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Nuclear

10 CFR 50.73

October 15, 2010 BW100109

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

Braidwood Station, Unit 2

Facility Operating License No. NPF-77

NRC Docket No. STN 50-457

Subject:

Licensee Event Report 2010-003-00 – Unit 2 Reactor Trip Caused by Phase to Ground Fault of a Failed Crossover Damper/Deionizer Assembly Due to an Inadequate Inspection Acceptance Criteria and Preventive Maintenance Inspection Frequency

The enclosed Licensee Event Report (LER) is being submitted in accordance with 10 CFR 50.73, "Licensee event report system", paragraph (a)(2)(iv)(A), as an event that resulted in a valid actuation of the reactor protection system and auxiliary feedwater system. On August 16, 2010, Braidwood Station Unit 2 received an actuation of the reactor protection system (reactor trip) and the auxiliary feedwater system due to a phase to ground fault of a failed crossover damper/deionizer assembly. 10 CFR 50.73(a) requires an LER to be submitted within 60 days following discovery of the event. Therefore, this report is being submitted by October 15, 2010.

There are no regulatory commitments contained in this letter. Should you have any questions concerning this submittal, please contact Mr. Ronald Gaston, Regulatory Assurance Manager, at (815) 417-2800.

Respectfully,

Amir Shahkarami Site Vice President Braidwood Station

Enclosure:

LER 2010-003-00

cc: NRR Project Manager - Braidwood Station

Illinois Emergency Management Agency - Division of Nuclear Safety

US NRC Regional Administrator, Region III

US NRC Senior Resident Inspector (Braidwood Station)

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LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)									request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burde estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose 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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On Augus reactor to	BSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) On August 16, 2010 at 0206, Unit 2 main generator received generator lockout relay trips, which caused the Unit 2 eactor to trip on a turbine trip above 30 percent power. Following the reactor trip, the auxiliary feedwater pumps utomatically started on low-low steam generator water levels.																	

The root cause of the Unit 2 reactor trip was determined to be an inadequate damper inspection acceptance criteria and preventive maintenance (PM) frequency that did not account for the more turbulent flow characteristics that the crossover damper is subjected to.

Corrective actions to prevent recurrence include revising the PM schedules to ensure the crossover damper assembly is inspected and/or replaced prior to failure, and revising the maintenance procedure for isophase bus duct PM to include additional inspection criteria for the crossover damper assembly.

There were no actual safety consequences impacting plant or public safety as a result of the event.

This event is being reported pursuant to 10 CFR 50.73(a)(2)(iv)(A) due to actuation of the reactor protection system (reactor trip) and the auxiliary feedwater system.

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LICENSEE EVENT REPORT (LER) U.S. NUCLEAR REGULATORY COMMISSION CONTINUATION SHEET

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NARRATIVE

A. Plant Operating Conditions Before The Event:

Event Date:

August 16, 2010

Event Time: 0206 CDT

Unit: 2

MODE: 1

Reactor Power: 100 percent

Unit 2 Reactor Coolant System (RC) [AB]:

Normal operating temperature and pressure

B. Description of Event:

No structures, systems, or components were inoperable at the start of this event that contributed to the event.

On August 16, 2010 at 0206, Unit 2 main generator received generator lockout relay trips (86G2B and 86G1B relays), which caused the Unit 2 reactor to trip on a turbine trip above 30 percent power.

Following the reactor trip, the auxiliary feedwater (AF) [BA] pumps automatically started on low-low steam generator water [SJ] levels and the steam dumps opened to control pressure, all of which are expected responses to a trip from full reactor power. Flow control valve 2AF005H to the 2D steam generator failed open and isolation valve 2AF013H was throttled to control flow.

Following the Unit 2 reactor trip, condensate water was automatically rejected to the condensate storage tank (CST) to prevent hot well overfill. An AF vent riser standpipe is connected to the CST header, and the influx of condensate filled the standpipe and resulted in an overflow of the standpipe onto the turbine deck. The overflow spread to openings in the turbine building floor and flowed down to the elevation below; entered a 4160V/480V substation cabinet located in Unit 1; caused a ground over-current on breaker 1435VU; and caused a trip of buses 133V and 133U. Loss of bus 133 caused the 1A and 1C circulating water pumps to trip, and at 0219 resulted in a trip of Unit 1 on loss of condenser vacuum. This Unit 1 event is addressed under Unit 1 LER 2010-001-00.

Operator response to the trip was proper and all safety related systems, structures, and components operated normally during this event except as noted above.

This event is reportable under 10 CFR 50.73(a)(2)(iv)(A), any event or condition that resulted in manual or automatic actuation of any of the systems listed in 10 CFR 50.73(a)(2)(iv)(B) including any event or condition that results in actuation of the reactor protection system (RPS) when the reactor is critical, and actuation of the PWR auxiliary feedwater system.

C. Cause of Event

The cause of the Unit 2 generator lockout relay trip was a phase-to-ground fault in the isolated phase (isophase) bus duct.

A root cause evaluation was performed to determine the cause of the trip. Inspections of the crossover dampers and deionizer grid assemblies (henceforth referred to as crossover damper assemblies) inside the isophase bus duct identified excessive wear and degraded flow damper blades. Additionally, deionizer grid fins were found detached from the damper outlet. Analysis of the failed components determined that a failed deionizer fin section of the damper assembly caused the Unit 2 isophase bus duct ground.

The cause of the crossover damper assembly failure was investigated. Based on the analysis performed, the cause for the increased degradation of the crossover damper assemblies is the more turbulent air flow characteristics that

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NARRATIVE

the dampers are subjected to. The rate of normal degradation for the crossover damper assemblies is accelerated when compared to the similar model bypass damper assemblies. The analysis noted that the inspection acceptance criteria for the damper assemblies was not detailed enough to account for this turbulent condition on the sub-components of the assembly. Therefore, the root cause for this event was determined to be an inadequate damper assembly inspection acceptance criteria and preventive maintenance frequency that did not account for the more turbulent flow characteristics that the crossover damper assemblies are subjected to.

A contributing cause for this event is that historic changes in operating conditions (i.e., two bus duct fan operation) have also increased the rate of degradation for the crossover damper assemblies. The station had not adequately evaluated the air flow characteristics for this change to understand how these factors affected the degradation.

D. Safety Consequences:

There were no actual or potential safety consequences impacting plant or public safety as a result of this event. Flow control valve 2AF005H to the 2D steam generator failed open, and isolation valve to 2AF013H was throttled to control flow.

All other safety related systems, structures, and components operated normally during this event.

This event did not result in a safety system functional failure.

E. Corrective Actions:

The corrective actions to prevent recurrence include:

- Revise the preventive maintenance schedule to ensure the crossover damper assemblies are inspected and/or
 replaced prior to failure, with the periodicity to be set through engineering analysis. The engineering analysis
 will determine the air flow characteristics for bus duct fan configurations and the impact of these configurations
 on internal isolated phase bus components and degradation rates.
- Revise the maintenance procedure for isophase bus duct preventive maintenance to include inspection criteria for the crossover damper assembly, including the requirement to remove the assemblies for inspection (to preclude over-reliance on robotic inspections), a detailed inspection of sub-components, dimensional tolerances for the sub-components (where possible), and a hold point for As Found inspection.

Other corrective actions include:

- Replacement of Unit 1 and Unit 2 crossover damper assemblies with a more robust design.
- Identify systems where the station has changed operating conditions that could increase degradation of internal
 components and determine if the evaluations were performed adequately (addressed the degradation rate of
 the components).
- Complete a case study for this event with all Engineering personnel, to focus on the organizational weaknesses associated with the oversight and monitoring for the isophase components.

F. Previous Occurrences:

There have been no previous, similar events identified at the Braidwood Station in the past three years.

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G. Component Failure Data:

Manufacturer H. K. Porter Company, Inc. Nomenclature Crossover Damper/Deionizer Grid

Assembly

<u>Model</u> L-98021X11 Rev. A

L-98021X11 Rev. A with 52412X5 with 52412X5 deionizer grid deionizer grid

Mfg. Part Number

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