



Commonwealth Edison

Dresden Nuclear Power Station

R.R. #1

Morris, Illinois 60450

Telephone 815/942-2920

March 30, 1992

CWS LTR #92-165

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Licensee Event Report 92-09, Docket 050237 is being submitted as required
by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73(a)(2)(i)(B).

L. F. Gerner for 3/31/92

Charles W. Schroeder
Station Manager
Dresden Nuclear Power Station

CWS/cfq

Enclosure

cc: A. Bert Davis, Regional Administrator, Region III
NRC Resident Inspector's Office
File/NRC
File/Numerical

(ZDVR/524)

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Dresden Nuclear Power Station, Unit 2	Docket Number (2) 0 5 10 10 10 2 13 17	Page (3) 1 of 0 4
Title (4) Unit 2/3 Reactor Building Vent Exhaust Iodine Sampling Discrepancy Due to Procedure Deficiency		

Event Date (5)			LER Number (6)				Report Date (7)			Other Facilities Involved (8)	
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)	
0	3	1 2 9 2	9 2	0 0 19	0 0	0	3	3 0 9 2	Dresden Unit 3	0 5 10 10 10 2 4 19	

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)				
POWER LEVEL (10) 0 9 6	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)	
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)	
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> Other (Specify	
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	<input type="checkbox"/> in Abstract	
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	<input type="checkbox"/> below and in	
	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	<input type="checkbox"/> Text)	

LICENSEE CONTACT FOR THIS LER (12)	
Name Keith A. Whittum Lead Chemist	TELEPHONE NUMBER AREA CODE 8 1 5 9 4 2 Ext. 2637 -2 19 2 10

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)	Expected Submission Date (15)	Month Day Year
<input checked="" type="checkbox"/> Yes (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> X NO	

ABSTRACT (Limit to 1400 spaces, i.e, approximately fifteen single-space typewritten lines) (16)

At 1500 hours on March 12, 1992 while Unit 2 was operating at 96% power and Unit 3 was in cold shutdown, the Health Physics Department discovered a Unit 2/3 Reactor Building Ventilation (RBV) Exhaust iodine sampling discrepancy while preparing a routine effluent report. It was found that the RBV sample point had not been continuously monitored for Iodine for a seven hour and 50 minute period on February 11, 1992. Investigation found that the combined sampler had been inoperable during this period and the individual RBV samplers had been operating as required; however, the charcoal cartridges required for iodine analysis had been inadvertently discarded because the technician involved was unaware that the individual samplers were to be used to satisfy Technical Specification requirements during this period. The root cause was attributed to procedure deficiency. Corrective actions included enhancements to appropriate sampling/analysis procedures. The safety significance of this event was minimal because particulate analyses from the individual samplers were normal and there was no indication of increased refuel floor or primary containment radiation levels during this period. The RBV exhaust duct is also equipped with automatic isolation on increasing radiation levels. A previous event involving an unrelated sampling deficiency was reported by LER 89-17/050237.

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TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2527 Mwt rated core thermal power

Nuclear Tracking System (NTS) tracking code numbers are identified in the text as (XXX-XXX-XX-XXXXX)

EVENT IDENTIFICATION:

Unit 2/3 Reactor Building Ventilation (RBV) [VA] Exhaust Iodine Sampling Discrepancy Due to Procedure Deficiency

A. CONDITIONS PRIOR TO EVENT:

Unit(s): 2(3) Event Date: March 12, 1992 Event Time: 1500 Hours
 Reactor Mode(s): N(N) Mode Name(s): Run(Shutdown) Power Level(s): 96 (0)%
 Reactor Coolant System (RCS) Pressure(s): 995(0) psig

B. DESCRIPTION OF EVENT:

At 1500 hours on March 12, 1992, with Unit 2 operating at 96% power and Unit 3 in cold shutdown, the Health Physics Department discovered a Unit 2/3 RBV exhaust Iodine sampling discrepancy while preparing a routine effluent report. It was discovered that the RBV exhaust had not been continuously monitored for Iodine for a seven hour and 50 minute period on February 11, 1992, contrary to Technical Specification Table 4.8.1.b. Investigation concluded that the combined RBV sampler [IL] in the Unit 2/3 RBV Separate Particulate Iodine Noble Gas (SPING) Monitor, which is normally utilized for this purpose, had been inoperable during this period because of modification work in progress on its power supply, 480V Motor Control Center 38-3 [ED]. While the combined sampler was inoperable, the individual Unit RBV samplers [IL] were operated for the purpose of obtaining the required samples. However, the technician analyzing the individual RBV samples discarded the charcoal cartridges without completing an Iodine analysis (as is the normal practice) because he was unaware that the individual samplers were being used to satisfy Technical Specification requirements.

C. APPARENT CAUSE OF EVENT:

This report is submitted in accordance with 10CFR50.73(a)(2)(i)(B), which requires the reporting of any condition prohibited by the Technical Specifications.

Investigation concluded that the root cause of this event was procedure deficiency. Dresden Chemistry Procedure (DCP) 1700-08, Particulate and Iodine Filter Change for the SPING Monitors, Dresden Chemistry Surveillance (DCS) 6210-02, B1 - Tuesday Surveillance Checklist, and DCS 6270-02, CR - Tuesday Surveillance Checklist, provided inadequate guidance concerning control of the samples when alternate sample points were being utilized. As such, the technician was unaware that the individual RBV samples needed Iodine analysis in this case.

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D. SAFETY ANALYSIS OF EVENT:

The particulate analysis results from the individual RBV samplers were normal and there was no indication on the Continuous Air Monitors [IL] of increasing radiation levels in the primary containments or refuel floor during the period in question. Additionally, the RBV exhaust ducts are equipped with radiation monitors which would have automatically isolated the RBV system, and started the Standby Gas Treatment System [BH] upon significant increase in radiation level. Therefore, this event had minimal safety significance.

E. CORRECTIVE ACTIONS:

Enhancements were implemented for procedures DCP 1700-08, DCS 6210-02, and DCS 6270-02 in order to prevent recurrence of this type of event. These enhancements formalized a local log of SPING operational data which is recorded at the time of sample collection, clarified the conditions that can result in the individual RBV samplers being utilized to meet Technical Specification requirements, and implemented a policy requiring Iodine analysis of all RBV sample points regardless of whether they are being used to satisfy Technical Specification requirements in order to provide redundant Iodine sample data.

F. PREVIOUS OCCURENCES:

LER/Docket Numbers Title

89-17/050237 Loss of Batch Waste Release Tank Composite Sample Due to Management Deficiency

In this event, the May 1989 Batch Waste Release Tank composite sample for Tritium and gross Alpha was inadvertently discarded before a sample aliquot could be sent off site for analysis. The following corrective actions were implemented regarding this event.

1. This event was reviewed with the personnel involved and is also included in the periodic tailgate meeting material to be reviewed with all Chemistry Department personnel (237-200-89-08801).
2. The Chemistry Department implemented a 28 day surveillance activity schedule and developed Chemistry Department Surveillance sheets to document all CT duties to be performed during the cycle (237-200-89-08802).
3. The Chemistry Department implemented procedures for the storage, handling, and shipping of the Batch Waste Release Tank composite samples. The procedures include shipping schedules as well as instruction for preparing the shipment and safeguards to ensure that the sample is not discarded prior to shipment. These sample requirements were added to the surveillance tracking program (237-200-89-08803).
4. The Chemistry Department implemented a dedicated storage area for samples requiring off-site analysis (237-200-89-08804).

LICENSE EVENT REPORT (LER) TEXT CONTINUATION

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- The Chemistry Department has also implemented a comprehensive upgrade of the entire sequence of Chemistry Surveillance Procedures (237-200-89-08805).

G. COMPONENT FAILURE DATA:

This section is not applicable.