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SEP 21 1984

MEMORANDUM FOR: C. E. Norelius, Director
Division of Reactor Projects
NRC Region III

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

SUBJECT: EVALUATION OF LERS FOR DAVIS-BESSE FROM APRIL 1, 1983 THROUGH AUGUST 31, 1984 - AEOD INPUT TO SALP REVIEW

In support of the ongoing SALP review, AEOD has reviewed the LERs for the Davis-Besse plant during the subject period. AEOD's review focused on the clarity and adequacy of the descriptions provided in the individual LERs.

We reviewed 69 LERs that the licensee submitted during the assessment period. In general, the LERs were acceptable and reasonably detailed to permit understanding of the events. However, we note that numerous LERs were deficient with regard to reporting similar previous failure data. We note that accurate reporting of such failure data is necessary for AEOD to perform its tasks of analyzing and evaluating operational data. The enclosure provides additional observations from our review of the LERs.

If you have any questions, please contact either myself or Hal Ornstein of my staff on FTS 492-4439.

"Original Signed by"
K. V. SEYFRIT"

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

Enclosure:
As Stated

cc w/enclosure:
A. DeAgazio, NRR

OFFICE	ROAB	C/ROAB					
SURNAME	HOrnstein:eh	KVSeyfrit					
DATE	9/21/84	9/21/84					

SALP REVIEW FOR DAVIS-BESSE

We reviewed 69 LERs which were submitted during the April 1, 1983 - August 31, 1984 assessment period, i.e., LER 83-016 to 83-074 and LER 84-01 to LER 84-010. Based upon our review, we made the following observations and conclusions:

1. The information provided was generally sufficient to provide the reader with a good understanding of each event.

2. There were no significant problems with the coded information (1983 LERs). The narrative descriptions of the events (1983 and 1984) were clear and adequate. The apparent causes of the occurrences were explained well, and corrective actions were provided. Many LERs were updated to reflect information which was obtained subsequent to taking corrective actions (LERs 83-016, 018, 025, 029, 033, 034, 036, 044, 057, and 069).

3. In many cases, the licensee's referencing of previous events of a similar nature was shallow, incomplete, or wrong. For example:

   a. Several LERs only listed similar previous failures which had occurred within the previous year; they did not give a complete picture of earlier similar occurrences (LERs 83-018, 83-030, 83-038, 83-041, 83-042, 83-055, and 83-058).

   b. LER 83-060 stated that similar failures had occurred but did not give any specific reference.

   c. LERs 83-051 and 83-051, Rev. 1, reported the failure of a snubber in a main steam line. The LERs stated that no snubber failures had been reported previously. Although such a statement is factually correct, it does not reflect the fact that Davis-Besse had experienced similar snubber failures previously, but they were not reported by the licensee. IE inspection report 50-346/79-33, February 12, 1980, noted damaged piston rod wiper seals on four large bore steam generator snubbers, and one snubber on the reactor coolant drain system was observed to be leaking heavily.

      IE inspection report 50-346/80-22 noted that six steam generator snubbers and eight primary coolant pump snubbers were defective and were returned to the manufacturer for overhaul and modification.

d. Regarding containment radiation monitor failures, LER 83-018 indicated that there were two previous failures within the previous year, whereas the revised LER 83-018, Rev. 1, stated that there had been no previous similar occurrences. A check of a previous LER, 82-055, showed that prior to October 1982 there had been 12 such failures.

We also note that LER 83-028 reported radiation monitor failures in the spent fuel pool/fuel handling area. That LER stated that there had been no similar failures of those monitors since 1978; however, specific references for those earlier failures were not given. LER 83-056 documented a similar failure and referenced LER 83-028 without any mention of the pre-1978 failures. LER 83-056 focused on the radiation monitor failures and did not address the root cause (fuse failures) or the high occurrence of fuse failures at Davis-Besse.

e. LER 83-060 reported a failed torque switch on a containment isolation valve. The licensee's statement on failure data was incomplete, i.e.,

> "Although there have been occurrences of failed torque switches, none have been similar to the failure in CV 5090 and CV 5070. In addition, there have been no previous occurrences similar to the failure of CV 5071."

f. LER 83-050 discussed a lack of administrative controls which resulted in a missed surveillance test of DHR system isolation valves. The LER states that "there have been no previous similar occurrences." Our search of the LER files from 1980 to the present found many surveillance tests that were missed, i.e., LERs 80-031, 81-028, 81-039, 81-050, 81-071, 81-079, 82-025, 82-044, and 83-017.

4. Regarding multiple event reporting in a single LER, the events generally were combined correctly in accordance with the guidelines of NUREG-0161 (General Instruction #7).

5. Five Preliminary Notifications (PNs) were issued during the SALP assessment period (PNO-III-83-117, 83-130, 84-003, 84-021, and 84-041). The events described in four of those PNs were reported by the licensee in LERs. However, two events which were described in PNO-III-83-117 were not reported in LERs. The events involved inadvertent control rod insertions which were caused by electrical faults in the control rod drive system. We believe that those events should have been reported in an LER.