.2 Industry Wide Experience

Human errors, design/engineering problems and errors, and component failures are the primary root causes of AFW System failures identified in a review of industry wide system operating history. Common cause failures, which disable more than one train of this operationally redundant system, are highly risk significant, and can result from all of these causes.

This section identifies important common cause failure modes, and then provides a broader discussion of the single failure effects of human errors, design/engineering problems and errors, and component failures. Paragraphs presenting details of these failure modes are coded (e.g., CC1) and cross-referenced by inspection items in Section 3.0.

### 5.2.1 Common Cause Failures

The dominant cause of AFW system multiple-train failures has been human error. Design/engineering errors and component failures have been less frequent, but nevertheless significant, causes of multiple train failures.

CC1. Human error in the form of incorrect operator intervention into automatic AFW system functioning during transients resulted in the temporary loss of all safety-grade AFW pumps during events at Davis Besse (NUREG-1154, 1985) and Trojan (AEOD/T416, 1983). In the Davis Besse event, improper manual initiation of the steam and feedwater rupture control system (SFRCS) led to overspeed tripping of both turbine-driven AFW pumps, probably due to the introduction of condensate into the AFW turbines from the long, unheated steam supply lines. (The system had never been tested with the abnormal, cross-connected steam supply lineup which resulted.) In the Trojan event the operator incorrectly stopped both AFW pumps due to misinterpretation of MFW pump speed indication. The diesel driven pump would not restart due to a protective feature requiring complete shutdown, and the turbine-driven pump tripped on overspeed, requiring local reset of the trip and throttle valve. In cases where manual intervention is required during the early stages of a transient, training should emphasize that actions should be performed methodically and deliberately to guard against such errors.

CC2. Valve mispositioning has accounted for a significant fraction of the human errors failing multiple trains of AFW. This includes closure of normally open suction valves or steam supply valves, and of isolation valves to sensors having control functions. Incorrect handswitch positioning and inadequate temporary wiring changes have also prevented automatic starts of multiple pumps. Factors identified in studies of mispositioning errors include failure to add newly installed valves to valve

checklists, weak administrative control of tagging, restoration, independent verification, and locked valve logging, and inadequate adherence to procedures. Illegible or confusing local valve labeling, and insufficient training in the determination of valve position may cause or mask mispositioning, and surveillance which does not exercise complete system functioning may not reveal mispositionings.

CC3. At ANO-2, both AFW pumps lost suction due to steam binding when they were lined up to both the EFWT and the hot startup/blowdown demineralizer effluent (AEOD/C404, 1984). At Zion-1 steam created by running the turbine-driven pump deadheaded for one minute caused trip of a motor-driven pump sharing the same inlet header, as well as damage to the turbine-driven pump (Region 3 Morning Report, 1/17/90). Both events were caused by procedural inadequacies.

CC4. Design/engineering errors have accounted for a smaller, but significant fraction of common cause failures. Problems with control circuit design modifications at Farley defeated AFW pump auto-start on loss of main feedwater. At Zion-2, restart of both motor driven pumps was blocked by circuit failure to de-energize when the pumps had been tripped with an automatic start signal present (IN 82-01, 1982). In addition, AFW control circuit design reviews at Salem and Indian Point have identified designs where failures of a single component could have failed all or multiple pumps (IN 87-34, 1987).

CC5. Incorrect setpoints and control circuit settings resulting from analysis errors and failures to update procedures have also prevented pump start and caused pumps to trip spuriously. Errors of this type may remain undetected despite surveillance testing, unless surveillance tests model all types of system initiation and operating conditions. A greater fraction of instrumentation and control circuit problems has been identified during actual system operation (as opposed to surveillance testing) than for other types of failures.

CC6. On two occasions at a foreign plant, failure of a balance-of-plant inverter caused failure of two AFW pumps. In addition to loss of the motor driven pump whose auxiliary start relay was powered by the inverter, the turbine driven pump tripped on overspeed because the governor valve opened, allowing full steam flow to



the turbine. This illustrates the importance of assessing the effects of failures of balance of plant equipment which supports the operation of critical components. The instrument air system is another example of such a system.

CC7. Multiple AFW pump trips have occurred at Millstone-3, Cook-1, Trojan and Zion-2 (IN 87-53, 1987) caused by brief, low pressure oscillations of suction pressure during pump startup. These oscillations occurred despite the availability of adequate static NPSH. Corrective actions taken include: extending the time delay associated with the low pressure trip, removing the trip, and replacing the trip with an alarm and operator action.

CC8. Design errors discovered during AFW system reanalysis at the Robinson plant (IN 89-30, 1989) and at Millstone-1 resulted in the supply header from the EFWT being too small to provide adequate NPSH to the pumps if more than one of the three pumps were operating at rated flow conditions. This could lead to multiple pump failure due to cavitation. Subsequent reviews at Robinson identified a loss of feedwater transient in which inadequate NPSH and flows less than design values had occurred, but which were not recognized at the time. Event analysis and equipment trending, as well as surveillance testing which duplicates service conditions as much as is practical, can help identify such design errors.

CC9. Asiatic clams caused failure of two AFW flow control valves at Catawba-2 when low suction pressure caused by starting of a motor-driven pump caused suction source realignment to the Nuclear Service Water system. Pipes had not been routinely treated to inhibit clam growth, nor regularly monitored to detect their presence, and no strainers were installed. The need for surveillance which exercises alternative system operational modes, as well as complete system functioning, is emphasized by this event. Spurious suction switchover has also occurred at Callaway and at McGuire, although no failures resulted.

CC10. Common cause failures have also been caused by component failures (AEOD/C404, 1984). At Surry-2, both the turbine driven pump and one motor driven pump were declared inoperable due to steam binding caused by leakage of hot water through multiple check

valves. At Robinson-2 both motor driven pumps were found to be hot, and both motor and steam driven pumps were found to be inoperable at different times. Backleakage at Robinson-2 passed through closed motor-operated isolation valves in addition to multiple check valves. At Farley, both motor and turbine driven pump casings were found hot, although the pumps were not declared inoperable. In addition to multi-train failures, numerous incidents of single train failures have occurred, resulting in the designation of "Steam Binding of Auxiliary Feedwater Pumps" as Generic Issue 93. This generic issue was resolved by Generic Letter 88-03 (Miraglia, 1988), which required licensees to monitor AFW piping temperatures each shift, and to maintain procedures for recognizing steam binding and for restoring system operability.

CC11. Common cause failures have also failed motor operated valves. During the total loss of feedwater event at Davis Besse, the normally-open AFW isolation valves failed to open after they were inadvertently closed. The failure was due to improper setting of the torque switch bypass switch, which prevents motor trip on the high torque required to unseat a closed valve. Previous problems with these valves had been addressed by increasing the torque switch trip setpoint - a fix which failed during the event due to the higher torque required due to high differential pressure across the valve. Similar common mode failures of MOVs have also occurred in other systems, resulting in issuance of Generic Letter 89-10, "Safety Related Motor-Operated Valve Testing and Surveillance (Partlow, 1989)." This generic letter requires licensees to develop and implement a program to provide for the testing, inspection and maintenance of all safety-related MOVs to provide assurance that they will function when subjected to design basis conditions.

CC12. Other component failures have also resulted in AFW multi-train failures. These include out-of-adjustment electrical flow controllers resulting in improper discharge valve operation, and a failure of oil cooler cooling water supply valves to open due to silt accumulation.

## 5.2.2 Human Errors

HE1. The overwhelmingly dominant cause of problems identified during a series of operational readiness

evaluations of AFW systems was human performance. The majority of these human performance problems resulted from incomplete and incorrect procedures, particularly with respect to valve lineup information. A study of valve mispositioning events involving human error identified failures in administrative control of tagging and logging, procedural compliance and completion of steps, verification of support systems, and inadequate procedures as important. Another study found that valve mispositioning events occurred most often during maintenance, calibration, or modification activities. Insufficient training in determining valve position, and in administrative requirements for controlling valve positioning were important causes, as was oral task assignment without task completion feedback.

HE2. Turbine driven pump failures have been caused by human errors in calibrating or adjusting governor speed control, poor governor maintenance, incorrect adjustment of governor valve and overspeed trip linkages, and errors associated with the trip and throttle valve. TTV-associated errors include physically bumping it, failure to restore it to the correct position after testing, and failures to verify control room indication of TTV position following actuation.

HE3. Motor driven pumps have been failed by human errors in mispositioning handswitches, and by procedure deficiencies.

### 5.2.3 Design/Engineering Problems and Errors

DE1. As noted above, the majority of AFW subsystem failures, and the greatest relative system degradation, has been found to result from turbine-driven pump failures. Overspeed trips of Terry turbines controlled by Woodward governors have been a significant source of these failures (AEOD/C602, 1986). In many cases these overspeed trips have been caused by slow response of a Woodward Model EG governor on startup, at plants where full steam flow is allowed immediately. This oversensitivity has been removed by installing a startup steam bypass valve which opens first, allowing a controlled turbine acceleration and buildup of oil pressure to control the governor valve when full steam flow is admitted.

DE2. Overspeed trips of Terry turbines have been caused by condensate in the steam supply lines. Condensate slows down the turbine, causing the governor valve to open farther, and overspeed results before the governor valve can respond, after the water slug clears. This was determined to be the cause of the loss-of-all-AFW event at Davis Besse (AEOD/602, 1986), with condensation enhanced due to the long length of the cross-connected steam lines. Repeated tests following a cold-start trip may be successful due to system heat up.

DE3. Turbine trip and throttle valve (TTV) problems are a significant cause of turbine driven pump failures (IN 84-66). In some cases lack of TTV position indication in the control room prevented recognition of a tripped TTV. In other cases it was possible to reset either the overspeed trip or the TTV without resetting the other. This problem is compounded by the fact that the position of the overspeed trip linkage can be misleading, and the mechanism may lack labels indicating when it is in the tripped position (AEOD/C602, 1986).

DE4. Startup of turbines with Woodward Model PG-PL governors within 30 minutes of shutdown has resulted in overspeed trips when the speed setting knob was not exercised locally to drain oil from the speed setting cylinder. Speed control is based on startup with an empty cylinder. Problems have involved turbine rotation due to both procedure violations and leaking steam. Terry has marketed two types of dump valves for automatically draining the oil after shutdown (AEOD/C602, 1986).

At Calvert Cliffs, a 1987 loss-of-offsite-power event required a quick, cold startup that resulted in turbine trip due to PG-PL governor stability problems. The short-term corrective action was installation of stiffer buffer springs (IN 88-09, 1988). Surveillance had always been preceded by turbine warmup, which illustrates the importance of testing which duplicates service conditions as much as is practical.

DE5. Reduced viscosity of gear box oil heated by prior operation caused failure of a motor driven pump to start due to insufficient lube oil pressure. Lowering the pressure switch setpoint solved the problem, which had not been detected during testing.

DE6. Waterhammer at Palisades resulted in AFW line and hanger damage at both steam generators. The AFW spargers are located at the normal steam generator level, and are frequently covered and uncovered during level fluctuations. Waterhammers in top-feed-ring steam generators resulted in main feedline rupture at Maine Yankee and feedwater pipe cracking at Indian Point-2 (IN 84-32, 1984).

DE7. Manually reversing the direction of motion of an operating valve has resulted in MOV failures where such loading was not considered in the design (AEOD/C603, 1986). Control circuit design may prevent this, requiring stroke completion before reversal.

DE8. At each of the units of the South Texas Project, space heaters provided by the vendor for use in preinstallation storage of MOVs were found to be wired in parallel to the Class 1E 125 V DC motors for several AFW valves (IR 50-489/89-11; 50-499/89-11, 1989). The valves had been environmentally qualified, but not with the non-safety-related heaters energized.

#### 5.2.4 Component Failures

Generic Issue II.E.6.1, "In Situ Testing Of Valves" was divided into four sub-issues (Beckjord, 1989), three of which relate directly to prevention of AFW system component failure. At the request of the NRC, in situ testing of check valves was addressed by the nuclear industry, resulting in the EPRI report, "Application Guidelines for Check Valves in Nuclear Power Plants (Brooks, 1988)." This extensive report provides information on check valve applications, limitations, and inspection techniques. In-situ testing of MOVs was addressed by Generic Letter 89-10, "Safety Related Motor-Operated Valve Testing and Surveillance" (Partlow, 1989) which requires licensees to develop and implement a program for testing, inspection and maintenance of all safety-related MOVs. "Thermal Overload Protection for Electric Motors on Safety-Related Motor-Operated Valves - Generic Issue II.E.6.1 (Rothberg, 1988)" concludes that valve motors should be thermally protected, yet in a way which emphasizes system function over protection of the operator.

CF1. The common-cause steam binding effects of check valve leakage were identified in Section 5.2.1, entry

CC10. Numerous single-train events provide additional insights into this problem. In some cases leakage of hot MFW past multiple check valves in series has occurred because adequate valve-seating pressure was limited to the valves closest to the steam generators (AEOD/C404, 1984). At Robinson, the pump shutdown procedure was changed to delay closing the MOVs until after the check valves were seated. At Farley, check valves were changed from swing type to lift type. Check valve rework has been done at a number of plants. Different valve designs and manufacturers are involved in this problem, and recurring leakage has been experienced, even after repair and replacement.

CF2. At Robinson, heating of motor operated valves by check valve leakage has caused thermal binding and failure of AFW discharge valves to open on demand. At Davis Besse, high differential pressure across AFW injection valves resulting from check valve leakage has prevented MOV operation (AEOD/C603, 1986).

CF3. Gross check valve leakage at McGuire and Robinson caused overpressurization of the AFW suction piping. At a foreign PWR it resulted in a severe waterhammer event. At Palo Verde-2 the MFW suction piping was overpressurized by check valve leakage from the AFW system (AEOD/C404, 1984). Gross check valve leakage through idle pumps represents a potential diversion of AFW pump flow.

CF4. Roughly one third of AFW system failures have been due to valve operator failures, with about equal failures for MOVs and AOVs. Almost half of the MOV failures were due to motor or switch failures (Casada, 1989). An extensive study of MOV events (AEOD/C603, 1986) indicates continuing inoperability problems caused by: torque switch/limit switch settings, adjustments, or failures; motor burnout; improper sizing or use of thermal overload devices; premature degradation related to inadequate use of protective devices; damage due to misuse (valve throttling, valve operator hammering); mechanical problems (loosened parts, improper assembly); or the torque switch bypass circuit improperly installed or adjusted. The study concluded that current methods and procedures at many plants are not adequate to assure that MOVs will operate when needed under credible accident conditions. Specifically, a surveillance test which the valve passed might result in undetected valve inoperability due to component failure



(motor burnout, operator parts failure, stem disc separation) or improper positioning of protective devices (thermal overload, torque switch, limit switch). Generic Letter 89-10 (Partlow, 1989) has subsequently required licensees to implement a program ensuring that MOV switch settings are maintained so that the valves will operate under design basis conditions for the life of the plant.

CF5. Component problems have caused a significant number of turbine driven pump trips (AEOD/C602, 1986). One group of events involved worn tappet nut faces, loose cable connections, loosened set screws, improperly latched TTVs, and improper assembly. Another involved oil leaks due to component or seal failures, and oil contamination due to poor maintenance activities. Governor oil may not be shared with turbine lubrication oil, resulting in the need for separate oil changes. Electrical component failures included transistor or resistor failures due to moisture intrusion, erroneous grounds and connections, diode failures, and a faulty circuit card.

CF6. Electrohydraulic-operated discharge valves have performed very poorly, and three of the five units using them have removed them due to recurrent failures. Failures included oil leaks, contaminated oil, and hydraulic pump failures.

CF7. Control circuit failures were the dominant source of motor driven AFW pump failures (Casada, 1989). This includes the controls used for automatic and manual starting of the pumps, as opposed to the instrumentation inputs. Most of the remaining problems were due to circuit breaker failures.

CF8. "Hydraulic lockup" of Limitorque SMB spring packs has prevented proper spring compression to actuate the MOV torque switch, due to grease trapped in the spring pack. During a surveillance at Trojan, failure of the torque switch to trip the TTV motor

resulted in tripping of the thermal overload device, leaving the turbine driven pump inoperable for 40 days until the next surveillance (AEOD/E702, 1987). Problems result from grease changes to EXXON NEBULA EP-0 grease, one of only two greases considered environmentally qualified by Limitorque. Due to lower viscosity, it slowly migrates from the gear case into the spring pack. Grease changeover at Vermont Yankee affected 40 of the older MOVs of which 32 were safety related. Grease relief kits are needed for MOV operators manufactured before 1975. At Limerick, additional grease relief was required for MOVs manufactured since 1975. MOV refurbishment programs may yield other changeovers to EP-0 grease.

CF9. For AFW systems using air operated valves, almost half of the system degradation has resulted from failures of the valve controller circuit and its instrument inputs (Casada, 1989). Failures occurred predominantly at a few units using automatic electronic controllers for the flow control valves, with the majority of failures due to electrical hardware. At Turkey Point-3, controller malfunction resulted from water in the Instrument Air system due to maintenance inoperability of the air dryers.

CF10. For systems using diesel driven pumps, most of the failures were due to start control and governor speed control circuitry. Half of these occurred on demand, as opposed to during testing (Casada, 1989).

CF11. For systems using AOVs, operability requires the availability of Instrument Air (IA), backup air, or backup nitrogen. However, NRC Maintenance Team Inspectors have identified inadequate testing of check valves isolating the safety-related portion of the IA system at several utilities (Letter, Roe to Richardson). Generic Letter 88-14 (Miraglia, 1988), requires licensees to verify by test that air-operated safety-related components will perform as expected in accordance with all design-basis events, including a loss of normal IA.

## 6 References

Beckjord, E. S., *Closeout of Generic Issue II.E.6.1, 'In Situ Testing of Valves*, Letter to V. Stello, Jr., U.S. Nuclear Regulatory Commission, Washington, DC, June 30, 1989.

Brooks, B. P., *Application Guidelines for Check Valves in Nuclear Power Plants (NP-5479)*, Electric Power Research Institute, Palo Alto, California, 1988.

Casada, D. A., *Auxiliary Feedwater System Aging Study, Volume 1. Operating Experience and Current Monitoring Practices (NUREG/CR-5404)* U.S. Nuclear Regulatory Commission, Washington, DC, 1989.

Gregg, R. E. and R. E. Wright, *Appendix Review for Dominant Generic Contributors (BLB-31-88)* Idaho National Engineering Laboratory, Idaho Falls, Idaho, 1988.

Miraglia, F. J., *Resolution of Generic Safety Issue 93, Steam Binding of Auxiliary Feedwater Pumps (Generic Letter 88-03)* U.S. Nuclear Regulatory Commission, Washington, DC, February 17, 1988.

Miraglia, F. J., *Instrument Air Supply System Problems Affecting Safety-Related Equipment (Generic Letter 88-14)* U.S. Nuclear Regulatory Commission, Washington, DC, August 8, 1988.

Partlow, J. G., *Safety-Related Motor-Operated Valve Testing and Surveillance (Generic Letter 89-10)* U.S. Nuclear Regulatory Commission, Washington, DC, June 28, 1989.

Rothberg, O., *Thermal Overload Protection for Electric Motors on Safety-Related Motor-Operated Valves - Generic Issue II.E.6.1 (NUREG-1296)* U.S. Nuclear Regulatory Commission, Washington, DC, June 1988.

Travis, R., and J. Taylor, *Development of Guidance for Generic, Functionally Oriented PRA-Based Team Inspections for BWR Plants-Identification of Risk-Important Systems, Components and Human Actions (TLR-A-3874-TG4)* Brookhaven National Laboratory, Upton, New York, 1989.

### AEOD Reports

AEOD/C404, W. D. Lanning, *Steam Binding of Auxiliary Feedwater Pumps*, U.S. Nuclear Regulatory Commission, Washington, DC, July 1984.

AEOD/C602, C. Hsu, *Operational Experience Involving Turbine Overspeed Trips*, U.S. Nuclear Regulatory Commission, Washington, DC, August 1986.

AEOD/C603, E. J. Brown, *A Review of Motor-Operated Valve Performance*, U.S. Nuclear Regulatory Commission, Washington, DC, December 1986.

AEOD/E702, E. J. Brown, *MOV Failure Due to Hydraulic Lockup From Excessive Grease in Spring Pack*, U.S. Nuclear Regulatory Commission, Washington, DC, March 19, 1987.

AEOD/T416, *Loss of ESF Auxiliary Feedwater Pump Capability at Trojan on January 22, 1983*, U.S. Nuclear Regulatory Commission, Washington, DC, January 22, 1983.

### Information Notices

IN 82-01, *Auxiliary Feedwater Pump Lockout Resulting from Westinghouse W-2 Switch Circuit Modification*, U.S. Nuclear Regulatory Commission, Washington, DC, January 22, 1987.

IN 84-32, E. L. Jordan, *Auxiliary Feedwater Sparger and Pipe Hanger Damage*, U.S. Nuclear Regulatory Commission, Washington, DC, April 18, 1984.

IN 84-66, *Undetected Unavailability of the Turbine-Driven Auxiliary Feedwater Train*, U.S. Nuclear Regulatory Commission, Washington, DC, August 17, 1984.

IN 87-34, C. E. Rossi, *Single Failures in Auxiliary Feedwater Systems*, U.S. Nuclear Regulatory Commission, Washington, DC, July 24, 1987.



## References

IN 87-53, C. E. Rossi, *Auxiliary Feedwater Pump Trips Resulting from Low Suction Pressure*, U.S. Nuclear Regulatory Commission, Washington, DC, October 20, 1987.

IN 88-09, C. E. Rossi, *Reduced Reliability of Steam-Driven Auxiliary Feedwater Pumps Caused by Instability of Woodward PG-PL Type Governors*, U.S. Nuclear Regulatory Commission, Washington, DC, March 18, 1988.

IN 89-30, R. A. Azua, *Robinson Unit 2 Inadequate NPSH of Auxiliary Feedwater Pumps*, Also, Event Notification 16375, August 22, 1989, U.S. Nuclear Regulatory Commission, Washington, DC, August 16, 1989.

## Inspection Report

IR 50-489/89-11; 50-499/89-11, *South Texas Project Inspection Report*, U.S. Nuclear Regulatory Commission, Washington, DC, May 26, 1989.

## NUREG Report

NUREG-1154, *Loss of Main and Auxiliary Feedwater Event at the Davis Besse Plant on June 9, 1985*, U.S. Nuclear Regulatory Commission, Washington, 1985.

# Distribution

No. of  
Copies

No. of  
Copies

## OFFSITE

## OFFSITE

19 U.S. Nuclear Regulatory Commission

4 Point Beach Resident Inspector Office

B. K. Grimes  
OWFN 9 A2

J. H. Taylor  
Brookhaven National Laboratory  
Building 13  
Upton, NY 11973

F. Congel  
OWFN 8E2

R. Travis  
Brookhaven National Laboratory  
Building 130  
Upton, NY 11973

A. C. Thadani  
OWFN 8E2

R. Gregg  
EG&G Idaho, Inc.  
P.O. Box 1625  
Idaho Falls, ID 83415

R. J. Barret  
OWFN 13 D1

G. M. Holahan  
OWFN 2

D. R. Edwards  
Professor of Nuclear Engineering  
University of Missouri - Rolla  
Rolla, MO 65401

K. F. ...  
OWFN 1 A2

10 J. Chung  
OWFN 10 A2

## ONSITE

J. N. Hannon  
OWFN 13 E21

23 Pacific Northwest Laboratory

2 B. Thomas  
OWFN 12 H26

L. R. Dodd  
R. F. Gore (10)  
N. E. Maguire-Moffitt  
R. C. Lloyd  
B. D. Shipp  
F. A. Simonen  
T. A. Vehc  
T. V. Vo  
Publishing Coordination  
Technical Report File (5)

2 U.S. Regulatory Commission  
Region 3

H. J. Miller  
E. G. Greenman

BIBLIOGRAPHIC DATA SHEET

(See instructions on the reverse)

1. REPORT NUMBER  
(Assigned by NRC. Add Vol., Supp., Rev.,  
and Addendum Numbers, if any.)

NUREG/CR-5898  
PNL-8105

2. TITLE AND SUBTITLE

Auxiliary Feedwater System Risk-Based Inspection Guide for the  
Point Beach Nuclear Power Plant

3. DATE REPORT PUBLISHED

MONTH YEAR  
February 1993

4. FIN OR GRANT NUMBER

L1310

5. AUTHOR(S)

R. C. Lloyd, N. E. Moffitt, B. F. Gore, T. V. Vo, T. A. Vehce

6. TYPE OF REPORT

Technical

7. PERIOD COVERED (Inclusive Dates)

3/92 to 1/93

8. PERFORMING ORGANIZATION - NAME AND ADDRESS (If NRC, provide Division, Office or Region, U.S. Nuclear Regulatory Commission, and mailing address; if contractor, provide name and mailing address.)

Pacific Northwest Laboratory  
Richland, WA 99352

9. SPONSORING ORGANIZATION - NAME AND ADDRESS (If NRC, type "Same as above"; if contractor, provide NRC Division, Office or Region, U.S. Nuclear Regulatory Commission, and mailing address.)

Division of Systems Safety and Analysis  
Office of Nuclear Reactor Regulation  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

10. SUPPLEMENTARY NOTES

11. ABSTRACT (200 words or less)

In a study sponsored by the U.S. Nuclear Regulatory Commission (NRC), Pacific Northwest Laboratory has developed and applied a methodology for deriving plant-specific risk-based inspection guidance for the auxiliary feedwater (AFW) system at pressurized water reactors that have not undergone probabilistic risk assessment (PRA). This methodology uses existing PRA results and plant operating experience information. Existing PRA-based inspection guidance information recently developed for the NRC for various plants was used to identify generic component failure modes. This information was then combined with plant-specific and industry-wide component information and failure data to identify failure modes and failure mechanisms for the AFW system at the selected plants. Point Beach was selected as one of a series of plants for study. The product of this effort is a prioritized listing of AFW failures which have occurred at the plant and at other PWRs. This listing is intended for use by NRC inspectors in the preparation of inspection plans addressing AFW risk-important components at the Point Beach plant.

12. KEY WORDS/DESCRIPTORS (List words or phrases that will assist researchers in locating the report.)

Inspection, Risk, PRA, Point Beach, Auxiliary Feedwater (AFW)

13. AVAILABILITY STATEMENT

Unlimited

14. SECURITY CLASSIFICATION

(This Page)

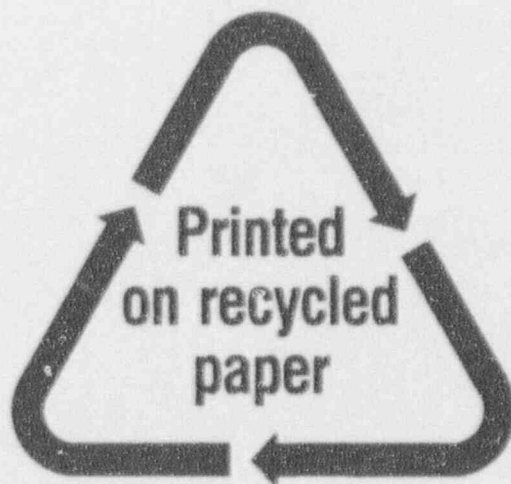
Unclassified

(This Report)

Unclassified

15. NUMBER OF PAGES

16. PRICE



Federal Recycling Program

UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001

OFFICIAL BUSINESS  
PENALTY FOR PRIVATE USE, \$300

120555139531  
US NRC-OADM 1 JAN 1993  
DIV FOIA & PUBLICATIONS SVCS  
TPS-PDR-NUREG  
C-211  
WASHINGTON

DC 20555

FIRST CLASS MAIL  
POSTAGE AND FEES PAID  
USNRC  
PERMIT NO. G-67



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001

OFFICIAL BUSINESS  
PENALTY FOR PRIVATE USE, \$300

120555139531  
US NRC-0ADM 1 JAN 1993  
DIV FOIA & PUBLICATIONS SVCS  
TPS-PDR-NUREG  
D-211  
WASHINGTON  
DC 20555

FIRST CLASS MAIL  
POSTAGE AND FEES PAID  
USNRC  
PERMIT NO. G-67