

FEB 6 1984

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

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

SUBJECT: SALP INPUT FOR SEQUOYAH UNITS 1 AND 2 FOR THE
 PERIOD JANUARY 1, 1983 THROUGH DECEMBER 31, 1983

AEOD reviewed 183 LERs from the Sequoyah site in support of the ongoing SALP review. Our review concentrated on completeness, accuracy, and consistency of the submitted information. We found no significant report deficiencies, but we did find areas that could be improved.

A summary of the criteria used and the findings subject to those criteria is attached for your information. If you have any questions regarding this review, please contact either myself or Dorothy Zukor of my staff. Ms. Zukor can be reached at (301) 492-4431.

Original signed by
 K. V. SEYFRIT

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

Attachment:
 As stated

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

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A handwritten signature in cursive script that reads "Karl V. Seyfrit".

Karl V. Seyfrit, Chief
Reactor Operations Analysis Branch
Office for Analysis and Evaluation
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Sequoyah Unit 1

AEOD found 107 LERs and two revisions in the NRC Document Control System for the January 1, 1983 to December 31, 1983 assessment period. Three prompt notifications (PNs) were also found, one affecting both units. The largest percentage of events (60%) was attributed to component failures. The "other" category accounted for 21% of the events. Ten percent of the reports were due to personnel error and five percent were due to design, manufacturing, or construction errors. Four percent of the events were due to deficient procedures. No events were attributable to external causes. Based on the review of the available reports, our findings are as follows.

1. LER Completeness

- a. Was the information given sufficient to provide a good understanding of the event?

In general, enough information was given to clearly and adequately describe the event. In a few cases, however, it was difficult to determine the exact system being discussed, because only the surveillance instruction number was given. For example, in LER 83-002, one can determine from checking the referenced LERs that the system being discussed is the Upper Head Injection System (UHI). The LER does not state this explicitly. A similar deficiency was noted in LER 83-088.

- b. Were the LERs coded correctly?

All of the entries reviewed appeared to be essentially correct and the codes agreed with the information in the narrative descriptions. Some of the system codes, however, were unnecessarily vague. For example, in many LERs where the Auxiliary Feedwater System was involved, the system code was given as "WB" which is "cooling system for reactor auxiliaries and controls." Although this is correct, it could have been more accurately coded as "CH" which is "feedwater systems and controls."

- c. Was supplementary information provided when needed?

Of the 107 LERs reviewed for Unit 1, 22 included supplemental information. This additional information routinely clarified the information in the LER. The lack of supplemental information for the other LERs did not inhibit the reader's understanding of the event.

- d. When follow-up reports are promised, are they delivered?

Two follow-up reports were promised, in LERs 83-070 and 83-102. No revised LERs were found for these events.

e. Were similar occurrences adequately referenced?

The great majority of similar occurrences were accurately referenced, but some references were inconsistent. For example, LER 83-134 references LER 83-047 as a previous similar occurrence. It does not reference LERs 83-116 or LER 83-57 which also appear to be previous similar occurrences.

2. Multiple Event Reporting in a Single LER

Ten LERs contained information in a single LER that should have been reported in separate LERs.

3. Prompt Notification Follow-Up Reports

None of the three submitted PNs were followed up by LERs. It appears that two of them should have been, because LER 83-71 involves a possible violation of the chemistry limits of the secondary side and LER 83-77 involves overpressurization of the condensate storage tank which provides water to the auxiliary feedwater system.

Sequoyah Unit 2

AEOD found 76 LERs and three revisions for the January 1, 1983 to December 31, 1983 assessment period in the NRC Document Control System. Two PNs were found, one affecting both units. The largest percentage (59%) of reports were due to component failures. The next two largest categories were "others" with 22% of the total and "personnel errors" with 15% of the total. Four percent of the events were the results of inadequate procedures. Based on our review of the available reports, our findings follow.

1. LER Completeness

a. Was the information given sufficient to provide a good understanding of the event?

In most cases, the information provided was enough to adequately and clearly describe the event. In LERs 83-013 and 83-109, a clear verbal statement of the system being tested was not given.

b. Were the LERs coded correctly?

All of the entries reviewed appeared to be correct and agreed with the information in the narrative descriptions. The same vagueness discussed for Unit 1 concerning the coding of the auxiliary feedwater system applies here as well.

c. Was supplementary information provided when needed?

Of the 76 LERs reviewed, 8 contained supplemental information. Some of the supplements greatly enhanced the LER by giving the background of a particular problem and an account of the efforts in progress to resolve it. A lack of supplemental information did not inhibit the reader from understanding the other LERs.

d. When follow-up reports are promised, are they delivered?

Seven follow-up reports were promised, two were found.

e. Were similar occurrences reported accurately?

The great majority of similar occurrences were accurately referenced. One problem was found with respect to the subcooling margin monitor in that all previous occurrences were not mentioned after the fifth event occurred. LER 83-190 should include six previous events (LER 83-034, 83-046, 83-069, 83-074, 83-085, and 83-095). It only mentions one. No other examples of inadequate referencing were found.

2. Multiple Event Reporting in a Single LER

Four LERs contained information in a single LER that should have been reported in separate LERs.

3. Prompt Notification Follow-up Reports

Neither of the two PNs submitted were followed up by LERs. It appears that neither of them had to be.

In summary, for both units, our review indicates that based on the stated criteria, the licensee provided adequate event reports during the assessment period, although, as mentioned above, specific areas need improvement.