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NUREG/CR-0861
ORNL/NUREG/NSIC-165

**Summary and Bibliography of Safety-Related
Events at Pressurized-Water Nuclear
Power Plants as Reported in 1978**

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R. B. Gallaher

1132 084

Prepared for the U.S. Nuclear Regulatory Commission
Office of Nuclear Regulatory Research
Under Interagency Agreements DOE 40-551-75 and 40-552-75

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1132 085

NUREG/CR-0861
ORNL/NUREG/NSIC-165
Dist. Category AE

Contract No. W-7405-eng-26

Engineering Technology Division

SUMMARY AND BIBLIOGRAPHY OF SAFETY-RELATED EVENTS AT
PRESSURIZED-WATER NUCLEAR POWER PLANTS
AS REPORTED IN 1978

R. L. Scott
R. B. Gallaher

Manuscript Completed - August 6, 1979

Date Published - September 1979

Prepared for the U.S. Nuclear Regulatory Commission
Office of Nuclear Regulatory Research
Under Interagency Agreements DOE 40-551-75 and 40-552-75

NRC FIN No. B0126

Prepared by the
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Oak Ridge, Tennessee 37830
operated by
UNION CARBIDE CORPORATION
for the
DEPARTMENT OF ENERGY

1132 086

Printed in the United States of America. Available from
National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road, Springfield, Virginia 22161

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FOREWORD

The Nuclear Safety Information Center (NSIC), which was established in March 1963 at Oak Ridge National Laboratory, is principally supported by the U.S. Nuclear Regulatory Commission's Office of Nuclear Regulatory Research. Support is also provided by the Division of Reactor Research and Technology of the Department of Energy. NSIC is a focal point for the collection, storage, evaluation, and dissemination of safety information to aid those concerned with the analysis, design, and operation of nuclear facilities. The Center has developed a system of keywords to index the information which it catalogs. The title, author, installation, abstract, and keywords for each document reviewed are recorded at the central computing facility in Oak Ridge. The references are cataloged according to the following categories:

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15. Environmental Surveys, Monitoring, and Radiation Dose Measurements (inactive September 1973)
16. Meteorological Considerations
17. Operational Safety and Experience
18. Design, Construction and Licensing
19. Internal Exposure Effects on Humans Due to Radioactivity in the Environment (inactive September 1973)

20. Effects of Thermal Modifications on Ecological Systems
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21. Radiation Effects on Ecological Systems (inactive September 1973)
22. Safeguards of Nuclear Materials

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Telephone 615-574-0391
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PREVIOUS REPORTS IN THIS SERIES

1. W. R. Casto and E. N. Cramer, *Safety-Related Occurrences in Nuclear Facilities as Reported in 1967 and 1968*, ORNL/NSIC-69 (July 1970).
2. R. L. Scott and W. R. Casto, *Safety-Related Occurrences in Nuclear Facilities as Reported in 1969*, ORNL/NSIC-87 (August 1971).
3. R. L. Scott, *Safety-Related Occurrences in Nuclear Facilities as Reported in 1970*, ORNL/NSIC-91 (December 1971).
4. R. L. Scott and R. B. Gallaher, *Safety-Related Occurrences in Nuclear Facilities as Reported in 1971*, ORNL/NSIC-106 (September 1972).
5. R. L. Scott and R. B. Gallaher, *Safety-Related Occurrences in Nuclear Facilities as Reported in 1972*, ORNL/NSIC-109 (December 1973).
6. R. L. Scott and R. B. Gallaher, *Annotated Bibliography of Safety-Related Occurrences in Nuclear Power Plants as Reported in 1973*, ORNL/NSIC-114 (November 1974).
7. R. L. Scott and R. B. Gallaher, *Annotated Bibliography of Safety-Related Occurrences in Nuclear Power Plants as Reported in 1974*, ORNL/NSIC-122 (May 1975).
8. R. L. Scott and R. B. Gallaher, *Annotated Bibliography of Safety-Related Occurrences in Boiling-Water Nuclear Power Plants as Reported in 1975*, ORNL/NUREG/NSIC-126 (July 1976).
9. R. L. Scott and R. B. Gallaher, *Annotated Bibliography of Safety-Related Occurrences in Pressurized-Water Nuclear Power Plants as Reported in 1975*, ORNL/NUREG/NSIC-127 (July 1976).
10. R. L. Scott and R. B. Gallaher, *Annotated Bibliography of Safety-Related Occurrences in Boiling-Water Nuclear Power Plants as Reported in 1976*, ORNL/NUREG/NSIC-137 (September 1977).
11. R. L. Scott and R. B. Gallaher, *Annotated Bibliography of Safety-Related Occurrences in Pressurized-Water Nuclear Power Plants as Reported in 1976*, ORNL/NUREG/NSIC-138 (August 1977).
12. R. L. Scott and R. B. Gallaher, *Annotated Bibliography of Safety-Related Events in Boiling-Water Nuclear Power Plants as Reported in 1977*, ORNL/NUREG/NSIC-149, (November 1978).
13. R. L. Scott and R. B. Gallaher, *Annotated Bibliography of Safety-Related Events in Pressurized-Water Nuclear Power Plants as Reported in 1977*, ORNL/NUREG/NSIC-150 (November 1978).

SUMMARY AND BIBLIOGRAPHY OF SAFETY-RELATED
EVENTS AT PRESSURIZED-WATER NUCLEAR POWER
PLANTS AS REPORTED IN 1978

R. L. Scott R. B. Gallaher

ABSTRACT

This bibliography contains 100-word abstracts of reports submitted to the U.S. Nuclear Regulatory Commission concerning operational events that occurred at pressurized-water-reactor nuclear power plants in 1978. The 2084 abstracts included in the bibliography describe incidents, failures, and design or construction deficiencies experienced at the facilities. They are arranged alphabetically by reactor name and then chronologically for each reactor. Keyword and permuted-title indexes are provided to facilitate location of the abstracts of interest. Tables summarizing the information contained in the bibliography are also presented. The information listed in the tables includes instrument failures, equipment failures, system failures, causes of failures, deficiencies noted, and the time of occurrence (i.e., during refueling, operation, testing, or construction). Three of the more interesting events that occurred during the year are reviewed in detail.

INTRODUCTION

This report (along with ORNL/NUREG/NSIC-164) is the eleventh of a series, issued annually by the Nuclear Safety Information Center (NSIC), presenting abstracts of reports of safety-related events submitted to the U.S. Nuclear Regulatory Commission (NRC) by licensees of light-water reactors in the United States during the previous year. In particular, this report contains abstracts of 2084 events reported by licensees of pressurized-water-reactor nuclear power plants in the United States during 1978. The abstracts are presented on microfiche, which are filed in an envelope attached to the back cover of this report. The previous reports in the series¹⁻¹³ cover the period 1967 through 1977. In addition, five related NSIC reports¹⁴⁻¹⁸ contain information on reactor operating experiences reported by the NRC (formerly the Atomic Energy Commission) for the period 1966 through 1977.

As a result of the continual growth in the number of facilities and consequently in the number of safety-related events reported each year,

it has been necessary since 1975 to compile the abstracts of the events in two separate documents. The 1978 events occurring at boiling-water-reactor nuclear power plants are presented in ORNL/NUREG/NSIC-164, *Summary and Bibliography of Safety-Related Events at Boiling-Water Nuclear Power Plants as Reported in 1978*.

The reports of safety-related events abstracted in the bibliography were submitted by power plant licensees to the NRC in accordance with federal regulations. The reporting requirements for nuclear facility licensees are included in Title 10, *Code of Federal Regulations*, Parts 20, 40, 50, 70, and 73 and described in detail in NRC Regulatory Guide 1.16 (Ref. 19). The requirements for reporting design or construction deficiencies in nuclear facilities that have been granted construction permits are given in Title 10, *Code of Federal Regulations*, Part 50, Section 55, Paragraph e (Ref. 20).

The information for this report was obtained from the NSIC computer files in the form of 100-word abstracts of the reports submitted by power reactor licensees to the NRC. The abstracts, together with appropriate keywords used for computer storage and retrieval, were prepared by technical specialists at NSIC. Input to the computer is a continuing process; therefore, persons desiring an updating of the information on operating experiences at nuclear power plants may obtain a literature search by contacting the NSIC.

The NSIC computer also provides a bimonthly printout of those events which resulted in reactor shutdown and their causes; these are published in each issue of the bimonthly journal, *Nuclear Safety*.

The 100-word abstracts in the bibliography are arranged alphabetically by reactor name and then chronologically for each reactor. In addition, tables are presented that indicate the number of times a piece of equipment, an instrument, or a system was reported as having been involved in a malfunction. Included in the tables are causes, deficiencies, and time of occurrences (i.e., during operation, refueling, construction, or testing — both preoperational and surveillance). This is followed by a brief discussion of three events that were considered to be the most interesting of those reported during the year.

In addition to the abstracts describing each event, keyword and permuted-title indexes are provided on microfiche for quickly locating abstracts in which a particular item of interest is discussed. For example, persons interested in the problems experienced with diesel generators can find the relevant abstracts listed under the keyword *generator*, *diesel*; or using the permuted-title index, they can find the abstracts listed with the word *diesel* or the word *generator*.

Before reviewing the bibliography, it may also be helpful to review the "Method of Indexing Licensee Event Reports" (p. 23), which shows a typical abstract with its component parts identified. Note the list of keywords, which gives a quick indication of the contents of the abstract. The availability of the original material is also indicated, that is, the NRC Public Document Room, 1717 H Street, Washington, D.C. 20555.

SUMMARY OF SAFETY-RELATED EVENT DATA

The 2084 abstracts in the bibliography were reviewed and tabulations were made of significant items to indicate the total number of reports concerned with those items. These tabulations indicate items that should receive more attention by reactor operators, designers, or other interested parties.

Table 1 lists the number of reports concerned with the various systems. As in previous years, the main cooling system and the reactor protection system were the dominant systems involved in the events reported. Combined, these systems accounted for 19% of the total number of 1978 reports. The secondary cooling (steam) system was also involved in a substantial number of reports, followed closely by the electric power system.

Table 2 lists the number of reports concerned with various types of equipment. Valves, pumps, and piping were the equipment items most frequently involved in the events reported, accounting for 43% of the reports. Valves accounted for 21% of the total number of reports, pumps accounted for 13%, and piping accounted for 9%.

Table 3 lists the number of reports concerned with the listed instrumentation. Again, this year, as in every year since 1972, switches

Table 1. Number of reports concerned
with the listed systems

System	Percent of total number of reports	Number of reports
Main cooling	11	227
Reactor protection	8	176
Secondary cooling	8	176
Electric power	8	160
Feedwater	7	151
Emergency electric power	6	124
Containment isolation	6	115
Condenser cooling	5	96
Coolant purification	4	85
Radiation monitoring	4	84
Engineered safety features	4	83
Reactor control	4	78
Safety injection	4	75
Service water	3	61
Shutdown cooling	3	61
Fire protection	3	56
Ventilation	3	53
Containment spray	2	52
Containment	2	47
Pneumatic	2	35
Emergency cooling	2	32
Waste disposal	1	28
Containment air cooling	1	27
Containment purge	1	23
Component cooling	1	22
Hydraulic	<1	7
Core reflooding	<1	4
Containment filtering	<1	3

accounted for more reports than any other instrument. In 1978, switches were involved in 285 of the events reported, accounting for 14% of the total number of reports. Lagging far behind were radiation monitors, level sensors, pressure sensors, and relays, each of which accounted for 5% or less of the total.

Table 4 lists the identified causes of the safety-related events reported and the number of reports concerned with each cause. Inherent failures were involved in 47% of the reports; these are failures for which there was no obvious reason. Examples of these types of events

Table 2. Number of reports concerned
with the listed equipment

Equipment	Percent of total number of reports	Number of reports
Valves	21	434
Pumps	13	261
Pipes and pipe fittings	9	194
Seals	7	140
Storage containers	6	121
Diesel generators	6	118
Support structure	5	113
Internal combustion engines	5	107
Cables and connectors	5	98
Valve operators	5	96
Steam generators	4	93
Breakers	4	88
Control rods	3	72
Pressurizer	3	68
Shock absorber	2	48
Fastener	2	45
Control rod drives	2	38
Heat exchangers	2	38
Solenoid	2	37
Blowers	2	36
Motors	2	36
Bearings	1	29
Turbines	1	27
Filters, screen	1	26
Heaters	1	26
Tubing	1	25
Batteries and chargers	1	24
Check valves	1	23
Condensers	1	22
Pressure vessels	1	22
Generators	<1	17
Transformers	<1	15
Accumulators	<1	14
Fuel elements	<1	14
Cooling tower	<1	8
Crane	<1	7
Flanges	<1	7
Nozzle	<1	7
Demineralizer	<1	6
Air driers	<1	4
Recombiners	<1	1

Table 3. Number of reports concerned
with the listed instrumentation

Instrumentation	Percent of total number of reports	Number of reports
Switch	14	285
Radiation monitors	5	108
Level sensors	4	90
Pressure sensors	4	76
Relays	4	72
Electronic function units	3	66
Flow sensors	3	60
Position instrument	3	53
Power-range instrument	2	41
Temperature sensors	2	33
Solid state device	1	22
In-core instrument	<1	18
Alarm	<1	17
Indicators	<1	14
Start-up-range instrument	<1	13
Recorders	<1	13
Amplifier	<1	12
Meteorological instrument	<1	12
Intermediate-range instrument	<1	9
Seismic instrument	<1	8
Failed-fuel detection instrument	<1	2

Table 4. Number of reports concerned with the listed
cause of the safety-related events

Cause	Percent of total number of reports	Number of reports
Inherent failure	47	975
Operator error	11	227
Design error	10	211
Administrative error	9	184
Maintenance error	6	135
Installation error	5	112
Fabrication error	4	86
Weather	1	27
Lightning	<1	3

include (1) an excessive number of fish impinged on the intake screens, (2) instrument set-point drift, and (3) spurious trips of instruments or equipment. The causes listed account for 93% of the reports; the remaining 7% of the reports did not give a reason for failure, and most indicated that further investigation was required.

Table 5 lists the time periods in which the various events took place and the associated number of reports. It should be noted that those items discovered during testing could be remedied with little or no effect on reactor operation.

Table 5. Number of reports for the listed time of occurrence of off-normal events

Time of occurrence	Percent of total number of reports	Number of reports
Operation	52	1095
Testing	31	644
Construction	9	187
Refueling	8	158

Table 6 is a list of deficiencies considered to be of interest and the number of reports associated with each one. The most frequently reported deficiency is "leak," which includes any type of leak, such as water or steam from pipes, valves, or fittings. A deficiency in communication covers those events involving a misunderstanding between personnel; it also includes misinterpretation of procedures or technical specifications.

Table 7 is an alphabetical listing of the nuclear reactor units from which reports were received and the associated number of reports. Those reactors which were in commercial operation all year are listed first, followed by those which were in the power-ascension phase part of the year, and then by those which were under construction all year. Excluding Indian Point 1, which was shut down all year, 76 nuclear units are represented in this bibliography, which contains 2084 abstracts of reports. For the 38 nuclear units which were operational all year, there are 1613

Table 6. Number of reports concerned with the listed deficiency

Deficiency	Percent of total number of reports	Number of reports
Leak	9	181
Procedures	8	169
Set point drift	7	139
Instrument calibration	6	123
Welds	4	73
Crud	3	68
Communication	3	53
Crack	2	48
Lubrication	2	48
Vibration	2	44
Wear	2	34
Age	1	28
Corrosion	1	26
Records	1	26
Stress	<1	19
Airborne release	<1	14
Fatigue	<1	7
Stress corrosion	<1	6
Erosion	<1	4
Fire	<1	4

reports — an average of 42 reports per unit (compared to 34 in 1976 and 1977). For the 4 units in the power-ascension stage, there were 355 reports — an average of 89 reports per unit. For the 34 units which were under construction, there are 244 reports — an average of 7 reports per unit. It should be pointed out that Table 7 indicates that there are 2212 reports, whereas the bibliography contains abstracts of 2084 reports. The reason for this discrepancy is that a few of the reports involved more than one unit of a multiple-unit plant, and this is particularly true of those units which were under construction.

Tables 8 and 9 tabulate the number of reports submitted for the listed units which were commercially operable all year. In Table 8 the tabulation is by age; in Table 9 the tabulation is by power — design electrical rating (DER) in megawatts (electrical) [MW(e)]. These tables were prepared to see if age or power level was a factor in the number of reportable events occurring at a nuclear unit. Both age and power appear to be factors, although it may not be readily apparent from just a cursory inspection of the tables.

Table 7. Number of reports involving the alphabetically listed units^a

Name	Percent of total number of reports	Number of reports	Age (years)	Design electrical rating [net MW(e)]
In commercial operation all year				
Arkansas Nuclear 1	2	35	4.4	850
Beaver Valley 1	3	62	2.6	852
Calvert Cliffs 1	3	57	4.0	845
Calvert Cliffs 2	2	48	2.1	845
Cook 1	3	71	3.9	1054
Crystal River 3	5	102	1.9	825
Davis-Besse 1	6	126	1.3	906
Farley 1	5	97	1.4	829
Fort Calhoun	2	46	5.4	457
Ginna	<1	8	9.1	490
Haddam Neck	2	34	11.4	575
Indian Point 2	2	37	5.5	873
Indian Point 3	2	39	2.7	873
Kewaunee	2	40	4.7	535
Maine Yankee	1	28	6.1	790
Millstone 2	1	29	3.1	828
Oconee 1	1	27	5.7	887
Oconee 2	<1	14	5.1	887
Oconee 3	<1	19	4.3	887
Palisades	2	45	7.0	668
Point Beach 1	<1	18	8.2	497
Point Beach 2	<1	11	6.4	497
Prairie Island 1	1	30	5.1	530
Prairie Island 2	1	23	4.0	530
Rancho Seco	<1	19	4.2	913
Robinson 2	2	34	8.3	712
Salem 1	4	77	2.0	1090
San Onofre 1	<1	19	11.5	430
St. Lucie 1	2	49	2.7	802
Surry 1	2	50	6.5	822
Surry 2	2	47	5.8	822
Three Mile Island 1	1	24	4.5	819
Trojan	2	36	3.0	1130
Turkey Point 3	<1	16	6.2	693
Turkey Point 4	<1	14	5.5	693
Yankee Rowe	2	41	18.1	175
Zion 1	5	94	5.5	1040
Zion 2	2	47	5.0	1040

Table 7 (continued)

Name	Percent of total number of reports	Number of reports	Age (years)	Design electrical rating [net MW(e)]
In power ascension part of year				
Arkansas Nuclear 2	2	51		
Cook 2	5	103		
North Anna 1	7	138		
Three Mile Island 2	3	63		
Under construction all year				
Beaver Valley 2	<1	5		
Bellefonte 1	<1	11		
Bellefonte 2	<1	13		
Braidwood 1	<1	1		
Braidwood 2	<1	1		
Byron 1	<1	3		
Byron 2	<1	3		
Callaway 1	<1	4		
Catawba 1	<1	6		
Catawba 2	<1	6		
Diablo Canyon 1	<1	3		
Diablo Canyon 2	<1	2		
Farley 2	<1	3		
McGuire 1	<1	10		
McGuire 2	<1	10		
Midland 1	<1	10		
Midland 2	<1	10		
North Anna 2	1	28		
North Anna 3	<1	14		
North Anna 4	<1	14		
Salem 2	<1	3		
San Onofre 2	<1	7		
San Onofre 3	<1	6		
Seabrook 1	<1	1		
Seabrook 2	<1	1		
Sequoyah 1	<1	17		
Sequoyah 2	1	21		
South Texas 1	<1	2		
South Texas 2	<1	2		
St. Lucie 2	<1	1		
Tyrone 1	<1	1		
Waterford 3	<1	2		
Watts Bar 1	<1	14		
Watts Bar 2	<1	9		

^aThree reports not included involved Indian Point 1, which was shut down all year with no decision on its future.

Table 8. Number of reports for the listed unit which was commercially operable all year (by age since first electrical generation)^a

Name	Age ^a (years)	Percent of total number of reports	Number of reports
Yankee Rowe	18.1	2	41
San Onofre 1	11.5	<1	19
Haddam Neck	11.4	2	34
Ginna	9.1	<1	8
Robinson 2	8.3	2	34
Point Beach 1	8.2	<1	18
Palisades	7.0	2	45
Surry 1	6.5	2	50
Point Beach 2	6.4	<1	11
Turkey Point 3	6.2	<1	16
Main Yankee	6.1	1	28
Surry 2	5.8	2	47
Oconee 1	5.7	1	27
Indian Point 2	5.5	2	37
Turkey Point 4	5.5	<1	14
Zion 1	5.5	5	94
Fort Calhoun	5.4	2	46
Oconee 2	5.1	<1	14
Prairie Island 1	5.1	1	30
Zion 2	5.0	2	47
Kewaunee	4.7	2	40
Three Mile Island 1	4.5	1	24
Arkansas Nuclear 1	4.4	2	35
Oconee 3	4.3	<1	19
Rancho Seco	4.2	<1	19
Calvert Cliffs 1	4.0	3	57
Prairie Island 2	4.0	1	23
Cook 1	3.9	3	71
Millstone 2	3.2	1	29
Trojan	3.0	2	36
Indian Point 3	2.7	2	39
St. Lucie 1	2.7	2	49
Beaver Valley 1	2.6	3	62
Calvert Cliffs 2	2.1	2	48
Salem 1	2.0	4	77
Crystal River 3	1.9	5	102
Farley	1.4	5	97
Davis-Besse 1	1.3	6	126

^a Average age - 5.4; median age - 5.1.

Table 9. Number of reports for the listed unit which was commercially operable all year (by design electrical rating)^a

Name	DER [net MW(e)]	Percent of total number of reports	Number of reports
Trojan	1130	2	36
Salem 1	1090	4	77
Cook 1	1054	3	71
Zion 1	1040	5	94
Zion 2	1040	2	47
Rancho Seco	913	<1	19
Davis-Besse 1	906	6	126
Oconee 1	887	1	27
Oconee 2	887	<1	14
Oconee 3	887	<1	19
Indian Point 2	873	2	37
Indian Point 3	873	2	39
Beaver Valley 1	852	3	62
Arkansas Nuclear 1	850	2	35
Calvert Cliffs 1	845	3	57
Calvert Cliffs 2	845	2	48
Farley	829	5	97
Millstone 2	828	1	29
Crystal River 3	825	5	102
Surry 1	822	2	50
Surry 2	822	2	47
Three Mile Island 1	819	1	24
St. Lucie 1	802	2	49
Maine Yankee	790	1	28
Robinson 2	712	2	34
Turkey Point 3	693	<1	16
Turkey Point 4	693	<1	14
Palisades	668	2	45
Haddam Neck	575	2	34
Kewaunee	535	2	40
Prairie Island 1	530	1	30
Prairie Island 2	530	1	23
Point Beach 1	497	<1	18
Point Beach 2	497	<1	11
Ginna	490	<1	8
Fort Calhoun	457	2	46
San Onofre 1	430	<1	19
Yankee Rowe	175	2	41

^a Average DER - 801; median DER - 824.

The total number of reports for the 19 oldest reactors was 613, whereas the number of reports for the 19 most recently built reactors was 1000 - 63% more reports than for the older reactors. This tends to indicate that there will be fewer failures or malfunctions of safety-related equipment as the unit ages and experience is gained in operation.

The same type of count was made based on power level. The number of reports for the 19 smallest units was 577, whereas the number of reports for the 19 largest units was 1036 - 80% more reports than for the smaller units. This seems to indicate that fewer problems can be expected with smaller units.

While it should be recognized that the data presented are not absolute, especially when you consider that the reporting habits throughout the industry may not be uniform, the tables and data do seem to indicate that a low-power, older reactor will probably have fewer problems than a high-power, newly built reactor. However, one factor to be considered in this conclusion is that the newly built reactors are the larger units and, to date, the feedback of operating information from the operators to the designers of these larger units has been limited. In addition, the newer, larger units are more complicated than the older, smaller units.

The final bit of information gleaned from reviewing the bibliography is that, of the 2084 reports, 67 indicated that a reactor shutdown occurred or was required because of equipment failure or malfunction.

REVIEW OF SELECTED SAFETY-RELATED EVENTS

A review of the reported events indicated that most were of a routine and inconsequential nature; however, a few were significant or unique. Three events that were considered to be the most interesting are presented here to illustrate the types of experiences that occurred in 1978.

Failure of Burnable-Poison-Rod Assemblies at Crystal River 3

On Dec. 12, 1977, an alarm sounded indicating a possible power tilt at Crystal River Nuclear Plant, Unit 3, a pressurized-water-reactor (PWR) operated by the Florida Power Corporation. Another alarm sounded on

Jan. 1, 1978, followed sporadically during the next few days by other alarms from the loose-parts monitoring system. Finally, on Feb. 17, 1978, the loose-parts system initiated a continuous alarm indicating the presence of loose parts in steam generator B. To minimize potential damage from any loose part in the primary coolant system, the operators reduced reactor power and shut off one of the two reactor coolant pumps in the affected loop.^{21,22}

On Mar. 3, 1978, the reactor was shut down for inspection of steam generator B. Several parts of a burnable-poison-rod assembly were found in the steam generator, and the steam generator tubes at the tube-to-tube-sheet welds were damaged. There were indications of a small leak from the primary to the secondary cooling system. Burnable-poison-rod assembly parts were also found in the core-support assembly, in various fuel assemblies, and in the plenum and bottom of the reactor vessel. It was necessary to completely defuel the reactor to facilitate inspection.

The cause of the failure was attributed to wear of the coupling mechanism's positive latch to the fuel assemblies. The burnable-poison-rod assemblies were all removed from the core and will not be replaced, because they are no longer needed to help control the larger reactivity existing during the early stages of core life.

Similar burnable-poison-rod assemblies were also in use at Davis-Besse, Unit 1, and are still in use at Three Mile Island, Unit 2. The burnable-poison-rod assemblies were removed from Davis-Besse, Unit 1, and were not replaced. However, the burnable-poison-rod assemblies were still needed to help control core reactivity at Three Mile Island, Unit 2; therefore, retaining collars were added to the assemblies to keep them in place.

The steam generator at Crystal River, Unit 3, was repaired, and the station was placed back in service but only after a lengthy shutdown of seven months.

Station Blackout at Beaver Valley

On July 28, 1978, the main transformer failed at the Beaver Valley Power Station, a PWR operated by the Duquesne Light Company. As a consequence, the generator, turbine, and reactor tripped, and safety

injection occurred. Also, all off-site power was lost. The portions of the plant associated with both the primary and the secondary systems were placed in a hot shutdown, using emergency diesel generator power.²³

The blackout of the station was caused by the following series of events. The transformer failure caused the following relays to trip: main generator differential, main generator differential auxiliary, main transformer differential, main transformer differential auxiliary, main generator ground overcurrent, and main generator ground backup overcurrent. When these relays tripped, the station service buses successfully transferred to the off-site sources -- two 138-kV buses in the nearby Shippingport Power Station switchyard. Fifteen seconds later, as the Beaver Valley turbine generator coasted down while still supplying fault current to the short circuit, the main generator "out-of-step" relays operated -- when they should not have -- and caused isolation of the Beaver Valley 345-kV switchyard by tripping all 345-kV line breakers and the tie to the 138-kV autotransformer. In addition, three of the five 138-kV breakers in the 138-kV Shippingport switchyard tripped; when this occurred, the Shippingport Power Station was the only power source on the 138-kV bus supplying power to the two remaining 138-kV loads and the Beaver Valley Power Station system transformers. However, this total load exceeded the capacity of the Shippingport Power Station, so the frequency declined to approximately 58 Hz.

The Shippingport Power Station was then manually tripped; this removed the last source of power to Beaver Valley. Immediately, the No. 1 emergency diesel generator came on the line and supplied power to one of the redundant trains of safety-related equipment, but the No. 2 emergency diesel failed to "pick up a field" and, although running at nominal speed, did not provide power to the redundant emergency bus. About 15 min into the blackout, the field was manually "flashed" on the second diesel, and it assumed its load.

No adverse conditions developed in the reactor core as a result of the station blackout; although there was no forced flow in the reactor coolant system during the blackout, heat was removed from the reactor core by thermal circulation and transferred to the steam generators. The reactor coolant system was not adversely affected by the blackout either;

the water remained subcooled and at near-normal level in the pressurizer, and the system was not overpressurized. The main transformer was returned to the vendor's shop for rewinding.

Common-Cause Incident Involving
Nonnuclear Instrumentation

On Mar. 20, 1978, a short to ground in nonnuclear instrumentation at Rancho Seco resulted in a reactor trip and a subsequent reactor-cooling-system (RCS) cooldown rate that exceeded the technical specifications limit.²⁴ This PWR is owned by the Sacramento Municipal Utility District, Sacramento, Calif.

Before the cooldown transient, the plant was operating at a power level of 70%, with all four reactor coolant pumps operating and an average RCS temperature of 306°C. Shortly before 4:25 AM, a control room operator began replacing a burned-out light bulb in a back-lighted push-button switch assembly on one of the control consoles. The dc power for this switch is provided from the "Y" portion of the nonnuclear instrumentation (NNI-Y). During replacement of the light bulb, the assembly was pulled from the panel and flipped down, exposing the bulbs. A bulb was dropped into the open light-assembly cavity, creating a short to ground, whereupon the current-limiting and undervoltage protection for the NNI-Y dc power supplies was actuated, cutting off the ac power to all NNI-Y dc power supplies. Preliminary investigations have shown that approximately two-thirds of the NNI signals (pressure, temperature, level, flow, etc.) were affected. The inevitable erroneous signals gave faulty information to both the control room and the integrated control system (ICS). Attempting to match equipment output with plant requirements, the ICS reduced main feedwater flow to zero, which caused the RCS pressure to increase. A reactor trip from high pressure followed.

After the reactor trip, the operators were still hampered by the lack of instrumentation and by equipment responding to inaccurate signals. For approximately 9 min following the trip, pressure slowly decayed to about 13.8 MPa (2000 psig) in the RCS. It has been postulated that the pressure remained fairly adequate during this period owing to the cooling provided by makeup flow into the RCS and to the lifting of a pressurizer

code safety valve below its set point of 17.5 MPa (2500 psig). On the loss of feedwater flow, an auxiliary feedwater pump had started; however, the auxiliary feedwater valves remained closed in response to erroneous level signals from the once-through steam generators — another effect of the NNI-Y dc power failure. The level signal for steam generator A drifted to zero over a 9-min period, whereas that for steam generator B drifted full scale. In reality, both steam generators boiled dry during this period. When the startup level for steam generator A drifted below the low-level set point, the ICS opened the auxiliary feedwater valve, admitting water to the shell side. This influx of water created a heat sink for the RCS, causing a rapid pressure drop. The operators also may have increased the main-feed-pump flow at this time, and this provided another source of water for steam generator A. The RCS pressure dropped rapidly to 11.1 MPa (1600 psig), at which point both auxiliary feedwater bypass valves opened automatically and began filling both steam generators with water.

Until power was restored to NNI-Y approximately 1 hr and 10 min after the reactor trip, the operators continued the injection of auxiliary feedwater that was started automatically. Since it did not appear that the RCS temperature indication was reliable, the operators maintained RCS pressure as well as possible, using the pressurizer level indication and the RCS pressure indication that was available. These two parameters were controlled by adjusting the high-pressure injection flow. Unfortunately, the pressurizer heaters were not available for pressure control because of the NNI power loss. As injection of auxiliary feedwater continued, both steam generators were completely filled, and water began to enter the steam lines. This large heat sink continued to rapidly cool the RCS, unknown to the operators who had no information on the temperature.

When power was finally restored to NNI-Y, the operators realized that the RCS temperature had dropped to $\sim 141^{\circ}\text{C}$ and that the technical specifications had been violated. Immediate action was taken to return to the permissible operating region: spraying the pressurizer to reduce pressure, keeping three reactor cooling pumps operating (pump combinations

were changed) to increase the temperature, shutting off auxiliary feedwater flow, and draining the steam generators.

The short caused by the light bulb drew excessive current through the 24-V dc power supplies that service components in NNI cabinets 5, 6, and 7. The power for these cabinets is designated NNI-Y, while the power for cabinets 1, 2, 3, and 4 is designated as NNI-X. The four power supplies for NNI-Y are operated current-limited with a set point of 7.5 A. The subsequent reduction in voltage caused an undervoltage monitor to operate, opening the two shunt breakers through which ac power from inverter D and inverter J is supplied to the dc power supplies. Loss of these power supplies meant that every component in cabinets 5, 6, and 7 operating on dc power was not functioning properly. An NNI signal could have been affected two ways between its source and the receiving component. The signal could be interrupted completely owing to a contact opening when it was de-energized. Because most of the signals are -10 V to +10 V, this would have resulted in a midscale reading or, in some cases, a reading anywhere between -10 V and +10 V being transmitted to the indicator or sent to the ICS as an actual plant parameter. If a signal-conditioning component (buffer amplifier, square root extractor) was affected, this would have meant that the desired conditioning would not have been performed on the signal or that the component might not have passed the true signal so that erroneous values would have been sent to the indicator or to the ICS. Since signal paths in the NNI are not restricted to either the X or Y cabinets, about two-thirds of the signals passed through at least one component in cabinets 5, 6, or 7 and therefore would have been invalid.

Practically no permanent records of the plant parameters during the transient were kept. A major source of information was the posttrip transient review, which prints out selected data periodically following a reactor trip. It was not possible to extensively analyze this and the other data available (recorder outputs, hourly log, etc.) during the transient. Over a period of several days following the incident, the plant engineers were able to trace which signals were valid, determine what equipment operated at which times, and then interpolate a temperature trace which indicated that the RCS temperature fell from about 312 to

141°C in slightly more than 1 hr. This cooldown rate of approximately 150°C/hr is well above the permitted rate of 40°C/hr.

To ensure that all components of the plant were in satisfactory condition, Babcock & Wilcox (B&W) personnel evaluated the effects of the transient on the reactor vessel, the reactor coolant piping, the pressurizer, the once-through steam generators, the fuel assemblies, the reactor cooling pumps and seals, and the control-rod-drive mechanisms. The B&W team recommended to the Nuclear Regulatory Commission (NRC) that Rancho Seco be permitted to return to power under certain specified conditions.

The Plant Review Committee reviewed the B&W recommendations and requested that a special test procedure and a casualty procedure be written to ensure compliance. At the committee's request, the following tasks were also completed prior to start-up:

1. Because of possible damage to steam lines from the injection of water, they were checked for any deformations.
2. A 15.5-MPa (2255-psig) leak test was performed on the reactor cooling system.
3. The overvoltage trip set points on the NNI dc power supplies were increased from 27 V to 29 V to prevent spurious trips.

The special test procedure addressed conditions such as reactor maneuvering limits for the first start-up, increased surveillance of the loose-parts monitors for a week, an operability check of on-line and redundant NNI, and daily surveillance of the primary and secondary radio-chemistry for a week to check for leaking components. The casualty procedure was written to provide required operator actions for restoration of NNI power following a trip similar to the one experienced. The Plant Review Committee also required that a procedure be written giving operator instructions if NNI power cannot be restored.

On Friday, Mar. 24, the reactor was again taken to criticality, and the initial power ascension began.

CONCLUSION

We can all profit by the experience of others as long as there is free communication among the interested parties. This compilation was

prepared with this objective in mind, and the intent is to provide some guidance as to where additional effort can be expended to minimize the occurrence and the recurrence of off-normal incidents at nuclear power plants. In this way, the safety, reliability, and availability of nuclear facilities should be improved.

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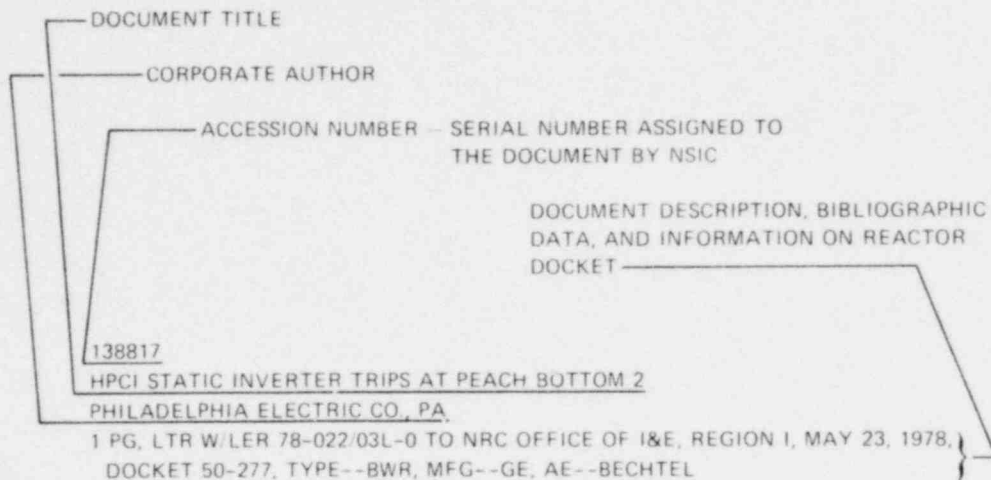
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