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APR 24 1984

APR 2-

MEMORANDUM FOR: Charles E. Norelius, Director
Division of Project and Resident Programs
NRC Region III

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

SUBJECT: SALP INPUT FOR DONALD C. COOK UNITS 1 and 2 FOR THE PERIOD APRIL 1, 1983 THROUGH MARCH 31, 1984

AEOD reviewed 201 LERs from the Donald C. Cook site in support of the ongoing SALP review. Our review concentrated on completeness, accuracy, and consistency of the submitted information. We found no serious 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.

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

Attachment:
As stated

cc w/attachment:
Dave Wigginton, PM-D.C. Cook

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DATE		4/24/84	4/24/84	4/24/84			

ATTACHMENT

Donald C. Cook, Unit 1

AEOD found 108 LERs and nine revisions in the NRC Document Control System for the April 1, 1983 to March 31, 1984 assessment period. The largest percentage of events (54%) was attributed to component failures. Seventeen percent were due to personnel errors. The "other" category accounted for 11% of the events. Ten percent of the events were due to deficient procedures and eight percent were due to design, manufacturing, or construction errors. No events were attributable to external causes. Two Prompt Notifications (PNs) were found, one affecting both units. Based on our 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?

      Yes, enough information was given to clearly and adequately describe each event.

   b. Were the LERs coded correctly?

      All of the entries reviewed appeared to be essentially correct and the system codes agreed with the information in the narrative descriptions. There were some errors, however: LER 84-040 gave the wrong docket number for Unit 1, and two LERs 83-067 were found.

   c. Was supplementary information provided when needed?

      Of the 108 LERs reviewed for Unit 1, 31 included supplemental information. The 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. LERs 83-052 and 84-001 are particularly good examples where additional clarifying information was included.

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

      Fourteen follow-up reports were promised, eight were found. If the follow-up report was not in the form of an LER, it was not counted. In a few cases, the follow-up report may not have been issued yet, as in the case of LER 83-115.

   e. Were similar occurrences adequately referenced?

      The great majority of similar occurrences were accurately referenced. Some references, however, were misleading. For example, numerous events involved fire doors failing to latch properly. A reference was given only if the same door failed repeatedly. Unless

one searched all of the LERs, one would not notice that many different fire doors failed to latch properly significantly increasing the actual number of failures involving these doors.

2. Multiple Event Reporting in a Single LER

No LERs contained information in a single LER that should have been reported in separate LERs.

3. Prompt Notification Follow-Up Reports

Neither one of the two PNs submitted were followed up by LERs and it does not appear that any follow-up was necessary.

Donald C. Cook, Unit 2

AEOD found 93 LERs and six revisions for the April 1, 1983 to March 31, 1984 assessment period. One LER, 83-076 could not be found in the NRC Document Control System and was obtained from the INPO LER listing. The largest percentage of events (51%) was attributed to component failures. Twenty percent were due to personnel error. The "others" category accounted for 13% of the events. Eight percent of the events were due to deficient procedures and eight percent were due to design, manufacturing, or construction errors. No events were attributable to external causes. Two Prompt Notifications, two special reports, and an explanatory letter were also found. Based on our 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?

Yes, enough information was given to clearly and adequately describe each event.

b. Were the LERs coded correctly?

Most of the entries appeared to be essentially correct and the coding agreed with the information in the narrative descriptions. Four LERS were coded incorrectly: 83-082 and 84-001 both gave invalid codes and 84-002 gave no system code at all. LER 83-126 gave the wrong licensee code.

c. Was the supplementary information provided when needed?

Of the 93 LERs reviewed for Unit 2, 28 included supplemental information. In general, the additional information 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. LERs 83-073 and 84-001 are particularly good examples where additional clarifying information was included.

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

Seven follow-up reports were promised, two were found. Only follow-up reports in the form of a LER were counted. In the case of LER 84-003, the follow-up report may not yet have been issued.

e. Were similar occurrences adequately referenced?

The great majority of similar occurrences were accurately referenced, some references, however, were misleading. For example, numerous events involved fire doors failing to latch properly. A reference was given only if the same door failed repeatedly. Unless one searched all of the LERs, one would not notice that many different fire doors failed to latch properly significantly increasing the actual number of failures involving these doors.

2. Multiple Event Reporting in a Single LER

Two LERs, 83-054 and 83-081 contained information in a single LER that should have been reported in separate LERs.

3. Prompt Notification Follow-Up Reports

One of the two PNs was followed up by a letter giving the reason for an unscheduled outage. The other PN concerned a bomb hoax and no follow-up was necessary.

In summary, our review indicates that based on the stated criteria, the licensee provided adequate event reports during the assessment period. However, as mentioned above, some specific areas could be improved.

Beaver Valley Unit 1

AEOD found 51 LERs including four revisions in the NRC Document Control System for the December 1, 1982 to March 31, 1984 assessment period. The largest percentage of events (45%) was attributed to component failures. The "other" category accounted for 22% of the events. Fifteen percent of the reports were due to personnel errors and ten percent were due to design, manufacturing, or construction errors. Six percent of the events were due to deficient procedures. Two percent of the 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, sufficient information was given to clearly and adequately describe the event. The licensee interpreted and complied with the intent of the procedures of NUREG-0161 for reporting events prior to 1984. The LERs submitted for 1984 events were consistent with the guidance provided in NUREG-1022.

   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.

   c. Was supplementary information provided when needed?

      In general, supplemental information was provided when needed. For a large number of LERs, the LER form was coded to indicate that an attachment of additional information was provided. However, the attachment indicated only that additional information was not required to satisfy the reporting requirements.

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

      No LERs were found that promised follow-up reports.

   e. Were similar occurrences adequately referenced?

      Similar occurrences and repetitive events were usually referenced. The reasons were not identified, nor obvious, for two of the updated LERs (83/28-1 and 83/30-1).

2. Multiple Event Reporting in a Single LER

In general, no multiple events were reported in a single LER that should have been reported in separate LERs.