

LICENSEE EVENT REPORT (LER)

Facility Name (1) Dresden Nuclear Power Station, Unit 2 Docket Number (2) 0 | 5 | 0 | 0 | 0 | 2 | 3 | 7 Page (3) 1 | of | 0 | 4

Title (4) Failure to Obtain Grab Sample of Unit 2/3 Chimney Effluent 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 Names		Docket Number(s)															
0	9	0	8	17	8	7	0	2	5	0	0	1	0	0	1	8	7	Dresden Unit 3	0	5	0	0	0	2	4	9
													N/A	0	5	0	0	0	1	1						

OPERATING MODE (9) N THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

POWER LEVEL (10) 0   9   5	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> Other (Specify in Abstract below and in Text)
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name: Anthony Anandappa, Technical Staff Engineer (X-529) TELEPHONE NUMBER: AREA CODE 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) Yes (If yes, complete EXPECTED SUBMISSION DATE) X | NO

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

With Unit 2 at 95% power and Unit 3 shut down for Feedwater System modifications, the low, medium, and high range Separate, Particulate, Iodine, and Noble Gas (SPING) 2/3 chimney monitor was out of service for calibration/repair. This required that 2/3 chimney noble gas grab samples be taken once per shift in accordance with Technical Specification Table 3.2.5. However, the afternoon shift grab sample was not taken on September 3, 1987, due to personnel error on the part of the Radiation-Chemistry Foreman on duty in that a Radiation-Chemistry Technician was not adequately informed of the need to perform this task. The Foreman involved was specifically counselled on performance expectations in the area of job assignments and proper follow-up.

The safety significance of this event was minimal since the General Electric chimney monitoring system was in service during this period, allowing particulate, iodine, and low range noble gas monitoring at all times. A previous event involving failure to complete the grab sample requirement is reported by LER #86-25 on Docket #050237.

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**LICENSEE EVENT REPORT (LER) TEXT CONTINUATION**

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TEXT

**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].

**EVENT IDENTIFICATION:**

Failure to obtain grab sample of Unit 2/3 chimney effluent due to personnel error.

**A. PLANT CONDITIONS PRIOR TO EVENT:**

Dresden Unit(s): 2/3                      Event Date: 9/3/87                      Event Time: 1700 hours  
 Reactor Mode(s): N                      Mode(s) Name: Run/Shutdown                      Power Level(s): 95%/0  
 Reactor Coolant System (RCS) Pressure(s): 1005 psig/0 psig

**B. DESCRIPTION OF Event:**

With Unit 2 at 95% rated thermal power and Unit 3 shut down for Feedwater System modifications, the low, medium, and high range Separate, Particulate, Iodine, and Noble Gas (SPING) 2/3 chimney monitor [IL] was out of service for calibration/repair. This required that 2/3 chimney noble gas grab samples be taken once per shift in accordance with Technical Specification Table 3.2.5. However, the afternoon shift grab sample was not taken on September 3, 1987, due to personnel error on the part of the Radiation-Chemistry Foreman on duty in that a Radiation-Chemistry Technician was not adequately informed of the need to perform this task.

At the beginning of the day shift on September 4, 1987, a Chemist discovered that grab sample results had not been entered for 1700 hours on September 3, 1987. He notified the Radiation-Chemistry General Foreman. An investigative team was then assembled at the request of the Station Manager.

**C. APPARENT CAUSE OF EVENT:**

This report is submitted in accordance with 10 CFR 50.73(a)(2)(i)(B), which requires the reporting of any operation or condition prohibited by the plant's Technical Specifications. The root cause of the event was failure of the afternoon shift Radiation-Chemistry Foreman to request the afternoon shift Radiation-Chemistry Technician to obtain the grab sample, and inadequate shift turnover communications between Radiation-Chemistry Foremen and Technicians regarding the need to perform this task. A lighted red sign in the Radiation-Chemistry Office area was in operation and annotated to remind personnel of the grab sample requirement.

Contributing factors to this error were numerous activities requiring attention of the Radiation-Chemistry Foreman. Additionally, the Radiation-Chemistry Foreman Log contained no mention of the grab sample requirement for this shift.

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TEXT

**D. SAFETY ANALYSIS OF EVENT:**

The safety significance of the event was minimal because the General Electric (GE) monitoring system was in service allowing particulate, iodine, and low range noble gas monitoring at all times. The pre-event and post-event samples were both well within the allowable ranges.

**E. CORRECTIVE ACTIONS:**

To prevent a similar event from occurring, the following corrective actions have been initiated:

1. A memo was issued to all Radiation-Chemistry and Laboratory Foremen by the Radiation-Chemistry Supervisor providing direction on what is expected in terms of ensuring assignments are communicated to workers and then followed up on to ensure completion.
2. Improved shift turnover requirements between oncoming and offgoing Radiation-Chemistry personnel have been initiated. A turnover sheet will be included as part of routine shift turnover. A memo from the Radiation-Chemistry Supervisor has been issued to the Radiation-Chemistry Technicians outlining these shift turnover expectations.
3. The Radiation-Chemistry Foreman on the afternoon shift on September 3, 1987 was specifically counselled on performance expectations in the area of job assignments and proper follow-up.
4. The above mentioned memos and summary of the event was included in a recent Radiation-Chemistry Department tailgate session.
5. The purpose of having the red backlighted reminder signs will be reviewed with the Radiation-Chemistry personnel by the Radiation-Chemistry Supervisor.
6. This event will be reviewed with all station personnel in an upcoming tailgate session.

**F. PREVIOUS EVENTS:**

1. Reportable Event No. 87-020 under Docket #050237 dated 6/9/87.

The SPING sampler had been in a potentially degraded condition during the period between June 2, 1987 and June 8, 1987. A damaged filter paper during installation was the cause of the event. As a corrective action a new tougher nylon type filter is now being used.

2. Reportable Event No. 87-24 on Docket #050237 dated May 18, 1987.

This event concerned the failure of the SPING sampler due to water intrusion. As corrective action a review of Technical Specification requirements and previous events was conducted with all Radiation-Chemistry Technicians. Also, additional training on the SPING system was provided to licensed and non-licensed Operations personnel attending the rotating training schedule.

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TEXT

- Reportable Event No. 86-25 on Docket #050237 dated November 26, 1986.

This event also involved a failure to properly perform the 2/3 chimney grab sample as required with the 2/3 chimney SPING out of service. However, in this case a grab sample was taken but the results were invalid due to improper sampling techniques. Corrective action included training of appropriate personnel regarding proper sampling techniques as required by the Technical Specifications.

**G. COMPONENT FAILURE DATA:**

N/A



**Commonwealth Edison**  
Dresden Nuclear Power Station  
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Telephone 815/942-2920

October 1, 1987

EDE LTR #87-652

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

Licensee Event Report #87-025-0, Docket #050237 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73(a)(2)(i)(B).

E.D. Eenigenburg  
Station Manager  
Dresden Nuclear Power Station

EDE/kjl

Enclosure

cc: A. Bert Davis, Regional Administrator, Region III  
File/NRC  
File/Numerical

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