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	NPM 2002-0583			
To:	Ken Peveler :	0		
From:	A. J. Cayia	Conjo		
Date:	October 31, 2002			
Subject:	POTENTIAL AFV TEAM	Y COMMON MOI	DE FAILURE EVE	INT RESOLUTION
Copy To:	D. Schoon J. Freels R. Flessner M. Rosseau	S. Thoms T. VandenBosch R. Wood File	J.P. Cown T. Coutu T. Kendall	J. Anderson K. Davison B. Zipp

I am forming an event resolution team to provide management oversight to drive resolution of the issue involving the potential to have a common mode failure due to orifice plugging in the AFW minimum flow recirc line orifices and am assigning you as the team leader for this effort. This issue is described in CAP 029952 attached. The following organization is established which will report to you to ensure that we effectively resolve this issue:

- > Incident Investigation Stu Thomas
- > On-line Work Risk Management John Anderson
- > Interim Corrective Actions Duane Schoon
- > Issue Resolution Team and Root Cause Evaluation Jim Freels

Fritzie Flentje is assigned to support you in your efforts. I would like you to step out of your role as Nuclear Oversight Manager and assign your supervisors to act in your stead until this issue is resolved. I expect that schedules and actions will be established for each of the focus areas identified. Additionally, you, Fritzie Flentje and each of the managers above will comprise our Inspection Interface Team for the special inspection, which will commence Thursday, October 31, 2002.

The assignments and tasks below should continue to be revised as you pursue resolution of this issue. The assignments for each of the above efforts are as follows:

Incident Investigation - Stu Thomas

The scope of this effort is to conduct an incident investigation to collect the facts surrounding the maintenance conducted on the P-38 A motor driven auxiliary feedwater pump, the post maintenance testing, the evaluation of the corrosion products discovered in the recirc orifice and concluding with the decision to declare the auxiliary feedwater pumps inoperable on Tuesday, October 29, 2002. The incident investigation is to be completed using applicable portions of NP 5.3.3 "Incident Investigation and Post-trip Review" for guidance.

On-line Work Risk Management – John Anderson

The focus of this effort is to ensure that we comply with procedure 10.3.7 "On-line Safety Assessment" while we are in elevated risk due to the potential for common mode plugging of

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the AFW recirc orifices. This effort should continue and provide you daily updates until interim corrective actions have restored on-line risk to a "green" condition.

Interim Corrective Actions – Duane Schoon

The focus of this effort is to complete the interim corrective actions which are comprised of administrative controls, training for the operators, and procedure changes and also to perform an independent objective review of the adequacy of each of these corrective actions.

1. Complete the interim administrative controls, operator training and EOP and AOP changes to establish appropriate operator guidance for all accident sequences of interest.

Issue Manager: Duane Schoon Team Leader: Terry Vandenbosch

2. Independently evaluate the procedure changes being made to the EOPs and AOPs and assess their adequacy to provide adequate operator guidance. Additionally, evaluate the adequacy of the temporary information tags and objectively evaluate our decision to declare the AFW pumps operable after taking interim actions to address this issue on Tuesday October 29, 2002.

Responsible Manager: Tom Coutu/K. Davison

3. Independently evaluate the briefings and training conducted or planned for operating crews. We would like an objective look to ensure that the training was adequate and well documented.

Responsible Manager: Kevin Davison/T. Coutu

Engineering Resolution Team and Root Cause Evaluation

In addition to completing the root cause evaluation, the efforts of this team are to include completing the risk evaluation on an expedited basis, analyzing the potential for the orifice to become plugged, and conducting testing as appropriate to provide input to the PRA efforts being conducted.

1. Ensure that the root cause evaluation team completes the RCE in a timely and objective manner. The root cause team must evaluate why the original modification that installed the recirc orifices did not address the potential for orifice plugging and as importantly why our organization did not identify the issue when the recirc line was changed to provide a safety related open function in response to the recent red AFW finding. The charter for the RCE team is attached.

Issue Manager: Jim Freels RCE team leader: Rich Flessner

2. Ensure that the PRA work to evaluate the risk significance of this potential common mode failure is completed expeditiously.

Responsible Manager: Jim Freels Team Leader: Rick Wood NPM 2002-0583 October 31, 2002 Page 3

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3. Evaluate hydraulic system response to determine if the orifices could become plugged.

Responsible Manager: Jim Freels Team Leader: Tom Kendall

4. Develop a test plan to evaluate plugging of a spare orifice. Use the vendor utilized by Kewaunee to evaluate the AFW suction orifice issue as appropriate.

Responsible Manager: Jim Freels Team Leader: Tom Kendall

5. Analyze the sample of corrosion products for metallurgical content to enable us to determine the source of the corrosion products.

Responsible Manager: Jim Freels Team Leader: Bill Zipp

 $\mathbf{f}_{a}^{\frac{1}{2}}$ Evaluate the auxiliary feedwater system to determine the sources and quantity of potential corrosion products.

Responsible Manager: Jim Freels Team Leader: Bill Zipp

7. Contact the vendor of the orifice to obtain test data and other relevant information that could be used as input to the PRA work.

Responsible Manager: Jim Freels Team Leader: Tom Kendall

8. Identify all other applications of this type of orifice in the Point Beach units and determine applicable operating history. Evaluate suitability of this orifice type in all other applications.

Responsible Manager: Jim Freels Team Leader: Tom Kendall

9. Ensure that modifications to the orifice design or a replacement orifice are pursued expeditiously to resolve any questions relating to the potential for the orifice to become plugged.

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Responsible Manager: Jim Freels Responsible Design Lead: Mike Rosseau

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STATE CHANGE HISTORY	_		÷
Initiate AR Pro 10/29/2002 Dy WILLIAM ZIPP	e-Screen 12 41 27 PM r (None)		
SECTION 1			
Activity Request Id:	CAP029952		
Activity Type:	CAP	Submit Date:	10/29/2002 12:41:27 PM
One Line Description:	Possible Common Mode	e Failure of Aux Feed Recirculation Li	nes
✤ Detailed Description:	10/29/2002 12:41:27 PM Partial plugging of the m occurred during testing of line remained above ope were run to check for ex event has led to the con pumps (3 per unit) could recic onfice could then r safety related function to considers use of our cre normal CST water suppl size of material that mig rust nodules from the ca be introduced from the C	A - WILLIAM ZIPP: ini-recirc orifice (RO-4008) in the reci- on 10/24. This is documented in CAP erational limits during the event, and t tent of condition with no reduction in a clusion that it is possible the mini-reci- l plug during an emergency when aux ender its associated pump inoperable o maintain a required amount of flow f dited water supply (service water), bu by. This is because of the small orific ht credibly be introduced into the syst irbon steel supply piping, sand/silt, an CST water supply, though this is thoug	irc line from aux feed pump P-38A 029908. Flow through the recirc he remaining aux feed pumps recirc flows found. Review of this irc onfices for all the aux feed a feed is needed. Plugging of the e, as this flowpath provides a for pump protection. This at may also be an issue using the e opening sizes compared to the teem from service water, such as d lake grass. Material could also ght to be a very pure supply of
Initiator:	ZIPP, WILLIAM 🗟 🕄	Initiator Department:	EESB Engineering Equipment Systems BOP Mechanical PB
Date/Time of Discovery:	10/29/2002 11:21:55 AM	Date/Time of Occurrence:	10/29/2002 11:21:55 AM
Identified By:	Site-identified	System:	(None)
Equipment # (1st):	(None)	Equipment Type (1st):	(None)
Equipment # (2nd):	(None)	Equipment Type (2nd) :	(None)
Equipment # (3rd):	(None)	Equipment Type (3rd) :	(None)
Site/Unit:	Point Beach - Common		
Why did this occur?:	10/29/2002 12:41:27 Pl My opinion: It is explain	M - WILLIAM ZIPP: ned via considering the history for the	aux feed recirc lines:
	2-3 years ago, due to re orifices were redesigner anti-cavitation models. U1R27. The new orifice was conceptualized, the flow to the steam gener considered possible, but the beginning of an acc onfice blockage. Nov/Dec 2001: Issue o "red" finding. PBNP de pump operability. EOP the pumps from overhe means of verifying recir	circ line vibration, cavitation, and ensidering and a modification was initiated to realize and a modification was initiated to realize have smaller passages than the ore recirc line's function was to LIMIT flor ators. Potential for blockage of the ore it justified based on the short length or ident. The recirc line's function to limit frecirc line AOV failing closed on loss sign philosophy evolves to needing resist and AOPs revised to ensure minimulating is maintained, and absent that, to flow is that the recirc AOV indicates	suing weld failures, the recirc eplace the existing onfices with one being done last month during iginal model. At the time the mod ow, ensuring adequate forward nfices was explored, and f time the recirc line is needed at it flow bounds any postulated s of instrument air; subsequent ecirc line flow to maintain aux feed um forward flow required to protect that recirc flow is present. The sopen, as there is no control room
	indication of recirc flow.	Apparently, the impact of the new of	ntice mod was not considered

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	Unclear to me at this p	Oint.	
•	Summer 2002: Recirc internals of the check v potential common mod	Ine AOV function to open becomes a s valve in the common return line to the C le failure. Again, the onfice appears to l	afety related function. The STs was removed to eliminate a have not been considered.
Immediate Action Taken:	10/29/2002 12:41:27 F Discussed with engine Licensing. The shift m 10/29/2002. Came to	PM - WILLIAM ZIPP. ering management, Ops management i anager declared all four aux feed pump concensus on immediate actions neede	ncluding the on-shift DSS, s inoperable at approx. 1025 on ed.
Recommendations:	10/29/2002 12:41:27 F 1) Write and hang tem aux feed flow of greate stop affected pump.; b 2) Make changes to af minimum forward flow 50.59) 3) Review for reportab 4) Review for mPSA s the onfices are modele 5) Review for impact of indicator (EESN). 6) Redesign the recirc >1/8" (basis: service v indication of recirc line	PM - WILLIAM ZIPP: p info tags on the pump handswitches, i er than 50 gpm (P-38 A/B) or 75 gpm (1/ rief the Ops crews on the issue. (Ops) fected AOPs, EOPs, and other critical p is maintained, or the affected pump is s illity; report the issue (Licensing) ignificance determination process persp ed (PSA). in aux feed pump unavailability for NEI of line onfices to make use of an onfice do water zurn strainer size is 1/8"). Conside flow. (design engr)	requiring that a minimum forward (2 - P29) be maintained, if not, rocedures to ensure that topped. (Ops, Engr support ective. Evalute the present way cornerstone performance esign that has aperture size of er providing Control Room with
Notify Me During Eval?:	N	SRO Review Required?:	Y
SECTION 2		. .	
Operability Status: Basis for Operability:	(None)	Compensatory Actions:	Ν
Outplanned TSAC Entry:	Ν	External Notification:	N
SECTION 3			
Screened?:	N	Significance Level:	(None)
INPO OE Reqd?:	N	Potential MRFF?:	Ν
♦ QA/Nuclear Oversight?:	N	Licensing Review?:	Ν
Good Catch/Well Doc'd?:	: NA		
SECTION 4			
Inappropriate Action:			
Process:	(None)	Activity:	(None)
Human Error Type:	(None)	Human Perf Fail Mode:	(None)
Equip Failure Mode:	(None)	Process Fail Mode:	(None)

Hot Buttons:	(None)	
SECTION 5		

(None)

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Equip Failure Mode:

Org/Mgt Failure Mode:

CAP Admin:	PBNP CAP Admin	Prescreener:	(None)
♥ Project:	Corrective Action		

♦ Group Causing Prob:

(None)

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Program (CAP)		
AR Pre-Screen	Active/Inactive:	Active
WILLIAM ZIPP 🗟	Owner:	(None)
Parent	Last Modified Date:	10/29/2002 6:32:25 PM
DAN WEBER	Last State Change Date:	10/29/2002 12:41:27 PM
WILLIAM ZIPP 🛱		
0		
N		•
0	original_project_id:	0
Point Beach		
	Program (CAP) AR Pre-Screen WILLIAM ZIPP S Parent DAN WEBER S WILLIAM ZIPP S 0 0	Program (CAP) AR Pre-Screen Active/Inactive: WILLIAM ZIPP Close Date: DAN WEBER Close Date: WILLIAM ZIPP Close Date: 0 original_project_id: Point Beach

ATTACHMENTS AND PARENT/CHILD LINKS

Principal to OPR000031 Possible Common Mode Failure of Aux Feed Recirculation Lines

CHANGE HISTORY

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10/29/2002 6:23:38 PM by DAN WEBER

Last Modified Date Changed From 10/29/2002 12:41:27 PM To 10/29/2002 6:23:38 PM Last Modifier Changed From WILLIAM ZIPP To DAN WEBER 10/29/2002 6:32:25 PM by DAN WEBER

Last Modified Date Changed From 10/29/2002 6:23:38 PM To 10/29/2002 6:32:25 PM Attachment Added: Principal to OPR000031: Possible Common Mode Failure of Aux Feed Recirculation Lines

Root Cause Investigation Charter

CAP029952 RCE000191

Issue Manager: Jim Freels

Problem Statement:

Discovery during the evaluation of CAP029908 (P-38A, MDAFW Pump had inadequate recirc flow during IT-10) that the recirculation line restricting flow orifices had become plugged during plant operation causing a reduced flow (but above minimum required) and that a potential existed for a common mode failure where all AFW pump recirculation lines could have restricted flow rates resulting in eventual pump failure.

Investigation Scope:

Determine the following:

- Timeline of key events
- The root and contributing causes of why the condition exists, including any potential human performance issues
- Why the problem was not identified previously

Make recommendations for:

- Correcting the problem, including any remedial actions
- Preventing recurrence of the problem
- Applicability of the root cause to other areas (extent of condition), including verification that a safety-related AFW recirculation flow path exists for the postulated failure modes

Team Members:

Team Leader – Richard Flessner, Engineering Processes Team Member – Kevin Bennett, Engineering Processes Team Member – Eric Schmidt, System Engineering Team Member – William Bosacki, KNPP Design Engineering

<u>Milestones:</u>		
Status Update – 11/4/02		
Status Update – 11/11/02		
Draft Report - 11/18/02		
Final Report - 11/26/02		
Approved:	Date:	10/30/02
Jim Freels, PBNP Engineering Director		•