



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
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MEMORANDUM FOR: Eric H. Johnson, Chief  
Reactor Project Branch No. 1  
Division of Resident, Reactor Project  
and Engineering Programs, RIV

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

SUBJECT: EVALUATION OF LERs FOR FOR ST. VRAIN  
AEOD INPUT TO SALP REVIEW COVERING THE  
PERIOD FROM OCTOBER 1, 1983, TO NOVEMBER 30, 1984

In support of the ongoing SALP reviews, AEOD has reviewed the LERs for Fort St. Vrain. Our review concentrated on LER Form completeness and the clarity, understandability, and adequacy of the event report contents.

From the LERs that were reviewed, we concluded that the licensee provided adequate event reports during the assessment period. We found no significant deficiencies and the reports complied with the guidelines of NUREG-0161 and NUREG-1022 in all reviewed categories.

The enclosure provides additional observations from our review of the LERs. If you should have any questions regarding this report, please contact either myself or Ted Cintula of my staff. Mr. Cintula can be reached at FTS 492-4494.

A handwritten signature in cursive script that reads "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:  
T. Colburn, NRR  
G. L. Plumlee, RIV

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AEOD INPUT TO SALP REVIEW FOR FORT ST. VRAIN

The Licensee submitted about 35 reports, plus updates, during the assessment period from October 1, 1983 to November 30, 1984. Our review included the following LER numbers:

83-041 to 83-055  
84-001 to 84-009

The LER review followed the general instructions and procedures of NUREG-0161 and NUREG-1022. The specific review criteria and our findings follow:

1. LER Completeness

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

1983 LERs

The information in the two free-form narrative sections of the LER Form was consistently brief and to the point. There were a few instances of overrunning narratives, but they were of small magnitude and would not be a problem for future abstracting. Our review concluded the LERs provided sufficient information to provide a clear and adequate description of the occurrence, the direct consequences and the corrective action. The reports typically included specific details of the event such as valve identification numbers, model numbers, number of operable redundant systems, the date of completion of repairs, etc., to provide a good understanding of the event. The reports were easy to read and meaningful.

1984 LERs

The abstract described the major occurrences of the event, including all component or system failures that contributed to the event and the significant corrective actions taken or planned to prevent recurrence as stated in NUREG-1022.

- b) Were the LERs coded correctly?

1983 LERs

We checked the codes that the licensee selected against the narrative description of the event for accuracy. We agreed with the licensee's selection in all coded fields except for a few entries. These disagreements were minor and did not detract from our overall impression of a judicious selection of coded information.

#### 1984 LERs

We agreed with the licensee's selection in all coded fields.

- c) Was supplemental information provided when needed?

#### 1983 LERs

The licensee provided additional supplementary information with every LER. The attachments typically provided plant specific detailed information such as the limiting condition of operation, the purpose of the system, all functions performed by the defective component, etc., which was useful in assessing the full impact of the event rather than just a restatement of the original arguments. The attachments were well organized with each topic of discussion separated and titled. In addition, the licensee typically provided tabular information and simplified flow schematics with the supplemental information. These aids greatly assisted in explaining the event. In view of both the quantity and quality of the supplemental information, we concluded that the licensee was outstanding in this category.

#### 1984 LERs

The narrative description in the attachments was very informative and the new reports provided substantial detail about the events. The licensee typically stated the purpose of the system and all functions performed by the defective component. The safety analysis often assumed the conservative loss of the complete system to describe a worst case scenario. Some reports included diagrams and tables to help explain the event and the narratives and diagrams were coded with symbols so it was easy to follow all system/component interactions of the event. We thought the supplemental information was excellent.

- d) Follow-up Reports

#### 1983 LERs

The licensee positively stated in each LER as to whether the LER would be updated at some future date or that no further corrective action was required. However, only one of the promised LERs was actually updated in this assessment period (LER 83-050). A review of the data base showed that thirteen other older LERs were also updated in this assessment period. A review of these LERs showed the updated reports contained new narrative information and the codes were revised correctly in accordance with the guidelines of NUREG-0161. The portions of the narratives that were revised were identified by a vertical line in the left hand margin of the page so the extent of corrected information was readily apparent to all readers.

1984 LERs

Three of the new reports have been updated so far. They were updated correctly by the standards of NUREG-1022 and the above comments would be applicable.

- e) Were similar occurrences properly referenced?

1983 and 1984 LERs

Previous LER numbers of events of a similar nature were referenced correctly. In addition, the licensee positively stated when there have been no previous similar reports.

2. Multiple Event Reporting in a Single LER

The licensee submitted several LERs that combined multiple events of component failures into a single report. These multiple events were combined correctly into a single LER in accordance with the guidelines of NUREG-0161 and NUREG-1022.

3. Prompt Notification Follow-up Reports

Only two PNs were issued in this SALP assessment period, the failure of six of the 37 control rod pairs to insert on June 22, 1984 and an excessive Beta radiation liquid release on July 20, 1984. Each of these events were reportable, and they were reported as LERs 84-008 and 009. Therefore, it appears the licensee is reporting all events that are required to be reported.