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CORRESPONDENCE CONTROL TICKET

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Chairman Nils J. Diaz
FYI
Tom Sundzel

9 Twin Orchard Drive
Oswego, NY 13126
January 5, 2005

Mr. A. Christopher Bakken III
President, Chief Nuclear Officer
PSEG Nuclear LLC
80 Park Plaza
PO Box 570
Newark, NJ 07101

Dear Mr. A. Christopher Bakken III:

I am making these comments based on my reading of your Hope Creek LER 354/04-010-00 and some other information I have read on the NRC website, including ADAMS document ML043510279, Hope Creek Recirc Pump "B" Questions and Answers.

Rather than fix a failed open moisture separator drain valve, apparently some of your engineering and management people decided "to continue operating the moisture separator with the drain valve failed open." (Ref. Page 5 of 7) If your operators and their supervisors and their managers had walked out into the plant, they should have identified that the valve was open due to a failed (breached) instrument air line. But, even if they did not identify that the airline was the cause of the failed open valve, they should have noticed the sound of escaping air in that area. And, if that was not possible, I would like to know what value your plant operator tours are?

But, that is not the cause, is it? A pipe hanger wore a hole into an instrument air line. Perhaps that may have taken a few weeks. If so, wouldn't it be reasonable to expect that an operator on rounds would have seen it. And, shouldn't this have been reported for corrective action? I didn't notice any mention of this in the LER.

But, that is not the cause, is it? Before the pipe hanger could rub on the instrument air line, it had to change position from where it was supposed to be. In this case, it has been stated that the pipe hanger, (of unspecified weight) was unscrewed from the, apparently threaded rod with an eye in the other end. How did it unscrew? The eye was probably not able to turn. This leaves the other end. If it was attached with a nut, wouldn't it seem that a loose nut should be lying on the floor where alert plant staff would see it?

So, here is what I think. Due to high vibration at the pipe hanger location, the rod became disconnected from the pipe hanger. Next, for an unspecified period of time that I would guess at about two weeks, the pipe hanger continued to rub on the instrument line in response to the continuing vibration. Then, the pipe hanger wore through the instrument line and released the air, opening the valve.

Now some engineering and some management people decided to not fix it. (Or, apparently, not even to look at it and hear the escaping instrument air.) About 25 days later, as a result of continuous two phase flow, the possibly inadequately previously repaired nozzle connection failed.

This is approximately where your LER starts explaining what happened.

Why weren't the initiating causes clearly identified in the LER and corrective actions selected to address the cause(s) of this event, not later results of those causes?

Yours truly,

Tom Gurdziel

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