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March 22, 1994

U.S. Nuclear Regulatory Commission
Attn: Mr. David L. Meyer
Chief, Regulatory Publications Branch
Division of Freedom of Information
and Publication Services
Office of Administration
Washington, D.C. 20555

ULNRC-02979

Dear Mr. Meyer:

**DOCKET NUMBER 50-483
CALLAWAY PLANT
COMMENTS ON DRAFT NUREG-1022
"EVENT REPORTING SYSTEMS, 10CFR50.72 AND 50.73"**

Union Electric Company submits the attached comments to the subject draft NUREG-1022. The comments are marked on the attached applicable pages of the draft NUREG. A summary of the comments is also provided on a separate attachment.

Sincerely,

A. C. Passwater
Manager, Licensing & Fuels

ACP/TPS/JGB/lrj

Attachments

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UNION ELECTRIC, CALLAWAY PLANT

ATTACHMENT TO ULNRC-02979

SUMMARY OF DRAFT NUREG-1022 COMMENTS

SPECIFIC COMMENTS:

- 2.7, page 13
paragraph 3 Disagree that a single component failure discovered during surveillance testing is reportable if the failure mechanism could reasonably be expected to occur in one or more redundant components and thereby prevent fulfillment of the system's safety function. Merely predicting failure is not firm evidence that the redundant components could have failed. Surveillance testing of the redundant components would uncover the failure mechanism.
- 3.2.1, page 24 The definition of initiation of any nuclear plant shutdown is not clear for a T/S required shutdown begun in Modes 3 or 4 with completion in Modes 4 or 5. The temperature/pressure reductions of these modes occur after the plant is subcritical. Suggest a Mode 3 or 4 initiation of a shutdown be triggered on the deliberate reduction of RCS temperature with the intent of reducing the plant mode.
- page 115 The draft NUREG currently requires the inclusion of all corrective actions that are tracked by the licensee's internal corrective action system. Suggest this requirement be revised to list only the major, directly related corrective actions for the event.
- page 115 Delete the requirement to include a statement regarding the performance and results of a HPES evaluation. It appears this added requirement was made for the sole purpose of increasing reporting requirements without changing the rule.

staff, there was no need to report under 10 CFR 50.72 and 50.73 because the NRC was aware of the situation. Some licensee personnel have also expressed a similar understanding for cases in which the NRC staff identified a reportable event or condition to the licensee via inspection or assessment activities. Such means of reporting do not satisfy 10 CFR 50.72 and 50.73. The requirement is to report to the ENS and LER systems events or conditions meeting the criteria stated in the rules.

2.7 Multiple Component Failures

There have been cases in which licensees have not reported multiple, sequentially discovered failures of systems or components occurring during planned testing. This situation was identified as a generic concern on April 13, 1985, in NRC Information Notice (IN) 85-27, "Notifications to the NRC Operations Center and Reporting Events in Licensee Event Reports," regarding the reportability of multiple events in accordance with §§50.72(b)(2)(iii) and 50.73(a)(2)(v) (event or condition that alone could prevent fulfillment of a safety function). [This reporting criterion is discussed in Section 3.3.3 of this report.]

IN 85-27 described multiple failures of a reactor protection system during control rod insertion testing of a reactor at power. One of the control rods stuck. Subsequent testing identified 3 additional rods that would not insert (scram) into the core and 11 control rods that had an initial hesitation before insertion. The licensee considered each failure as a single random failure; thus each was determined not to be reportable. Subsequent assessments indicated that the instrument air system, which was to be oil-free, was contaminated with oil that was causing the scram solenoid valves to fail. While the failure of a single rod to insert may not cause a reasonable doubt that other rods would fail to insert, the failure of more than one rod does cause a reasonable doubt that other rods could be affected, thus affecting the safety function of the rods.

A single component failure in a safety system is reportable if it is determined that the failure mechanism could reasonably be expected to occur in one or more redundant components and thereby prevent fulfillment of the system's safety function. In addition, as indicated in IN 85-27, multiple failures of redundant components of a safety system are sufficient reason to expect that the failure mechanism, even though not known, could prevent the fulfillment of the safety function.

Relief Valve Testing

When performing periodic surveillance tests of safety or relief valves it is not uncommon to find more than one valve to be lifting outside of the TS-allowed tolerance band, which is typically plus or minus 1 percent.

If not reportable under §§ 50.72(b)(2)(iii) and 50.73(a)(2)(v) [event or condition that alone could prevent fulfillment of a safety function], this situation would still usually be reportable under §50.73(a)(2)(v1) (common cause failure) because the existence of similar discrepancies in multiple


3.2.1 Plant Shutdown Required by Technical Specifications

§50.72(b)(1)(i)(A)	§50.73(a)(2)(i)(A)
Licensees shall <u>report</u> : "The <u>initiation</u> of any nuclear plant shutdown required by the plant's Technical Specifications."	Licensees shall <u>submit a Licensee Event Report on</u> : "The <u>completion</u> of any nuclear plant shutdown required by the plant's Technical Specifications."

If not reported as an emergency under §50.72(a), licensees are required to report the initiation of a plant shutdown required by TS to the NRC via the ENS as soon as practical and in all cases within 1-hour of the initiation of a plant shutdown required by TS to the NRC via the ENS. If the shutdown is completed, licensees are required to submit an LER within 30 days.

Discussion

This 50.72 reporting requirement is intended to capture those events for which TS require the initiation of reactor shutdown to provide the NRC with early warning of safety significant conditions serious enough to warrant that the plant be shut down.

For §50.72 reporting purposes, the phrase "initiation of any nuclear plant shutdown" includes the performance of any action to start reducing reactor power to achieve a nuclear plant shutdown required by TS. 

A reduction in power for some other purpose, not constituting initiation of a shutdown required by TS, is not reportable under this criterion. This includes reducing power only for the purpose of repairing a component.

For §50.73 reporting purposes, the phrase "completion of any nuclear plant shutdown" is defined as the point in time during a TS required shutdown when the plant enters the first shutdown condition required by a limiting condition for operations (LCO) e.g., hot standby (Mode 3) for PWRs with the standard technical specifications (STS). For example, if at 0200 hours a plant enters an LCO action statement that states, "restore the inoperable channel to operable status within 12 hours or be in at least Hot Standby within the next 6 hours." the plant must be shut down (i.e., at least in hot standby) by 2000 hours. An LER is required if the inoperable channel is not returned to operable status by 2000 hours and the plant enters hot standby.

An LER is not required if a failure was or could have been corrected before a plant has completed shutdown (as discussed above) and no other criteria in 50.73 apply. This includes a situation where the plant is shutdown, the problem is fixed, and the plant is restarted before the shutdown was required by TS.

Reasonable and credible alternative conditions may include normal plant operating conditions, potential accident conditions, or additional component failures, depending on the event. Normal alternative operating conditions and off-normal conditions expected to occur during the life of the plant should be considered. The intent of this section is to obtain the result of the considerations that are typical in the conduct of routine operations, such as event reviews, not to require extraordinary studies.

(4) Corrective Actions

§50.73(b)(4)

The LER shall contain: "A description of any corrective actions planned as a result of the event, including those to reduce the probability of similar events occurring in the future."

Discuss all corrective actions or enhancements that resulted from the event. The narrative should include the corrective actions that were tracked by the licensee's internal corrective action system. Include when the corrective action was or will be implemented. The term "corrective actions" includes both the actions to restore the system or component to service and the actions to prevent recurrence. Discuss repair or replacement actions as well as actions that will reduce the probability of a similar event occurring in the future. For example, "the pump was repaired and a discussion of the event was included in the training lectures." Another example, "although no modification to the instrument was deemed necessary, a caution note was placed in the calibration procedure for the instrument before the step in which the event was initiated."

Some are not major nor directly related.

In addition to a description of any corrective actions planned as a result of the event, describe corrective actions on similar or related components that were done, or are planned, as a direct result of the event. For example, if pump 1 failed during an event and required corrective maintenance, and that same maintenance also was done on pump 2, so state. *delete.*

If a human performance evaluation was performed, include a statement that the evaluation was performed and its results. List corrective actions adopted by management, including organizational or personnel changes. If the corrective action taken includes personnel disciplinary actions, do not refer to specific individuals by name. *

If an independent contractor or consultant was brought in to review the event, so state. Note any pertinent industry supported studies.

If a study was conducted, and results are not available within the 30-day period, report the results of the study in a revised LER if they result in substantial changes in the corrective action planned. (See Section 5.1.6 for further discussion of submitting revised LERs.)