Commonwealth Edison
Dresden Nuclear Power Station
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December 24, 1992

CWS LTR #92-770

U.S. Nuclear Regulatory Commission
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Licensee Event Report 92-040-00, Docket 0500237 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73(a)(2)(i).

L. F. Gerner for
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

310068

IE22
1/1

ZDVR/806

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1)	Docket Number (2)	Page (3)
Dresden Nuclear Power Station, Unit 2	0 5 0 0 0 2 3 7	1 of 0 5

Title (4)
Critical Date for Completion of DIS 0700-06 was Exceeded Due to Management 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)
									N/A	
1 1	3 0	9 2	9 2	0 4 0	0 0	1 2	2 8	9 2		0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)			
N	___ 20.402(b)	___ 20.405(c)	___ 50.73(a)(2)(iv)	___ 73.71(b)
POWER LEVEL (10) 0 7 6	___ 20.405(a)(1)(i)	___ 50.36(c)(1)	___ 50.73(a)(2)(v)	___ 73.71(c)
	___ 20.405(a)(1)(ii)	___ 50.36(c)(2)	___ 50.73(a)(2)(vii)	___ Other (Specify
	___ 20.405(a)(1)(iii)	X 50.73(a)(2)(i)	___ 50.73(a)(2)(viii)(A)	in Abstract
	___ 20.405(a)(1)(iv)	___ 50.73(a)(2)(ii)	___ 50.73(a)(2)(viii)(B)	below and in
	___ 20.405(a)(1)(v)	___ 50.73(a)(2)(iii)	___ 50.73(a)(2)(x)	Text)

LICENSEE CONTACT FOR THIS LER (12)

Name	TELEPHONE NUMBER
	AREA CODE
Kirk Robbins, I.M. Surveillance Coordinator Ext. 2314	8 1 5 9 4 2 - 2 9 2 0

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		Expected Submission Date (15)	Month	Day	Year
___ Yes (If yes, complete EXPECTED SUBMISSION DATE)	___ X NO				

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

On November 30, 1992, the Instrument Maintenance (IM) Surveillance Coordinator discovered that Dresden Instrument Surveillance (DIS) 0700-06, Average Power Range Monitor (APRM) [IG] Flow Biased Scram, Rod Block and Downscale Calibration, had not been completed prior to the critical date, November 29, 1992. The surveillance had been started during day shift November 25, 1992. Due to a significant revision to the procedure, the time required to complete this procedure had increased from approximately four hours to approximately forty hours. The cause of this event was management deficiency. Adequate measures were not in place to ensure proper communication of required due dates and critical dates to the First Line Supervisors and to communicate problems with assigned work to the Scheduling Group. The safety significance is minimal as the "1 out of 2 twice" RPS logic was maintained, meeting the requirements of Technical Specification Table 3.1.1. Corrective actions included placing the APRM channels not completed prior to 0000 November 30, 1992, in 'Bypass' until DIS 0700-06 had been completed. Long term corrective actions will include measures to improve communication between the Scheduling Group and the First Line Supervisors, and to identify expected increased procedure performance durations following procedure revision.

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:

On November 30, 1992, the Instrument Maintenance (IM) Surveillance Coordinator discovered that Dresden Instrument Surveillance (DIS) 0700-06, Average Power Range Monitor (APRM) Flow Biased Scram, Rod Block and Downscale Calibration, had not been completed prior to the critical date. A review of the General Surveillance System (GSRV) indicated that the critical date for completion of DIS 0700-06 was November 29, 1992. A review of the actual surveillance indicated that Channels 1,2,5 and 6 (four of six) were completed. At the time of the event, it was verified that APRM Channel 3 was assigned to Reactor Protection System (RPS) Channel A and APRM Channel 4 was assigned to RPS Channel B, and that no APRMs had been bypassed or taken Out-of-Service since 0000 November 30, 1992. Therefore, Unit 2 met the limiting condition for operation at all times.

A. Conditions Prior to Event:

Nuclear Unit: Dresden Unit 2 Event Date: November 30, 1992 Event Time: 0000 hours

Reactor Modes: N Mode Name: Run Power Level: 76%

Reactor Coolant System (RCS) Pressure: 994 psig

B. Description of Event

During the performance of Dresden Instrument Surveillance (DIS) 0700-06, Average Power Range Monitor (APRM) [IG] Flow Biased SCRAM, Rod Block and Downscale Calibration, it was discovered that the critical date for completing the surveillance had past. The General Surveillance System (GSRV) reported that DIS 0700-06 had a due date of November 22, 1992, and a critical date of November 29, 1992. DIS 0700-06 was a newly upgraded procedure which checked the entire APRM Loop, and was 38 pages in length. The previous revision did not address the calibration from this perspective and was 6 pages in length.

On November 20, 1992, the Instrument Maintenance Department (IMD) was scheduled to perform DIS 0700-6 during Shift 1. No work was performed on this job due to performing work assigned a higher priority. No comments were left on the Supervisor's turnover sheet to indicate the status of the surveillance. The surveillance was not carried over on the work schedule for Shift 2 or Shift 3. On November 21, 1992, DIS 0700-06 was scheduled for performance during Shift 1 on the opposite unit (Unit 3). The Supervisor's turnover sheet indicated that the surveillance had been stopped due to procedure problems and that a marked-up copy of the procedure had been left on the General Supervisor's desk for review.

On November 23, 1992, the IMD Department Surveillance Coordinator questioned the status of DIS 0700-06. The IMD Daily Scheduler informed him that the procedure was being revised with an expected approval date of November 24, 1992, and that the surveillance would be scheduled following approval. DIS 0700-06 completed the Dresden On-Site Review (DOSR) process and was approved November 24, 1992. On November 25, 1992, DIS 0700-06 was scheduled for performance during Shift 2 on Unit 2. Work was commenced on APRM Channel 1. Due to the increased procedure length and the newness of the revision, the duration required for the first channel was 8 hours. The surveillance was continued on Shift 3. APRM Channel 5 was then completed.

Due to the Thanksgiving Holiday, Thursday, November 26, 1992, continuation of the surveillance did not occur until Shift 2, November 27, 1992. DIS 0700-06 was performed on APRM Channel 2. The recorder failed the calibration. The Operations Shift Supervisor was informed, Nuclear Work Request (NWR) D14388 was written to repair and calibrate the recorder, and the recorder was entered into the Degraded Equipment Log. On November 28, 1992, DIS 0700-06 was performed on APRM Channel 6. This recorder also failed the calibration. The Operations Shift Supervisor was informed, NWR D14426 was written to repair and calibrate the recorder, and the recorder was entered into the Degraded Equipment Log. The required critical date was incorrectly indicated on the turnover sheet as the due date. Interviews with the First Line Supervisors and workers involved indicate that they were unaware of the approaching critical date. As a result, Control Room personnel were not informed. The turnover sheet indicated that the work was to be continued.

On November 30,1992, the IMD Surveillance Coordinator was informed that the job was still in progress. At 0830, the Station Control Room Engineer and the Operating Engineer for Unit 2 were informed that the critical date , November 29, 1992, for DIS 0700-06 had past and the surveillance was not complete. APRM Channels 3 and 4 were placed in 'Bypass' until the surveillance could be completed on them. A review of the Operator's log indicated that no APRM channels were bypassed after 2400 November 29, 1992.

C. Apparent Cause of the Event

This event is being reported in accordance with Title 10 of the Code of Federal Regulations Part 50 Section 73(a)(2)(i)(b), which requires the reporting of any operation or condition prohibited by the plant's Technical Specifications.

The root cause of this event is management deficiency. There were no administrative controls in place to communicate the surveillance due dates to the First Line Supervisors. Existing procedures and practices were not adequate to ensure that all Technical Specification surveillance requirements were met in this case.

A contributing cause to this deficiency was attributed to the failure to recognize the significant increase in time required for completion of the newly approved procedure. In the past, this surveillance had been completed entirely in one four-hour period. Following the procedure upgrade, it required approximately forty hours. This increased duration was not recognized by the Scheduling Group nor the First Line Supervisors.

D. Safety Significance

Prior to this event, DIS 0700-06 had been completed monthly as required by Technical Specification Table 4.2.1. At the time the surveillance went past its critical date, APRM Channels 1,2,5, and 6 were completed. Although the recorders for APRM Channels 2 and 6 failed the calibration, they provide no trip functions are not required for Post-Accident Monitoring. Therefore, the recorders were placed in the Degraded Equipment Log and Channels 1,2,5, and 6 were considered operable. A review of the Operator's Log was conducted and it was determined that the required RPS logic of "1 out of 2 twice" was met throughout the event.

Due to the fact that the Technical Specification requirements for APRM Instrumentation were satisfied throughout this event, the safety significance of this event is minimal.

E. Corrective Actions:

Immediate corrective actions involved verifying that APRM Channels 1,2,5, and 6 had been completed and that the instrument trips were within specification. APRM channels 3 and 4 were placed in 'Bypass' until the calibration for these channels was complete.

The Instrument Maintenance Department has begin using the turnover sheets generated by Project 2 which includes surveillance due dates and critical dates.

The Instrument Maintenance Procedure Writers will identify expected durations required to complete a surveillance if the changes made during a revision or upgrade to the procedure are extensive. A Department Memo detailing this expectation will be issued by 1/7/93 (NTS 237-180-92-39601).

This event will be tailgated to the Instrument Maintenance Department with emphasis on communicating unexpected occurrences during any assigned work tasks. This will be complete by 1/7/93 (NTS 237-180-92-39602).

F. Previous Occurrences:

LER/Docket Numbers	Title
91-002-00/0500249	Violation of Primary Containment Post Accident Monitor Surveillance Interval Due to Management Deficiency

On May 6, 1991, it was discovered that DIS 2400-05, Post Accident Containment Hydrogen/Oxygen Analyzer had exceeded its critical date due to management deficiency. Corrective actions included a revision to Dresden Administrative Procedures to include notification of the Department Head of past due surveillances.

G. Component Failure Data

No equipment failures were involved in this event; therefor, this section is not applicable.