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Ref. # 10CFR50.73(a)(2)(i)(B)

CP- 201100762 Log # TXX-11069

June 27, 2011

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

SUBJECT: COMANCHE PEAK NUCLEAR POWER PLANT DOCKET NO. 50-446 LICENSEE EVENT REPORT 446/11-001-00, INOPERABILITY OF ECCS TRAINS DUE TO GAS VOID

Dear Sir or Madam:

Enclosed is Licensee Event Report (LER) 446/11-001-00, "Inoperability of ECCS Trains Due to Gas Void," for Comanche Peak Nuclear Power Plant (CPNPP) Unit 2.

This letter contains no new regulatory commitments regarding CPNPP Units 1 and 2.

Should you have any questions concerning this submittal, please contact Mr. Tim Hope, Manager, Nuclear Licensing, at (254) 897-6370.

Sincerely,

Luminant Generation Company LLC

**Rafael Flores** 

By:

/ Fred W. Madden Director, Oversight & Regulatory Affairs

A member of the STARS (Strategic Teaming and Resource Sharing) Alliance

Callaway · Comanche Peak · Diablo Canyon · Palo Verde · San Onofre · South Texas Project · Wolf Creek

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# Enclosure

c - E. E. Collins, Region IV B. K. Singal, NRR Resident Inspectors, Comanche Peak

					APPROVED BY OMB: NO. 3150-0104 EXPIRES: 10/31/2013													
(10-2010) LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)							Exprince: 10/31/2013 Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@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.											
1. FACILITY NAME						2. DOCKET NUMBER 3. PAGE					GE							
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4. TITLE Inoperability of ECCS Trains Due to Gas Void																		
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2   20.2201(b)   20.2203(a)(3)(i)     20.2201(d)   20.2203(a)(3)(i)   20.2203(a)(3)(ii)     20.2203(a)(1)   20.2203(a)(4)   20.2203(a)(4)     20.2203(a)(2)(ii)   50.36(c)(1)(i)(A)   50.36(c)(1)(i)(A)     20.2203(a)(2)(ii)   50.36(c)(2)   50.36(c)(2)     0   20.2203(a)(2)(ii)   50.36(c)(2)     0   20.2203(a)(2)(iv)   50.46(a)(3)(ii)     20.2203(a)(2)(v)   50.73(a)(2)(i)(A)     20.2203(a)(2)(v)   50.73(a)(2)(i)(B)					3)(i) 3)(ii) 4) i)(A) ii)(A) ii)(A) i)(A)	$ \begin{array}{c c c c c c c c c c c c c c c c c c c $						elow A						
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14. SUPPLEMENTAL REPORT EXPECTED   YES (If yes, complete 15. EXPECTED SUBMISSION DATE)   NO						1!	5. EXI SUBM DA	PECTED ISSION ATE		MONTH	DA	Y	YEAR					
ABSTRACT (L On April 2	imit to 1400 sr 6, 2011, C	oaces, i.e., omanch	approximat e Peak I	ely 15 s Nucles	ingle-si ar Pov	oaced type wer Pla	ewritten lir a <b>nt (CP</b> I	nes) NPP)	Uni	it 2 wa	s in M	ode 2	during	a pla	nned ou	itage.	At 0	020,

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ultrasonic testing in support of Unit 2 Emergency Core Cooling System (ECCS) void verifications identified a void calculated to be approximately 3.71 ft3. Using conservative analytical methods at the time of discovery, the size and location of the void rendered both trains of the Containment Spray (CT), Safety Injection (SI), and Residual Heat Removal (RHR) systems inoperable requiring entry into Technical Specification 3.0.3. Limiting Condition for Operation Action Requirement (LCOAR) A2-11-231 was subsequently entered. The void was then vented via vent valve 2SI-8978 and the piping ultrasonically verified free of voids. LCOAR A2-11-231 was exited at 0143, April 26, 2011. The direct cause of this event was the introduction, transport, and accumulation of gases in the vicinity of 2SI-0047, resulting in a void of sufficient size that very conservative analytical methods used at the time of discovery determined the CT, SI, and RHR systems were rendered inoperable. Subsequent analysis of the event has shown that both trains of RHR and SI would have fulfilled their respective safety functions. However, the same analysis determined that one (1) train of containment spray would have been inoperable upon Unit 2 entry into Mode 4. Corrective actions include revision of the post-outage void verification program to require the conduct of preliminary void verifications at locations where potentially dual-train operability-affecting voids may form after entry into Mode 5 but prior to entry into Mode 4 and revision of STA-698 to include a requirement to periodically review fill and vent procedures to ensure all known gas intrusion mechanisms (e.g., pressure damming) are considered. In addition, vent valves 2SI-8978 and 1SI-0240 will be incorporated into the appropriate venting procedures. All times in this report are approximate and Central Daylight time unless otherwise noted.

NRC FORM 366 (10-2010)

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omanche Peak Nuclear Power Plant Unit 2	05000 446		NUMBER	NO.	2 OF	4
DATA		2011 -	001	00		
I. DESCRIPTION OF THE REPORTABLE	CEVENT					
A. REPORTABLE EVENT CLASSIFIC	CATION					
Based on preliminary review of the even 10CFR50.73(a)(2)(v) "Any event or co structures or systems that are needed to accident" and 10CFR50.73(a)(2)(vii) " independent train or channel to becom become inoperable in a single system of an accident."	ent, the event was r ndition that could to: (B) Remove resi Any event where a ne inoperable in mu lesigned to: (B) Ren	eported und have preven dual heat; c single caus altiple system nove residu	der the follow ated the fulfil or (D) Mitiga e or conditio ns or two ind al heat; or (1	wing criter Ilment of tl ate the cons n caused a dependent D) Mitigato	ia: he safety functio sequences of an it least one trains or chann e the consequent	on of els to ces of
"Subsequent analysis of the event has sl safety functions. However, the same an inoperable upon Unit 2 entry into Mod being reported under 10CFR50.73(a)( Technical Specifications."	hown that both trai nalysis determined le 4 contrary to Teo 2)(i)(B) "Any opera	ns of RHR that one (1) chnical Spec ation or con	and SI would train of con cifications 3. dition which	d have fulf tainment s 3.6 and 3.0 was prohi	illed their respe pray would hav ).4, thus this eve bited by the pla	ctive e bee nt is nt's
<b>B. PLANT CONDITION PRIOR TO EV</b>	ENT					
On April 26, 2011, CPNPP Unit 2 was i	in Mode 2 during a	planned ou	tage.			
C. STATUS OF STRUCTURES, SYSTEM	AS, OR COMPON	ENTS THA	T WERE IN	OPERAB	LE AT THE ST	ART
OF THE EVENT AND THAT CONTR	RIBUTED TO 'THI	E EVENT				
There were no inoperable structures, sy	stems, or compone	nts that con	tributed to t	he event.		
D. NARRATIVE SUMMARY OF THE E	VENT, INCLUDIN	IG DATES	AND APPR	OXIMATH	E TIMES	
CPNPP Unit 2 was performing a reacto 1538, April 25, 2011, and was critical at verification inspections, a 3.71 ft3 void v Storage Tank Isolation Valve 2SI-0047 entered Limiting Condition for Operati Containment Spray[EIIS: (BE)], Safety The void was removed by aligning temp stream of water was observed flowing fi LCOAR A2-11-231 was exited at 0143, Prior to the April 2011 2RF12 refueling	r power ascension 1754. At 0020, Ap. was discovered in t [EIIS: (BQ)(TK)(IS on Action Require Injection [EIIS: B porary tubing from rom 2SI-8978. Void April 26, 2011.	from refuel ril 26, 2011, he high poir SV)] and ve ment (LCO. Q)], and Re 2SI-8978 to I elimination ctions of pip	ing outage 2 during post at piping run nt valve 2SI- AR) A2-11-2 sidual Heat o a drain and n was then v	RF12. Unit outage voi containin 8978 [EIIS 31 for LC0 Removal [] venting the erified via	t 2 entered Mod id g Refueling Wa S: (BQ)(V)]. Uni O 3.0.3, Two Tr EIIS: (BP)] Inop he system until a ultrasonic inspe y tested to verify	e 2 at ter it 2 ains c perab a stea ection y the
	, outage, various se	cuons or hit	mg were un	asonicany	y icsicu to verify	y the

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NRC FORM 366A (10-2010) LICENSEE EVENT REPORT (LER)<sup>U.S. NUCLEAR REGULATORY COMMISSION</sup> CONTINUATION SHEET

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	05000 440	2011 - 001 - 00	T			

#### NARRATIVE

Further analysis demonstrated that the declaration of inoperability was a conservative action, and RHR and SI would have fulfilled their respective safety functions and been operable. The analysis confirmed that one (1) train of containment spray was inoperable, however the containment spray safety function would have been fufilled with the remaining operable CT train.

# E. THE METHOD OF DISCOVERY OF EACH COMPONENT OR SYSTEM FAILURE, OR PROCEDURAL PERSONNEL ERROR

This condition was identified as a result of void verification inspections required by CPNPP procedure STA-698, "Gas Intrusion Program." The inspections are required to be conducted following the isolation of the Residual Heat Removal (RHR) system from the Reactor Coolant System (RCS).

#### **II. COMPONENT OR SYSTEM FAILURES**

### A. CAUSE OF EACH COMPONENT OR SYSTEM FAILURE

Not applicable - No component failures were identified during this event.

# **B. FAILURE MODE, MECHANISM, AND EFFECTS OF EACH FAILED COMPONENT**

Not applicable - No component failures were identified during this event.

# C. SYSTEMS OR SECONDARY FUNCTIONS THAT WERE AFFECTED BY FAILURE OF COMPONENTS WITH MULTIPLE FUNCTIONS

Not applicable - No component failures were identified during this event.

#### **D. FAILED COMPONENT INFORMATION**

Not applicable - No component failures were identified during this event.

#### **III. ANALYSIS OF THE EVENT**

# A. SAFETY SYSTEM RESPONSES THAT OCCURRED

Not applicable - No safety system responses occurred as a result of this event.

#### **B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY**

One (1) train of Containment Spray was inoperable upon Unit 2 entry into Mode 4 on April 24, 2011 at 0518 until the LCOAR was exited on April 26, 2011 at 0143.

NRC FORM 366A (10-2010) LICENSEE EVENT REPORT (LER)<sup>U.S. NUCLEAR REGULATORY COMMISSION</sup> CONTINUATION SHEET

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NARRATIVE

## C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

The primary function of the ECCS is to remove the stored and fission product decay heat from the reactor core during accident conditions. The analysis methodology used to determine system operability in this event conservatively postulates that the entirety of the discovered void would enter the suction of a single pump, thereby preventing the pump from performing its designated safety function. Further analysis demonstrated that the declaration of inoperability was a conservative action, and RHR and SI would have fulfilled their respective safety functions and been operable. This analysis is based on detailed study of the void transport and piping design. The analysis confirmed that one (1) train of containment spray was inoperable, however the containment spray safety function would have been fufilled with the remaining operable CT train. Based on the above, it is concluded that the health and safety of the public were unaffected by this condition and this event has been evaluated to not meet the definition of a safety system functional failure per 10CFR50.73(a)(2) (v).

### **IV. CAUSE OF THE EVENT**

The direct cause of this event was the introduction, transport, and accumulation of gases in the vicinity of 2SI-0047, resulting in a void of sufficient size that very conservative analytical methods used at the time of discovery determined the Containment Spray, Safety Injection, and Residual Heat Removal systems were rendered inoperable. The gas void was the result of the RHR system fill and vent evolution and subsequent RHR operation that transmitted the void to its final location. Contributing to this event was the fact that vent valve 2SI-8978 (located in the section of piping where the void was discovered) was not included in applicable venting procedures. The cause of this event was the failure to identify a unique system configuration and the untimely identification and removal of a gas void that could have potentially rendered both trains of the Containment Spray, Safety Injection, and Residual Heat Removal systems inoperable.

#### V. CORRECTIVE ACTIONS

Immediate corrective action was the venting of the gas void and returning the ECCS systems to operability. After vent valve 2SI-8978 was discovered not to be in the applicable venting procedures, the Unit 1 vent valve counterparts were also reviewed. The review discovered Unit 1 vent valve 1SI-0240 was also not included in applicable venting procedures. Consequently, 2SI-8978 and 1SI-0240 will be incorporated into the appropriate venting procedures. Subsequent corrective actions include revision of the post-outage void verification program to require the conduct of preliminary void verifications at locations where potentially dual-train operability-affecting voids may form after entry into Mode 5 but prior to entry into Mode 4 and revision of STA-698 to include a requirement to periodically review fill and vent procedures to ensure all known gas intrusion mechanisms (e.g., pressure damming) are considered.