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February 17, 2010

PG&E Letter DCL-10-015

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

Docket No. 50-275, OL-DPR-80 Docket No. 50-323, OL-DPR-82 Diablo Canyons Unit 1 & Unit 2 Licensee Event Report 1-2010-001-00 Control Room Ventilation Pressurization Due to Radiation Detector Failures

Dear Commissioners and Staff:

Pacific Gas and Electric Company submits the enclosed licensee event report (LER) regarding a control room ventilation pressurization event due to radiation detector failures from moisture intrusion. This initial LER is submitted in accordance with 10 CFR 50.73(a)(2)(vii).

There are no new or revised regulatory commitments in this report.

This event did not adversely affect the health and safety of the public.

Sincerely,

James R. Becker

swh/2246/50274212

Enclosure

cc/enc:

Elmo E. Collins, NRC Region IV

Michael S. Peck, NRC Senior Resident Inspector

Alan B. Wang, NRR Project Manager

INPO

Diablo Distribution

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NRC FOF (9-2007)	RM 366			U.S.	NUCLE	AR RE	GULATO	RY COMMI	SSION	APPRO	VED BY OMB	: NO. 3150	-0104	4	EXPIRES	08/31/2010
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On October 13, 2009, 11:57 PDT, the combined Diablo Canyon Power Plant (DCPP) control room ventilation system (CRVS) [VI] transferred automatically to its pressurization mode of operation (mode 4) due to a high radiation signal from a system radiation monitor. On October 13, 2009, 12:26 PDT, radiation detector 1-RM-25 was found to be trending up and indicating 3 R/hr. Plant technicians removed this monitor from service upon verification of an invalid signal from the detector. On October 13, 2009, 14:42 PDT, radiation monitor 1-RM-26 was found to be trending up and was removed from service. On October 14, 2009, 0300 PDT, radiation monitor 2-RM-25 was found to be trending up and was removed from service.

On October 15, 2009, plant technicians determined the cause of the 1-RM-25 failure to be water intrusion. On December 24, 2009, plant technicians determined the cause of the 1-RM-26 failure to also be water intrusion. Based on this finding, it was concluded that a common mode failure had occurred and was reportable under 10 CFR 50.73(a)(2)(vii).

NRC FORM 366 (9-2007) PRINTED ON RECYCLED PAPER

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TEXT

## I. Plant Conditions

At time of discovery, Unit 1 was in Mode 1 (Power Operation) at approximately 100 percent reactor power with normal operating reactor coolant temperature and pressure; Unit 2 was in Mode 1 (Power Operation) at approximately 100 percent reactor power with normal operating reactor coolant temperature and pressure.

## II. Description of Problem

#### A. Background

The CRVS has four distinct modes of operation: mode 1: normal operation mode, mode 2: fire mode, mode 3: recirculation mode, and mode 4: pressurization mode. For the mode 4 - pressurization mode, no air is supplied from, or discharged to, the outside. The suction header is supplied by recirculation flow from the control room. The control room is pressurized. CRVS mode 4 operations can occur from manual operation or automatic initiation on high radiation signal or engineered safety feature (ESF) Phase 'A' Isolation.

Control room air supplies for both Units are monitored by four radiation monitors, 1-RM-25, 1-RM-26, 2-RM-25, and 2-RM-26. The safety function of these radiation monitors is to shift the CRVS to mode 4 on a high radiation alarm from any one of these detectors.

#### B. Event Description

On October 13, 2009, 11:57 PDT, the combined DCPP CRVS transferred to its pressurization mode of operation (mode 4) due to a high radiation signal from a system radiation monitor.

On October 13, 2009, 12:26 PDT, radiation monitor 1-RM-25 was found to be trending up and indicating 3 R/hr. Plant technicians removed this monitor from service upon verification of an invalid signal from the monitor.

On October 13, 2009, 14:42 PDT, radiation monitor 1-RM-26 was found to be trending up. Plant technicians removed this monitor from service upon verification of an invalid signal from the monitor.

On October 14, 2009, 0300 PDT, radiation monitor 2-RM-25 was found to be trending up. Plant technicians removed this monitor from service upon verification of an invalid signal from the monitor.

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On October 15, 2009, plant technicians determined the cause of the 1-RM-25 failure to be water intrusion.

On October 24, 2009, plant technicians completed the repairs of 1-RM-25.

On December 24, 2009, plant technicians determined the cause of the 1-RM-26 failure to be water intrusion, confirming a common mode failure, and also completed the repairs of 1-RM-26.

On January 2, 2010, plant technicians completed the repairs of 2-RM-25.

C. Status of Inoperable Structures, Systems, or Components that Contributed to the Event

None.

D. Other Systems or Secondary Functions Affected

No additional safety systems were adversely affected by this event.

E. Method of Discovery

Plant Technicians assigned to repair 1-RM-25 and 1-RM-26 replaced the affected components and determined the cause of the component failures to be water intrusion.

F. Operator Actions

None.

G. Safety System Responses

On October 13, 2009, 11:57 PDT, the combined DCPP CRVS transferred automatically to its pressurization mode of operation (mode 4) due to an invalid high radiation signal from a system radiation monitor 1-RM-25.

## III. Cause of the Problem

A. Immediate Cause

None.

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#### B. Cause

The cause of the failures was determined to be wind-driven water intrusion past barriers (o-rings) designed for weatherproofing of the CRVS environmental radiation monitors.

## IV. Assessment of Safety Consequences

This event was reviewed against the reporting criteria of 10 CFR 50.73(a)(2)(vii) and found to be applicable. Under this regulation, "Any event where a single cause or condition caused at least one independent train or channel to become inoperable in multiple systems or two independent trains or channels to become inoperable in a single system designed to:

- (A) Shut down the reactor and maintain it in a safe shutdown condition;
- (B) Remove residual heat;
- (C) Control the release of radioactive material; or
- (D) Mitigate the consequences of an accident."

However, there were no safety consequences as a result of this event. The failure mode of the radiation detector placed the CRVS in a safe mode by activating the pressurization portion of the system and isolating the DCPP control room from external elements.

This event was reviewed to determine if it meets the criteria for a safety system functional failure. 10 CFR 50.73(a)(2)(vi) provides that "Events covered in paragraph (a)(2)(v) of this section may include one or more procedural personnel errors, equipment failures, and/or discovery of design, analysis, fabrication, construction, and/or procedural inadequacies. However, individual component failures need not be reported pursuant to paragraph (a)(2)(v) of this section if redundant equipment in the same system was operable and available to perform the required safety function."

Although 3 of the 4 CRVS radiation detectors failed, radiation detector 2-RM-26, which is in the same system, was operable and available to perform its required safety function.

Based on the foregoing, this event is not considered risk significant and did not adversely affect the health and safety of the public.

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## V. <u>Corrective Actions</u>

- A. Immediate Corrective Actions
  - 1. Plant technicians verified the absence of a high radiation condition.
  - 2. Plant technicians remove affected radiation monitors from service.
- B. Corrective Actions to Prevent Recurrence (CAPR)
  - 1. The failed radiation detectors were replaced.
- C. Prudent Measure
  - 1. A protective weather coating was applied to the radiation monitors.

## VI. Additional Information

A. Failed Components

1-RE-25, 1-RE-26, 2-RE-25

B. Previous Similar Events

None.

C. Industry Reports

None.