

UNITED STATES NUCLEAR REGULATORY COMMISSION REGION III 799 ROOSEVELT ROAD GLEN ELLYN, ILLINOIS 60137

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Docket No. 50-461

Illinois Power Company ATTN: Mr. W. C. Gerstner Executive Vice President 500 South 27th Street Decatur, IL 62525

Gentlemen:

As part of the Nuclear Regulatory Commission's (NRC) Systematic Assessment of Licensee Performance (SALP) Program, the NRC's Office of Analysis and Evaluation of Operational Data (AEOD) performed an assessment of Licensee Event Reports (LERs) issued by Clinton during the period of September 1, 1986 through August 31, 1987.

This is the first time Clinton's LER's have been evaluated by AEOD. This review provides an overview of the quality of the LER's by comparing the contents of the LER's to the reporting requirements of 10 CFR 50.72(b) and the guidelines contained in NUREG-1022. AEOD noted deficiencies in reporting the manufacture and model numbers of failed components, and indicated that the cause and corrective actions were not always summarized in the abstracts. However, the results of AEOD's evaluation revealed that Clinton's overall LER quality is above the current industry average of 8.5 points, thus Clinton scored 9.2 out of a possible 10 points.

Enclosed for your review is a copy of AEOD's evaluation of your LER quality. Please contact us if you have any questions.

Sincerely,

Rhade & Morelins

Charles E. Norelius, Director Division of Reactor Projects

Enclosure: AEOD Assessment

See Attached Distribution

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Illinois Power Co.

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cc w/enclosure: DCD/DCB (RIDS) Licensing Fee Management Branch Resident Inspector, RIII Roy Wight, Manager Nuclear Facility Safety Mark Jason, Assistant Attorney General, Environmental Control Division Richard Hubbard J. W. McCaffrey, Chief, Public Utilities Division H. S. Taylor, Quality Assurance Division David Rosenblatt, Governor's Office of Consumer Services

LICENSEE EVENT REPORT (LER)

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QUALITY EVALUATION FOR

CLINION 1

DURING THE PERIOD FROM

SEPTEMBER 1, 1986 TO AUGUST 31, 1987

SUMMARY

An evaluation of the content and quality of a representative sample of the Licensee Event Reports (LERs) submitted by Clinton 1 during the period from September 1, 1986 to August 31, 1987 was performed. This evaluation provides an overview of the quality of the LERs by comparing their contents to the reporting requirements of 10 CFR 50.73(b) and the guidelines contained in NUREG-1022 and its Supplements No. 1 and 2.

This is the first time the Clinton 1 LERs have been evaluated using this methodology. The results of this evaluation indicate that the overall quality of the Clinton 1 LERs, for the three areas that are evaluated (i.e., the text, abstract, and coded fields), is above the current industry average. Clinton's average LER score is 9.2 compared to a current industry average score of 8.5.

The only important text requirement that is considered deficient is the requirement to identify (e.g., by manufacturer and model number) each component that fails during an event. In addition, the abstract scores are less than they should be because cause and corrective action information, which was provided in the text, was not always summarized in the abstracts.

LER QUALITY EVALUATION FOR CLINTON 1

INTRODUCTION

In order to evaluate the overall quality of the contents of the Licensee Event Reports (LERs) submitted by Clinton 1 during the period from September 1, 1986 to August 31, 1987, a sample of the unit's LERs was evaluated. This evaluation was performed by comparing the contents of each LER to the reporting requirements of 10 CFR 50.73(b) and the guidelines contained in NUREG-1022¹ and its Supplements No. 1² and 2.³ The sample consists of a total of 15 LERs, which is considered to be the maximum number of LERs necessary to be evaluated for a unit/station. See Appendix A for a list of the LER numbers in the sample.

This is the first time that the Clinton 1 LERs have been evaluated using the same methodology. It was necessary to start the evaluation before the end of the assessment period because the input was due such a short time after the end of the assessment period. Therefore, those LERs prepared by the unit late in the assessment period were not available for selection.

METHODOLOGY

The evaluation consists of a detailed review of each selected LER to determine how well the content of its text, abstract, and coded fields meet the criteria of 10 CFR 50.73(b). In addition, each selected LER is compared to the guidance for preparation of LERs presented in NUREG-1022 and Supplements No. 1 and 2 to NUREG-1022; based on this comparison, suggestions were developed for improving the quality of the LERs. The purpose of this evaluation is to provide feedback to improve the quality of LERs. It is not intended to increase the requirements concerning the "content" of these reports beyond the current requirements of 10 CFR 50.73(b). Therefore, statements in this evaluation that suggest

measures be taken are not intended to increase requirements and should be viewed in that light. However, the minimum requirements of the regulation must be met.

The evaluation process for each LER is divided into two parts. The first part of the evaluation consists of documentiny comments specific to the content and presentation of each LER. The second part consists of determining a score (0-10 points) for the text, abstract, and coded fields of each LER.

The LER specific comments serve two purposes: (1) they point out what the analysts considered to be the specific deficiencies or observations concerning the information pertaining to the event, and (2) they provide a basis for a count of general deficiencies for the overall sample of LERs that was evaluated. Likewise, the scores serve two purposes: (1) they serve to illustrate in numerical terms how the analysts perceived the content of the information that was presented, and (2) they provide a basis for determining an overall score for each LER. The overall score for each LER is the result of combining the scores for the text, abstract, and coded fields (i.e., 0.6 x text score + 0.3 x abstract score + 0.1 x coded fields score = overall LER score).

The results of the LER quality evaluation are divided into two categories: (1) detailed information and (2) summary information. The detailed information, presented in Appendices A through D, consists of LER sample information (Appendix A), a table of the scores for each sample LER (Appendix B), tables of the number of deficiencies and observations for the text, abstract and coded fields (Appendix C), and comment sheets containing narrative statements concerning the contents of each LER (Appendix D). When referring to Appendix D, the reader is cautioned not to try to directly correlate the number of comments on a comment sheet with the LER scores, as the analysts have flexibility to consider the magnitude of a deficiency when assigning scores (e.g., the analysts sometimes make comments relative to a requirement without deducting points for that requirement).

RESULTS

A discussion of the analysts' conclusions concerning LER quality is presented below. These conclusions are based solely on the results of the evaluation of the contents of the LERs selected for review and as such represent the analysts' assessment of the unit's performance (on a scale of 0 to 10) in submitting LERs that meet the criteria of 10 CFR 50.73(b) and the guidance present in NUREG-1022 and its supplements.

Table 1 presents the average scores for the sample of LERs evaluated for the unit. In order to place the scores provided in Table 1 in perspective, the distribution of the overall average score for all units/stations that have been evaluated using the current methodology is provided on Figure 1. Figure 1 is updated each month to reflect any changes in this distribution resulting from the inclusion of data for those units/stations that have not been previously evaluated or those that have been reevaluated. (Note: The previous score for those units/stations that are reevaluated is replaced with the score from the latest evaluation). Table 2 an , Appendix Table B-1 provide a summary of the information that is the basis for the average scores in Table 1. For example, Clinton 1's average score for the text of the LERs that were evaluated is 9.2 out of a possible 10 points. From Table 2 it can be seen that the text score actually results from the review and evaluation of 17 different requirements ranging from the discussion of plant operating conditions prior to the event [10 CFR 50.73(b)(2)(ii)(A)] to text presentation. The resultant percentage scores in the text summary section of Table 2 provide an indication of how well each text requirement was addressed by the unit for the 15 LERs that were evaluated. Based on similar methodology, the percentage scores for the various sections of the abstract and the items in the coded fields were also computed and are shown in Table 2.

As indicated in Table 2, certain requirements or areas within the text, abstract, and coded fields are causing the unit difficulty when preparing LERs. Relatively low percentage scores may indicate that the unit needs additional guidance concerning these requirements, or it may indicate that the unit understands the basic requirement but has either:

· TABLE 1. SUMMARY OF SCORES FOR CLINTON 1

		Average	High	Low
	Text	9.2	9.9	8.3
	Abstract	8.9	9.8	7.5
	Coded Fields	9.7	10.0	9.0
	Overall	9.2	9.7	8.2
a. Se	e Appendix B for a summa	ry of scores for e	ach LER that w	as evaluated.

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TABLE 2. LER REQUIREMENT PERCENTAGE SCORES FOR CLINTON 1

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Requirements [50.73(b)] - Descriptions	Scores ()
<pre>(2)(ii)(A) Plant condition prior to event (2)(ii)(B) Inoperable equipment that contributed (2)(ii)(C) Date(s) and approximate time(s)</pre>	87 (15) b 92 (15)
<pre>(2)(ii)(D) Root cause and intermediate cause(s) (2)(ii)(E) Mode, mechanism, and effect (2)(ii)(F) EIIS codes</pre>	95 (15) 100 (6) 33 (15)
<pre>(2)(ii)(G) Secondary function affected (2)(ii)(H) Estimate of unavailability (2)(ii)(I) Method of discovery</pre>	b 17 (3) 97 (15)
<pre>(2)(ii)(J)(1) - Operator actions affecting course (2)(ii)(J)(2) - Personnel error (procedural deficiency) (2)(ii)(K) - Safety system responses</pre>	100 (3) 95 (8) 100 (11)
<pre>(2)(ii)(L) Manufacturer and model no. information (3) Assessment of safety consequences (4) Corrective actions</pre>	50 (6) 95 (15) 93 (15)
<pre>(5) Previous similar event information (2)(i) Text presentation</pre>	100 (15) 94 (15)

ABSTRACT

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	Requirements [50.73(b)(1)] - Descriptions	Perc	entage a es ()
	Major occurrences(immediate cause/effect)	98	(15)
-	Plant/system/component/personnel responses	100	(11)
-	Root cause information	88	(15)
-	Corrective action information	77	(15)
-	Abstract presentation	84	(15)

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TABLE 2. (continued)

CODED FIELDS

		Percentage
	Item Number(s) - Descriptions	Scores ()
1, 2, and 3 -	Plant name(unit #), docket #, page #s	100 (15)
4	Title	87 (15)
5, 6, and 7 -	Event date, LER no., report date	98 (15)
8	Other facilities involved	100 (15)
9 and 10	Operating mode and power level	100 (15)
11	Reporting requirements	100 (15)
12	Licensee contact information	100 (15)
13	Coded component failure information	100 (15)
14 and 15	Supplemental report information	100 (15)

a. Percentage scores are the result of dividing the total points for a requirement by the number of points possible for that requirement. (Note: Some requirements are not applicable to all LERs; therefore, the number of points possible was adjusted accordingly.) The number in parenthesis is the number of LERs for which the requirement was considered applicable.

b. A percentage score for this requirement is meaningless as it is not possible to determine from the information available to the analyst whether this requirement is applicable to a specific LER. It is always given 100% if it is provided and is always considered "not applicable" when it is not.

(1) excluded certain less significant information from a number of the discussions concerning that requirement or (2) totally failed to address the requirement in one or two of the selected LERs. The unit should review the LER specific comments presented in Appendix D to determine why it received less than a perfect score for a requirement.

Specific Deficiencies and Observations

The deficiencies and observations of most concern for the text, abstract, and coded field sections of the LERs are discussed separately below. See Appendix D for a list of all deficiencies and observations.

Text Deficiencies and Observations

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The requirement to provide adequate identification for failed components, Requirement 50.73(b)(2)(ii)(L), was not included in three of the six LERs involving a failed component. In most cases this requirement can be met by simply providing the manufacturer and model number for each failed component. For certain components (e.g., pipes, fitting, etc.) the material and size of the failed component may be more appropriate information. Whatever information is provided, it should be specific enough to allow the reader to determine if the failed component is the same as one that is used at his facility. In addition, there are instances when component identification can be important to the reader, even though the component did not fail. For example, if the design of a component contributes to the event, it would be helpful (although not required) to provide information that would enable others to specifically identify that component.

An estimate for the elapsed time of safety system train inoperability, Requirement 50.73(b)(2)(ii)(H), was not provided for two of the LERs involving train unavailability. This requirement can usually be met by providing adequate dates and times for the occurrences discussed in the text.

The Energy Industry Identification System (EIIS) component function identifier and/or system name codes were not provided or were only partially provided in 11 of the LERs. These codes should be provided for all components and systems referred to in the text.

Abstract Deficiencies and Observations

While there are no specific requirements for an abstract, other than those given in 10 CFR 50.73(b)(1), an abstract should, as stated in NUREG-1022, Supplement No. 2, summarize the following information from the text:

1.	Cause/Effect	What happened that made the event reportable.
2.	Responses	Major plant, system, and personnel responses as a result of the event.
3.	Root/Intermediate Cause	The underlying cause of the event. What caused the component and/or system failure or the personnel error.
4.	Corrective Actions	What was done immediately to restore the plant to a safe and stable condition and what was done or planned to prevent recurrence of the event.

Number 3 and 4 were not adequately addressed in seven and twelve of the LERs, respectively. In most instances, the problem was one of not mentioning or summarizing information that was available in the text. Cause and corrective action information should take precedence over safety assessment and reportability information if space is a problem. In addition, five abstracts had minor problems in the area of presentation; see the abstract comments in Appendix D.

Coded Fields Deficiencies and Observations

A minor deficiency (the titles are generally good) in the area of coded fields involves the titles, Item (4). Three titles failed to include adequate cause information, two failed to include an adequate result of the event and four failed to indicate the link between the cause and the result. While the result is considered to be the most important part of the title, cause and link information (as suggested in NUREG-1022, Supplement No. 2) must be included to make a title complete. Example titles are presented in Appendix D for many of the LERs that were considered to have poor titles.

SUMMARY

Table 3 provides a summary of the areas that need improvement for the Clinton 1 LERs. For additional and more specific information concerning deficiencies, the reader should refer to the information presented in Appendices C and D. General guidance concerning requirements can be found in NUREG-1022, and NUREG-1022 Supplements No. 1 and 2.

As was mentioned earlier, this is the first time that the Clinton 1 LERs have been evaluated using the same methodology; their scores are very good for a first-time evaluation. Clinton 1's overall average LER score (9.2) is well above the current industry overall average of 8.5. (Note: The industry overall average is the result of averaging the latest overall average LER score for each unit/station that has been evaluated using this methodology.)

TABLE 3. AREAS MOST NEEDING IMPROVEMENT FOR CLINTON 1 LERS

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Areas	Comments		
Manufacturer and model number	Component identification information should be included in the text whenever a component fails. In addition, (although not specifically required by the current regulation) it would be helpful to identify a component if its design is suspected of contributing to the event.		
Safety train unavailability	Sufficient dates and times should be included in the text to enable the reader to determine the length of time that safety system trains or components were out of service.		
EIIS codes	EIIS codes should be provided in the text for each component or system referred to in the text.		
Abstracts	Cause and corrective action information from the text should be summarized in the abstract.		
Coded Fields			
a. Titles	Titles should include cause and result information and the link between them in each title.		

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REFERENCES

- Office for Analysis and Evaluation of Operational Data, <u>Licensee Event</u> <u>Report System</u>, NUREG-1022, U.S. Nuclear Regulatory Commission, September 1983.
- Office for Analysis and Evaluation of Operational Data, <u>Licensee Event</u> <u>Report System</u>, NUREG-1022 Supplement No. 1, U.S. Nuclear Regulatory Commission, February 1984.
- Office for Analysis and Evaluation of Operational Data, <u>Licensee Event</u> <u>Report System</u>, NUREG-1022 Supplement No. 2, U.S. Nuclear Regulatory Commission, September 1985.

APPENDIX A

LER SAMPLE SELECTION INFORMATION FOR CLINION 1

Sample Number	LER Number	Comments
l	86-005-00	
2	86-010-00	SCRAM
3	86-016-01	
4	86-019-01	ESF
5	86-020-00	ESF
6	86-021-00	ESF
7	86-024-00	ESF
8	87-001-01	ESF
9	87-003-00	ESF
10	87-014-00	ESF
11	87-015-00	
12	87-017-00	SCRAM
13	87-025-00	SCRAM
14	87-029-00	SCRAM
15	87-033-00	

TABLE A-1. LER SAMPLE SELECTION FOR CLINTON 1

APPENDIX B

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EVALUATION SCORES OF INDIVIDUAL LERS FOR CLINION 1 TABLE B-1. EVALUATION SCORES OF INDIVIDUAL LERS FOR CLINTON 1

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			LER S	Sample Nu	mber			
	1	2	З	4	5	6	7	8
Text	9.6	9.5	9.6	9.1	9.5	9.5	9.6	9.3
Abstract	9.4	9.5	8.5	9.5	9.8	9.2	9.0	9.0
Coded Fields	9.8	10.0	9.5	9.0	9.5	9.5	9.0	10.0
Overall	9.5	9.6	9.2	9.2	9.6	9.4	9.4	9.3
**********			LER S	ample Nur	a mber			
	9	10	11	12	13	14	15	Average
Text	8.5	9.9	9.1	9.8	8.3	8.3	8.8	9.2
Abstract	8.7	8.0	8.8	9.5	8.3	7.5	8.5	8.9
Coded Fields	9.8	9.5	10.0	10.0	9.7	9.5	10.0	9.7
Overall	8.7	9.3	9.1	9.7	8.4	8.2	8.8	9.2
a. See Append	dix A f	or a lis	t of the	correspo	onding Li	ER numbe	rs.	

APPENDIX C

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DEFICIENCY AND OBSERVATION COUNTS FOR CLINION 1 TABLE C-1. TEXT DEFICIENCIES AND OBSERVATIONS FOR CLINTON 1

	Number of LERs with Deficiencies and Observations			
Description of Deficiencies and Observations	Sub-paragraph Totals ^a	Paragraph Totals () ^b		
50.73(b)(2)(ii)(A)Plant operating conditions before the event were not included or were inadequate.		3 (15)		
50.73(b)(2)(ii)(B)Discussion of the status of the structures, components, or systems that were inoperable at the start of the event and that contributed to the event was not included or was inadequate.		0(6)		
50.73(b)(2)(ii)(C)Failure to include sufficient date and/or time information.		5 (15)		
 a. Date information was insufficient. b. Time information was insufficient. 	1 4			
50.73(b)(2)(ii)(D)The root and/or intermediate cause of the component or system failure was not included or was inadequate.		3 (15)		
a. Cause of component failure was not	2			
 b. Cause of system failure was not included or was inadequate. 	1			
50.73(b)(2)(ii)(E)The failure mode, mechanism (immediate cause), and/or effect (consequence) for each failed component was not included or was inadequate.		0(6)		
 a. Failure mode was not included or was inadequate. b. Mechanism (immediate cause) was not included or was inadequate. 				

c. Effect (consequence) was not included or was inadequate.

TABLE C-1. (continued)

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	Number of Deficie Obser	LERs with ncies and vations
Description of Deficiencies and Observations	Sub-paragraph Totals [®]	Paragraph Totals () ^b
50.73(b)(2)(ii)(F)The Energy Industry Identification System component function identifier for each component or system was not included.		11 (15)
50.73(b)(2)(11)(G)For a failure of a component with multiple functions, a list of systems or secondary functions which were also affected was not included or was inadequate.		(0)
50.73(b)(2)(ii)(H)For a failure that rendered a train of a safety system inoperable, the estimate of elapsed time from the time of the failure until the train was returned to service was not included.		3 (3)
50.73(b)(2)(ii)(I)The method of discovery of each component failure, system failure, personnel error, or procedural error was not included or was inadequate.		1 (15)
a. Method of discovery for each component failure was not included	0	
 b. Method of discovery for each system failure was not included or was inadequate 	0	
c. Method of discovery for each personnel error was not included or	1	
 Method of discovery for each procedural error was not included or was inadequate. 	0	

	Number of LERs with Deficiencies and Observations	
Description of Deficiencies and Observations	Sub-paragraph Totals [®]	Paragraph Totals () ^b
50.73(b)(2)(ii)(J)(1)-Operator actions that affected the course of the event including operator errors and/or procedural deficiencies were not included or were inadequate.		0(3)
50.73(b)(2)(ii)(J)(2)The discussion of each personnel error was not included or was inadequate.		2 (8)
a. OBSERVATION: A personnel error was implied by the text, but was not	0	
 b. <u>50.73(b)(2)(ii)(J)(2)(i)</u>Discussion as to whether the personnel error was cognitive or procedural was not included or was inadequate 	0	
c. $50.73(b)(2)(ii)(J)(2)(ii)$ Discussion as to whether the personnel error was contrary to an approved procedure, was a direct result of an error in an	0	
approved procedure, or was associated with an activity or task that was not covered by an approved procedure was not included or was inadequate		
d. <u>50.73(b)(2)(ii)(J)(2)(iii)</u> Discussion of any unusual characteristics of the work location (e.g., heat, noise) that directly contributed to the personnel error was not included or was inadequate	0	
e. <u>50.73(b)(2)(ii)(J)(2)(iv)</u> Discussion of the type of personnel involved (i.e. contractor personnel, utility licensed operator, utility nonlicensed operator, other utility personnel) was not included or was inadequate.	2	

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	Number of LERs with Deficiencies and Observations		
Description of Deficiencies and Observations	Sub-paragraph 	Paragraph Totals () ^b	
$\frac{50.73(b)(2)(ii)(K)}{\text{safety system responses were not included or were inadequate.}}$		0 (11)	
50.73(b)(2)(ii)(L)The manufacturer and/or model number of each failed component was not included or was inadequate.		3 (6)	
50.73(b)(3)An assessment of the safety consequences and implications of the event was not included or was inadequate.		3 (15)	
a. DBSERVATION: The availability of other systems or components capable of mitigating the consequences of the event was not discussed. If no other systems or components were available, the text should state that none	0		
 b. OBSERVATION: The consequences of the event had it occurred under more severe conditions were not discussed. If the event occurred under what were considered the most severe conditions, the text should so state. 	0		
50.73(b)(4)A discussion of any corrective actions planned as a result of the event including those to reduce the probability of similar events occurring in the future was not included or was inadequate.		4 (15)	

	Number of LERs with Deficiencies and Observations			
Description of Deficiencies and Observations	Sub-paragraph Totals ^a	Paragraph Totals () ^b		
a. A discussion of actions required to correct the problem (e.g., return the component or system to an operational condition or correct the personnel error) was not included or was inadequate.	0			
b. A discussion of actions required to reduce the probability of recurrence of the problem or similar event (correct the root cause) was not included or was inadequate	2			
c. OBSERVATION: A discussion of actions required to prevent similar failures in similar and/or other systems (e.g., correct the faulty part in all components with the same manufacturer and model number) was not included or was inadequate.	0			
50.73(b)(5)Information concerning previous similar events was not included or was		0 (15)		

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TABLE C-1. (continued)

inadequate.

TABLE C-1. (continued)

		Number of LERs with Deficiencies and Observations			
Descr	iption of Deficiencies and Observations	Sub-paragraph Totals ^a	Paragraph Totals () ^b		
50.73 inade	(b)(2)(i)Text presentation quacies.		1 (15)		
a.	OBSERVATION: A diagram would have aided in understanding the text discussion	0			
b.	Text contained undefined acronyms	0			
c.	The text contains other specific deficiencies relating to the readability.	1			

a. The "sub-paragraph total" is a tabulation of specific deficiencies or observations within certain requirements. Since an LER can have more than one deficiency for certain requirements, (e.g., an LER can be deficient in the area of both date and time information), the sub-paragraph totals do not necessarily add up to the paragraph total.

b. The "paragraph total" is the number of LERs that have one or more requirement deficiencies or observations. The number in parenthesis is the number of LERs for which the requirement was considered applicable.

TABLE C-2. ABSTRACT DEFICIENCIES AND OBSERVATIONS FOR CLINTON 1

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	Number of LERs with Deficiencies and Observations		
Description of Deficiencies and Observations	Sub-paragraph Totals ^a	Paragraph Totals () ^b	
A summary of occurrences (immediate cause and effect) was not included or was inadequate.		2 (15)	
A summary of plant, system, and/or personnel responses was not included or was inadequate.		0 (11)	
 a. Summary of plant responses was not included or was inadequate. b. Summary of system responses was not included or was inadequate. c. Summary of personnel responses was not included or was inadequate. 			
A summary of the root cause of the event was not included or was inadequate.		7 (15)	
A summary of the corrective actions taken or planned as a result of the event was not included or was inadequate.		12 (15)	

		Number of LERs with Deficiencies and Observations		
Descr	iption of Deficiencies and Observations	Sub-paragraph Totals ^a	Paragraph Totals () ^b	
Abstr	act presentation inadequacies.		6 (15)	
æ.	OBSERVATION: The abstract contains information not included in the text. The abstract is intended to be a summary of the text, therefore, the text should discuss all information summarized in the abstract.	3		
b.	The abstract was greater than 1400 spaces.	1		
с.	The abstract contains undefined acronyms and/or plant specific designators	0		
d.	The abstract contains other specific deficiencies (i.e., poor summarization, contradictions, etc.).	2		

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TABLE C-2. (continued)

a. The "sub-paragraph total" is a tabulation of specific deficiencies or observations within certain requirements. Since an LER can have more than one deficiency for certain requirements, the sub-paragraph totals do not necessarily add up to the paragraph total.

b. The "paragraph total" is the number of LERs that have one or more deficiency or observation. The number in parenthesis is the number of LERs for which a certain requirement was considered applicable.

C-8

TABLE C-3. CODED FIELDS DEFICIENCIES AND OBSERVATIONS FOR CLINTON 1

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		Number of LERs with Deficiencies and Observations		
Descr	ription of Deficiencies and Observations	Sub-paragraph Totals ^a	Paragraph Totals () ^b	
Facil	ity Name		0 (15)	
a. b. c.	Unit number was not included or incorrect. Name was not included or was incorrect. Additional unit numbers were included but not required.			
Docke	et Number was not included or was rect.		0 (15)	
Page incor	Number was not included or was rect.		0 (15)	
Title	was left blank or was inadequate.		8 (15)	
a.	Root cause was not given or was	3		
b.	Result (effect) was not given or	2		
с.	Link was not given or was inadequate.	4		
Event	Date		0 (15)	
a. b.	Date not included or was incorrect. Discovery date given instead of event date.			
LER N	umber was not included or was incorrect.		0 (15)	
Repor	t Date		1 (15)	
a. b.	Date not included. OBSERVATION: Report date was not within thirty days of event date (or discovery date if appropriate)	0 1		

TABLE C-3. (continued)

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	Number of LERs with Deficiencies and Observations			
Description of Deficiencies and Observations	Sub-paragraph Totals ^a	Paragraph <u>Totals (</u>) ^b		
Other Facilities information in field is inconsistent with text and/or abstract.		0 (15)		
Dperating Mode was not included or was inconsistent with text or abstract.		0 (15)		
Power level was not included or was inconsistent with text or abstract.		0 (15)		
Reporting Requirements		0 (15)		
 a. The reason for checking the "OTHER" requirement was not specified in the abstract and/or text. b. OBSERVATION: It may have been more appropriate to report the event under a different paragraph. c. OBSERVATION: It may have been appropriate to report this event under additional unchecked paragraph. 	an			
Licensee Contact		0 (15)		
 a. Field left blank. b. Position title was not included. c. Name was not included. d. Phone number was not included. 				
Coded Component Failure Information		0 (15)		
 a. One or more component failure sub-fields were left blank. b. Cause, system, and/or component code is inconsistent with text. c. Component failure field contains data when no component failure occurred. d. Component failure occurred but entire field left blank. 				

TABLE C-3. (continued)

	Number of LERs with Deficiencies and Observations		
Description of Deficiencies and Observations	Sub-paragraph Totals ^a	Paragraph Totals () ^b	
Suppiemental Report		0 (15)	
 a. Neither "Yes"/"No" block of the supplemental report field was checked. b. The block checked was inconsistent with the text. 			
Expected submission date information is inconsistent with the block checked in Item (14).		0 (15)	

a. The "sub-paragraph total" is a tabulation of specific deficiencies or observations within certain requirements. Since an LER can have more than one deficiency for certain requirements, the sub-paragraph totals do not necessarily add up to the paragraph total.

b. The "paragraph total" is the number of LERs that have one or more requirement deficiencies or observations. The number in parenthesis is the number of LERs for which a certain requirement was considered applicable.

APPENDIX D

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LER COMMENT SHEETS FOR CLINION 1

14

Section		Comments
1. LER Number:	86-	005-00
Scores: Text =	9.6	Abstract = 9.4 Coded Fields = 9.8 Overall = 9.5
Text	1.	$\frac{50.73(b)(2)(ii)(F)}{1}$ - The Energy Industry Identification System code for each component and/or system referred to in the text is not included.
	2.	50.73(b)(2)(ii)(I)More detail about the type of review (e.g., daily surveillance) would be helpful. In other words why was the review being done? This information was stated more clearly in the Abstract, but still doesn't indicate how often "routine" is.
Abstract	1.	50.73(b)(1)Summary of cause is vague. The abstract doesn't make it clear that the employee was negligent in performing his duties.
	2.	OBSERVATION: The abstract is intended to be a summary of the text; therefore, the text must include all information summarized in the abstract. This abstract contains information that was not included in the text. The abstract contains details not noted in the text [e.g., the times of the first missed fire watch and more detail about the review (see text comment 2)].
Coded Fields	1.	No comment.

D-1

Section		Comments
2. LER Number:	86~0	010-00
Scores: Text =	9.5	Abstract = 9.5 Coded Fields = 10.0 Overall = 9.6
Text	1.	$\frac{50.73(b)(2)(ii)(F)}{1 dentification System code for each component and/or system referred to in the text is not included.$
Abstract	1.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. The immediate corrective actions to temporarily defeat the MSL radiation detector channels is not mentioned.
Coded Fields	1.	No comment.

Section	-	Comments
3. LER Number	: 86-	016-01
Scores: Text	= 9.6	Abstract = 8.5 Coded Fields = 9.5 Overall = 9.2
Text	1.	How did new information become available (the information that prompted this revision)?
	2.	50.73(b)(2)(ii)(F)The Energy Industry Identification System code for each component and/or system referred to in the text is not included.
	3.	The use of "revision bars" in the margin is good.
Abstract	1.	50.73(b)(1)Summary of cause information is inadequate. The abstract says the entire Standby Gas Treatment System was removed from service while the text says Train B was removed from service.
	2.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. The revision to procedure CPS 3007.02 was not mentioned in the abstract.
Coded Fields	1	The title lacks some detail. A better title might be "Failure of Operator To Recognize Technical Specification (TS) Requirements Concerning LCDs Causes Violation of TS 3 0 4"

Section		Comilients		
4. LER Number	: 86-	019-01		
Scores: Text	= 9.1	Abstract = 9.5 Goded Fields = 9.0 Overall = 9.2		
Text	1.	50.73(b)(2)(ii)(A)A brief description of the operating mode was not included with each operating mode number referred to in the text.		
	2.	50.73(b)(2)(ii)(F)The Energy Industry Identification System code for each corponent and/or system referred to in the text is not included.		
	3.	50.73(b)(4)In the last paragraph of the <u>Corrective</u> Action Section a reference is made to "temporary modifications", but the text isn't clear what these modifications were.		
	4.	The text is not clear about how long the "B" ventilation system was in the High Radiation Mode. Did it remain in this mode as long as it was tripped downscale?		
Abstract	1.	50.73(b)(1) The corrective action summary has the same deficiency as the text (see text comment 4).		
	2.	The abstract contains greater than 1400 spaces. If space is needed or the abstract is too long, it is okay to eliminate the summary of the safety consequences and reportability.		
Coded Fields	1.	Item (4)Title: Result is inadequate and cause information is not included. A more appropriate title might be "Emergency Ventilation System Actuation from Spurious High Radiation Monitor Signal due to Improperly Sealed Electrical Box".		

D-4

Section		Comments
5. LER Number:	86-0	20-00
Scores: Text =	9.5	Abstract = 9.8 Coded Fields = 9.5 Overall = 9.6
Text	1.	50.73(b)(2)(ii)(F)The Energy Industry Identification System code for each component and/or system referred to in the text is not included.
Abstract	1.	No comment.
Coded Fields	1.	Item (4)Title: Cause (rust particulate in transmitter) is inadequate.

Section	No. of Concession	Comments
6. LER Number:	86-	021-00
Scores: Text =	9.5	Abstract = 9.2 Coded Fields = 9.5 Overall = 9.4
Text	1.	$\frac{50.73(b)(2)(ii)(F)}{1}$ The Energy Industry Identification System code for each component and/or system referred to in the text is not included.
	2.	$\frac{50.73(b)(2)(ii)(J)(2)(iv)}{experienced difficulty in reading the logic diagrams?}$
Abstract	1.	$\frac{50.73(b)(1)}{1}$ Summary of cause information is inadequate. None of the contributing factors were mentioned.
	2.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. There are too many corrective actions to summarize them all in the abstract but the aspects concerning personnel (i.e., the training and counseling could have been mentioned).
Coded Fields	1.	Item (4)Title: Link (while performing maintenance activity) is not included.

Section		Comments
7. LER Number:	86-0	024-00
Scores: Text =	9.6	Abstract = 9.0 Coded Fields = 9.0 Overall = 9.4
Text	1.	50.73(b)(2)(ii)(A)The term shutdown needs further explanation so the reader will know the plant condition (e.g., cold, hot, or refueling shutdown).
	2.	50.73(b)(2)(ii)(F)The Energy Industry Identification System code for each component and/or system referred to in the text is not included.
Abstmact	1.	50.73(0)(1)More summary of the corrective actions is needed. Space to do this could be made by eliminating the summary of the reportability and the safety assessment.
	2.	OBSERVATION: The abstract is intended to be a summary of the text; therefore, the text must include all information summarized in the abstract. This abstract contains information that was not included in the text. The initial plant conditions are described better in the abstract than in the text (see text comment 1).
Coded Fields	1.	Item (4)Title: Link (during maintenance activities) is not included.
	2.	Item (7)OBSERVATION: Report date is not within thirty days of event date (or discovery date if appropriate).

Section	Comments		
8. LER Number:	87-1	001-01	
Scores: Text =	9.3	Abstract = 9.0 Coded Fields = 10.0 Overall = 9.3	
Text	1.	$\frac{50.73(b)(2)(ii)(A)}{}$ Information concerning the plant operating conditions before the event is not included.	
	2.	50.73(b)(2)(ii)(F)The Energy Industry Identification System ('s for each component and/or system referred to in 1 text is not included.	
Abstract	1.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. The calibration checks of the level transmitters and the checks of other instruments with common sensing lines and power supplies are not mentioned.	
	2.	OBSERVATION: The abstract is intended to be a summary of the text; therefore, the text must include all information summarized in the abstract. This abstract contains information that was not included in the text. The plant operating conditions are not included in the text.	
Coded Fields	1.	No comment	

D-8

Section		Comments
9. LER Number	: 87-0	003-00
Scores: Text :	= 8.5	Abstract = 8.7 Coded Fields = 9.8 Overall = 9.7
Text	1.	50.73(b)(2)(ii)(D)The root and/or intermediate cause discussion concerning the broken pin is inadequate. Why was the pin broken? Was the second actuation also the result of placing the switch in the "unload" position?
	2.	50.73(b)(2)(ii)(F)The Energy Industry Identification System code for each component and/or system referred to in the text is not included.
	3.	50.73(b)(2)(ii)(L)Identification (e.g., manufacturer and model no.) of the failed component(s) discussed in the text is not included.
	4.	50.73(b)(3)Was the 0.1 ppm chlorine reading also the result of the broken pin? If not, what was the reason for the higher than normal reading?
Abstract	1.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. Those corrective actions designed to prevent recurrence (fix the problem) were not mentioned.
	2.	Additional space is available within the abstract field to provide more information but it was not utilized.
Coded Fields	1.	Item (4) The title does not indicate that the "high chlorine mode" is an Engineered Safety Feature.

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Section		Comments			
10. LER Number	r: 87.	-014-00			
Scores: Text =	= 9.9	Abstract = 8.0 Coded Fields = 9.5 Overall = 9.3			
Text	1.	50.73(b)(2)(ii)(C)When were the systems secured?			
Abstract	1.	50.73(b)(1)Summary of cause is inadequate. The fact that the technician failed to follow the procedure was not made clear.			
	2.	50.73(b)(1)Summary of corrective actions to prevent recurrence of this event are not included.			
	3.	If space is needed for the items discussed above the reportability and safety assessment summaries could be left out of the abstract.			
Coded Fields	1.	<u>Item (4)</u> Title: Link (while performing a calibration procedure) is not included. Since the title is already getting long some details in the title could be eliminated. For example, the title might read "High Pressure Core Spray Actuation during Calibration Procedure due to Technician's Error".			

Section		Comments
11. LER Num	iber: 87.	-015-00
Scores: Tex	t = 9.1	Abstract = 8.8 Coded Fields = 10.0 Overall = 9.1
Text	1.	50.73(b)(4)Discussion of corrective actions taken or planned is inadequate. Were the procedural deficiencies in the area of snubbers corrected? Since two more procedural deficiencies were identified from the "expanded sample" of audited surveillance procedures, could any other deficiencies have occurred that weren't audited?
Abstract	1.	50.73(b)(1)Summary of occurrences [immediate cause(s) and effects(s)] is not included for the snubber procedural deficiencies.
	2.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. The audit of other procedures is not mentioned. See also text comment number 1.
Coded Fields	1.	No comment.

Section	· ·····	Comments	
12. LER Numbe	er: 87	-017-00	
Scores: Text	= 9.8	Abstract = 9.5 Coded Fields = 10.0 Overall = 9.7	
Text	1.	50.73(b)(2)(ii)(C)The time 0410 is given twice in the text. Once for the "B Prime" operator actions while testing Division I and again for the start of the same surveillance for Division II. Are these times correct? If so, was it a different operator (other than "B Prime") that started the Division II surveillance?	
Abstract	1.	50.73(b)(1)Summary of cause information is inadequate. The abstract does not indicate that the cause is "believed" but not known for sure. The contributing factor (the already lit low pre_ure annuciator light) was not mentioned.	
	2.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. The fact that the setpoint drift problem will be resolved was not mentioned.	
Coded Fields	1.	No comments.	

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Sect		Comments
13. LEK Number	: 87.	-025-00
Scores: Text =	8.3	Abstract = 8.3 Coded Fields = 9.7 Overall = 8.4
Text	1.	$\frac{50.73(b)(2)(ii)(C)}{}$ A time/date is needed to indicate when the value was repaired and returned to service.
	2.	50.73(b)(2)(ii)(D)The root and/or intermediate cause discussion concerning the system leak is not included. The text isn't clear on what system leakage means in the <u>Cause of Event</u> section (i.e., the feedwater system or the hydraulic oil system).
	3.	50.73(b)(2)(ii)(F)The Energy Industry Identification System components codes for the pump and the pressure switch were not included.
	4.	50.73(b)(2)(ii)(L)Identification (e.g., manufacturer and model number) of the Hydraulic Control Unit is not included.
	5.	50.73(b)(3)Details are needed to show that the calculations in the Final Safety Analysis Report are bounding.
	6.	50.73(b)(4)What was done to prevent the system from leaking and, therefore, keep the pump from cycling? Without knowing details about the system leakage (see text comment 2), it isn't clear that the corrective actions taken will prevent recurrence.
	7.	Some ideas are not presented clearly (hard to follow) (see text comments 2 and 6).
Abstract	1.	50.73(b)(1)Summary of cause is inadecuate. The excessive cycling of the pump and the system leakage are not mentioned.
	2.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. The on-site inspection of the Hydraulic Control Unit by the vendor was not mentioned.
	3.	The reportability and safety assessment summaries could be eliminated to provide room for the items discussed above, if needed.
Coded Fields	1.	No comment.

D-13

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Section		Comments
14. LER Numbe	r: 87-	-029-00
Scores: Text	= 8.3	Abstract = 7.5 Coded Fields = 9.5 Overall = 8.2
Text	1.	50.73(b)(2)(ii)(C)When was FCV IFW004 returned to service?
	2.	50.73(b) (ii)(D) The root and/or intermediate cause discussion concerning solenoid valve and control circuit board failures is inadequate. Why were these components faulty?
	3.	50.73(b)(2)(ii)(F)The Energy Industry Identification System code for each component and/or system referred to in the text is not included.
	4.	50.73(b)(2)(ii)(H)A time estimate of the unavailability of the failed train/system is not included for the MDRFP train. See text comment 1.
	5.	50.73(b)(2)(ii)(L)Identification (e.g., manufacturer and model no.) of the failed component(s) discussed in the text is not included.
	6.	50.73(b)(4)A discussion of actions required to reduce the probability of recurrence (i.e, correction of the root cause) is inadequate. See text comment 2.
Abstract	1.	50.73(b)(1)Summary of occurrences [immediate cause(s) and effects(s)] is not included for the solenoid valve and control circuit board.
	2.	50.73(b)(1)Summary of cause of the solenoid value and circuit board failures is not included.
	3.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. Replacement of the failed components not included.
Coded Fields	1.	<u>Item (4)</u> Title: Cause (solenoid valve and circuit board failures) is vague.

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Section		Comments
15. LER Numbe	r: 87	-033-00
Scores: Text	= 8.8	Abstract = 8.5 Coded Fields = 10.0 Overall = 8.8
Text	1.	$\frac{50.73(b)(2)(ii)(C)}{}$ The times the LCO was entered and cleared were not included.
	2.	$\frac{50.73(b)(2)(ii)(J)(2)}{error/procedural deficiency is inadequate.}$
		50.73(b)(2)(ii)(J)(2)(iv)Discussion of the type of personnel involved (e.g., contractor personnel, utility licensed operator, utility nonlicensed operator, other utility personnel) is not included. Who (by type of personnel or organization) was responsible for the procedural deficiency?
	3.	50.73(b)(3)Discussion of the assessment of the safety consequences and implications of the event is inadequate. Are there any other systems (safeguards) to mitigate the consequences of the loss of the Turbine Stop Valve and Turbine Control Valve Fast closure scrams? Other than an operator noticing the problem, is there any other way (e.g., an alarm) that this problem would have been identified.
Abstract	1.	50.73(b)(1) Summary of cause information is inadequate. The fact that the procedure was a revision and that here was a problem concerning what revision is used was not mentioned.
	2.	50.73(b)(1)Summary of corrective actions taken or planned as a result of the event is inadequate. The corrective actions taken to prevent recurrence were not mentioned.
Coded Fields	1.	No comments.