A. Items

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50-335

SALP

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

JUL 07 1983

MEMORANDUM FOR: Hugh C. Dance, Chief
Project Branch #2
Division of Project and Resident Programs
Region II

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

Karl - I am concerned that we may not have sufficient information to make these findings i.e. we don't have first hand information what happen here we should Jack

SUBJECT: EVALUATION OF LERs FOR ST. LUCIE-1 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 St. Lucie Unit 1. 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 a safety assessment could be made by someone reasonably familiar with the plant. However, we thought the licensee escaped too frequently from providing a meaningful description of the probable consequences and safety implications of the event by only referencing that the health and safety of the public was not effected.

We did not evaluate the LERs for Unit 2 because this unit has just been licensed and a representive sample of LERs was not submitted in this assessment period. They will be reviewed in the next assessment period.

A/4/12

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

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

Enclosure:
As stated

cc: w/enclosure
S. Elrod, RII
D. Sells, NRR

SALP REVIEW FOR ST. LUCIE-1

The licensee submitted about 70 LERs in the period of assessment from July 1, 1982 to May 30, 1983. Our review included the following LER numbers:

82-030 through 82-071
83-001 through 83-026

Only one report was updated (LER 82-053).

In this quantity of LERs, there were only five ten-day reports, a surprisingly low proportion of the total. Of these, we noted that LERs 82-063, 83-019 and 83-026 were not submitted with the mandatory supplemental information to NRC Form 366. A future detailed report was promised for 83-019. LERs 82-063 and 83-026 appeared to be acceptable without the mandatory supplementary information. Supplemental information was supplied on many of the 30-day reports.

We initially thought that too few of the reports were being updated because only one of the LERs was updated in the assessment period. In reading through the LERs, we noted only two update reports were promised by the licensee (83-019 and 83-024). One possible explanation for the few updates was the preponderence of 30-day reports. We checked for updated LERs prior to this assessment period and found that a higher proportion of updated reports had been submitted in the past. In this assessment period we thought 83-011 was the only LER that warranted a follow-up report where an updated report was not promised by the licensee. We concluded that there was no real problem in the number of reports that were being updated by this licensee.

In the report that was updated, 82-053, we noted the cover letter did not state the reason for the update. The LER did contain additional narrative information and one coded item was corrected. We also noted that three new coding errors were introduced by the update. This was not typical.

The fact that this report was an update was clearly identified across the top of the LER form, the cover letter identified the report as update 1, and coded boxes and dates were updated correctly.

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 was familiar with and strived to comply with the guidelines and instructions of NUREG-0161. We found no substantive differences between the LERs and the guidelines for their preparation.

In a typical LER, the transmittal letter identified the event number, the title of the event and the applicable technical specification. The licensee identified each page of the LER package with the LER number, docket number and page number to minimize potential problems in assembly or transmittal of a complete event package.

The typical LER submittal was informative and sufficiently detailed to fully understand the event. 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 taken to prevent recurrence. The applicable technical specification was stated in the LER form. Response times and the time span from the last failure/maintenance were often given. In some LERs, the total number of failures in the plant lifetime was stated. Quantities, sizes, pressures, valve numbers, component serial numbers and hours out-of-service and other specific numerical information relevant to the assessment of the event were reported routinely by the licensee. Tables of fuel burnup and personnel exposures were provided in appropriate LERs. Supplemental

information was provided on events that required greater explanation. We believe the licensee provided sufficient detailed information to enable us to understand the event.

The repetitive event LER numbers were referenced in the LER form or in the attachment. We especially liked the fact the licensee noted when the event was the first occurrence at this unit, or the total number of similar events that have occurred during the lifetime of the unit.

The LER form was neatly completed with the typing centered in the code boxes. There were remarkably few typo's or omissions. The LERs were easy to read, understandable, and although the narratives were direct and concise, they were a complete and meaningful abstract of the event. There were no overrunning narratives - a frequent problem with other licensees. It was obvious that the licensee desired to comply with the guidelines and instructions of NUREG-0161.

We checked the codes the licensee used against the narrative sections for accuracy. In general, we were impressed with the careful selection and correct useage of coded information. We disagreed with the licensees use of codes in the following areas:

(1) The code CH for events involving the feedwater system and controls in Item (11) SYSTEM CODE is applicable only to BWRs. The code for PWRs is HH.

(2) Item (14) COMPONENT CODE

LER No.	ST. LUCIE	AEOD
82-039	ZZZZZZ	TRANSF
82-043	ZZZZZZ	INSTRU
82-050	XXXXXX	PUMPXX
82-058	XXXXXX	PENETR

LER No.	ST. LUCIE	AEOD
82-062	XXXXXX	INSTRU
83-004	ZZZZZZ	PUMPXX
83-011	ZZZZZZ	ENGINE or RELAY X
83-016	ZZZZZZ	PUMPXX

Of course, the component manufacturer code would change accordingly. In addition, for Item 31, we suggest the period of surveillance (monthly, etc.) be stated rather than just routine surveillance. Other codes were used correctly. The licensee claims to participate in NPRDS. In summary, the digital information was excellent.

In our opinion, the licensee escaped too frequently from providing meaningful probable consequences of the event by stating that the health and safety of the public was not affected. The probable consequences should describe which redundant systems were available and operable and other safety systems that could be affected by the failure described in the LER. The tendency of not providing probable consequences is somewhat understandable in view of the preponderence of 30-day reports by this licensee. The safety implications of these relatively minor events may be easily forgotten, awkward to write, and 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. In view of the small number of ten-day reports received in this assessment period, we suspect that far less reports will be received from St. Lucie-1 with implementation of the new reporting rule.

We noted that different people were identified with "name of preparer." Apparently, the licensee is correctly directing inquiry to a person familiar with the event, rather than to a corporate contact. The continuity

and accuracy observed in our review probably means that the LERs are checked in-house by a second party prior to submittal.

The following are our specific (negative only) comments on two of the latter LERs in the assessment period:

83-021 Loss of Shutdown Cooling

(1) The two of the four shutdown cooling hot leg suction valves are not identified with valve numbers.

(2) The LER notes this was the 6th event of this type, but the other events were not identified with their LER numbers.

(3) No adverse effect on the health or safety of the public is not meaningful or sufficient as the licensee's only statement of the probable consequences of a loss of shutdown cooling.

(4) The component manufacturer code of Z999 is incompatible with a component code of INSTRU. Manufacturers that are not included in the list should be designated as X999 when the component code is specified.

83-022 Thermal Shield

(1) The sizes of the loose objects are not provided.

(2) The LER states all large parts have been removed.
The disposition of small parts are not stated.
Because the size of the parts were not provided, the reader is uninformed as to which foreign objects were removed.

(3) The LER does not provide any statement of the probable consequences or safety implications of presumed operation with loose parts or a defective thermal shield. Even the disclaimer of no adverse effect on the health and safety of the public was not offered.

(4) Item 37 - Personnel Exposures - is coded 040. The expected number of personnel to be exposed is 80 people with a total exposure of 40 rem. Therefore, the correct entry should have been 080.