## VANDERBILT School of Engineering

### **Risk-Informing:** *When, Where, and How to Start*

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### Nuclear Environmental Engineering Research Group (NEERG) at Vanderbilt

- Since 2010, the NEERG has performed research for the Electric Power Research Institute (EPRI), the U.S. Department of Energy Office of Nuclear Energy (DOE-NE), and commercial advanced reactor customers.
- Intellectual areas:
  - Nuclear fuel cycle analysis and modeling (LWRs and advanced reactors)
  - Risk/safety analysis of advanced nuclear reactors
    - EPRI/NEERG Safety-in-Design (SiD) methodology
  - Collaboration-based siting of back-end fuel cycle facilities
  - Public-private partnerships in commercial nuclear development
  - Technology readiness assessment



Program on Technology Innovation: Early Integration of Safety Assessment into Advanced Reactor Design— Project Capstone Report

2019 TECHNICAL REPORT







### Safety-in-Design Methodology

- Historically, safety analysis of nuclear reactors has been:
  - Deterministic in nature; and
  - Performed after design had largely been completed.
- SiD was developed to help meet advanced reactor safety expectations through early and iterative incorporation of safety analysis, using Process Hazards Analysis (PHA) methodologies.
  - Use of SiD allows incremental progression of the safety case—eventually supporting quantitative risk assessment.

Question: When, where, and how do we start using SiD as part of non-LWR design?



### Some SiD-related References:

- "Compilation of Molten Salt Reactor Experiment (MSRE) Technical, Hazard, and Risk Analyses: A Retrospective Application of Safety-in-Design Methods," S. Krahn (PI) and B. Chisholm, EPRI, Technical Report 3002018340, September 2020.
- "Early Integration of Safety Assessment into Advanced Reactor Design Project Capstone Report," S. Krahn, (PI), Program on Technology Innovation, EPRI, Technical Report 3002015752, October 2019.
- "A systematic approach to identify initiating events and its relationship to Probabilistic Risk Assessment: demonstrated on the Molten Salt Reactor Experiment," B. Chisholm, S. Krahn, K. Fleming, Progress in Nuclear Energy, Vol. 129, 103507, November 2020.
- "Literature Review of Preliminary Initiating Events for a Gas-Cooled Fast Reactor Conceptual Design," Ibrahim, I., Harkema, M., Krahn, S., Choi, H., Bolin, J., Thornsbury E., Nuclear Technology (2025).
- "Development and Demonstration of a Prototype Molten Salt Sampling System," M. Harkema, S. Krahn, P. Marotta, A. Burak, X. Sun, P. Sabharwall, in press, Nuclear Technology (2025).





## When to Start?

...as early as possible!

## **Motivation to Start Early**

- PHA methods are flexible. However, all PHA methods are not created equally.
- Choice of PHA for analysis of high hazard systems depends on:

### **Objectives of analysis team**

- -Team vs. individual approach
- -Documentation needs
- -Time required
- -Team leader expertise
- -Inductive vs deductive hazard identification
- -Recognition by a specific industry

### **Design Maturity**

- -Breadth of hazards considered
- -Preference for qualitative vs. quantitative results
- -Preference for identification of single vs. multiple failures
- -Identification of gross vs. specific hazards



PHA approach depends on the amount and nature of design & hazard information available







## **Iterative Nature** of SiD

- Safety analysis can begin as early as pre-conceptual design with simple PHA methods like what-if and what-if/checklist analyses.
- However, even simple PHA methods require supporting information.
  - E.g., you need an appropriate checklist to perform a what-if/checklist analysis...

Question: Where do we get the data to build a knowledge base to support performance of a PHA?









### Where to Start?

Do your homework!

## **Building a Knowledge Base**

- A need exists to build a knowledge base that can be used to support the SiD process throughout the design lifecycle
- At early stages of design, design-specific data to support PHA performance may not be available.
  - That does not mean that that relevant data are not available...just means we need to get creative
- Data sources that can feed into PHAs
  - Operating experience from previous operational or similar systems can be a valuable tool to identify hazards & initiators
  - **Stylized accidents** documented in the literature can assist with hazard identification
  - Identifying relevant phenomena can help establish a preliminary understanding of the phenomena of interest that could challenge plant safety





## **Historical Operating Experience**

- Many advanced reactor concepts evolved from technically similar reactors and test facilities that were designed, constructed, and operated during the 1950s-1970s.
  - Historical reactors and test facilities can represent the most thorough manufacturing, construction, operational, and retirement experience with a given reactor concept.
- Availability of historical design and operating data relevant to advanced reactor designs can vary based on the reactor concept in question.



### **Examples of Advanced Reactor Concepts and Historical Analogues**

Image Credits: (top) U.S. DOE Nuclear Energy Research Advisory Committee and the Generation IV International Forum, A Technology Roadmap for Generation IV Nuclear Energy Systems, GIF-002-00 (2002). (bottom, from left to right) U.S. Nuclear Regulatory Commission, Oak Ridge National Laboratory, Argonne National Laboratory

### How to Access Historical Data (Relatively Easily):

- Web-based keyword searches (Google Scholar, osti.gov)
- Component reliability databases (e.g., NaSCoRD, MOSARD)
- **GAIN Legacy Document Project**
- **Cooperative R&D Agreements (CRADAs) with national laboratories**

### **Some References:**

- "Incorporation of Historical Information into the advanced reactor design process: A case study Sowder, Transactions of the American Nuclear Society, 127(1): 856-859, 2022.
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- 123(1):1087-1090, 2020.







## **Using Historical Data for Design and Safety Analysis**

### **Factors Influencing Designer's Use of Historical Data**



### **Ouestions for Consideration**

Has the designer comprehensively explored and documented the available data sources for historical parallels and assessed them at a sufficient level of detail?

Has the designer used the historical data in a manner commensurate with the maturity of the historical parallel?

How is the designer using historical data to support uncertainty reduction for their design?

Are the data's uses commensurate with the designer's assessment of the completeness of the data and the quality assurance processes implemented?

Has the designer understood and documented any limitations associated with their usage of the historical data?

Is the designer using the data in a consistent, systematic fashion?





## **Modern Operating Experience**

- Operating experience data from existing component reliability databases and systems like T/H test loops, integrated effects test facilities, critical experiments (or even other industries) can be used as input to knowledge base
- Data can be from test system specific to the design in question or from a technically similar system relying on the same components, phenomena, etc.
- Some caveats:
  - Data specific to the design: need to collect and retain operations and maintenance data (and associated plans/policies)
  - Data from a technically similar system: data needs to be screened for relevancy
    - Expert judgement, delta analysis, etc.

### Some Modern Test Facilities...

Example	Location	Concept
Quarter-Scale Reactor Cavity Cooling System (RCCS) Facility	University of Wisconsin Madison	Gas-cooled reactor (GCR)
Molten salt flow loop test bed	Idaho National Laboratory	Molten salt reactor (MSR)
Mechanisms Engineering Test Loop (METL)	Argonne National Laboratory	Sodium fast reactor (SFR)



## **Stylized Accident Studies**

- <u>Although not a substitute for comprehensive</u> <u>initiating event identification</u>, prior safety analyses and transient studies documented in the literature can elicit understanding of undesirable events and event sequences that can challenge the plant's ability to perform its intended function.
- Resources necessary to comprehensively sort through relevant literature are nontrivial.
  - Time
  - Document accessibility

Concept Reviewed	# of Unique PIEs	# of References
GFR	192	28
HTGR	216	48
VHTR	101	20
UK GCR	40	10
Total	549	106

PIE Identification Results by Category and Reactor Concept Reviewed





## **Key Phenomena Identification**

- "...advanced reactors have little to no commercial operating experience; further, the fundamental physical phenomena that govern the performance of non-LWRs can deviate substantially from those in LWRs." (Chisholm et al., 2020)
  - E.g., flow reversal in gas reactor passive decay heat removal systems
- PHAs can help organize phenomenological data into event/accident sequences, but are not necessarily designed for or well suited to phenomena identification



 However, a wealth of PIRT literature exists for advanced reactors and may be acceptable for adoption for an early-stage design.

### **Examples of Recent PIRTs**

Concept	Examples of PIRTs
MSR GCR SFR	Diamond et al. (20 in Modeling and Si Reactors, BNL-114
	Holcomb et al. (20 Fundamental Safe 2021/2176.
	Lee et al. (2005). PIRT for Very High Reactors, KAERI/TI 05-00829 and ANL
	Aoyagi et al. (2019 Important Phenom Process for Develo Analysis Codes, Nu Design, 110240.
	Zhou et al. (2021). and Ranking Table Accidents for Chin Reactor, Annals of

### Performed

18). Phenomena Important imulation of Molten Salt 869-2018-IR.

21). Molten Salt Reactor ty Function PIRT, ORNL/TM-

Generation of a Preliminary Temperature Gas-Cooled R-3050/2005 (also INL/EXT---GenIV-066).

 D). Identification of mena Through the PIRT
Dpment of Sodium Fire
Duclear Engineering and

Phenomena Identification of Station Blackout a Sodium Cooled Fast Nuclear Energy, 108240.







## How to Start

We have all this data...now what do we do with it?

### **For More Information:**

## A Tale of Two Case Studies...

"Literature Review of Preliminary Initiating Events for a Gas-Cooled Fast Reactor Conceptual Design," Ibrahim, I., Harkema, M., Krahn, S., Choi, H., Bolin, J., Thornsbury E., Nuclear Technology (2025).

### Molten Salt Sampling System (MSSS) **Development**

### Type of Design Project: Subsystem

Historical Context: 2(ish) MSRs have been previously operated; 1 previous iteration of MSSS identified with detailed operating & maintenance records publicly available

Project Goal: Develop & demonstrate a risk-informed MSSS design that outperforms its historical predecessor **Resources:** 1 analyst (+reviewers), ~2-3 months part time/PHA

### **Preliminary Initiating Event (PIE) Identification for** the General Atomics Fast Modular Reactor (FMR)

**Type of Design Project:** Entire Reactor **Historical Context:** No GFRs have been operated, but moderate experience exists with gas-cooled concepts in the U.S. & U.K.; similar passive decay heat removal systems being studied for other GCRs and advanced LWRs

Project goal: Develop initial safety case for GFR design **Resources:** 2 analysts (+ reviewers), ~7-8 months part time

**STAMP-based Analysis of Historical Parallel** 



FMEA of Conceptual Design



FTA of As-Built Prototype



## MSSS—Background & Historical Context

Fissile/fertile consumption and production rates within specified bounds? an

No

- Understanding, predicting, and controlling the physical and chemical characteristics of the molten salt within first-generation MSRs requires a molten salt sampling system (MSSS) for periodic removal of fuel salt to meet ES&H and safeguardability monitoring needs.
- The Molten Salt Reactor Experiment (MSRE) used a system called the Sampler-Enricher (S-E) to isolate small samples of fuel salt for laboratory testing.
  - S-E's reliability, as documented in MSRE Semiannual Progress Reports, was insufficient for the design to be incorporated in modern MSR designs.
  - Lessons can be learned from systematic causal analysis of S-E failure & maintenance data using a fit-for-purpose variant of the Systems-Theoretic Accident Model and Process (STAMP)
    - STAMP was developed at MIT to account for complex accident contributors (e.g., system/operator feedback mechanisms, flaws in control process, hierarchical communication flaws, etc.).

Are fission product concentrations within acceptable ranges?

Yes

Yes

Have contaminants (e.g., air, moisture, water, other salt inventories, etc.) been detected in excessive quantities?

No

Have salt chemistry changes (e.g. redox condition) occurred that could impact operations?

No

### Potential ES&H, operability, and/or safeguards implications





### **S-E Performance by the Numbers**

- **Operations:** 744 total sampling evolutions over 4 years
  - 592 sampling (removal of fuel salt) operations
  - 152 enriching (addition of fuel salt) operations

### • Maintenance:

- Project management description of system operation: "some minor repairs" required (ORNL-TM-3524)
- However, S-E required corrective maintenance during <u>every biannual reporting period</u>
  - 64 (>1/month) occurrences were documented
  - 140 individual corrective actions identified in response
    - Not all of these were successful

**(the start of) threshold/criterion development:** MSSS should achieve higher degree of reliability than MSRE S-E

### An Excerpt from ORNL-4344, MSR Progress Report for Period Ending August 31, 1968

"On the sampling attempt that resulted in the sampler cable becoming tangled, there was no sign of trouble as the cable was unreeled...As it was being rewound, the motor stalled .... A few attempts to unreel and rewind convinced us that the cable was tangled in the isolation chamber as it had been on previous occasions... during repeated attempts to untangle the cable by unreeling and rewinding. In the course of 76 attempts, the drive stalled at various points as the coils of cable were shifted, but in the end there was no net gain. The isolation valves were left open for the next two weeks, but a slight purge of helium down the tube kept fission products from diffusing back up to the sampler ... "



## **STAMP-Based Causal Analysis**

Occurrence	Corrective Action (CA)	Effective CA?	DC, PC, MM, RR, D?	Relevant Hazard	Safety Constraint Violated	Design Insight
66-2-4: An empty sampling capsule was accidentally dropped while operators were attempting to use the manipulator to attach the capsule key to the latch. The capsule fell onto the gate of the operational valve.				Inability to sample or enrich fuel salt	Prevent loss of ability to understand fuel salt makeup; Maintain operability of the reactor	
	66-2-CA-5: A magnet on a cable was used to retrieve the magnetic latch key with capsule attached	Yes	RR			Capsule and latch the duration of MS using magnets for in MSSS design to a of utilizing magnet maintenance evolu
67-1-2: The small particles of salt that cling to the outside of the capsules that get dislodged during handling in 1C and 3A continued to increase the radiation levels inside the sampler-enricher; this has caused contamination spreading into the areas outside of the sampler-enricher				release of radioactive gas or particulates	prevent release of radioactive gas or particulates	
	67-2-CA-3: A ventilation duct connected to the main building ventilator system was installed near the transport cask position.	Yes	DC			Small salt particles the sampling vesse properly handled, spreading outside preventing contam

recovery occurred frequently throughout SRE S-E operation...success was achieved capsule removal....Care should be given avoid similar failures; however, the value ts to facilitate similar corrective utions should not be overlooked.

s/droplets attached to the externals of el can be difficult to contain. If not they can result in contamination the system boundary. Novel methods for nination may be required.

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### **STAMP-Based Causal Analysis: Repeated Instances of Repair** & Replacement



Capsule/latch recovery operations can be medium to long term maintenance operations in the S-E that impacted ability to understand fuel salt makeup. Care should be given in MSSS design to avoid similar failures; however, the value of utilizing magnets to facilitate similar corrective maintenance evolutions

> Credited as mitigation/recovery mechanism in later-stage FMEA



## **MSRE S-E Hazards**

Hazard	Consequence(s)	Corresponding Safety Constraint	Releva	
Release of airborne radiological material (e.g., gas, particulates, etc.)	-Potential for radiation exposure (direct and/or inhalation) to SE operator or other MSRE personnel	Prevent release of radiological material	An MSSS will likely inventory to the MSI containing SNM and products) with poten consequences that s design and safety ev	
Inability to sample or enrich fuel salt Risk-informed end point "Failure to obtain sample chosen as top level event later stage FTA	-Produces reduced understanding of the makeup of the fuel salt, which could lead to <b>reactor shutdown over a long-term</b> if ability to sample or enrich was not tored in time. bility to operate the SE also produced nability to add fissile material to the in ctor, which could lead to subcriticality I shutdown over a long-term.	Prevent loss of ability to understand fuel salt makeup Maintain operability of the reactor	design and safety ev Because of the simil S-E and the MSSS, enrich (if performed a future MSSS could (potential for inability composition) that sh design and safety ev	
Electric shock	-Potential for injury to MSRE personnel -Primarily an artifact of timeframe over which the system was designed and operated	Prevent electric shock to workers	Although this hazard timeframe the MSR light a broader catego industrial hazards— during MSSS design	

Hazards and safety constraints <u>realized during MSRE S-E operational occurrences</u> were identified as part of the STAMP-based analysis.

### ance to MSSS

feature a similar radiological RE S-E (i.e., fuel salt

I the full spectrum of fission ntial radiation exposure should be considered during valuations.

larity in mission for the MSRE the inability to sample or by the MSSS) fuel salt within d have similar consequences v to understand fuel salt nould be considered during valuations.

d is primarily an artifact of the E S-E operated, it brings to gory of hazards—standard that should be considered n and safety evaluations.

### **FMEA Results by the Numbers**

		Failur	e Mode			Impact on:			
221 total	ID	Functional Failure	Failure Mechanism	Detection	Safety	Operability	Safeguards	Mitigation/ Recovery	Action
331 total failures evaluated	SS1 (salt seal)	Melt too early	Improper fabrication	TLL, no sample optained	Potential for improper salt analysis/ subsequent reactor control actions	Potential for salt deposits that require cleaning. If melting time becomes	If capsule improper melting time occurs frequently, it	Routine	Operation testing: Develop written procedu for caps fabrication
Aggregate credited de provide im designs.	SS1 (salt seal) examin etection	Melt too late nation of 44 n and mitiga t design insi	Low temp in primary salt total frequer tion measur ghts for early	ntly es can y-stage	Potential for no sample collection, which could result in loss of ability to understand fuel salt composition	frequent issue, downtime may be required to implement design changes	monitoring isotopics on a timeline that supports IAEA diversion timeliness goals	maintenance specifications for capsule housing	Analysis safety: investiga potential model capsule time to n using COMSC

E.g., "no sample obtained" credited 10x as detection mechanism

## ns ons/ ure sule ion

ate Il to

melt

58 action itemsidentified.Resolution of actionitems can identify:

- Design changes to prevent/mitigate consequences
  Design elements
  - requiring maturation (e.g., through **safety analysis** or startup testing)



## **Testing Approach**



### Tested key functions at University of Michigan's Molten Salt Facility for Instrumentation Testing (MSFIT), a static

Key Failure event experienced during testing Failure event that could have occurred during testing, but was not experienced Failure event not able to be tested Higher-level failure mode

Failure of SCS to Failure of freeze collect sample in port to provide sampling adequate access position to salt inventory 22



## **Conclusions for Implementing SiD**

### • When to start:

- As early as preconceptual design, safety & design information can begin to be compiled to support early stage PHAs.
- In early stages, information does not need to come from design-specific sources, relevant data from technical parallels can be useful in building knowledge base.

### • Where to start:

- Build knowledge base by identifying and compiling data on:
  - Operating experience from historical & modern parallels
  - Stylized accident analysis information & results
  - Relevant phenomena
- As design matures, build in operations & maintenance data collection into test/demonstration programs

### • How to start:

- Approach depends on data availability & objectives of design/analysis process
- Regardless, start with generally applicable data and historical predecessor data (should it exist).
  - Move to using design-specific data as the design matures.

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### Acknowledgements

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### **U.S. Department of Energy**

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 $\mathbb{R}\mathbb{Z}$ Consortium For Risk Evaluation with Stakeholder Participation

### **70 YEARS OF SCIENCE & INNOVATION**

## Nuclear Energy University Program

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### **Backup Slides**

## **STAMP-Based Analysis: Process Overview**

### **1.** Functional 2. STAMP-Based Analysis of MSRE **Decomposition of S-E Operating Occurrences MSRE S-E** a. Create safety control structure a. Review MSRE S-E (SCS) design and b. Parse/discretize events in MSRE operating data S-E operational narratives b. Identify S-E c. STAMP-based causal analysis. functions and For each occurrence, identify: subfunctions System hazard c. Develop Goal of SCS functional Safety constraints violated decomposition for ٠ d. Categorize maintenance events S-E that reflects results of (b) as:

- Successful or unsuccessful
- Design change, procedure change, mitigative measure, repair/replacement, diagnostic
- e. Evaluate design change and repeated repair/replace occurrences for design insights

	3. Collect MSSS Stakeholder Input		4 R
a.	Identify stakeholders	a.	U fu
b.	Develop materials		d
	to brief		а
	stakeholders and		in
	collect stakeholder		fr
	input		b
C.	Brief stakeholders		a
	on MSSS design		st
	project and		С
	requested input		N
d.	Collect stakeholder		re
	input on MSSS		
	functionality		

Write MSSS **Functional** Requirements

sing MSRE S-E unctional ecomposition as framework, ntegrate insights rom STAMPased analysis nd MSSS takeholder input ollection to write ASSS functional equirements.

![](_page_28_Picture_8.jpeg)

## **FMEA Selection Matrix**

Method	Team vs. Individual Approach	Documentation Needs	Quantitative vs. Qualitative	Breadth of Hazards Considered	Single vs. Multiple Failures
What-if/ Checklist	Team (CCPS, 2008)	Low-Moderate (CCPS, 2008), which may not be appropriate for the level of detail available for the MSSS and the MSRE S-E.	Qualitative (U.S. NRC, 2001)	Loose structure of What-if analysis allows for broad range of hazards to be considered, while inclusion of Checklist can ensure key hazards are not overlooked (CCPS, 2008). However, many What-if/Checklist approaches have a focus on external hazards and well-understood phenomena.	Primarily used for single failures (CCPS, 2008); however, flexibility allows for consideration of multiple failures as well
HAZOP	Team (CCPS, 2008)	Moderate (U.S. NRC, 2001; CCPS, 2008). HAZOP typically relies on the availability of P&IDs or PFDs for a system; these design drawings are available for MSSS, which can allow for broader identification of hazards when considered in conjunction with detailed PHA approach like HAZOP.	Typically qualitative, but quantitative or semiquantitative frequencies and consequences can be assigned as deviations are developed and used as inputs to future quantitative studies (U.S. NRC, 2001)	Can identify broad range of hazards due to parameter-guideword approach (CCPS, 2008); however, HAZOP may struggle to capture deviations due to slow-developing effects (e.g., corrosion) (EPRI, 2019).	Better suited for single failures (CCPS, 2008)
FMEA	Individual or Team (CCPS, 2008)	Moderate-High (U.S. NRC, 2001; CCPS, 2008). FMEA requires design documentation down to the component level to determine failure modes and their effects, which has been developed for many of the critical functions of the MSSS concept.	Qualitative, Semi- Quantitative, or Quantitative (U.S. NRC, 2001)	FMEA can identify broad range of hazards at the component and functions levels of a system (CCPS, 2008), but is not particularly well-suited for identification of external hazards.	Better suited for single failures, unless failures are sequential (CCPS, 2008)

## **SCS** Testing

![](_page_30_Figure_1.jpeg)

![](_page_30_Figure_2.jpeg)

Failure of SCS to

<u>Key</u>

Freeze port testbed reconfigured to test SCS ability to collect a sample.

![](_page_30_Picture_4.jpeg)

![](_page_30_Picture_5.jpeg)

Pictures of the SCS outside (left) and inside (right) after second sample collection test (Image Credit: Adam Burak, University of Michigan)

testing

![](_page_30_Figure_8.jpeg)

![](_page_30_Figure_10.jpeg)

![](_page_31_Figure_0.jpeg)

Initial dry testing schematic (left) and prototype (right). The capsule housing is shaded in blue and the NCS and NDS are shaded in orange.

Key Failure event experienced during testing Failure event that could have occurred during testing, but was not experienced Failure event not able to be tested Higher-level failure mode

Failure of N1 to pass through reducer and seat in sampling position

UB (single-sided):

exhibited during

Capsule housing blockage preventing SCS transfer

![](_page_31_Figure_8.jpeg)

## **General Atomics FMR—Regulatory Basis for PIE** Identification

- The need for a robust and thorough initiating event identification process has been recognized by the ACRS<sup>1</sup>.
- Philosophy:
  - 'Clean sheet of paper'
  - No preconceived set or list of events
  - Develop a spectrum of events from AOOs to very unlikely events
- Draft NRC guidance<sup>2</sup> has also emphasized the importance of **systematic** identification of initiating events:
  - "Identification of initiating events (IEs) is the starting point for the safety assessment of nuclear power plants. Having a reasonably complete set of IEs is crucial in determining what events could propagate to undesirable consequences and in assessing overall plant risk."

![](_page_32_Picture_9.jpeg)

## **General Atomics FMR**—Initiating Event Identification Methodology

Approach: perform a comprehensive identification of initiating events from documented operating experience and accident analysis for similar concepts to inform the FMR safety case.

**1. Collect and Organize Initiating Events from Relevant Literature** 

**Concepts Reviewed:** 

- Other GFR conceptual designs
- HTGRs
- VHTRs
- UK CO<sub>2</sub>-cooled gas reactors

### 2. Categorization of PIEs

Due to the iterative nature of initiating event identification for the FMR concept (and GFRs in general), the identified IEs were given the label of 'Preliminary Initiating Events' (PIEs).

### 3. Analysis of PIEs in **Relation to GFRs and the FMR concept**

Evaluation of the results of the PIE identification effort and discussion of implications for GFR and FMR safety case development.

# FMR PIE Review: Results by Category & Concept

![](_page_34_Figure_1.jpeg)

ncept viewed	# of Unique PIEs	# of References
R	192	28
R	216	48
R	101	20
GCR	40	10
I	549	106

Co Rev

**30%** of PIEs (remaining PIEs): Events commonly analyzed for general NPP operations

**7%** of all PIEs: Potentially unique to gas-cooled reactors

13% of all PIEs: PLOFC

**20%** of all PIEs: Air/Water ingress

### 30% of all PIEs: DLOFC

![](_page_34_Picture_8.jpeg)

## FMR PIE Review: Observations & Implications

- Many PIEs included events expected to be analyzed as part of general NPP operations (e.g., LOOP, SBO, External Events).
- There is an emphasis on the evaluation of **DLOFC** and **aggravating events** (e.g., air/water ingress events) – 50% of all PIEs fell under one of these categories.
  - Prioritization of such event types for detailed analysis for FMR.
- The results revealed a lack of evaluation of several potentially important events for GFRs such as:
  - Helium purification system failures (contain radiological inventory and penetrate reactor pressure boundary)
    - Data needed!
  - External events.
- The FMR features a passive decay heat removal system--which is functionally different than the DHR systems included in the designs reviewed.
  - Performance of decay heat removal system thus the subject of detailed study via FMEA, functional FMEA, and Master Logic Diagram

![](_page_35_Picture_10.jpeg)

![](_page_35_Picture_15.jpeg)

![](_page_35_Figure_16.jpeg)