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File
SALP

Heltemes
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MEMORANDUM FOR: John F. Streeter, Chief
Project Branch #2
Division of Project and Resident Programs
Region III

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

SUBJECT: EVALUATION OF LERs FOR PALISADES FOR
THE PERIOD FROM JULY 1, 1982 TO MAY 30, 1983 -
AEOD INPUT TO SALP REVIEW

In support of the ongoing SALP reviews, AEOD has reviewed the LERs for Palisades. This review has focused on the usefulness of the submittals to AEOD, and on the accuracy and completeness of the licensee's reporting. In general, we found the licensee's submittals to be well above average in terms of reporting completeness and factual accuracy. The reports were informative, understandable and, as a package, they consistently met or exceeded the guidelines offered in Regulatory Guide 1.16 and NUREG-0161. The licensee's conscientiousness in submitting clear and descriptive narratives with attention to details to fulfill the purposes of reporting was evident from our review.

For AEOD's purpose, the LERs were consistent and sufficiently detailed to fully understand the event so that an informed safety assessment and its potential consequences could be made by someone reasonably familiar with the plant. However, we thought the licensee's safety assessment could be improved by:

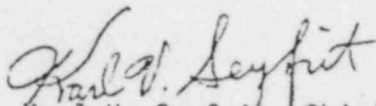
- (1) Providing the probable consequences for every LER.
- (2) Describing a complete safety implications scenario for each event.

In general we were pleased with the LER submittals, and with the exception of strengthening the probable consequences and safety implications, we hope the licensee continues to report in a similar fashion in the future. No other changes are requested.

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The enclosure provides additional observations from our review of the LERs. If you have any questions regarding this report, please contact either myself or Ted Cintula of my staff.



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

Enclosure:
As stated

cc: w/enclosure
B. Jorgenson, RIII
T. Wambach, NRR

SALP REVIEW FOR PALISADES

The licensee submitted about 70 LERs for the period of assessment from July 1, 1982 to May 30, 1983. This would be slightly more than should be expected from an operating unit in this period of time. However, about one-half of the LERs were for events that were repetitious in occurrence. We counted a minimum of:

5 LERs for Defective Snubbers

30 LERs for Liquid Level/Boron Concentration Deviations in the "B" (13 LERs), "C" (2 LERs) and "D" (15 LERs) Safety Injection (SI) Tanks.

In addition, there were three LERs for two concurrent safety injection tank technical specification violations.

The licensee stated that the snubber preventive maintenance program and the valve leakage problems associated with the safety injection tanks were to be addressed in the next refueling outage. This outage did not occur during the assessment period, so the high quantity of repetitious LERs was understandable.

Our review included the following LER numbers:

82-015 through 82-049
83-001 through 83-035

There were only a few updated reports. This review included the initial update reports for LER numbers:

82-016
82-019
82-024
82-033

There were no Revision 2 update reports.

We initially thought too few reports were being updated in consideration of the numbers of LERs in this assessment period. In reading through the LERs, we noted only one update report was promised by the licensee before the

refueling outage (83-006). We thought that LERs 82-026 and 83-002 should have been updated to provide a written statement of the final disposition of the problem. Of course, many of the reports should be updated during the refueling outage. We concluded that there was no real problem in the amount of reports that were being updated.

We were particularly impressed with the organization, quality of information and overall continuity of the LERs. The LERs were easy to read, understandable, and although direct and concise, they were complete as a meaningful abstract of the event. It was obvious that the licensee desired to comply with the guidelines and instructions of NUREG-0161.

In a typical LER, the transmittal letter identified the event number, the title of the event and the technical specification for reporting. In the LER form and included attachments, the licensee provided a detailed description of the event, the cause or causes of the occurrence, immediate corrective actions taken, scheduled corrective actions to be taken later, and any actions to be taken later. The applicable technical specification was referenced in the LER form. The period of surveillance was often noted (monthly, etc.) rather than routine surveillance. Repetitive LERs were identified in the attachment.

The licensee paid particular attention to describing the affected component and its location. Some typical descriptions were: "a 3/4 inch, 200 psi, threaded Bronze Valve ... MV-3415; Boric Acid Heat Trace Circuit 401 (Gravity Feedline to Charging Pumps); Snubber No. 17 (Main Feedline Upstream of Atmospheric Dump Valve CV-0780)." In addition, the licensee included tables, and sometimes, diagrams in the attachment. We thought the table in LER 82-033 was a perfect example to describe the history of the SI tank problems and we hope the licensee continues to use descriptive material in the future.

In addition, quantities, sizes, pressures, time of event, time out of service and other specific numerical information relevant to the assessment of the event were reported routinely by the licensee.

The narrative sections on the LER form were brief, but effective. The descriptions did not overrun the field on LER form - a typical problem with other licensees. Detailed information on events that required greater explanation were provided in the attachments, and many of the 30-day reports include these attachments. However, some 10-day reports did not include the mandatory attachment. We reviewed these LERs and noted these events were repetitious (the SI tanks or Generic Problems) and in our opinion the mandatory attachment probably would not provide significant meaningful additional information relevant to the event.

The licensee identified each page of the LER package with the LER number, plant name and page number to minimize potential problems in assembly or transmittal. Update reports were clearly identified across the top of the LER form and the coded boxes and dates were revised correctly. The updated reports were a complete meaningful entry rather than just additional or subsequent information to the original report.

The LER form was neatly completed with typing centered in the code boxes. There were remarkably few, if any, typo's or omissions. As previously stated, there were no overrunning narratives. The completed form was easy to read and, presumably, to code. The form used by Palisades did not have lines for entry of "name of preparer" or "phone."

We checked the codes the licensee used against narrative sections for accuracy. Overall, we were impressed by the careful selection of proper codes by the licensee. We did disagree with a few of the component codes; our selection is as follows:

| <u>LER NO.</u> | <u>PALISADES</u> | <u>AEOD</u> |
|----------------|------------------|------------------|
| 82-024 | ZZZZZZ | PUMPXX |
| 82-035 | ZZZZZZ | INSTRU |
| 82-037 | ZZZZZZ | FUELXX or FILTER |
| 83-004 | ZZZZZZ | VALVEX |
| 83-009 | ZZZZZZ | FUELXX |
| 83-010 | ZZZZZZ | BATTRY |

Of course, the component manufacturer code would change accordingly. Other codes were used correctly. The licensee participates in NPRDS. In summary, the digital information was excellent.

In our opinion, many of the LERs did not have a description, or a complete description, of the probable consequences of the event. This omission is somewhat understandable because there were so few potentially significant events in the assessment period and the safety implications associated with these minor events may be easily forgotten or may not seem especially relevant to the understanding of the event. This type of problem should not occur so frequently with implementation of the new LER reporting rule as it is expected that most of the less significant events will no longer require reporting. For now, perhaps for the simple events, all that may be necessary for the licensee to satisfy this reporting requirement is to provide a brief statement of the safety implications. For example, in the LERs concerning fire protection barriers/alarms, etc., a statement of the safety-related equipment protected by these systems, and their redundancy, may be sufficient. In the repetitious problems with the technical specification inoperability of the SI tanks, the safety implications of these events should have been discussed by the licensee, particularly where two SI tanks were simultaneously inoperable. In LER 82-024, the licensee describes a scenario where the operating service water pump(s) may go into a runout condition and trip, resulting in a loss of all service water flow. The

licensee correctly states that this condition was not analyzed in the FSAR. In our opinion, the licensee should have also included the safety-related equipment cooled by the service water system, and the conditions at which the loss of this equipment would have had a significant safety effect.