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NP-33-02-009-01

Docket No. 50-346

License No. NPF-3

March 26, 2004

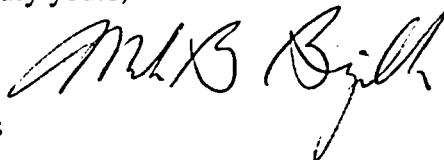
United States Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Ladies and Gentlemen:

LER 2002-009-01
Davis-Besse Nuclear Power Station, Unit No. 1
Date of Occurrence – November 29, 2002

Enclosed please find Revision 1 to Licensee Event Report (LER) 2002-009. LER 2002-009 was submitted voluntarily in accordance with NUREG-1022, Event Reporting Guidelines, Section 2.7 to provide written notification of the degradation of the High Pressure Injection thermal sleeves. Also in accordance with the guidance of NUREG-1022, revision bars have been added to the right margin to denote changes from the previous submittal of LER 2002-009 dated February 3, 2003. This revision provides an update to the results of the root cause evaluation performed and an update to our commitments.

Very truly yours,



AWB/s

Attachment
Enclosure

cc: Regional Administrator, USNRC Region III
DB-1 NRC Senior Resident Inspector
DB-1 NRC Senior Project Manager, USNRC
Utility Radiological Safety Board

IE22

COMMITMENT LIST

The following list identifies those actions committed to by the Davis-Besse Nuclear Power Station in this document. Any other actions discussed in the submittal represent intended or planned actions by Davis-Besse. They are described only as information and are not regulatory commitments. Please notify the Manager - Regulatory Affairs (419-321-8450) at Davis-Besse of any questions regarding this document or associated regulatory commitments.

| <u>COMMITMENTS</u> | <u>DUE DATE</u> |
|--|-----------------------|
| Upon discovery of the cracks in both the 2-1 HPI thermal sleeve and the 2-2 HPI/MU thermal sleeve, the degraded thermal sleeves were removed and new thermal sleeves were installed. | Complete |
| The Augmented Inservice Inspection Program has been updated to schedule a radiographic and ultrasonic test of the 2-1 and 2-2 thermal sleeves in the 14th refueling outage. The radiographic examination will focus on the weld buttons and outer roll region to determine if there appears to have been any thermal sleeve movement. The ultrasonic test will examine the safe-end and safe-end to elbow welds. | 14th Refueling Outage |
| The Augmented Inservice Inspection Program has also been revised to include an augmented VT-1 visual examination of the HPI/MU thermal sleeve once every other refueling outage, following the 13th refueling outage (commencing with the 15th refueling outage). | Ongoing |
| DBNPS has initiated and will complete an Engineering Change Request to determine the long-term action for thermal sleeve crack initiation. | 15th Refueling Outage |
| The inspection procedure (NA-QC-05560, "Visual Examination Procedure For VT-1, VT-3, And General Visual Inspections") was revised to include requirements of the Augmented VT-1 examination of the thermal sleeves and the acceptance criteria. | Complete |

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

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| FACILITY NAME (1) Davis-Besse Unit Number 1 | | DOCKET NUMBER (2) 05000346 | PAGE (3) 1 OF 6 |
|--|--|-------------------------------|--------------------|

TITLE (4)
Degradation of the High Pressure Injection Thermal Sleeves

| EVENT DATE (5) | | | LER NUMBER (6) | | | REPORT DATE (7) | | | OTHER FACILITIES INVOLVED (8) | |
|----------------|-----|------|----------------|-------------------|-----------------|-----------------|-----|------|-------------------------------|------------------------|
| MONTH | DAY | YEAR | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | MONTH | DAY | YEAR | FACILITY NAME | DOCKET NUMBER |
| 11 | 29 | 2002 | 2002 | -- 009 -- | 01 | 03 | 26 | 2004 | FACILITY NAME | DOCKET NUMBER 05000 |
| | | | | | | | | | FACILITY NAME | DOCKET NUMBER 05000 |

| | | | | | | | | | | |
|-------------------------|--|--------------------|--------------------|----------------------|---|--|--|--|--|--|
| OPERATING MODE (9) D | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR s: (Check all that apply) (11) | | | | | | | | | |
| POWER LEVEL (10) 000 | 20.2201(b) | 20.2203(a)(3)(i) | 50.73(a)(2)(i)(C) | 50.73(a)(2)(vii) | | | | | | |
| | 20.2201(d) | 20.2203(a)(3)(ii) | 50.73(a)(2)(ii)(A) | 50.73(a)(2)(viii)(A) | | | | | | |
| | 20.2203(a)(1) | 20.2203(a)(4) | 50.73(a)(2)(ii)(B) | 50.73(a)(2)(viii)(B) | | | | | | |
| | 20.2203(a)(2)(i) | 50.36(c)(1)(i)(A) | 50.73(a)(2)(iii) | 50.73(a)(2)(ix)(A) | | | | | | |
| | 20.2203(a)(2)(ii) | 50.36(c)(1)(ii)(A) | 50.73(a)(2)(iv)(A) | 50.73(a)(2)(x) | | | | | | |
| | 20.2203(a)(2)(iii) | 50.36(c)(2) | 50.73(a)(2)(v)(A) | 73.71(a)(4) | | | | | | |
| | 20.2203(a)(2)(iv) | 50.46(a)(3)(ii) | 50.73(a)(2)(v)(B) | 73.71(a)(5) | | | | | | |
| | 20.2203(a)(2)(v) | 50.73(a)(2)(i)(A) | 50.73(a)(2)(v)(C) | OTHER | | | | | | |
| | 20.2203(a)(2)(vi) | 50.73(a)(2)(i)(B) | 50.73(a)(2)(v)(D) | OTHER | Specify in Abstract below or in NRC Form 366A Voluntary | | | | | |

LICENSEE CONTACT FOR THIS LER (12)

| | |
|--|--|
| NAME Aaron W. Bless, Engineer – Licensing | TELEPHONE NUMBER (Include Area Code) (419) 321-8543 |
|--|--|

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

| CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO EPIX | CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO EPIX |
|-------|--------|-----------|--------------|--------------------|-------|--------|-----------|--------------|--------------------|
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|--|--|--|--|-------------------------------|----|-------|-----|------|
| SUPPLEMENTAL REPORT EXPECTED (14) | | | | EXPECTED SUBMISSION DATE (15) | | | | |
| YES (if yes, complete EXPECTED SUBMISSION DATE). | | | | X | NO | MONTH | DAY | YEAR |

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On November 29, 2002, with the reactor defueled, during a borescope examination a crack was discovered on the 2-2 High Pressure Injection (HPI)/Makeup thermal sleeve. Inspection of the 2-1 HPI thermal sleeve on December 3, 2002 also revealed a cracked thermal sleeve. After discovery of the two cracks, the degraded thermal sleeves were replaced. The crack in either thermal sleeve did not affect the ability of the HPI system to perform its designed function nor did either crack provide a source of Reactor Coolant System pressure boundary leakage. The cause of the cracks appears to be high cyclic thermal fatigue. This event was determined to not meet the requirements of a reportable condition under 10 CFR 50.73. However, due to the industry interest in HPI thermal sleeve failure, this event is being reported voluntarily as a License Event Report in accordance with the guidance provided in Section 2.7 of NUREG-1022, Revision 2, Event Reporting Guidelines.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

| FACILITY NAME (1) | DOCKET NUMBER (2) | LER NUMBER (6) | | | PAGE (3) |
|---------------------------|-------------------|----------------|-------------------|-----------------|----------|
| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | |
| Davis-Besse Unit Number 1 | 05000346 | 2002 | -- 009 -- | 01 | 2 OF 6 |

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

DESCRIPTION OF OCCURRENCE:

On November, 29, 2002, with the reactor defueled, while performing a borescope examination it was discovered that the thermal sleeve [BQ-SLV] connected to the 2-2 High Pressure Injection (HPI)/Makeup (MU) nozzle was cracked. Inspection of the 2-1 HPI thermal sleeve on December 3, 2002, also revealed a cracked thermal sleeve. No cracking was observed during the inspection of the remaining two HPI thermal sleeves. The cracks on the thermal sleeves were axial cracks at the downstream end of the thermal sleeve.

The HPI system [BQ] is part of the Emergency Core Cooling System, which is designed to maintain core cooling in the event of a Loss of Coolant Accident. The HPI system is connected to the Reactor Coolant System (RCS) [AB] via four HPI nozzles [BQ-NZL], one per cold leg. The HPI nozzles on the RCS piping each contain a thermal sleeve designed to protect the nozzle from thermal stress by minimizing the thermal transient on the nozzle and RCS pipe when cold injection water flow is initiated through the hot nozzle. Of these four HPI lines to the RCS, two are connected with the Makeup and Purification System.

The Makeup and Purification System [CB] has many design functions, one of which is to control the RCS inventory during all phases of normal reactor operation. During normal operation the one operating makeup pump is connected to the RCS cold leg by the 2-2 HPI line and a minimum makeup flow is maintained through a manually set bypass around the makeup control valve. This bypass flow is provided to minimize thermal fatigue of the HPI/MU nozzle thermal sleeve by maintaining a minimum flow of makeup water.

BACKGROUND INFORMATION

During the 5th refueling outage at the Davis-Besse Nuclear Power Station (DBNPS), two pieces of the HPI/MU thermal sleeve were discovered in the reactor vessel when it was defueled during a refueling inspection (Refer to DBNPS LER 1988-015, Revision 1). The failure of the 2-1 HPI/MU thermal sleeve was concluded to be high cyclic thermal fatigue.

Both the 2-1 (the normal makeup line at the time) and 2-2 thermal sleeves were replaced in the 5th refueling outage. A branched type linear indication on the 2-2 HPI thermal sleeve was located approximately in the same area of the failure on 2-1 HPI/MU thermal sleeve. However, subsequent visual and liquid penetrant examinations performed on the 2-2 HPI thermal sleeve showed no cracking. The broken thermal sleeve on HPI line 2-1 allowed makeup water to impinge on the mouth of the HPI nozzle. Both a liquid dye penetrant inspection and a manual ultrasonic examination were performed on the HPI nozzle which revealed minor flaws in the cladding. These minor flaws were evaluated and found to not extend into the base metal and determined to be acceptable for continued service in the unrepaired condition with the continued use of this nozzle as the normal makeup flow path. However, a modification was completed in the 6th refueling outage that installed new piping to re-route normal makeup flow through a different HPI nozzle (2-2 HPI line) to eliminate any possibility of cold makeup flow effects upon the thermal sleeve in nozzle 2-1 or the nozzle itself.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

| FACILITY NAME (1) | DOCKET NUMBER (2) | LER NUMBER (6) | | | PAGE (3) |
|---------------------------|-------------------|----------------|-------------------|-----------------|----------|
| Davis-Besse Unit Number 1 | 05000346 | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | 3 OF 6 |
| | | 2002 | -- 009 -- | 01 | |

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

DESCRIPTION OF OCCURRENCE (continued):

Visual inspections of the 2-2 HPI/MU thermal sleeve were performed during the 10th (April 24, 1996) and 12th (May 8, 2000) refueling outages. No cracks were identified in these two inspections. The other 3 HPI thermal sleeves were not inspected due to no identified cracks on 2-2 HPI/MU thermal sleeve.

CURRENT DISCOVERY

The inspection of the 2-2 HPI/MU thermal sleeve was scheduled to be conducted after the reactor was defueled in the 14th refueling outage. However, an opportunity during the 13th refueling outage existed with the reactor defueled, therefore the inservice examination was performed. On November 29, 2002, it was discovered that the 2-2 HPI/MU thermal sleeve, which was modified for normal makeup flow during the 6th refueling outage, was cracked. Inspection of the 2-1 HPI thermal sleeve on December 3, 2002, also revealed a cracked thermal sleeve. No cracking was observed during the inspection of the remaining two HPI thermal sleeves. Both the 2-1 and 2-2 HPI thermal sleeves have been used for normal makeup flow, one cycle (cycle 6) for 2-1 and seven cycles (cycles 7-13) for 2-2.

There have been several problems discovered at Babcock and Wilcox plants (and throughout the industry) associated with the HPI and HPI/MU thermal sleeves as stated in Framatome ANP, "Interim BWOOG Report on HPI/MU Nozzle Cracking" Document Identifier 51-5000239-01. The industry has been made aware of problems due to thermal cyclic fatigue in thermal sleeves and other components through the issuance of operating experience and correspondence from the Nuclear Regulatory Commission (NRC) and the industry. One such example is NRC Information Notice 82-30: "Loss of Thermal Sleeves in Reactor Coolant System Piping at Certain Westinghouse PWR Power Plants", which was written to "provide further notification regarding the continuance of thermal sleeve failures in both pressurized and boiling water reactor (PWR and BWR) plants."

The visual borescopic inspections performed on the 2-1 and 2-2 thermal sleeves identified axial cracks at the downstream end of each of the thermal sleeves. Neither crack exhibited any loss of material from the thermal sleeve based on these visual inspections, therefore the thermal sleeves provided thermal protection to the RCS piping. The crack in either thermal sleeve does not render the HPI system incapable of performing its designed safety function, therefore this event has been determined not to meet any of the reporting requirements under 10 CFR 50.72 or 10 CFR 50.73. However, due to the interest of the industry in thermal sleeve and thermal nozzle problems, this event is being reported voluntarily as a License Event Report in accordance with the guidance provided in Section 2.7 of NUREG-1022, Revision 2, Event Reporting Guidelines.

APPARENT CAUSE OF OCCURRENCE:

The cracking of the 2-2 and 2-1 HPI thermal sleeves appears to have been caused by high cyclic thermal fatigue. The thermal mixing of hot reactor coolant and the relatively low amount of cool makeup flow may have generated cyclic thermal stresses in the sleeve. Cyclic thermal stresses may have also been caused by changes in normal makeup flow. In addition to the thermal cyclic stresses which were present in each of the thermal sleeves, a contributor to the cracking could

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

| FACILITY NAME (1) | DOCKET NUMBER (2) | LER NUMBER (6) | | | PAGE (3) |
|---------------------------|-------------------|----------------|-------------------|-----------------|----------|
| Davis-Besse Unit Number 1 | 05000346 | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | 4 OF 6 |
| | | 2002 | -- 009 -- | 01 | |

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

APPARENT CAUSE OF OCCURRENCE (continued):

have been flow induced vibration from the RCS flow in the RCS cold leg. The end of the thermal sleeve extends into the cold leg approximately 2 inches and the flow through the cold leg could provide additional stress to an already weakening thermal sleeve which has seen thermal cyclic stress.

The current alignment of normal makeup flow is through the HPI 2-2 line, however the 2-1 HPI thermal sleeve that was installed during the 5th refueling outage was exposed to one single fuel cycle of operation as the normal makeup flow path during the 6th fuel cycle. Visual testing was performed during the 6th refueling outage with no indications of thermal stress fatigue; therefore no further tests were conducted at that time. The thermal cyclic stress from the one cycle of operation as the normal makeup flow path could provide enough thermal cyclic stress in the sleeve along with flow induced vibration from the RCS cold leg flow for seven cycles to cause the crack identified on the 2-1 thermal sleeve. A vendor with thermal hydraulic analysis experience was consulted and it is believed that cracks could initiate as early as in their first cycle of service as a makeup flow path.

The thermal sleeves that were discovered to have cracked this outage (HPI lines 2-2 and 2-1) were of a newer design than the sleeve that failed in 1988, however the thermal sleeves maintained the same temperature gradients and maintained the same flow characteristics at the discharge end and were expected to respond similarly to fluctuating temperature fields. A corrective action that was initiated due to the 1988 failure of the 2-1 HPI/Makeup thermal sleeve was to increase the minimum bypass flow. The bypass flow was increased in 1988 to approximately 11 - 15 gallons per minute (gpm) to preclude thermal stratification of flow within the sleeve and to minimize the effects of high cycle mixing at the thermal sleeve end. In 2001 Framatome ANP released "Interim BWOG Report on HPI/MU Nozzle Cracking," Document Identifier 51-5000239-01 which recommends approximately 50 gpm flow through the thermal sleeve for a typical 1.5-inch inner diameter (ID) thermal sleeve. Framatome ANP states in this report that this would prevent the mixing zone of warm and cool fluid in the thermal sleeve, thereby reducing thermal cycling in the sleeve itself. It appears that the previous increase in flow through the thermal sleeve was not sufficient based on new and updated calculations (Framatome ANP Report 51-5000239-01, "Interim BWOG Report on HPI/MU Nozzle Cracking").

Two additional contributing causes identified in the evaluation of the thermal sleeve degradation were 1) low frequency of inspection on the HPI/MU nozzle documented in the Augmented Inservice Inspection program and 2) the quality of inspections. The inspections prior to the 13th refueling outage of the thermal sleeve were performed without established criteria for quality of visual image. The visual examinations performed were not qualified examinations (i.e., the examinations included no criteria to ensure a minimum level of acuity).

The thermal sleeves installed in the HPI nozzles are to limit stresses from thermal shock to acceptable values in the HPI injection connection to the reactor coolant inlet piping. The thermal sleeves in the 2-1 and 2-2 HPI line were visually examined and found to have axial cracks at the downstream end of the thermal sleeve. Based on borescopic visual inspections performed on the

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

| FACILITY NAME (1) | DOCKET NUMBER (2) | LER NUMBER (6) | | | PAGE (3) |
|---------------------------|-------------------|----------------|-------------------|-----------------|----------|
| Davis-Besse Unit Number 1 | 05000346 | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | 5 OF 6 |
| | | 2002 | -- 009 -- | 01 | |

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

ANALYSIS OF OCCURRENCE:

thermal sleeve, and ultrasonic examinations of the safe end to nozzle weld, the thermal sleeve was still providing relief of thermal shock to the HPI nozzle connection to the RCS cold leg, however it was in a degraded condition. The pressure boundary showed no crack indications or indications of leakage.

The two nozzles with cracked thermal sleeves had both previously been used as the primary makeup flow path. Both are a changed design from the originally installed thermal sleeve. The two HPI nozzles that have never been used for makeup (and their thermal sleeves) have had no failures or relevant indications over the life of the plant and are original design thermal sleeves.

While cracks in the thermal sleeve are an undesired condition, the cracks found in the 2-1 and 2-2 thermal sleeves did not render the HPI system incapable of performing its designed safety function. And as stated above the HPI pressure boundary safe end welds showed no crack indications nor indications of leakage. Therefore because the cracking of the thermal sleeves did not render the HPI system inoperable nor did the condition actually degrade the pressure boundary to cause pressure boundary leakage, this event has been determined to not meet any of the requirements for reportability under 10 CFR 50.72 or 10 CFR 50.73.

However, due to the interest of the industry in thermal sleeve and thermal nozzle problems, this event is being reported voluntarily as a Licensee Event Report in accordance with the guidance provided in Section 2.7 of NUREG-1022, Revision 2, Event Reporting Guidelines.

CORRECTIVE ACTIONS:

Upon discovery of the cracks in both the 2-1 HPI thermal sleeve and the 2-2 HPI/MU thermal sleeve, the degraded thermal sleeves were removed and new thermal sleeves were installed. The original sleeve material (prior to 1988) was ASTM A336 Class F8M for both the 2-1 and 2-2 HPI thermal sleeves. Thermal sleeve material for the 1-1 and 1-2 HPI thermal sleeves is currently still ASTM Class F8M. No cracking was observed during the inspection of the 1-1 and 1-2 HPI thermal sleeves. The replacement sleeve material, both in 1988 and 2002, is ASTM SA336 Class F316. There were no indications of leakage on the adjacent RCS cold leg piping.

The Augmented Inservice Inspection program was revised to perform visual inspections of all 4 HPI thermal sleeves following Revision 0 of this Licensee Event Report. However, after completion of the evaluation on the thermal sleeve issue, it was determined that observations and operating histories define that the HPI/MU nozzle thermal sleeve cracking is related to the inservice nozzle for normal makeup flow and is not related to HPI function. Therefore, to perform the examination on all 4 HPI thermal sleeves has been determined to not be required. The Augmented Inservice Inspection Program has been updated to schedule a radiographic and ultrasonic test of the 2-1 and 2-2 thermal sleeves in the 14th refueling outage. The radiographic examination will focus on the weld buttons and outer roll region to determine if there appears to have been any thermal sleeve movement. The ultrasonic test will examine the safe-end and safe-end to elbow welds.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

| FACILITY NAME (1) | DOCKET NUMBER (2) | LER NUMBER (6) | | | PAGE (3) |
|---------------------------|-------------------|----------------|-------------------|-----------------|----------|
| Davis-Besse Unit Number 1 | 05000346 | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | 6 OF 6 |
| | | 2002 | -- 009 -- | 01 | |

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

CORRECTIVE ACTIONS (continued):

The Augmented Inservice Inspection Program has also been revised to include an augmented VT-1 visual examination of the HPI/MU thermal sleeve once every other refueling outage, following the 13th refueling outage (commencing with the 15th refueling outage). Performance of this examination requires the reactor to be defueled.

The minimum makeup flow during normal operation of the makeup system through to the HPI line used to minimize thermal fatigue of the HPI/MU thermal sleeve is lower than the 50 gpm recommended by the 2001 Framatome ANP document. Initial reviews indicated that the DBNPS design is not capable of the 50 gpm flow rate based on the demineralizer as the limiting component. DBNPS has initiated and will complete an Engineering Change Request (ECR 04-0106-00) to determine the long-term action for thermal sleeve crack initiation.

Improved remote inspection equipment (due to the availability of higher resolution video equipment) and inspection procedure changes occurred prior to the discoveries of the cracks in the two thermal sleeves. The inspection procedure (NA-QC-05560, "Visual Examination Procedure For VT-1, VT-3, And General Visual Inspections") was revised to include requirements of the Augmented VT-1 examination of the thermal sleeves and the acceptance criteria. These changes have resulted in lower threshold of detection (reduction in the size of defect that can be detected). The ability to use inspection and inspection driven replacement is directly linked to the threshold of detection.

FAILURE DATA:

Davis-Besse has issued a previous LER (LER 1988-015, Revision 1) on loose parts discovered in the reactor vessel which investigations revealed that thermal cyclic fatigue resulted in loss of material from the HPI/MU thermal sleeve. Previous corrective action to increase the flow through the thermal sleeve is believed to not have been sufficient due to greater flow (approximately 50 gpm for 1.5 inch ID thermal sleeves) recommendations by Framatome ANP in 2001.

Energy Industry Identification System (EIIS) codes are identified in the text as [XX].

NP-33-02-009-01

Condition Reports 2002-09739 and 2002-09928