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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On 3/23/97, while reviewing previous shifts log book entries, a Nuclear Station Operator recognized that DOS 0040-09, Unit 3 Operating Power Sources and Distribution, was not being performed every 8 hours while the Unit 3 Diesel Generator was declared inoperable, as required by Technical Specification 3.9.A.2.a. The Operating Surveillance was immediately performed to bring the station in compliance with the Tech Spec requirement, along with performance of the surveillance at a conservative frequency of every subsequent 6 hours to assure compliance. The primary cause of the event was determined to be human error, with a contributing cause in the methodology utilized by Operations to track existing active LCOs and Tech Spec action statements. As a result of the event, Operations will implement the shift turnover requirement for each Unit Supervisor to reference the original Tech Spec or DATR document for each active LCO, assuring that the supervisor clearly understands Tech Spec/DATR LCO, verifying that the appropriate LCO actions are being taken.

This event is reportable per 10CFR50.73(a)(2)(i)(B), operation prohibited by Technical Specifications.

NRC FORM 366A (5-92) U.S. NUCLEAR REGULATORY COMMISSION APPROVED BY ONB 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) TEXT CONTINUATION FACILITY NAME (1) DOCKET NUMBER (2) LER NUMBER (6) PAGE (3) SEQUENTIAL REVISION Dresden Nuclear Power Station, YFAR NUMBER NUMBER 2 OF 5 Unit 3 05000249 97 002 00 TEXT (If more space is required, use additional copies of NRC Form 366A) (17) PLANT AND SYSTEM IDENTIFICATION General Electric - boiling water reactor - 2527 MWt rated core thermal power. Energy Industry Identification System (EIIS) codes are identified in the text as [XX] and are obtained from IEEE Standard 805-1984, IEEE Recommended Practice for System Identification in Nuclear Power Plants and Related Facilities. EVENT IDENTIFICATION: Licensed Operators Fail to Perform Tech Spec LCO Required Surveillance due to Programmatic Failure in Task Methodology and Human Error. PLANT CONDITIONS PRIOR TO EVENT: Α. Unit: 3 Event Date: March 22, 1997 Event Time: 1140 Reactor Mode: 1 Mode Name: Run Mode Power Level: 063 Reactor Coolant System Pressure: 1000 psia B.1. DESCRIPTION OF EVENT: This event is reportable pursuant to 10CFR50.73(a)(2)(i)(B), which requires the reporting of any operation prohibited by Technical Specifications. On Friday 3/21/97, Operations performed a pre-task review, in preparation for the Unit 3 Diesel Generator [EK] endurance run. The Diesel Generator run was scheduled for the day shift of 3/22/97 and required the associated Diesel Generator to perform over a 24 hour period. The Unit 3 NSO made arrangements with the appropriate support groups to assure their availability to support the test. On 3/22/97, Operations performed a review of Appendix X, Technical Specification Action Statement Initiated Surveillances, to assure that no additional LCOs

would be entered when the Diesel Generator was declared inoperable for the performance of the surveillance. Operations discovered that the Unit 3 WR Torus level indicator repair was not yet completed and would place Unit 3 on a 48 hour LCO once the Unit 3 Diesel Generator became inoperable for the testing. Instrument Maintenance was contacted to assure that the repair of the Torus level indicator and subsequent closure of the work package would occur prior to the scheduled testing time.

At 1100 on 3/22/97, repairs to the WR Torus level indicator were complete and Operations exited the appropriate Technical Specification. Preparation began for the U3 Diesel Generator run, including performance of the HLA briefing.

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At 1140, Technical Specification 3.9 was entered for Unit 3 Diesel Generator being declared inoperable for the performance of the Diesel Generator endurance run. DOS 0040-09, Unit 3 Operating Power Sources and Distribution (Attachment 1 and 2), and Appendix X for the Diesel Generator inoperability were initiated and completed within the 1 hour Technical Specification requirement. At approximately 1150 hours, the Unit 3 Unit Supervisor performed a post-task review of the Technical Specifications for Diesel Generator inoperability and proceeded to enter the LCO log in the computer and the Shift Manager Log. The computer based LCO log entry stated the appropriate start time for the LCO, the appropriate numeric LCO action statement, but only stated the performance of DOS 0040-09 was completed within the required hour. No reference was made regarding the requirement for performance of the DOS every subsequent 8 hours, as required by the Tech Specs.

The afternoon and midnight shifts reviewed the active Technical Specification LCOs as part of their oncoming turnover activities, but utilized the computer LCO log for the performance of this task rather than the actual Technical Specification and Dresden Administrative Technical Specification (DATR) documents. With this computerized log failing to contain the full Tech Spec action statement, specifically the subsequent 8 hour surveillance requirement, the subsequent Operating Teams failed to recognize and perform the required Diesel Generator LCO actions.

This condition continued until approximately 1800 hours on 3/23/97, when during shift turnover activities a Nuclear Station Operator discovered that the once per 8 hour surveillance checks for Technical Specification 3.9.A.2.a were not performed. Operations took immediate corrective measures by performing DOS 0040-09 immediately and corrected the computer based LCO entry to reflect the 8 hour requirement.

### B.2. ADDITIONAL PROBLEM IDENTIFIED

During mid 1996, the Site Quality Verification (SQV) Audit Group identified that an adverse trend in non-consequential Tech Spec and DATR events was evident. Though non-consequential, Operations recognized the significance of this trend, and through the performance of a Root Cause investigation identified the factors causing the events. Corrective measures were implemented and an effectiveness review of those measures performed. The effectiveness review concluded that Operations performance was better, evident by the reduction in events over the succeeding 4 months, but a few low level performance events were found.

As a result of this event, Operations performed a review of the station events database which identified that few overall events, yet these few events all resulted in reportable Licensee Event Reports (and are listed in the Previous Occurrences section of this report). With the numerous actions which had been implemented in the past, the Operations Root Cause Team was not confident that they understood why errors were continuing and additionally identified that their failure contributed to this event.

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### C. CAUSE OF EVENT:

The primary cause for this event was a personnel performance error (NRC Cause Code A) by the Unit Supervisor by electronically logging that the initial electrical lineup was to be completed within one hour after declaring the U3 Diesel Generator inoperable, but failing to enter the subsequent 8 hour requirement into the Technical Specification LCO computer log.

A Contributing Cause was determined to be programmatic failure in the methodology for performance of the LCO log reviews (NRC Cause Code E). Unit Supervisors routinely review the active LCOs as part of their shiftly turnover activities, which was being accomplished by viewing the electronic LCO log, including the action statements entered at the time of the LCO entry. These entries are subject to error or inaccurate action statement content, as was evident during this event. This programmatic failure was also found to extend to the performance of LCO reviews by Shift Managers, who utilize the Dresden Station Plant Risk Report rather that the actual DATR and Tech Spec documents for performance of this review.

A second Contributing Cause is a failure of the Operating Root Cause Team to effectively correct the Operating Department's cyclic performance in the area of Tech Spec and DATR compliance.

# D. SAFETY ANALYSIS:

During the period where Control Room personnel failed to perform the Technical Specification required surveillance, panel walkdowns performed by Operations continued to monitor component performance, including breaker alignment for Unit 2 and 3 safety related busses. This action monitored the same components listed in DOS 0040-09 and resulted in no breaker abnormalities noted. A computer trend was performed for the same time span, resulting in identifying no bus voltages decreasing to less than the action statement acceptance criteria. As a result, it was concluded that the required parameters in DOS 0040-09 were being monitored and remained within the station acceptance criteria for the duration of the Technical Specification non-compliance. As a result, this event had minimal effect on plant or public safety.

### E. CORRECTIVE ACTIONS:

- 1. Operations Management will provide clarification on the accepted methodology for performance of shift turnover active LCO reviews. This activity now requires that the task be performed using the actual DATR or Tech Spec document, not the computerized LCO log. (2491809700201)
- 2. The Unit Supervisor was counseled regarding his inadequate electronic LCO log entry and has created an action plan for improving his overall job performance. His finalized plan was presented to Operations Management for approval. This event was documented in his personnel file in accordance with the approved station methodology. (Completed)

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- 3. The Unit Supervisor will revise the appropriate DAPs for shift turnover requirements, clarifying the acceptable methodology for task performance. (2491809700202)
- 4. Initiate a Trend PIF on the topic of Human Error in the performance of Tech Spec and DATR compliance, citing that we recognize that our performance is cyclic and perform a Team Root Cause investigation. (2491809700203)

## . PREVIOUS OCCURRENCES:

LER/Docket Number Title

96-010/05000237 Tritium Analysis Requirement Exceeded Due to Chemistry Management Personnel Error

96-003/05000249 Non-Routine Sample Time Requirement Exceeded Due to Chemistry Technician Personnel Error

96-007/05000249 Failure to Perform Surveillance During Unit Shutdown Due to Personnel Error Concerning Poor Communications

97-004/05000237 Channel Checks for ATWS Level and Pressure Instruments Performed at Incorrect Frequency due to Personnel Error during the Procedure Review Cycle.

These events was reviewed for applicability and was found to differ in the failure mechanism, human performance error vs. programmatic deficiency in task performance. As a result, the corrective actions were focused on personnel performance improvement and would not have prevented this type of programmatic failure.

COMPONENT FAILURE DATA:

None.

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