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Palo Verde Nuclear Generating Station William E. Ide Vice President Nuclear Production

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192-01096-WEI/SAB/DJS December 4, 2001

U. S. Nuclear Regulatory Commission ATTN: Document Control Desk Mail Station P1-37 Washington, DC 20555-0001

Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS) Unit 1, 2, and 3 Docket No. STN 50-528, 50-529 and 50-530 License No. NPF-41, NPF-51 and NPF-74 Licensee Event Report 2001-003-00

Attached please find Licensee Event Report (LER) 50-528/2001-003-00 that has been prepared and submitted pursuant to 10CFR50.73. This LER reports a plant shutdown of PVNGS Unit 2 based upon the discovery of Control Element Assembly (CEA) degradation in PVNGS Unit 3.

The Unit 3 CEA degradation was observed during the ninth refueling outage and was assumed to be transportable to Unit 2. Technical Specifications require all full length CEAs to be operable and therefore Unit 2 entered LCO 3.0.3 and shutdown to inspect the CEAs. This CEA degradation LER reports APS' activities for Units 1, 2, and 3. The corrective actions described in this LER are not necessary to maintain compliance with regulations. Arizona Public Service Company makes no commitments in this letter.

In accordance with 10CFR50.73(d), a copy of this LER is being forwarded to the NRC Regional Office, NRC Region IV and the Senior Resident Inspector. If you have questions regarding this submittal, please contact Daniel G. Marks, Section Leader, Regulatory Affairs, at (623) 393-6492.

Sincerely,

Will h sh

WEI/SAB/DJS/kg Attachment

cc: E. W. Merschoff J. H. Moorman L. R. Wharton (all with attachment)



APPROVED BY OMB NO. 3150-0104 EXPIRES 7-31-2004 NRC FORM 366 **U.S. NUCLEAR REGULATORY** Estimated burden per response to comply with this mandatory information collection COMMISSION (7-2001) request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to <u>bis1@nrc.gov</u>, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and LICENSEE EVENT REPORT (LER) Budget, Washington, DC 20503. If a means used to impose information collection does (See reverse for required number of not display a currently valid OMB control number, the NRC may not conduct or sponsor, digits/characters for each block) and a person is not required to respond to, the information collection. 2. DOCKET NUMBER 3. PAGE 1. FACILITY NAME 1 OF 6 Palo Verde Nuclear Generating Station Unit 1 05000528 4. TITLE Technical Specification Required Shutdown Due to Degraded Control Element Assemblies 7. REPORT DATE 8. OTHER FACILITIES INVOLVED 6. LER NUMBER 5. EVENT DATE FACILITY NAME DOCKET NUMBER SEQUENTIAL DAY YEAR YEAR REV NO MONTH DAY YEAR MONTH NUMBER Palo Verde Unit 2 05000529 FACILITY NAME DOCKET NUMBER 2001 - 0003 - 00 04 12 2001 2001 10 10 05000530 Palo Verde Unit 3 11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) 9. OPERATING 1 50.73(a)(2)(ix)(A) MODE 20.2203(a)(3)(ii) 50.73(a)(2)(ii)(B) 20.2201(b) 50.73(a)(2)(x) 50.73(a)(2)(iii) 20.2203(a)(4) 20.2201(d) 10. POWER 100 73.71(a)(4) LEVEL 50.36(c)(1)(i)(A) 50.73(a)(2)(iv)(A) 20.2203(a)(1) 73.71(a)(5) 50.36(c)(1)(ii)(A) 50.73(a)(2)(v)(A) 20.2203(a)(2)(i) 50.36(c)(2) 50.73(a)(2)(v)(B) 20.2203(a)(2)(ii) OTHER Specify in Abstract below or 50.73(a)(2)(v)(C) 50.46(a)(3)(ii) 20.2203(a)(2)(iii) in NRC Form 366A 50.73(a)(2)(v)(D) 50.73(a)(2)(i)(A) 20.2203(a)(2)(iv) х 50.73(a)(2)(vii) 20.2203(a)(2)(v) Х 50.73(a)(2)(i)(B) 50.73(a)(2)(i)(C) 50.73(a)(2)(viii)(A) 20.2203(a)(2)(vi) 50.73(a)(2)(viii)(B) 20.2203(a)(3)(i) 50.73(a)(2)(ii)(A) 12. LICENSEE CONTACT FOR THIS LER TELEPHONE NUMBER (Include Area Code) NAME 623-393-6492 Daniel G. Marks, Section Leader, Regulatory Affairs 13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT REPORTABLE TO EPIX MANU FACTURER REPORTABLE MANU-COMPONENT SYSTEM COMPONENT CAUSE CAUSE SYSTEM FACTURER TO EPIX C490 Y Х AA YEAR 15. EXPECTED MONTH DAY **14. SUPPLEMENTAL REPORT EXPECTED** SUBMISSION YES (If yes, complete EXPECTED SUBMISSION DATE) X NO DATE 16. ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On October 10, 2001, at approximately 0430 MST, Palo Verde Unit 2 was in Mode 1 (POWER OPERATION), operating at approximately 100 percent power when Control Room personnel were advised of a potentially transportable condition affecting the integrity of Control Element Assemblies (CEAs). Preliminary inspection of Unit 3 CEAs during refueling revealed one CEA with cracks. Due to the similar design and operating history of CEAs, similar cracks were assumed to also be present in Unit 2. Based upon the Unit 3 discovery, Unit 2 plant operators initiated a plant shutdown and at approximately 0937 MST, Palo Verde Unit 2 entered Mode 3 (HOT STANDBY). Unit shutdown occurred normally and following the manually inserted reactor trip per the unit shutdown procedure, all CEAs fully inserted into the core. Unit 2 was taken to Mode 6 (REFUELING) to inspect and replace the CEAs. The event did not adversely affect the health and safety of the public. In the past three years, there have been no previous similar events reported pursuant to 10CFR50.73 for CEA degradation at Palo Verde Nuclear Generating Station. This CEA degradation LER reports APS' activities for Units 1, 2, and 3.

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSI (7-2001) LICENSEE EVENT REPORT (LER)	ON				
1. FACILITY NAME	2. DOCKET		6. LER NUMBER	3. PAGE	
Palo Verde Nuclear Generating Station Unit 1		YEAR	SEQUENTAL NUMBER	REVISION NUMBER	
	05000528	2001 -	003 -	2 OF 6	

## 1. REPORTING REQUIREMENT(S):

This LER (50-528/2001-004-00) is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(A), to report the completion of a plant shut down required in Unit 2 (Docket Number 05000529 – License Number NPF-41) by Technical Specification 3.0.3 on October 10, 2001 at approximately 0937 Mountain Standard Time (MST). Also, this LER is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B), to report a condition prohibited by Technical Specifications where entry into Technical Specification 3.0.3 was performed for the suspected Control Element Assembly (CEA) degradation, and the condition was not corrected within one hour in Unit 2.

The degradation was also discovered in Unit 1 and Unit 3. The LCO was not applicable at the times of discovery for Units 1 and 3's CEA degradation. The time of discovery for Units 1 and 3 occurred during refueling activities (MODE 6) where the operability of the CEAs is not required. Also, during the Unit shutdowns prior to the Unit 1 and Unit 3 refueling outages, the CEAs performed their design functions. Due to the conservative decision to declare the Unit 2 CEAs inoperable, it is considered that the same condition prohibited by Technical Specifications existed in Unit 1 and Unit 3.

On October 10, 2001 at 0823 MST, APS made notification of the event to the Nuclear Regulatory Commission (NRC) via the emergency notification system (ENS# 38373).

# 2. DESCRIPTION OF STRUCTURE(S), SYSTEM(S) AND COMPONENT(S):

The paragraphs in this section provide brief descriptions of the major equipment and systems that were relied upon, influenced, or had a significant function in this event.

## Control Element Assemblies & Support Systems (CEAs) (EIIS: AA)

Palo Verde Unit 1, 2, and 3 are a Combustion Engineering (now Westinghouse), System-80 Nuclear Steam Supply System. The System-80 design uses full length Control Element Assemblies (CEAs) (EIIS: AA) consisting of assemblies of 4 or 12 fingers. Each CEA finger consists of an Inconel (Alloy 625) tube filled with boron carbide pellets. Within the tube, above the pellets, is a plenum that allows for expansion of the

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSIO (7-2001) LICENSEE EVENT REPORT (LER)	ON				
1. FACILITY NAME	2. DOCKET		6. LER NUMBE	3. PAGE	
Palo Verde Nuclear Generating Station Unit 1		YEAR	SEQUENTAL NUMBER	REVISION NUMBER	
	05000528	2001 -	003 -	3 OF 6	
	05000528	2001 -	003 -	3	

internal parts. This plenum contains a spacer and spring. The spring applies a compressive force on the pellets to restrain them inside the tube and prevent them from rising into the plenum. The lower 12 inches of each finger contains reduced diameter boron carbide pellets that are wrapped with stainless steel feltmetal material. The reduced diameter pellets and surrounding feltmetal provide space for the swelling of the pellets brought on by neutron interaction during operation in the reactor. Irradiation Assisted Stress Corrosion Cracking (IASCC) is predicted to be a life limiting factor for fingers using this design.

#### 3. INITIAL PLANT CONDITIONS:

On October 10, 2001, at approximately 0430 MST, Palo Verde Unit 2 was in Mode 1 (POWER OPERATION), operating at approximately 100 percent power. There were no major structures, systems, or components that were inoperable or otherwise contributed to the event.

### 4. EVENT DESCRIPTION:

During the ninth refueling outage of Palo Verde Unit 3 (Docket Number 05000530 – License Number NPF-74), an inspection of the Control Element Assemblies (CEAs) removed from the reactor was performed during planned CEA replacement activities. During initial inspections, several fingers of one CEA were observed to contain crack-like indications near the lower end of the finger. One of the fingers was also observed to emit a small stream of bubbles from the top of a crack-like indication. Due to the similarity of design and operating history of the CEAs in Unit 2, notification of the condition was immediately made to the Unit 2 Control Room.

Limiting Condition for Operation (LCO) 3.1.5 states: "All full length CEAs shall be OPERABLE . . ." No associated action in Technical Specification (TS) 3.1.5 applied to the suspected degradation in CEA integrity, therefore, Unit 2 entered TS LCO 3.0.3. On October 10, 2001, at approximately 0430 MST, Palo Verde Unit 2 entered TS LCO 3.0.3 and initiated actions to place the unit in Mode 3. Following an uncomplicated shutdown and a manual reactor trip from approximately 22 percent power per the unit shutdown procedure, all CEAs fully inserted into the core. Unit 2 entered Mode 3 at 0937 MST.

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSI (7-2001) LICENSEE EVENT REPORT (LER)	ON					
1. FACILITY NAME	2. DOCKET	6. LER NUMBER 3. PAGE				
Palo Verde Nuclear Generating Station Unit 1		YEAR	SEQUENTAL NUMBER	REVISION NUMBER	3. PAGE	
	05000528	2001 003 00			4 OF 6	

On October 11, 2001, at 1345 MST, Unit 2 entered Mode 5. After the shutdown, Unit 2 was taken to Mode 6 for a mid-cycle outage. Preliminary inspections of the Unit 2 CEAs during replacement activities found several CEA fingers with evidence of cracking near their lower ends. The nose cap of one finger of one CEA was also observed to have separated from the finger. All full length CEAs were replaced during the ensuing mid-cycle outage.

There were no safety system actuations and none were required.

### 5. ASSESSMENT OF SAFETY CONSEQUENCES:

The basic function of the Control Element Assemblies (CEAs) is to provide for reactivity control under all normal and adverse conditions during reactor operations and accident conditions. Cracks in CEA fingers can lead to loss of boron carbide, which would reduce the reactivity of the CEAs. Loss of CEA reactivity is outside the design requirements for CEAs. Loss of CEA reactivity may produce unacceptable power peaking factors, Departure from Nucleate Boiling Ratio (DNBR), Linear Heat Rates (LHRs), or Shut Down Margin (SDM). These factors could lead to reactor conditions inconsistent with the safety analysis. There were no CEA failures found sufficient to impact any Safety Margins, therefore the CEAs could continue to shut down the reactor, maintain the reactor in a safe shutdown condition and mitigate the consequences of an accident. Replacement of all full length CEAs in all three units at Palo Verde has returned the CEAs to their conforming condition. Part length CEAs are not relied upon for accident mitigation and are different in design such that the possibility of cracking is not a concern.

The event did not result in any challenges to the fission product barriers or result in any release of radioactive materials. Therefore, there were no adverse safety consequences or implications as a result of this event. This event did not adversely affect the safe operation of the plant or health and safety of the public.

The condition would not have prevented the fulfillment of the safety function and did not result in a safety system functional failure as defined by 10CFR50.73(a)(2)(v)

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION (7-2001) LICENSEE EVENT REPORT (LER)							
1. FACILITY NAME	2. DOCKET		6. LER NUMBEI	3. PAGE			
Palo Verde Nuclear Generating Station Unit 1		YEAR	SEQUENTAL NUMBER	REVISION NUMBER			
	2001 003			- 00	5 OF 6		

#### 6. CAUSE OF THE EVENT:

CEA failures were first detected in Unit 1(Docket Number 05000528 – License Number NPF-41) during the ninth refueling outage in the Spring of 2001. All of the full-length CEAs in Unit 1 were replaced during the refueling outage. The design of the Unit 1 CEAs was considered to be more limiting than the design of the CEAs in Units 2 and 3.

The failures found in Unit 3 were not consistent with design expectations, which resulted in APS' decision to immediately replace CEAs in Unit 2 and Unit 3. This was the first replacement of CEAs in all three units at Palo Verde and the first time CEA integrity issues have caused a plant shutdown. No previous shutdowns have occurred at Palo Verde for this cause.

An equipment root cause of failure analysis is being conducted in accordance with the APS Corrective Action Program. Preliminary findings suggest the CEA degradation is due to age related mechanisms exhibiting their effects at a rate faster than expected. Examinations of suspect CEAs will be performed as part of the ongoing investigation.

No unusual characteristics of the work location (e.g., noise, heat, poor lighting) directly contributed to the event. No personnel errors or procedural error contributed to this event.

If information is subsequently developed that would significantly affect a reader's understanding or perception of this event, a supplement to this LER will be submitted.

#### 7. CORRECTIVE ACTIONS:

APS replaced all Unit 1, Unit 2 and Unit 3 full length CEAs.

Actions to prevent recurrence include adjustment to the projected service life for Palo Verde CEAs in consideration of the observed failures and to reflect the findings of the equipment root cause failure analysis when it is complete.

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSI (7-2001) LICENSEE EVENT REPORT (LER)	ON				
1. FACILITY NAME	2. DOCKET		6. LER NUMBE	3. PAGE	
Palo Verde Nuclear Generating Station Unit 1		YEAR	SEQUENTAL NUMBER	REVISION NUMBER	
	05000528	2001	003 -	6 OF 6	

### 8. PREVIOUS SIMILAR EVENTS:

In the past three years, there have been no previous similar events reported pursuant to 10CFR50.73 for CEA degradation at Palo Verde Nuclear Generating Station. This CEA degradation LER reports APS' activities for Units 1, 2, and 3.

## 9. ADDITIONAL INFORMATION:

The reactor shut down (Unplanned Power Changes greater than 20 percent) was a single actual initiating event that affected only the initiating event cornerstone in the regulatory oversight and assessment process. The event was tabulated as part of the Unplanned Power Changes per 7,000 critical hours, in the performance indicator cornerstone of initiating events.