

50-286



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

FEB 8 1983

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

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

SUBJECT: SALP INPUT - POWER AUTHORITY OF THE STATE OF NEW YORK

In response to R. C. Haynes's memorandum of November 26, 1982, AEOD evaluated the Licensee Event Reports for Indian Point Station, Unit 3 for the period January 1, 1982 through December 31, 1982. AEOD's review focused on the accuracy and completeness of the licensee's reporting. Since Indian Point No. 3 Nuclear Power Plant was in a refueling outage since March 1982, only a small number of reports were submitted during the evaluation period. The results of our review are as follows:

Reporting (January 1, 1982 - December 31, 1982)

The Power Authority of the State of New York generally provides accurate and complete Licensee Event Reports (LERs), including attachments of additional information. The root causes were usually identified and proper corrective actions taken.

If you have any questions regarding this matter, please contact Wayne Lanning of my staff. Mr. Lanning can be reached at 492-4433.

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

cc: R. C. Haynes, RI  
P. Polk, NRR

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UNITED STATES  
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FEB 9 1983

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MEMORANDUM FOR: Richard C. Lewis, Director  
Division of Projects and Resident Programs  
NRC Region II

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

SUBJECT: EVALUATION OF BROWNS FERRY UNITS 1, 2, AND 3 LERS FOR  
THE PERIOD JULY 1, 1981 TO DECEMBER 31, 1982

The Office for Analysis and Evaluation of Operational Data has assessed the Licensee Event Reports (LERs) submitted under Docket Nos. 50-259, 50-260, and 50-296 during the subject period. This has been done in support of the ongoing SALP review of the Tennessee Valley Authority regarding their performance as licensee of the three Browns Ferry Nuclear Plant Units. Our perspective should be considered as 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 the LERs. Additionally the LERs were screened and sorted in an attempt to find trends or patterns which qualitatively might be interpreted as suggesting licensee performance needing improvement. Our review covered a majority of the LERs submitted during the assessment period for each of the three Browns Ferry Units.

The vast majority of the LERs submitted were fully adequate in all important respects with few exceptions. The LERs typically provided clear and concise descriptions of the cause and nature of the events as well as adequate explanations of the effects on both system function and public safety. Supplemental information was routinely provided in attachments to the LER forms. This enabled the LER reviewer to better understand the nature of the problems encountered, thereby facilitating evaluation of the safety significance of the event. The described corrective actions taken or planned by the licensee were considered to be commensurate with the nature, seriousness and frequency of the problems found.

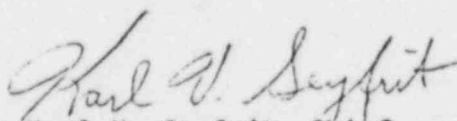
An unusual example of a poorly written report was LER 81-053 (attached) for Unit 2. The event description described the instrument only by its equipment code number. Without a search of drawings or the technical specifications, it was difficult to know the purpose of the instrument involved. At the same time, the writeup did not adequately describe the effect on system function although it was stated that redundant systems were available and operable. The "probable consequence" description should explain the effect of the problem on the system(s) involved. This was an atypical LER with regard to its adequacy, however.

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Supplemental reports were found to have been submitted for each case in which a report was explicitly committed to in the initial LER. In several cases, supplemental data was provided by TVA at a later date in the form of an LER revision as additional information became available. This was done even though there was no commitment to provide such additional information in the initial LER. We also noted that related or repetitive events appeared to be referenced as appropriate. All LERs reviewed were submitted on or before the due date with the apparent exception of LER 81-075 for Unit 3. Another isolated example of a deficient LER was LER 82-022, Rev. 1, for Unit 3. This LER contains three separate reportable events in the same report. We would normally expect that separate LERs be submitted for each occurrence. This is needed to properly establish the LER data base for a given plant. In spite of the inadequacies cited here, we would conclude that the licensees performance over all, as reflected by their preparation and submittal of LERs, was fully adequate.

As mentioned above AEOD also screened and sorted the LERs submitted by TVA during the subject period in an attempt to find potentially significant trends or patterns in the events which might be interpreted as possibly indicating some management weakness. LERs were sorted out when they involved cases where surveillance tests were performed late or incorrectly; operations personnel actions or activities were incorrect; trade or technician workmanship was deficient; procedures were inadequate, improper or lacking; recurrence control was inadequate; or followup LERs were not submitted as promised. The enclosure summarize the outcome of this sorting activity in tabular form. From our assessment of the quality (kind) and quantity (fraction) of the specific LERs tabulated in the enclosure we have concluded that collectively they are within the range of what one would normally expect to see at an "average" BWR facility during such a time interval.

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



Karl V. Seyfrit, Chief  
Reactor Operations Analysis Branch  
Office for Analysis and Evaluation  
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Enclosure:  
As Stated

cc: w/enclosure  
R. Clark, NRR  
D. Vassallo, NRR  
G. Paulk, RII