

A-189

GPK EAK II 189

DOCKETED
PRB 95-84 USNRC
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'95 OCT 20 P4:19

PRB MEETING MINUTES CONTINUATION SHEET

OFFICE OF SECRETARY
DOCKETING & SERVICE

- A. The board convened to review Deficiency Card 1-95-077, which documented the discovery of moisture in the tubing/fittings on 1PI-9053, 1PI-9057, and 1PI-9052, DG right and left bank starting air pressure gauges. The discussion centered around the possible cause(s) for the evidence of water in the gauges. The board concurred with the reportability determination for this DC, and the recommended corrective actions with the following comments:
- Reword the root cause stated on the Root Cause Determination Worksheet, to make it consistent with the conclusion stated in the discussion of root cause and corrective action
 - Add an interim corrective action to perform monthly follow-up moisture checks (for 3 months)
 - Revise the corrective action to state: "When calibrating instrumentation an appropriate calibration medium for that system should be utilized. Instrumentation, particularly the DG, shall be calibrated with air"
 - Consider adding this DC/Event to the continuing training program for I & C
 - Incorporate the following 4 step plan into the corrective actions:
 - 1) Determine the scope & feasibility of tubing blowdown
 - 2) Monthly moisture checks as stated above
 - 3) If positive results obtained from monthly checks (3 monthly cycles), then defer to outage
 - 4) Check for moisture during each calibration

Meeting Adjourned

9512210187 950914
PDR ADOCK 05000424
PDR

NUCLEAR REGULATORY COMMISSION
 Docket No. 50-424/425-OLA-3 EXHIBIT NO. II-189
 In the matter of Georgia Power Co. et al., Vogtle Units 1 & 2
 Staff Applicant Intervenor Other
 Identified Received Rejected Reporter SD
 Date _____ Witness Ken Stokes

Deficiency Card

Low

31062

Completed By Initiator	Card # <i>1-95-077</i>	<input checked="" type="checkbox"/> Unit 1	<input type="checkbox"/> Unit 2	<input type="checkbox"/> Common
	1: Description of Deficiency		(Additional Sheets Attached?) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Completed By USS Within 2 Hours	At approx. 1500 moisture was detected in the tubing/fittings on IPT 9053, 1B D/G right bank starting air pressure gauge. (=0.315in)			
	At approx 1700 moisture was detected in the tubing/fittings of IPT-9057, 1A D/G left bank starting air pressure gauge. (=1.62)			
	At approx 1800 moisture was detected in the tubing/fittings on IPT-9052, 1A D/G right bank starting air pressure gauge. (=0.165in)			
	MPL Tag Number	IPT-9052, 9053, 9057		
Location Of Deficiency?		1A + 1B D/G Engine Control Panel		
What is Affected By The Deficiency?/What Controls Were Violated?		Unknown		
How Was The Deficiency Discovered? <i>During testing under MWO 19502428</i>				
Event Time		Various		Date <i>8-18-95</i>
Discovered By?		<i>L.P. Noble</i>		Work # <i>4306</i> Dept. <i>T-C</i>
2. Shift Supervisor Review		Name of USS Reported To: <i>W.C. Thomas</i> Title <i>WLT-1437</i> Date <i>8-21-95</i>		
Plant Mode/Condition:		<i>1/100%</i>		
Is Immediate Notification Required?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If Yes, <input type="checkbox"/> 1 Hour, <input type="checkbox"/> 4 Hour, or <input type="checkbox"/> 24 Hour		Reported: Date <i>N/A</i> Time <i>N/A</i>		
Tech. Spec. Required Action Taken?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A		
List Applicable Tech. Spec. Section(s)		<i>3.8.1.1 - Yes were previous</i>		
Summarize Compensatory Action Taken:		<i>MOISTURE DRAINED, RECEIVERS DEWPOINT + CONTROL AIR DEWPOINT ARE SET. + OXYGEN Y/O.</i>		
LCO Initiated		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No # Type: Info LCO Fire <i>NO</i>		
WO Initiated		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No # <i>MWO 19502428</i>		
Signature Of USS		<i>WLT3</i> Date <i>8-21-95</i> Time <i>1452</i>		
Completed in 1 Day	3: NSAC Evaluation/Review (Check Appropriate Box)		Date Received: <i>8-21-95</i>	
	A. <input type="checkbox"/> No Disposition Required. Send Copy To Responsible Dept., Close Original			
	B. <input type="checkbox"/> Reportable Deficiency Report #			
C. <input checked="" type="checkbox"/> Deficiency, Not Reportable.				
Explanation: <i>Per discussion with system engineering this condition does not prevent the D/Gs from starting and performing their intended safety function. Tech. Specs. have not been violated as this is not reportable per 10 CFR 50.73.</i>				
<i>Note: This DC superseded DC #1-95-76.</i>				
Responsible Dept:		<i>Eng. Support</i>		
NSAC Reviewer:		<i>Tom [unclear]</i> Date: <i>8-21-95</i> NSAC Supervisor: <i>[unclear]</i>		

4. Disposition: *Hardware not affected - use as is. Water removed per MWD 19502428. [Signature] 9/11/95*

5. RCCA Required: Yes (Complete per 00058-C) No (Complete 6 & 7 below)

6. Cause(s), if known: *N/A*

7. Action to Prevent Recurrence, if applicable: *N/A*

Concurrence for Corrective Actions Assigned to Another Dept:

8. Cause Code(s): *EID, EID* Cause Dept(s): *Maint* *WJ 9-7-95*

Department Manager: *RR Hobbes* Date: *9/6/96*

9. Event Code(s): *2A* NSAC Initials: *TEW 9-2-95*

Completed in 1 Month By Responsible Department

Procedure Rev
0005B-C 10

ROOT CAUSE and CORRECTIVE ACTION REPORT

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EVENT INVESTIGATED

- | | |
|---|------------------------------|
| 1. DC # <u>1-95-077</u> | 2. Event Report # <u>N/A</u> |
| 3. RCCA requested by MGT. <input type="checkbox"/> | 4. Other (specify) _____ |
| 5. Personnel statement(s) attached. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

ROOT CAUSE ANALYSIS TECHNIQUE (Indicate each method used)

- | | |
|--|--|
| 1. Paper and Pencil Narrative (Figure 3) <input type="checkbox"/> | 5. Cause Identification Worksheet (Figure 7) <input checked="" type="checkbox"/> |
| 2. Barrier Analysis (Figure 4) <input type="checkbox"/> | 6. Fault Tree Analysis <input type="checkbox"/> |
| 3. Change Analysis (Figure 5) <input type="checkbox"/> | 7. Mgt Oversight Risk Tree (MORT) <input type="checkbox"/> |
| 4. Event/Root Cause Flow Chart (Figure 6) <input type="checkbox"/> | 8. Other _____ |

EVENT DESCRIPTION or FAILURE SCENARIO:

Narrative attached:
Sequence of Events attached:

BROADNESS REVIEW

PRIOR OR SIMILAR OCCURRENCE (Complete all line items. Check appropriate response)

1. DC Database reviewed	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
2. NPMIS Database reviewed	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
3. NPRDS Database reviewed	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
4. Isolated occurrence? If no, attach review	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	
5. Previous RCCA adequate?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	N/A <input checked="" type="checkbox"/>

IMPACT

1. Other tram/channel/unit checked?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
2. Other similar process checked?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
3. Other similar component?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	N/A <input type="checkbox"/>
4. Other (specify)			

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ROOT CAUSE(S) and CONTRIBUTING CAUSES: Include any previous corrective actions that were ineffective.	ROOT CAUSE CODE(S):
Water was most likely used to calibrate instruments and not completely removed. The procedure (22705-C) gives no guidance for removing the water when used in an air system.	F3D and E1D
Continuation Sheet attached: []	

Is the event a MPFF? Yes No *Rev 9/1/95 per consultation w/ K. Stoker*

RECOMMENDED CORRECTIVE ACTIONS:	EST. COMPLETION DATE
(1) Revise procedure 22705-C (and all other applicable procedures) to include instructions to properly remove all water when calibrating instruments used in air systems. For instruments on the diesel generator air system, use only nitrogen, air or some other gas as the calibrating medium.	September 29, 1995
(2) Brief technicians on procedure changes.	September 29, 1995
(3) Perform monthly moisture check on these gauges for both units to verify no water is present. If possible, blowdown the instrument line to remove any moisture. Take these actions for the next 3 months. If moisture is still present after 3 months ensure system engineer determines appropriateness of further corrective actions.	December 1, 1995

Continuation Sheet attached: []

M. J. Johns for KRA 12/7/95
 RESP. DEPT. MANAGER APPROVAL DATE

(NOT REQUIRED IF SAME AS RESPONSIBLE DEPARTMENT MANAGER)

<i>Karen Stoker</i>	<i>19/7/95</i>	<i>W. Brumby</i>	<i>19-7-95</i>
INVESTIGATOR	DATE	LEAD MANAGER/ERTL APPROVAL	DATE

OIT NUMBER(S): 31151 OIT INITIATED; COMMITMENTS REVIEWED:

all s/p/s 1
 TECHNICAL SUPPORT SUPERVISOR DATE

Version September 7, 1995 JLB Notes C:\ACTOR\3307\F&C\WATER.DOC

ATTACHMENT TO RCCA FOR DC #1-95-077
EVENT DESCRIPTION or FAILURE SCENARIO
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POSSIBLE CAUSES:

1. Water condensing from the control air.
2. High humidity air introduced in the system when the tubing was open for maintenance/calibration.
3. Water introduced during calibration of the instrument from:
 - A. Calibration using contaminated air
 - B. Calibration using nitrogen/dry air through tubing contaminated with water
 - C. Calibration using water

DISCUSSION:

1. For water to have condensed from the control air, the temperature inside the tubing would have to fall below the dew point temperature of the control air. Following the identification of the water in the tubing to the pressure gauges, dew point measurements were made of the air in the air receiver and in the 60 psig pneumatic air system per MWO 19502428. The dew point/pressure for the air receivers was 46.7°F/228 psig (PI-9053) and 42.8°F/237 (PI-9057) psig for train B and 46.6°F/228 psig (PI-9052) for train A. The dew point/pressure for the 60 psig pneumatic air system was 16.6°F/60 psig and 22.4°F/60 psig for trains A and B, respectively. Relating these readings to a dew point conversion chart (Reference Figure 27-L from Compressed Air and Gas Data, Third Edition, Ingersoll-Rand), the receiver and 60 psig pneumatic air system readings are reasonable (i.e. a dew point temperature of 46.7°F at 228 psig would be approximately 22°F at 60 psig). At these dew point values, for condensation to precipitate out of the control air in the tubing to the pressure indicators, the temperature inside the tubing would have to fall below 46.7°F.

After identification of the water in the instrument tubing, checks for moisture were made at the control air pressure gauge, control air test connection, air filter trap, and starting air receiver drain valve (reference MWO 19502428). No indications of moisture were found at these locations.

The Diesel Generator room is maintained above 50°F. The temperature inside of the control panel is also higher than the room temperature as shown in the room and panel temperatures taken and documented in MWO 19502428 (temperature

ATTACHMENT TO RCCA FOR DC #1-95-077
EVENT DESCRIPTION or FAILURE SCENARIO
PAGE 4 OF 5

DISCUSSION (Continued):

outside the panel was 86.2°F and the temperature inside the panel was 93.4°F). Based on the facts that (1) the tubing to the pressure indicators is located inside the panel, (2) the room and panel are maintained at a temperature above 50°F, and (3) the dew point of the starting air was 46.7°F, it can be concluded that it is highly improbable that the water was condensation from the control air. From the above, it can also be concluded that no condensation from the control air would be in the 60 psig pneumatic air system.

2. When the tubing system was open for maintenance/calibration of the instruments, it was exposed to the surrounding air in the building/control panel. If we postulate a room dry bulb temperature of 93°F (design outdoor temperature) and wet bulb temperature of 78°F (design outdoor temperature and relative humidity of approximately 51%), the specific humidity of the air will be 0.0175 pounds of moisture (lbm) per pound of dry air (lba) at standard conditions (reference 1993 ASHRAE Fundamentals psychometric chart). The density of dry air at 93°F is 0.07179 lba/ft³ (reference Buffalo Forge Fan Engineering Handbook, 8th Edition, Table 1.17). The following calculates the volume of air required to obtain 1 milliliter (ml) of water at these conditions:

$$1 \text{ ml} = 1 \text{ ml} \times 1/1000 \text{ l/ml} \times 0.035315 \text{ ft}^3/\text{l} = 3.53(10^{-5}) \text{ ft}^3$$

$$\begin{aligned} \text{Density of the water in the air} &= 0.07179 \text{ lba/ft}^3 \times 0.0175 \text{ lbm/lba} \\ &= 1.2563(10^{-3}) \text{ lbm/ft}^3 \end{aligned}$$

Density of water is 62.4 lbm/ft³. Therefore, the weight of 1 ml of water is:

$$62.4 \text{ lbm/ft}^3 \times 3.53(10^{-5}) \text{ ft}^3 = 2.2027(10^{-3}) \text{ lbm}$$

The volume of air required to extract 1 ml of water would be:

$$2.2027(10^{-3}) \text{ lbm} / 1.2563(10^{-3}) \text{ lbm/ft}^3 = 1.75 \text{ ft}^3 \text{ of air}$$

By comparison of the required volume of air and the actual volume of 1/4" tubing (volume in 5 feet of 1/4" tubing - $5 \text{ ft} \times \pi \times (0.097 \text{ in} / 12 \text{ in/ft})^2 = 1.026(10^{-3}) \text{ ft}^3$), it can be concluded that it is highly improbable that the water was caused from the surrounding air entering the piping system.

ATTACHMENT TO RCCA FOR DC #1-95-077
EVENT DESCRIPTION or FAILURE SCENARIO
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DISCUSSION (Continued):

3. When the instruments are calibrated, VEGP Procedure 22705-C is used. The procedure does not specify the source (i.e. air, water, etc.) to use. If air or nitrogen is used, from the discussion in 2 above, it can be concluded that it is highly improbable that the air or nitrogen itself would have caused the water.

The hose connecting the air/nitrogen supply to the instrument could have been contaminated with water and when the calibration occurred the water was transported from the hose to the 1/4" tubing. However, based on the fact that (1) the instrument and calibration connection is located in the top of the panel, (2) the hose would have been routed vertically to the connection, and (3) the volume of tubing (a few inches of 1/4" tubing) is very small, it is unlikely that the flowrate through the hose would have been sufficient to lift the water and carry it into the 1/4" tubing.

The other method of calibrating the instrument would be to use water. Although it is not common practice to use water as a calibration medium for air systems, it is a medium that is frequently utilized for calibration purposes. Hypothetically, if water was used to calibrate the suspect gauges it could have become trapped in the bourdon tube. Since the bourdon tube is a dead end device, the water would have been held by the "Straw Effect" until sufficient mechanical agitation caused it to be released into the tubing. The water trapped in the bourdon tube could be held for an extended period of time before being exposed to the tubing. Interviews with plant personnel indicate no water was used in recent calibrations on these suspect instruments, however, as mentioned above this water could have been retained for an extended period of time which would indicate the water was introduced during any calibration, particularly those beyond the memory of those individuals interviewed. The procedure used to calibrate these instruments does not restrict the use of water, therefore, this hypothetical situation would be the most likely cause of the water getting in the tubing.

Conclusions:

Based on the information available at this time and the above discussion, it can be concluded that the water most probably entered the system during a past instrument calibration.