Commonwealth Edison
Dresden Nuclear Power Station
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Morris, Illinois 60450
Telephone 815/942-2920

September 27, 1994

EDELTR 94-0029

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

Licensee Event Report 94-019-01, Docket 50-237 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10CFR50.73(a)(2)(i).

Sincerely,

E. D. Eenigenburg
Unit 2 Station Manager
Dresden Station

EDE/GP:cfq

Enclosure

cc: J. Martin, Regional Administrator, Region III
NRC Resident Inspector's Office
File/NRC
File/Numerical

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NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Dresden Nuclear Power Station, Units 2 and 3	05000237	1 OF 5

TITLE (4)
2/3 Chimney Grab Sample Not Obtained Within Required Time Frame Due to Personnel Error

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 NAME	DOCKET NUMBER
06	30	94	94	-- 019 --	01	09	26	94	Unit 3	05000249
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	N
POWER LEVEL (10)	100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.2201(b)		20.2203(a)(3)(i)		50.73(a)(2)(iii)		73.71(b)
	20.2203(a)(1)		20.2203(a)(3)(ii)		50.73(a)(2)(iv)		73.71(c)
	20.2203(a)(2)(i)		20.2203(a)(4)		50.73(a)(2)(v)		OTHER
	20.2203(a)(2)(ii)		50.36(c)(1)		50.73(a)(2)(vii)		(Specify in Abstract below and in Text, NRC Form 366A)
	20.2203(a)(2)(iii)		50.36(c)(2)		50.73(a)(2)(viii)(A)		
	20.2203(a)(2)(iv)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(B)		
	20.2203(a)(2)(v)		50.73(a)(2)(ii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Greg Petrovic, Operations Staff Ext. 3691	(815) 942-2920

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 15 single-spaced typewritten lines) (16)

When the 2/3 Chimney Noble Gas Monitor (SPING) is inoperable, a grab sample must be pulled every 8 hours using the backup General Electric sample system. Failure to pull this sample is a violation of Tech Spec Table 3.2.5. On 6/30/94, the Chemistry Technician failed to obtain a required sample from the 2/3 Chimney. The sample was obtained and analyzed by a Chemistry Technician on the following shift. The sample results were within the specified limits for radioactivity.

EVENT IDENTIFICATION:

2/3 Chimney Grab Sample Not Obtained Within Required Time Frame Due to Personnel Error

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 2 (3) Event Date: 6/30/94 Event Time: 0900

Reactor Mode: N (N) Mode Name: Run (Refuel) Power Level: 100% (0%)

Reactor Coolant System Pressure: 1000 psig (0 psig)

B. DESCRIPTION OF EVENT:

On 6/30/94 the 2/3 Chimney Noble Gas Monitor (SPING) was inoperable. In this situation, a grab sample must be pulled from the 2/3 Chimney using the General Electric sample system, which is a backup to the SPING. This sample must be pulled once per 8 hour shift. Failure to pull this sample is a violation of Tech Spec Table 3.2.5, "Radioactive Gaseous Effluent Monitoring Instrumentation".

A 2/3 Chimney grab sample was required to be pulled before 0530 on 6/30/94. The Chemistry Technician on Shift 1 of 6/30/94 was informed of the sample requirement through a written turnover which he received from the technician on the previous shift.

Prior to the beginning of his sample collection rounds the Shift 1 Chemistry Technician contacted the Shift Control Room Engineer (SCRE) to confirm the status of the Service Water Radiation Monitor that was inoperable requiring a sample to be pulled. No other required samples were discussed at this time. The Shift 1 SCRE did not mention the required 2/3 Chimney SPING sample due to the fact that during his turnover with the Shift 3 SCRE he was told that a discussion with the Shift 3 Chemistry Technician regarding the sampling requirements with the 2/3 Chimney SPING inoperable had taken place and that Chemistry understood their responsibilities. Also, the Out of Service causing the 2/3 Chimney SPING to be inoperable was ready to be cleared early on Shift 1, thus rendering the sample unnecessary.

At approximately 0100 on 6/30/94, the 2/3 Chimney SPING was back in service and ready to be made operational. The Shift 1 SCRE contacted the Shift 1 Chemistry Technician to have the 2/3 Chimney SPING reset and returned to operable status. The Chemistry Technician stated that he was not qualified to reset the 2/3 Chimney SPING and that the cognizant Health Physicist would have to be contacted. The Health Physicist was contacted by the SCRE and it was determined that he would have to come in to perform this evolution. The SCRE discussed this with the Shift Engineer and it was decided that the Health Physicist could do this first thing in the morning when he came in for his regular shift.

At approximately 0300 on 6/30/94, The Shift 1 SCRE received sample results for the inoperable Service Water Radiation Monitor from the Shift 1 Chemistry Technician. No other samples were discussed during this conversation.

At 0900 on 6/30/94, the Chemistry Supervisor could not find the sample results from the 2/3 Chimney. The Chemistry Supervisor telephoned the Shift 1 Chemistry Technician at home and asked him if he had pulled the sample. When it was confirmed that the sample had not been pulled as required, the Chemistry Supervisor directed a Shift 2 Chemistry Technician to pull the 2/3 Chimney sample.

The 2/3 Chimney gas sample was obtained at 0937 on 6/30/94. The sample was analyzed at 0945 on 6/30/94. The sample results were within specification.

C. CAUSE OF EVENT:

This report is being submitted in accordance with 10CFR50.73(a)(2)(i)(B) which requires the reporting of any operation or condition prohibited by the plant's Technical Specifications within 30 days of the event.

The root cause of the missed sample was inattention to detail by the Shift 1 Chemistry Technician. The technician missed an instruction on his shift turnover sheet which directed him to pull a grab sample from the 2/3 Chimney because the SPING was out of service.

A contributing factor to the missed sample was the fact that the Shift 1 SCRE did not mention the required 2/3 Chimney SPING sample during the conversations that occurred with the Shift 1 Chemistry Technician at 0100 and 0300 on 6/30/94 due to the mind sets that he had developed at the beginning of his shift which were that the Shift 1 Chemistry Technician was aware of the required sample and that the 2/3 Chimney SPING was to be returned to operable status early on Shift 1 rendering the sample unnecessary.

The previous corrective action for a missed chemistry sample was a computerized tracking program for surveillances generated by Technical Specification LCO conditions. A personal computer was installed in the Control Room that generated an alarm when required samples were to be taken to meet Tech Spec requirements as a back up to the Chemistry Department. In July 1993, due to continuing problems encountered with the computer program causing it to be ineffective, a decision was made to discontinue its use. At that time an oversight occurred by Operations Personnel to research this for any commitments and therefore it was not identified that the computer program was a corrective action to an LER two years previous, and thus a commitment to the NRC.

In place of the computer program it was decided to utilize the LCO Log as implemented by DAP 07-05, Operating Logs and Records. In conjunction with DAP 07-02, Conduct of Shift Operations, the LCO Log would be reviewed each shift as part of their shift turnovers by the Shift Engineer and the Shift Supervisors - Licensed. Also, Appendix A, Unit 2(3) Operator's Daily Surveillance Log, contains a Shift Supervisor sign off each shift for a review of the LCO Log. The Station believes that this constitutes an adequate tracking program for TECH SPEC LCO generated surveillances. (The last required sample due to a TECH SPEC LCO that was missed and not recognized by Operations Personnel was August 6, 1992.)

D. SAFETY ANALYSIS:

The failure to pull the 2/3 Chimney grab sample was a violation of Tech Spec Table 3.2.5, "Radioactive Gaseous Effluent Monitoring Instrumentation". The activity measured in the sample taken previous to the missed sample was less than the lower limit of detection of the laboratory instrumentation. The activity measured in the sample taken subsequent to the missed sample was also less than the lower limit of detection of the laboratory instrumentation. Based on these two samples, it is believed that there was no increase in the radioactivity of the 2/3 Chimney gas during the period of the missed sample.

E. CORRECTIVE ACTIONS:

After determining the 2/3 Chimney sample had not been pulled as required, the Chemistry Foreman immediately directed a Chemistry Technician to pull the sample. The last occurrence of a missed chemistry sample was over two years ago, and it is believed that this was an isolated incident.

Chemistry Management met with the technician and reviewed the event. The technician recognized where his error was made and acknowledged the need for future improvement. The importance of good communication, complete turnover between shifts, and attention to detail were emphasized to the technician. The event was discussed with all of the chemistry technicians in a department meeting. Chemistry technicians are encouraged to make special indication on their turnover sheets when extra or out of normal sampling is required.

Previous corrective actions to use a computer program and alarm system to track Tech Spec LCO generated surveillances were not effective, and the equipment was removed from the control room in July 1993. We did not properly identify the computer program as a commitment and notify the NRC when the decision was made to remove the system.

Operations Personnel recognized and acknowledged their error. They will be counseled as to their responsibilities related to Tech Spec LCO generated surveillances in accordance with DAP 07-05, "Operating Logs and Records", DAP 07-02, "Conduct of Shift Operations", and Appendix A, "Unit 2(3) Operator's Daily Surveillance Log". Operations personnel will also be counseled as to their responsibilities related to commitment identification when any existing program is not performing its intended function, or prior to changing any existing program, to allow for commitment modification where necessary.

F. PREVIOUS OCCURRENCES:

LER/Docket Numbers		Title
91-003	050237	River discharge composite sample for 9/2/91 to 10/3/91 not sent to vendor for analysis of Gross alpha, Fe-55, Sr-89, and Sr-90.
92-009	050237	Reactor Bldg Vent SPING missed iodine sample, surveillance with SPING inoperable, due to procedure deficiency.

92-018	050249	Service Water Grab Sample not analyzed within required time frame.
92-027	050237	Failure to Sample Reactor Water Due to Tech Spec Misinterpretation.

G. COMPONENT FAILURE DATA:

N/A