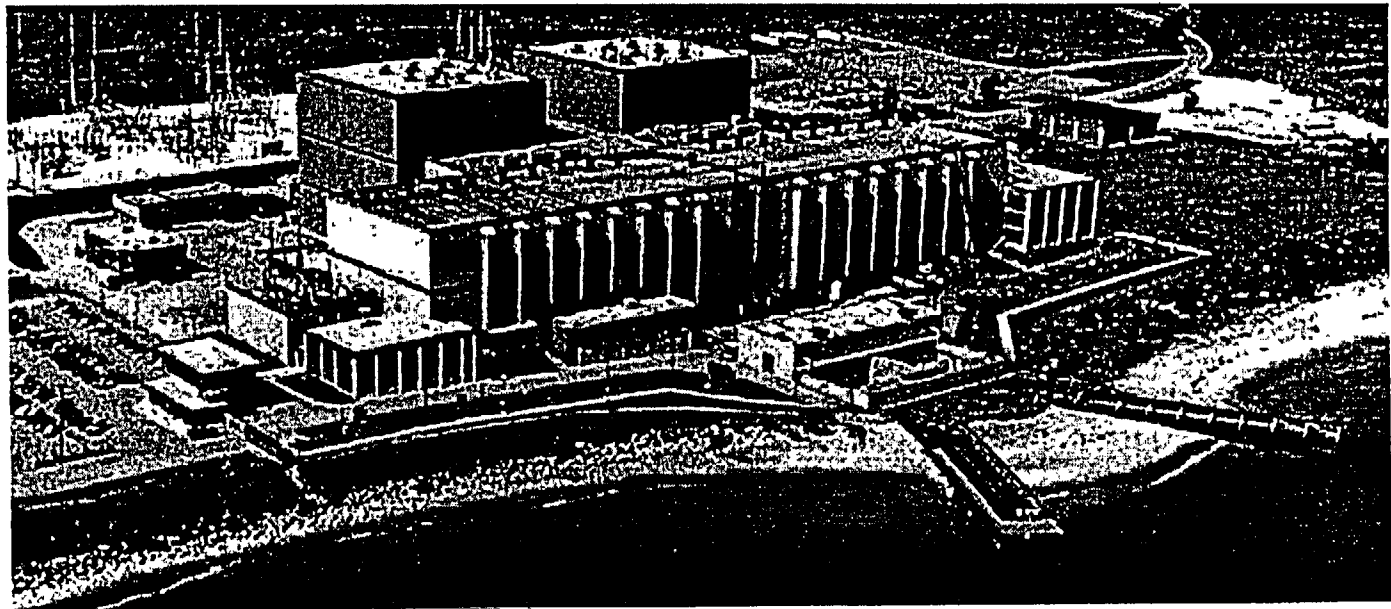


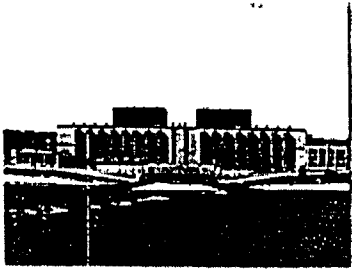
2/ 1/ 20  
5. 1. 1

# Point Beach Nuclear Plant Potential Common Mode Failure Auxiliary Feedwater

AFSD

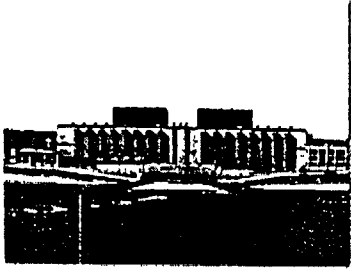


~~October 31, 2002~~



# INTRODUCTION

**Fred Cayia**

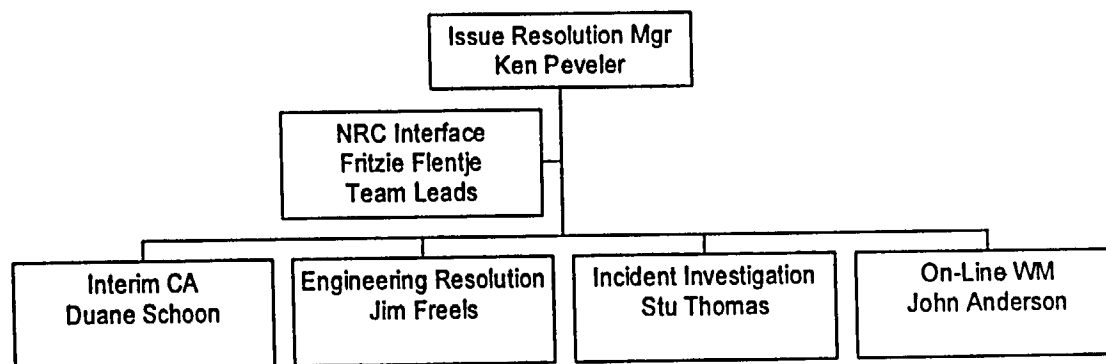


# AGENDA

- **Introduction (Fred Cayia)**
- **Response (Ken Peveler)**
- **System Design/Orifice Design (Tom Kendall)**
- **Root Cause Status (Rich Flessner)**
- **Immediate Corrective Actions (Duane Schoon)**
- **On-Line Risk Assessment (Jim Masterlark)**
- **Incident Investigation (Stu Thomas)**
- **Closing Comments (Fred Cayia)**



# ORGANIZATIONAL RESPONSE

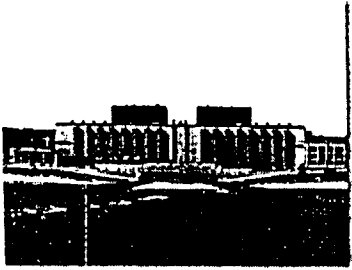


Procedures  
Training  
Admin  
Reviews  
Operability

RCE  
Analysis  
PRA  
Testing  
Design

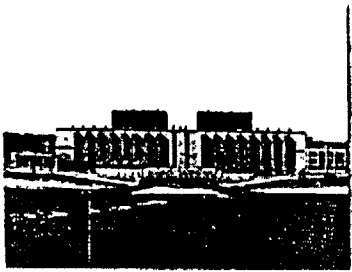
Collect  
Facts of  
Event

On-Line  
Work &  
Risk Mgmt



**AFW SYSTEM**  
**DESIGN/RECIRC LINE**  
**ORIFICE DESIGN**

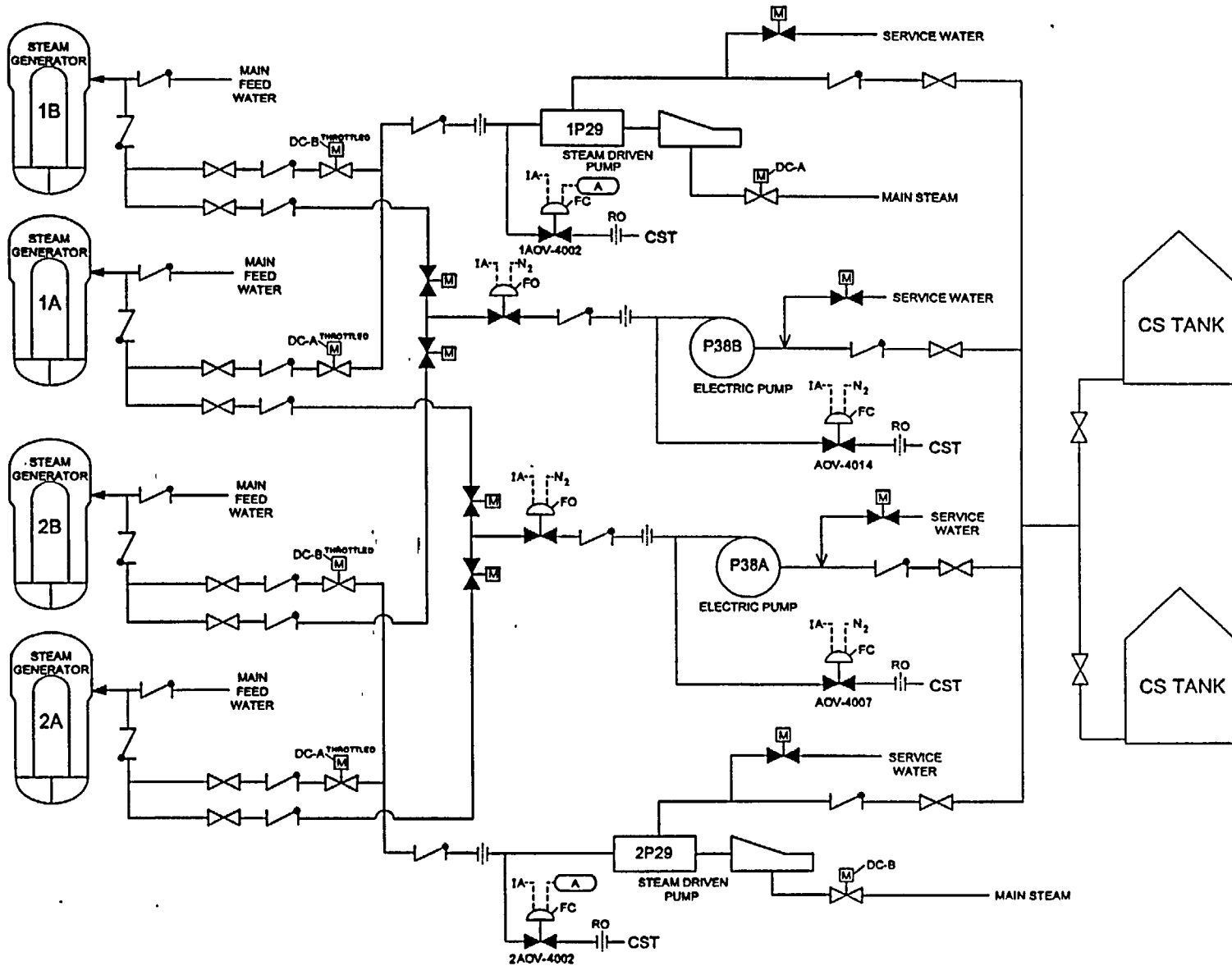
**Tom Kendall**

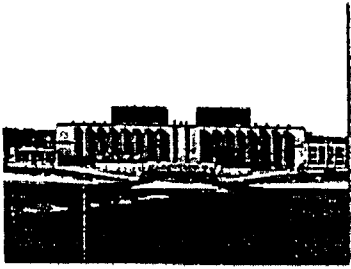


# AFW DESIGN BASIS

- Supply water to SG to remove decay heat and replenish SG inventory
- Safety-Related Functions:
  - Supply FW during accidents with main steam safety valve opening
  - Supply FW during accidents which require rapid RCS cooldown
  - Isolation capability

# AFW System - Major Flow Paths

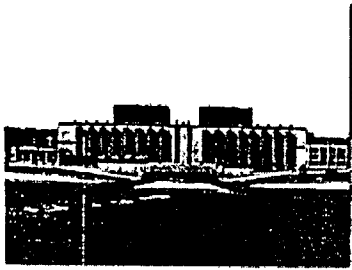




# ROOT CAUSE EVALUATION STATUS

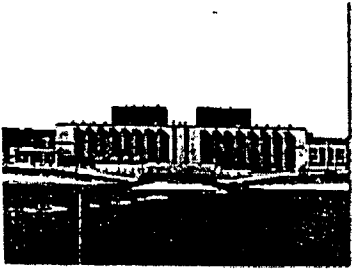
**Rich Flessner**





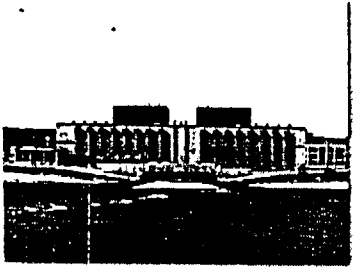
# ROOT CAUSE TEAM

- Team Leader – Engineering Processes
- Team Member – Engineering Processes
- Team Member – AFW System Engineer
- Team Member – Design Engineer (KNPP)



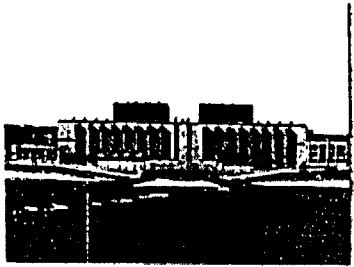
# ROOT CAUSE CHARTER

- 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



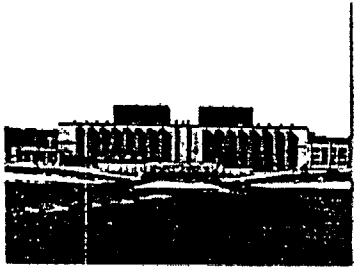
# ROOT CAUSE CHARTER

- 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



# RCE INVESTIGATION

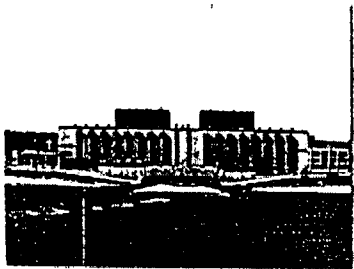
- SE/SCR for MR 99-029\*A-D recognized potential for SW plugging of RO
- Plugging not considered a concern because recirc flow not required
- 3 AFW pump recirc lines modified with new design RO prior to decision to upgrade recirc line to have a safety-function to provide flow to CST
- 1 AFW pump recirc line modified after recirc line safety function was changed



# IMMEDIATE CORRECTIVE ACTIONS

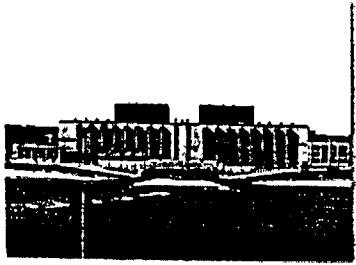
## ➤ Immediate Actions

- Information tags placed
- Shifts briefed and trained on issue
- Procedure changes
- Notification made to NRC
- Root Cause Evaluation initiated
  - Multi-discipline RCE Team



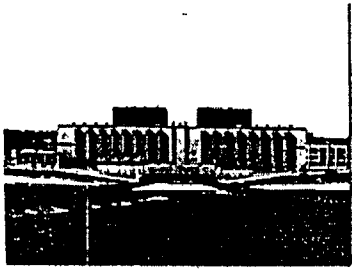
# ON-LINE RISK ASSESSMENT

**Jim Masterlark**



# On-Line Risk Monitoring

- Plant is currently at an elevated risk level due to additional Operator Actions.

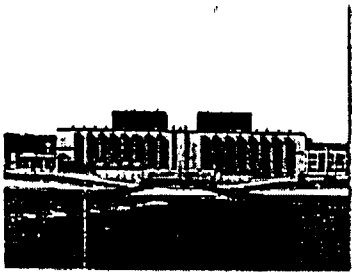


# On-Line Risk Monitoring

*Continued*

- Performed a Bounding Risk Evaluation
  - Large Uncertainty in Failure Probabilities
  - Bound Risk to ensure that we do not underestimate risk associated with both planned and unplanned configurations
  - Performed Simulator Runs and Operator/Training Interviews to assist with evaluation of Human Error Probabilities

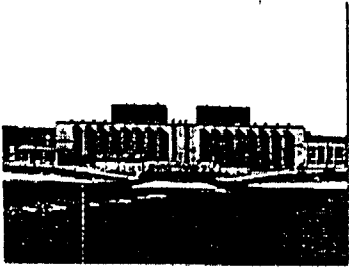




# On-Line Risk Monitoring

Continued

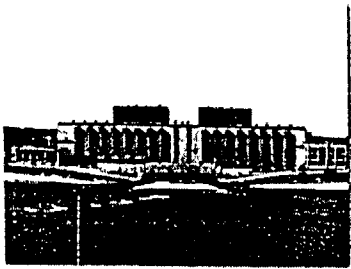
- Analysis Provides an Upper Bound for Risk
  - Assumes high probability for plugging orifice if Service Water is used
  - Does not account for water treatment for CST make-up. This would reduce probability for need to use raw Service Water for some transients/accidents.



# On-Line Risk Monitoring

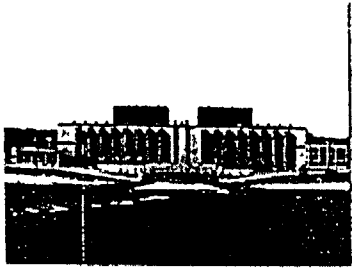
## Current Risk

- Current Risk Level is Yellow (safety monitor)
- Monitoring Planned plant activities to evaluate impact on risk
- Will receive appropriate approvals and take appropriate compensatory measures as needed.
- Risk model currently credits temporary information tags. Model will be updated as procedure changes are implemented.
- Expect risk to be near Green/Yellow threshold after all procedure changes are complete.



# INCIDENT INVESTIGATION

- Investigation of the maintenance and post-maintenance testing of P38A continues.
- Based on initial discussions and written statements of both operators and maintenance personnel, maintenance and testing activities were performed in accordance with procedures.



# CLOSING COMMENTS

**Fred Cayia**