UNITED STATES
NUCLEAR REGULATORY COMMISSION
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MEMORANDUM FOR: Edward G. Greenman
Project Branch #1
Division of Project and Resident Programs, R1

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

SUBJECT: EVALUATION OF LERs FOR MILLSTONE-2 FOR THE PERIOD FROM SEPTEMBER 1, 1982 TO AUGUST 31, 1983 - AEOD INPUT TO SALP REVIEW

In support of the ongoing SALP reviews, AEOD has reviewed the LERs for Millstone-2. This review has focused on the usefulness of the submittals to AEOD and on the accuracy and completeness of the licensee's reporting. We found the licensee's submittals to be clearly above average in terms of reporting completeness and factual accuracy with regard to the events reported. 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 an informed safety assessment and its potential consequences could be made by someone reasonably familiar with the plant. We could find no deficiencies with the LERs received in this assessment period and, consequently, we do not recommend any changes in the style or content of licensee reporting.

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:
P. Leech, NRR
J. Shedlosky, R1

AEOD SALP REVIEW FOR MILLSTONE-2

The licensee submitted about 40 LERs in the assessment period from September 1, 1982 to August 31, 1983. Our review included the following LER numbers:

82-037 through 82-053
83-001 through 83-024

The review did not include Unit 3 because it was not required to submit LERs in the assessment period. For Unit 2, all consecutively numbered LERs were retrievable so there were no missing, unsequentially numbered or cancelled LERs in this review. No special reports were submitted in the assessment period.

The LER review for Unit 2 followed guidelines provided by AEOD internal memorandum of June 28, 1983 and the general instructions and procedures of NUREG-0161. The SALP review is presented in a style consistent with the outline format of the above memorandum.

1. Review of LERs for Completeness.

a) Is the information sufficient to provide a good understanding of the event?

The information in the free-form narrative sections of the LER Form were consistently brief. There were no instances of overrunning narratives, a recurring problem with some licensees. Despite the conciseness of the licensee response in the two free-form sections of the LER Form, we found the information exceptionally informative, complete and meaningful. We believe the licensee interpreted and complied exactly with the intent of the procedures of NUREG-0161.

b) Review of Coded Information

We checked the codes the licensee selected against the narrative sections for accuracy. We disagreed with the licensee's choice of component code

in four LERs (82-44, 46, 47 and 83-02) and with the method of discovery in LER 82-48. We agreed with the licensee in all other coded fields. In view of the quantity of coded information available in this review (approx. 45 x 40) and the subjectiveness of some code decisions, we thought that the digital information was excellent. In addition, each coded entry was typed and centered within the coded boxes. There were no typos or omissions. The form was neat in appearance and readable.

c) Do the reports contain supplementary information when needed?
The licensee submitted five ten-day reports (82-49, 83-07, 08, 09 and and 24). Only LER 83-24 did not contain the mandatory supplementary information. In our opinion, the licensee was negligent in this event (damage to thermal shield) because the extent of damage was not described, nor were the probable consequences with continued operation, the apparent cause, what indications were apparent to operations that might be indicative of abnormal baffle integrity prior to its actual discovery, the response of the loose parts monitoring system, etc. We thought this event should have been described in detail by the licensee because of (1) the rarity of this type occurrence in the nuclear field and (2) the potential consequences of thermal shield blockage of any core flow passages or piping. We did not think the LER had sufficient information to reach a sound or meaningful conclusion. In fairness to the licensee, this was the only LER that we took exception with in the review process.

Nine other LERs contained voluntary supplemental information in addition to the LER Form. The attachments provided information useful in assessing the full impact of the event rather than just a restatement of the original arguments. We particularly liked the organized structure of the attachment with each category separated

and titled rather than long narrative passages. We concluded that the licensee responded with additional information readily and the additional information was pertinent and useful.

d) Follow-up Reports

The licensee only promised one followup report (83-037) and it was promised for the next cold shutdown period. It was received at this time. In addition, of the LERs in this assessment period, 83-16 was updated with additional corrective actions. We reviewed the data base and found that several older LERs were updated during the assessment period. We believe the licensee is conscientious in providing followup information as it became available. The updated reports did not comply with the style change guidance of NUREG-0161.

e) Were similar occurrences properly referenced?

Previous LER numbers of events of a similar nature were referenced correctly. In addition, the licensee positively stated when there have been no similar previous occurrences. A statement of this effect eliminates doubt as to whether similar events were unintentionally not referenced by the licensee.

2. Is component failure or other appropriate information being reported to NPRDS?

The licensee claims to be reporting events of this nature to the Nuclear Plant Reliability Data Service.

3. Multiple event reporting in a single LER

The only LER in this assessment period reporting multiple events was 83-12. Each of the events were combined correctly into a single LER report in accordance with guidance offered in NUREG-0161.

4. Relationship between PNs and LERs

Only one PN was issued in the assessment period, an inadvertent initiation of the emergency core cooling systems with the unit at 67% power. There was no corresponding LER for the event. Because of the lack of PNs issued in the assessment period, it is impossible to make a informed judgement as to whether the licensee is reporting all events that should be reported.