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MEMORANDUM FOR: Richard C. Lewis, Director
Division of Project 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 TURKEY POINT UNIT 3 AND 4 FOR THE PERIOD
JULY 1, 1982 THROUGH JUNE 30, 1983

Turkey Point Unit 3

AEOD evaluated the LERs from this unit for completeness and accuracy. Sixteen LERs were retrieved from our data base with event dates ranging from July 13, 1982 to April 19, 1983. Although relatively few LERs were submitted during the SALP evaluation period, the description of each event was adequate and the coding was accurate. Repetitive events were well documented and supplemental information was provided for 11 events. One updated LER was submitted. For each event the conditions of the event, the technical specification which was violated, and a list of previous similar events, if any, were given. Five events were reported to NPRDS. Generally, only events caused by equipment failure or whose cause was classified as "other" were reported to NPRDS.

The largest percentage (31%) of LERs submitted were attributed to personnel errors. The most serious event involved a loss of all auxiliary feedwater pump turbines at 100% power. Personnel error in rehanging clearance tags and lack of independent verification resulted in closing the steam supply lines to two pump turbines while the third was out of service. Both "component failures" and "others" each made up 25% of the total. Design, Construction or Manufacturing accounted for 13% of the events. No events were attributed to external causes and 6% were attributed to procedures. There were no significant repetitive events and no persistent or unresolved problems were found.

Turkey Point Unit 4

The LERs for the period covering July 13, 1982 to June 1, 1983 were reviewed for completeness and accuracy. Only eight LERs were found in the data base for this evaluation period. This may be because Unit 4 was shutdown for steam generator replacement from October, 1982 to June, 1983. The descriptions of the events were adequate and the coding was done properly. The only repetitive problem which remained unresolved involved heat tracing system and a task force was investigating the situation. For each event the circum-

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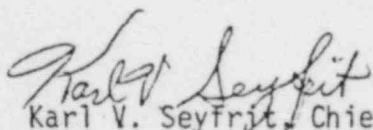
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stances surrounding the event, the technical specification violation and a list of similar events was given. Supplemental information was provided for seven of the eight events.

The largest percentage (38%) of the LERs were attributed to personnel error. "Component Failures" and "Design, Maintenance, and Construction" each comprised 25% of the total. Twelve percent of the events were classified in the "others" category.

General Comments on Both Units

It is difficult to evaluate the significance of the LERs which were submitted because there are so few. Keeping this in mind, it appears that personnel errors may present the major area where improvement could be made. This differs from most other SALP review where component failures usually are the major cause for event reports. In conclusion it appears that the licensees submittals are acceptable but very few in number.



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