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, Unit 2	05000237	1 OF 5

TITLE (4)
Significant Weakness of Administrative Control of Radioactive Material Identified Due to Radioactive Material Being Found Outside the Protected Area

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
04	11	95	95	-- 012 --	02	02	29	96	Dresden Unit 3	0500249
									Dresden Unit 1	0500010

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)					
POWER LEVEL (10)	000	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)
Jeffrey Place Ext. 3568	(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)

The Supplement (Revision 2) is being submitted to update the scope of corrective actions for the event based on a self-assessment. The original LER was submitted pursuant to the requirements of 10CFR50.73(a)(2)(i)(B) and Technical Specification 6.11.1. While performing an investigation of Radioactive Material found outside the Radiologically Posted Area, the investigative team was notified that a contaminated item was found in the Training Building on April 11, 1995, at approximately 1100 hours. Upon investigation, a total of fourteen contaminated items were identified outside the fence. This is indicative of a weakness of administrative control of contaminated material. The root cause for this event is a general lack of respect for radiation at the station. The causal factors are inadequate performance by RP Technicians in their work practices, poor worker accountability by First Line Supervision, and a lack of commitment for program implementation. The immediate corrective actions for this event were to control the material and perform detailed surveys of the protected and owner controlled areas. The safety significance for this event is considered minimal due to the low level of contamination found on the items.

EVENT IDENTIFICATION:

Significant Weakness of Administrative Control of Radioactive Material Identified Due to Radioactive Material Found Outside the Protected Area

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 2 (3) Event Date: 04/11/95 Event Time: 1100

Reactor Mode: N (N) Mode Name: Run (Run) Power Level: 100% (44%)

Reactor Coolant System Pressure: 1000 (932) psig

B. DESCRIPTION OF EVENT:

While performing an investigation into Radioactive Material (RAM) found outside the Radiologically Posted Area (RPA), the investigation team was notified by training personnel that a contaminated item was found in the Training Building. The Training Building is located outside the protected area. Radiation Protection (RP) personnel were dispatched to control the contaminated item and perform a detailed survey of the building. A total of eight contaminated items were identified in this search. Six additional items were identified upon expansion of the investigation to cover additional areas outside the fence. This is indicative of a weakness of administrative control of contaminated material at the Station.

There were twenty-eight events concerning the control of radioactive material documented during 1993; there were thirty-eight events documented concerning the control of radioactive material during 1994; and seven events, including this investigation, have been documented during 1995.

The initial investigation for RAM outside the RPA was initiated when contaminated oil filters were found in the clean garbage building. This investigation included an immediate action of a detailed survey of the protected and owner controlled areas. RPTs and supervisors from other ComEd sites participated in this action. This investigation identified 465 contaminated items outside the RPA, all of these instances were within the protected area fence except for the 14 items described above. A comprehensive check of 100 items in the Storeroom that had been previously tagged for unconditional release was also performed; this identified no problems.

C. CAUSE OF EVENT:

The Supplement (revision 2) being submitted to update the scope of corrective actions. The original LER was submitted pursuant to the requirements of 10CFR50.73(a)(2)(i)(B), any operation or condition prohibited by the Plant's Technical Specification(Technical Specification 6.11.1). The root cause for this event is a general lack of respect for radiation at the station. The causal factors are inadequate performance by RP Technicians in their work practices, poor worker accountability by First Line Supervision, and a lack of commitment for program implementation. It should be noted that 63% of the problem items may be attributed to less than ideal background conditions existing at the location of survey. These items were found to have direct contamination in the 1-2K dpm/100cm^2 range.

D. SAFETY ANALYSIS:

The safety consequence for this event is considered minimal due to the low levels of contamination found on the items. The majority of all items identified outside the RPA were also found to contain low levels of contamination. The safety significance of the levels of contamination is minimal. The number of contaminated items found is a significant issue for the Station and aggressive actions were taken promptly to correct these deficiencies, including a site lockdown and comprehensive survey. The site lockdown involved strict administrative controls to prevent cross contamination of previously released areas.

E. CORRECTIVE ACTIONS:

The immediate corrective actions for this event were to; 1) Control the material and properly secure the items, 2) Perform a detailed survey of the protected and owner controlled areas. The number of contaminated items found is a significant issue for the Station and aggressive actions were taken promptly to correct these deficiencies. These actions included a site lockdown and comprehensive survey of the protected and owner controlled areas. The site lockdown involved strict administrative controls to prevent cross contamination of previously released areas. This lockdown remained in place until surveys and immediate corrective actions were implemented.

Revision 2 to this report includes an update of the self-assessment performed in action number four of the original corrective actions. At the end of ninety days a self-assessment was performed and it was deemed that since many of the corrective actions had not been implemented, or had enough time to be effective, another self-assessment would be performed in six months. As a result of the self-assessment done at the end of this period it was determined that the corrective actions were poorly implemented thus making them ineffective. Some of the actions did not address the root cause and would not have prevented recurrence. In addition there was a lack of aggressiveness to implement some actions. To correct this problem there is now a single point of contact that has the support from senior management to ensure ownership and accountability over all actions. A committee of workers has also been established to provide input and support in solving this problem. Based on the self-assessment

identifying that the corrective actions did not prevent recurrence, additional different corrective actions will be taken.

A summary of the corrective actions based on the results of the investigation follow:

1. RP Management and cross-sectional discipline teams will benchmark other plants for information and ways to better control contaminated materials. (NTS# 237-180-95-01200S01)

2. Established Unconditional Release Criteria ≤ 100 cpm background through revision 2 of DRP 6020-03.(Ref. NTS# 237-180-95-01200S02)

3. Established an oil processing process for equipment use and controls for operations originating out of the Oil Processing Building through procedure change to DOP 0010-06. (Ref. NTS# 237-180-95-012000S03)

4. Based on two self-assesments, one within 90 days of completing the investigation and one perfomed during January 1996, it was determined that the original set of corrective actions did not prevent recurrence of uncontrolled radioactive material. A summary of the additional corrective actions based on the self-assessment follows (NTS# 237-180-95-01200S04):

4.1 Implement a color coding and control program for tools and equipment. The color coding process should enhance the worker and Radiation Protection Technician awareness of the contamination status of the tools and equipment. (NTS# 237-180-95-01200S09)

4.2 Lockdown the outside radiologically posted areas (RPA) to require a radiation protection escort to open the doors or have a RP Supervisor give permission to enter the areas. This will be evaluated after three months to determine if the practice should continue. (NTS# 237-180-95-01200S10)

4.3 Standardize the methods for releasing tools and materials. Provide clear guidance on the differences between the tool monitor and friskers and when each should be used. (NTS# 237-180-95-012000S11)

4.4 Perform a clean sweep survey of the site to identify additional uncontrolled items. (NTS# 237-180-95-01200S12)

4.5 Provide increased ComEd oversight of the contractors especially at release points. (NTS #: 237-180-95-01200S13)

4.6 A long term self-assessment schedule will be developed and placed into the nuclear tracking system or created as a surveillance. (NTS# 237-180-95-0120S14)

5. Initiated a procedure change to DRP 6020-03 (Revision 3) to address the concerns of the original Level II team for PIR 237-200-95-15500 concerning the Unconditional Release program. (Ref. NTS #: 237-180-95-01200S05)

6. RP Policy Memorandum PER-01 was written to address a quality verification process for technician unconditional releases. (Ref. NTS# 237-180-95-01200S06)

7. Established and began implementation of an action plan to reduce the number of outside RPAs. The number of outside RPAs has been reduced to a practical level. A list of authorized RPAs was established. disposal of materials is in accordance with the plan provisions. The plan is considered as a living document which may be subject to change as operational conditions evolve.
(Ref. NTS# 237-180-95-01200S07)

8. Results of this investigation have been presented to station employees during 1995 Nuclear General Employee Training. The results of this Level II investigation have been scheduled for inclusion into departmental continuing training. This departmental training is scheduled for completion during the 1996 training cycle.
(NTS# 237-180-95-01200S08)

F. PREVIOUS OCCURRENCES:

A review of recent LERs indicate this is the first LER although several previous non-reportable events were identified.

G. COMPONENT FAILURE DATA:

NONE.