



UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

FEB 22 1983

MEMORANDUM FOR: Richard W. Starostecki, Director
Division of Project and Resident Programs
Region I

FROM: Karl V. Seyfrit, Chief
Reactor Operations Analysis Branch
Office for Analysis and Evaluation
of Operational Data

SUBJECT: EVALUATION OF SUSQUEHANNA UNIT 1 LERs FOR THE PERIOD
FEBRUARY 1, 1982 TO JANUARY 31, 1983

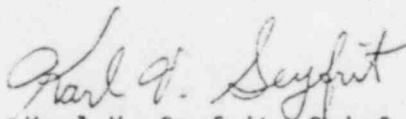
The Office for Analysis and Evaluation of Operational Data has assessed the Licensee Event Reports (LERs) submitted under Docket No. 50-387 during the subject period. This has been done in support of the upcoming SALP review of the Pennsylvania Power & Light Company, with regard to their performance as licensee of the Susquehanna Steam Electric Station plants. No LERs for Susquehanna Unit 2 were received for this period. Our perspective would be indicative of that of a BWR system safety engineer who although knowledgeable, is not intimately familiar with the detailed site-specific equipment arrangements and operations. Our review focused on the technical accuracy, completeness and intelligibility of LERs. Additionally, the LERs were screened and sorted in an attempt to cull out qualitative trends or patterns which could be interpreted as suggestive of licensee performance needing improvement. Our review covered a majority of the LERs submitted during the assessment period.

In general the LERs which were submitted were prepared adequately with occasional exceptions. The well written LERs provided clear and concise descriptions of the event as well as complete explanations of the effects on system function. It was noted however that several LERs were poor with respect to fully identifying or describing the purpose of the failed component in the effected system. An example of this was LER 82-044 (attached). The event description provided did not identify the equipment in question by a component code number or the system involved. Additionally, the LER does not state the specific corrective actions which were taken to prove the component operable. Licensee event reports 82-043 and 82-047 (attached) are similarly deficient in that the precise components in question are not explicitly identified by a specific equipment code number or name. The latter LER is also somewhat deficient in that it fails to explain the consequence of the failure either at the system level or the overall plant safety level. The LER write ups should normally provide such information. Redundancy, diversity or backup systems should be noted where possible. It was also found that LER 82-031 addressed five separate events in a single report. Separate events should be reported in separate LERs in order to establish a proper data base for each plant. Additionally, LER 82-001 (attached) stated that a revised LER would be submitted at a later date. From our available information no revised LER was received within the review period. Additionally, LER 82-002 appears to have been submitted late.

50-387
A4
8303030103 XA XA Copy Has Been Sent to PDR

Our screening for trends and patterns uncovered a great many cases involving personnel oversights or omissions. A large portion of the LERs involved incorrect operator actions or activities, procedural deficiencies or design deficiencies. If Susquehanna Unit 1 were a plant which had been operating for several years (or cycles) the quality (kind) and quantity (fraction) of the LERs in these categories might be interpreted as indicative of some management weaknesses. However, since these events have occurred during the initial phase of plant startup testing, we can not yet conclude that they are symptomatic of licensee performance needing improvement. On the contrary, from our past experience, we would consider the licensee's performance, as reflected by the LERs which were reviewed, to be typical of what one would expect to find at an "average" BWR facility in the initial phase of plant startup.

If you have any questions please contact either myself or Stuart Rubin (492-4436) of my staff.



Karl V. Seyfrit, Chief
Reactor Operations Analysis Branch
Office for Analysis and Evaluation
of Operational Data

Attachments: As stated

cc: G. Rhoads, RI
C. Michelson, AEOD

U.S. NUCLEAR REGULATORY COMMISSION
LICENSEE EVENT REPORT

APPROVED BY OMB
3184-6011
EXPIRES 4-30-87

CONTROL BLOCK

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 P A S E S 1 7 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 8
LICENSEE CODE 14 15 LICENSE NUMBER 31 32 LICENSE TYPE 34 35 CAT 36

01 REPORT 1 0 0 5 0 0 0 3 8 7 7 1 0 3 0 8 2 8 1 1 2 9 8 2 8
REPORT NUMBER 37 38 SOCKET NUMBER 40 41 EVENT DATE 44 45 REPORT DATE 48

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

01 During the startup test program, it was determined that an excess flow check
 02 valve had been returned to service, after maintenance, without the required
 03 surveillance being performed. This is reportable per Technical Specification
 04 4.9.1.9.c. No adverse consequences existed because the valve was not
 05 required to function.

*Why?
One?
Purged?
Effect
origin
later*

04 S D 11 A 17 A 13 V A L V E X 14 C 15 X 16
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE
 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
LEADING REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO OCCURRENCE CODE REPORT TYPE REVISION NO ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD INDICES ATTACHMENT SUBMITTED APPROX FORM DOB PRIME COMP SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

01 The valve was not thought to be a Technical Specification required valve.
 02 Therefore, it was not tracked on the LCO log as such. This will be reviewed
 03 with all shifts to note the importance of correctly identifying such items.

01 FACILITY STATUS 02 POWER 03 OTHER STATUS 30 04 METHOD OF DISCOVERY 05 DISCOVERY DESCRIPTION 22
 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
ACTIVITY CONTENT RELEASED OR RELEASED AMOUNT OF ACTIVITY 25 LOCATION OF RELEASE 26 PERSONNEL EXPOSURE NUMBER 27 DESCRIPTION 28 PERSONNEL IN USE 29 DESCRIPTION 30

8212080328

U.S. NUCLEAR REGULATORY COMMISSION
LICENSEE EVENT REPORTAPPROVED BY DWS
3156-0011
EXPIRES 4-30-82

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK

01 P A S E S 1 7 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5
LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 27 28 CAT 29

CONT

01 REPORT SOURCE 30 31 SOCKET NUMBER 32 33 EVENT DATE 34 35 REPORT DATE 36

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) which DG?

02 During the performance of a diesel generator monthly operability test, a
03 diesel generator tripped on high vibration. This event is reportable per
04 Technical Specifications 4.8.1.1.3 and 6.9.1.9.b. There were no adverse
05 consequences in that the unit was in cold shutdown at the time of the test.

06

07

08

09

SYSTEM CODE 10 CAUSE CODE 11 CAUSE SUBCODE 12 COMPONENT CODE 13
E E 11 E 12 B 13 I N S T R U 14 E 15 Z 16
SEQUENTIAL REPORT NO. 17 OCCURRENCE CODE 18 REPORT TYPE 19
047 03 L 0
ACTION TAKEN 20 FUTURE ACTION 21 EFFECT ON FLIGHT 22 SHUTDOWN METHOD 23 NOTES 24 ATTACHMENTS SUBMITTED 25 NRC-1 FORM 386 26 PRIME CORP. SUPPLIER 27 COMPONENT MANUFACTURER 28
E 18 X 19 Z 20 Z 21 00000 N 22 H 23 A 24 A 13618

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 1. is surmized that a vibration switch and a pressure regulator were both
11 involved with the diesel trip. Both were investigated and repaired and the
12 diesel successfully tested. The equipment will be monitored via the plant's
13 trend program.

14

15 FACILITY STATUS 16 POWER 17 OTHER STATUS 18 METHOD OF DISCOVERY 19 DISCOVERY DESCRIPTION 20
E 21 0000 22 n/a 23 B 24 monthly surveillance test

16 ACTIVITY CONTENT RELEASED OF RELEASE 17 AMOUNT OF ACTIVITY 18 LOCATION OF RELEASE 19
Z 20 21 n/a 22 n/a

17 PERSONNEL EXPOSURES NUMBER 18 TYPE 19 DESCRIPTION 20
000 21 Z 22 n/a

18 PERSONNEL INJURIES NUMBER 19 DESCRIPTION 20
000 21 n/a

19 LOSS OF OR DAMAGE TO FACILITY TYPE 20 DESCRIPTION 21
Z 22 n/a

20 PUBLICITY NUMBER 21 DESCRIPTION 22
000 23 n/a

21 8212080342

EXHIBIT A

A-1~~8208060146~~