

NRC FORM 366 (5-92)			U.S. NUCLEAR REGULATORY COMMISSION			APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95				
LICENSEE EVENT REPORT (LER)										
FACILITY NAME (1) Dresden Nuclear Power Station, Unit 2						DOCKET NUMBER (2) 05000237		PAGE (3) 1 OF 4		
TITLE (4) Operations fails to enter Drywell Radiation Monitor LCO due to inadequate Pre-job surveillance review.										
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
08	21	97	97	-- 015 --	00	09	15	97	None	None
OPERATING MODE (9)		1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
POWER LEVEL (10)		099	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: Scott Mathis, Trends Analyst Supervisor Ext. 2171								Phone: (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)		
YES (If yes, complete EXPECTED SUBMISSION DATE).					X	NO				
								MONTH	DAY	YEAR

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

On August 21, 1997, Operations performed a pre-task review of DIS 1600-16, Drywell High Radiation Monitor Group 2 Isolation Functional and Calibration Tests, identifying the need to enter Technical Specification (TS) 3.2.F., Accident Monitoring, during task performance. As a result of an inadequate review, Operations failed to identify that TS 3.2.A., Isolation Actuation, would need to be entered concurrently. After completion of the surveillance review, Operations granted approval for performance of DIS 1600-16. As Instrument Maintenance (IM) began calibration of the 2A Drywell High Radiation Monitor, Operations made a TS LCO entry under TS 3.2.F, missing the concurrent TS 3.2.A LCO. Later that day, IM suspended performance of the calibration. The following day, a new Operating Team performed a review of DIS 1600-16 in preparation for IMD to recommence performance of Radiation Monitor calibration, recognizing the previous failure to enter all appropriate TS LCOs. The cause of the event was determined to be error by the Unit Supervisor, who failed to perform an adequate pre-task review of DIS 1600-16, resulting in the failure to enter TS 3.2.A. Corrective actions include counseling of the individuals, review of all surveillances with a frequency of quarterly or greater to ensure Tech Specs for infrequently performed surveillances are pre-identified, and establishing an "apart in time" review process for Tech Spec surveillance LCO reviews to assure accuracy and independence of the review.

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NRC FORM 366A (5-92)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95	
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION				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.	
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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 Recommendation Practice for System Identification in Nuclear Power Plants and Related Facilities.

EVENT IDENTIFICATION:

Operations fails to enter Drywell Radiation Monitor LCO due to inadequate Pre-job surveillance review.

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 2 Event Date: August 21, 1997 Event Time: 1011
Reactor Mode: 1 Mode Name: Run Power Level: 99%
Reactor Coolant System Pressure: 1000 psig

B. 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 August 19, 1997, the Shift Schedule Planner met with the Unit 2 Unit Supervisor (Licensed Senior Reactor Operator) to perform a pre-task review of DIS 1600-16, Drywell High Radiation Monitor Group 2 Isolation Functional and Calibration Test, in addition to assessment of the contingency plan created for the test. The contingency plan addressed Technical Specification (TS) section 3.2.F., Accident Monitoring, and included actions to take should the Drywell Rad monitor fail to meet the surveillance Acceptance Criteria. The pre-task review failed to identify TS 3.2.A., Isolation Actuation.

At 0845 on August 21, 1997, Instrument Maintenance requested authorization to begin performance of DIS 1600-16, Drywell High Radiation Monitor Group 2 Isolation Functional and Calibration Test. The Unit 2 Unit Supervisor delayed start of this surveillance due to high volume of work in progress on the shift, which included a reactivity change (power ascension) through Control Rod manipulations. During this time, the Unit 2 Unit Supervisor reviewed the surveillance and associated contingency plan. The Unit Supervisor, having performed the surveillance review two days earlier, had the mindset that only one LCO entry would be required. The Unit 2 Unit Supervisor approached the Unit 3 Unit Supervisor (Licensed Senior Reactor Operator), requesting a peer check for the TS LCO entry, who concurred with the LCO entry into TS 3.2.F. and its corresponding 72 hour time limit. The Unit 3 Unit Supervisor's review was limited to concurrence with the identified LCO and lacked independence in LCO determination. With rod movement concluded, the Unit 2 Unit Supervisor notified the Shift Manager of the LCO entry into 3.2.F., authorized the Instrument Maintenance Department to start DIS 1600-16, and logged the surveillance start in the Unit 2 Unit Supervisor's log.

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At 1011, Instrument Maintenance began performance of DIS 1600-16, but failed to complete the surveillance by the end of the shift. The 2A Drywell Radiation Monitor was left in a normal, available, but inoperable condition, and work was suspended for the day. Unit 2 remained in the LCO since performance of full calibration was not yet complete.

On August 22, 1997, the oncoming Unit 2 Unit Supervisor discovered Technical Specification 3.2.A. was not entered for degradation of the Group 2 Isolation Actuation logic while the monitor was inoperable. The day shift Operating Team instructed IMD to place the 2A Drywell Radiation Monitor into an operable condition. This required finishing a section of DIS 1600-16 and verifying acceptance criteria met. The Drywell Radiation Monitor was then declared operable. As a result of the missed Technical Specification LCO entry, the involved Operators were temporarily removed from shift pending completion of the investigation.

C. CAUSE OF EVENT:

The primary cause for this event was a cognitive personnel performance error (NRC Cause Code A) by the Unit Supervisor by not performing an adequate review of DIS 1600-16 and subsequently not entering Technical Specification 3.2.A. The Unit 2 Unit Supervisor failed to utilize all available resources in his decision process as a result of exhibiting a high level of confidence during task performance. His performance was beneath Operations Standards and resulted in a shortcut during the review process.

A Contributing Cause was determined to be programmatic failure in the methodology for performance of peer checking and review of LCO's. (NRC Cause Code E). The Unit Supervisor's review (peer check) of LCO's does not always entail an entire process review to determine if all LCO's have been identified for a given surveillance, but instead, is usually limited to concurrence that identified LCOs are correct.

D. SAFETY ANALYSIS:

During the period where Control Room personnel failed to enter the Technical Specification for the degraded isolation function, Operations awareness of the degraded condition was increased. Also during this time period, the 2B Drywell Radiation Monitor remained operable. Operations personnel continuously monitor their panels, with no load changes occurring during this time. If plant conditions would have changed, 2B would have alerted them. A review of Drywell Radiation was performed for the period of noncompliance resulting in observing no change in radiation levels, assuring that the isolation function was never challenged during this period. As a result, this event had minimal effect on plant or public safety.

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E. CORRECTIVE ACTIONS:

1. The Unit Supervisors involved understand their responsibility to adequately self check their actions, the requirement for procedural review, and understand how their actions resulted in non-compliance to the Technical Specifications. Operations has taken the appropriate disciplinary actions in accordance with station policy. (Complete)
2. Shift Managers held discussions with the members of their teams to discuss recent events and how Operations Standards were not upheld. (Complete)
3. Operations will pre-review all surveillances with a frequency of quarterly or longer to ensure Tech Spec and DATR LCOs are pre-identified. (2371809701501)
4. Operations will establish a process where surveillances are reviewed for Tech Spec and DATR LCOs, starting from the E-5 work week. This review will be performed by the Operating Team responsible for the work execution week. Additionally, Operations will implement "apart in time" independent surveillance reviews, from which a comparison will be performed to assure the accuracy of the reviews. This action will replace the peer check methodology currently in place which only assures that the identified Tech Specs are correct, and fails to challenge whether all applicable Tech Specs have been identified. (2371809701502)

F. PREVIOUS OCCURRENCES:

<u>LER/Docket Number</u>	<u>Title</u>
97-002/05000249	Licensed Operators Fail to Perform Tech Spec LCO Required Surveillance Due to Programmatic Failure in Task Methodology and Human Error.

The corrective actions from this event identified an inadequate work practice, where Supervisor's were relying on computer made LCO entries to determine future actions on subsequent operating shifts, instead of utilizing the original documents (TS's or DATR's). The corrective actions included changing the methodology to require usage of the original document for active LCO reviews. This action was effective in increasing accuracy of the LCO reviews, but failed to correct the pre-task review process to assure independence.

G. COMPONENT FAILURE DATA:

None.