REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: FACIL:50-315	:9809150274 DOC.DATE: 98/09/08 NOTARIZED: NO DOCK Donald C. Cook Nuclear Power Plant, Unit 1, Indiana M 0500	•••
AUTH.NAME WEBER,G. SAMPSON,J.R. RECIP.NAME	AUTHOR AFFILIATION Indiana Michigan Power Co. (formerly Indiana & Michigan	Ele

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SUBJECT: LER 98-022-02:on 980415, postulated failure of SAT N regulator was noted. Caused by failure to perform adequate SE formprocedure rev.10CFR50.59 program has been upgraded to meet current industry standards. With 980908 ltr.

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September 8, 1998

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> **Operating License DPR-58** Docket No. 50-315

Document Control Manager:

In accordance with the criteria established by 10 CFR 50.73 entitled Licensee Event Report System, the following report is being submitted:

98-022-02

Sincerely,

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J. R. Sampson Site Vice President

/mbd

Attachment

9809150274 980908 PDR ADOCK 050003

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ĀDOCK 05000315

C:

- Caldwell (Acting), Region III J. L.
- R. P. Powers
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- J. B. Kingseed
- R. Whale
- Hahn D.

Records Center, INPO NRC Resident Inspector

PDR

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RC Form 36 -95)	56		U.S. NUCLEAR REGULATORY COMMISSION							IISSION	APPROVED BY OMB NO. 3150-9104 EXPIRES 04/30/38						
LICENSÉE EVENT REPORT (LER)								ESTMATED BURDEN PER RESPONSE TO COMPLY WITH THIS M INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSON ARE INCORPORATED INTO THE LICENSING PROCESS AND FED INDUSTRY, FORWARD COMMENTS REGARDING BURDEN ESTMAT INFORMATION AND RECORDS MANAGEMENT REARCH (T-6 F33). U.S.									
(See reverse for required number of digits/characters for each block)							REGULATION AND RECORDS MANAGEMENT BRANCH (T& F33), U.S. MOCU REGULATORY COMMESSION, WASHINGTON, DC 203554001, AND TO PAPERNORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT / BUDGET, WASHINGTON, DC 20303										
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F	Postu	lated I	Failure	of	Spray A	ddit	ive Tank N	litrogen F	Regulat	or Poter	ntially	Results in Una	analyzed	Condi	lion		
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certain circumstances, this scenario may preclude both pumps from performing their safety functions. The pumps' failure mode would be "gas binding," with a resultant loss of discharge pressure. It was determined that this represented an unanalyzed condition due to a potential for both trains of the Containment Spray (CTS) system to be rendered inoperable by a single active failure, and an ENS notification was made in accordance with 10CFR50.72(b)(2)(i) for an unanalyzed condition.

The root cause of this condition is the failure to perform an adequate safety evaluation for the procedure revision performed in 1981 that permanently repositioned the nitrogen shutoff valve to normally open. The 10CFR50.59 program has been upgraded to meet current industry standards and expectations.

The postulated "gas binding" scenario was evaluated for safety significance. Other potential scenarios, involving diversion of sodium hydroxide, were also analyzed. The probability of gas binding was low, therefore this postulated scenario had low safety significance. Unavailability of sodium hydroxide had been previously analyzed and the postulated scenarios had been bounded by existing analyses. Therefore the health and safety of the public was not jeopardized.

NRC FORM 366A		•	U.S.	NUCLEA	RR	EGULATORY	COMMISSION		
	SEE EVENT REPORT (TEXT CONTINUATION	LER)					N		
FACILITY NAME (1)	DOCKET NUMBER(2)			NUMBE			PAGE (3)		
Cook Nuclear Plant Unit 1	50-315	YEAR 98		UENTIA UMBER 022		REVISION NUMBER 02	2 of 5		
TEXT (If more space is required, use additional copies of NRC	Form (366A) (17)		<u> </u>	!	I		. <u></u>		
CONDITIONS PRIOR TO THE EVENT Unit 1 was in Mode Five, Cold Shutdown Unit 2 was in Mode Five, Cold Shutdown	*			•		•	۰ مې		
DESCRIPTION OF EVENT During performance of a Safety System Functional raised with regard to the single failure vulnerability the subsequent review it was determined that the through which a single failure might establish a part certain circumstances, these scenarios may preclu- failure mode would be "gas binding," with a resulta	v of the system relative to system did have single f ith for nitrogen to enter th ude both pumps from pe ant loss of discharge pres	o the Spr failure vu he suctio rforming ssure.	ray Ad Ineral on pipi their	ditive T bility. S ing of b safety f	Cank Scen oth (Tuncl	arios were CTS pump tions. The	s a result of discovered s. Under pumps'		
Nitrogen is continuously supplied to the Unit 1 and Unit 2 SATs via a pressure-reducing regulator and nitrogen supply shutoff valves. The nitrogen is used as a cover gas to prevent dilution of the tank contents, sodium hydroxide, through absorption of moisture from the air. The regulator is to supply nitrogen at 3 to 5 psig with a maximum pressure of 12 psig.									
In 1981 a procedure change was made to the nitrogen valve line up to the SAT. The normal operating position of the nitrogen shutoff valve was changed from closed to open. This change created the possibility that if the nitrogen regulator were to fail in conjunction with the failure of a SAT low level switch or SAT valve, it would be possible for nitrogen to become entrained in the fluid flow and enter the suction of the pumps. The pumps could then potentially become gas bound, and unable to perform their design functions.									
CAUSE OF EVENT The cause of this event was the failure to perform an adequate safety evaluation for the procedure revision which permanently incorporated the valve position change from normally closed to normally open. The actual change to the procedure was accomplished via Temporary Change Sheet 3 to Revision 3, and converted into a permanent change with Revision 4 to the procedure. No safety evaluation could be located for the Temporary Change Sheet, therefore, its contents can only be assumed. The safety evaluation for Revision 4 was on file, however, and did not contain justification for the "no" answers other than a statement that the procedure did not affect or interface with any safety related system. This safety evaluation was inadequate in that it did not thoroughly consider the potential effects of the valve position change.									
ANALYSIS OF EVENT On April 15, 1998, it was determined that an unan Containment Spray (CTS) system to be rendered in accordance with 10CFR50.72(b)(2)(i) for an una 10CFR50.73(a)(2)(ii) for an unanalyzed condition	inoperable by a single a analyzed condition. This	ctive fail	ure, a	nd an E	INS	notification	n was made		
Nitrogen is continuously supplied to the Unit 1 and supply shutoff valves. Since implementation of th open". By procedure, the regulator is verified to n to the tank prevents dilution of the tank contents, a Suction piping from the SAT to the CTS eductors open, permitting sodium hydroxide flow from the S failure of either valve from precluding accomplishe	e 1981 procedure chang naintain nitrogen pressur 30%-34% sodium hydrox includes two valves in pa SAT to the CTS pumps.	ge, the sh re betwee xide, thro arallel. C The para	nutoff en 3 a bugh a Dne sa allel a	valves and 5 ps absorpti afety ful irranger	have sig. ion c nctio nent	e been nor The nitrog of moisture on of the tw t prevents	mally "sealed en supplied from the air. vo valves is to a single		

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NRC FORM 366A (4-95)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER(2)		LE	R NUMB	ER (6)	PAGE (3)
Cook Nuclear Plant Unit 1	50-315	YEAR	SEQUENTIAL NUMBER			REVISION NUMBER	3 of 5
		98		022		02	

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

ANALYSIS OF EVENT (cont'd)

safety function. When the SAT reaches its low-level setpoint, these valves must close to ensure that nitrogen, or air, is not admitted into the suction piping of the CTS pumps.

The following analysis examines potential Spray Additive and Containment Spray System failure modes and their effects. The potential failure modes of interest to this analysis are those that could lead to one or both of the following effects:

(1) Nitrogen or air being admitted into CTS pump suctions.

(2) Sodium hydroxide inventory of SAT being diverted from the CTS active flow path.

All scenarios considered the current configuration of continuous nitrogen makeup to the SAT.

Since the nitrogen regulator, 12-GRV-330, is not safety related, credit is not taken for its function. The effects of a failed open nitrogen regulator are limited by the SAT safety valve, SV-107, set at 10 +/- 2 psig. The nitrogen pressure in the SAT is assumed to be the maximum setpoint value of the SAT relief valve, 12 psig.

The nitrogen regulator function is monitored daily from the Control Room in accordance with Procedure OHP 4030.STP.030, "Daily and Shift Surveillance Checks," by observation of IPI-200, the SAT pressure indicator.

It should be noted that while OHP 4030.STP.030 does require daily monitoring of SAT pressure, the notification limit is 1 psig, decreasing. That is, the notification limit is intended to prompt corrective action upon loss of nitrogen pressure, not an overpressure condition.

The principal difference between operating with nitrogen normally in service and with nitrogen normally isolated from the SAT is the response of tank pressure to decreasing sodium hydroxide level. With the nitrogen system normally isolated from the tank, the 3 to 5 psig nitrogen overpressure rapidly decreases to zero psig as tank fluid level decreases. According to the tank curve, the total internal volume of the SAT is 5,273 gallons. With level at the Technical Specification minimum of 4,000 gallons, the maximum initial volume available for nitrogen is 1,273 gallons. Using the ideal gas law and an initial nitrogen pressure of 5 psig, tank pressure will reach zero psig when the gas volume has been expanded to 1,706 gallons, that is, after about 433 gallons of sodium hydroxide have been drained from the tank.

At zero pressure, redundant tank vacuum breakers minimize further reduction of tank pressure.

With respect to the scenarios discussed here, the primary effect of operating with nitrogen normally isolated is that, well prior to tank fluid level being drawn down to the low level setpoint, SAT overpressure would be reduced from 5 psig to zero psig. With nitrogen supplied continuously, tank pressure must be assumed constant at the limiting value of 12 psig.

The following table summarizes the various scenario evaluations. For each case, two concerns are addressed:

(1) The potential for nitrogen or air to enter the CTS pump suctions, causing a failure of both CTS trains

(2) The potential for sodium hydroxide to be diverted from the active CTS flow path.

A "No" indicates that no adverse impact would result from the scenario. A "Yes" indicates that the scenario has the potential for an adverse impact.

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	Cook Nuclear Plant Un	it 1	. 50-315	YEAR 98		QUENTIAL IUMBER 022	REVISION NUMBER 02	4 of 5
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	Summary of the Potentia	l for an Adverse	e Impact with the Nitro	ogen Suppl	y Va	lves Open	l	•
Casė #	Case Description	Nitrogen or Air Intrusion	Sodium Hyroxide Diversion		No	otes	•	
•	Scenario 1 – Failure o	f SAT shutoff va	alve to close on low-l	ow SAT lev	el			
1A 1B	RWST, No Flow RWST, Full Flow	No No	No No				Refueling V or Cases 1A	
1C 1D	Recirc Sump, No Flow Recirc Sump, Full Flow	Yes Yes '	Yes No				o Conatinme Cases 1C ar	
	Scenario 2 – Failure o	f SAT shutoff va	alve and eductor shu	off valve to	clos	e on low §	SAT level	
2		Yes ′	No			·····		
· .	Scenario 3 – Failure c	f CTS pump to	run	•				
3		Yes	Yes	•	<u> </u>		•	
,	Scenario 4 – Failure c	of CTS pump an	d valves on one train	after repos	sition	ing on CT	S actuation	
4A 4B	Aligned to RWST Aligned to Recirc. Sump	No Yes	No Yes		•		•	
	, Scenario 5 – Loss of s	sodium hydroxic	le following application	n of spray	term	ination cri	eria	
5.	l	Yes	Yes	·····		*		
open, wl	nitrogen SAT shutoff valve nich although possible, is n will have an adverse impa	ot probable. W						
The sign	ificance of this event is mir	nimized by seve	ral factors:					•
	ne regulator must fail open; o credit has been taken for		essure greater than a	ero psig;				

(3) no credit has been taken for increasing containment sump level and.(4) no credit has been taken for operator action.

Engineering personnel reviewed the design and performance of the nitrogen regulators and concluded that the safety significance of the potential adverse impact scenarios is low. There was no evidence that the regulator had ever failed at the plant. A review of the design of the nitrogen regulator did not identify any probable failure mechanism that could cause the regulator to suddenly fail open. The vendor had no knowledge of any cases of the regulator failing open. One failure

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NRC FORM 366A		.	U.S. NUCL	EAR	REGULATORY	COMMISSION
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Cook Nuclear Plant Unit 1	50-315	YEAR	SEQUENT NUMBE		L REVISION NUMBER	5 of 5
•	-	98	022		02	-
TEXT (If more space is required, use additional copies of NRC Fo ANALYSIS OF EVENT (cont'd) mechanism could have caused a gradual increase in probably have been identified by the daily operator ve All cases involving diversion of sodium hydroxide wo to containment spray. In those cases, the amounts c an akaline spray. This would accomplish the function containment atmosphere. This had been verified by volumes of available sodium hydroxide. Therefore th	pressure over severa erifications of proper r uld still include the ad of sodium hydroxide a n of the spray additive past analyses of cont	hitrogen p dition of r dded to th , to enhai ainment p	ressure. nost of the ne spray w nce the re wH with va	e ava vould mova rious	ailable sodiu be sufficien al of iodine f assumptior	m hydroxide It to maintain rom the is of reduced
CORRECTIVE ACTIONS The nitrogen valve lineup will be revised to show a n will be placed in the closed position.	ormally closed positio	n for the r	nitrogen sl	nutof	f valves, and	I the valves
Additionally, the UFSAR system flow diagrams will be conditions exist.	e reviewed against ac	tual valve	lineups to	o ens	sure that no	similar
No further preventive actions are required. The 10C standards and expectations. As previously stated in being stressed by department managers. All person 1998. Although the requirements for performance of ensure the quality of those safety screenings were re-	LER 315/97-019-01, on the second seco	complete m safety s e procedu	and accur creenings ralized, th	ate : wei	safety scree	nings are I in early

Adequate barriers now exist by means of the technical review process and Safety Evaluation screening of procedure changes to ensure that a similar event will not occur in the future, therefore no further preventive actions are being taken.

FAILED COMPONENT IDENTIFICATION Not Applicable

PREVIOUS SIMILAR EVENTS 315/97-019-01 316/81-005/01T-0

NRC FORM 366A (4-95)

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