Commonwealth Edison
Zion Generating Station
101 Shiloh Blvd.
Zion, Illinois 60099
Telephone 312/746-2084

November 29, 1989

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

Dear Sir:

The enclosed Licensee Event Report number 89-010-00, Docket No. 50-304/DPR-48 from Zion Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.73(a)(2)(i)(B), which requires a 30 day written report when any operation or condition occurs that is prohibited by the plant's Technical Specifications.

Very truly yours,

W. R. Kunz

for T. P. Joyce
Station Manager
Zion Generating Station

TPJ/PG/nd

Enclosure: Licensee Event Report

cc: NRC Region III Administrator
NRC Resident Inspector
INPO Record Center
CECo Distribution List

IE22
1/1

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1)	Docket Number (2)	Page (3)
Zion Unit 2	0 5 0 0 0 3 0 4	1 of 0 3

Title (4)

Steam Generator Blowdown Sample Missed Surveillance 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)
											N/A	
1 0	3 0	8 9	8 9	---	0 1 0	---	0 0	1 1	2 9	8 9		

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)			
1	___ 20.402(b)	___ 20.405(c)	___ 50.73(a)(2)(iv)	___ 73.71(b)
POWER LEVEL (10) 0 9 9	___ 20.405(a)(1)(i)	___ 50.36(c)(1)	___ 50.73(a)(2)(v)	___ 73.71(c)
	___ 20.405(a)(1)(ii)	___ 50.36(c)(2)	___ 50.73(a)(2)(vii)	___ Other (Specify in Abstract below and in Text)
	___ 20.405(a)(1)(iii)	X 50.73(a)(2)(i)	___ 50.73(a)(2)(viii)(A)	
	___ 20.405(a)(1)(iv)	___ 50.73(a)(2)(ii)	___ 50.73(a)(2)(viii)(B)	
	___ 20.405(a)(1)(v)	___ 50.73(a)(2)(iii)	___ 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name	TELEPHONE NUMBER
Paul Geddes LER Coordinator ext. 201	AREA CODE 7 0 8 7 4 6 - 2 0 8 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	
				N							

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 fifteen single-space typewritten lines) (16)

Unit 2 was in Mode 1 at 99% power. The Mechanical Maintenance Department had Work Requests to work on two Steam Generator (S/G) Blowdown System Valves. The Out Of Service (OOS) was written and brought to the Control Room for review and approval. The Shift Control Room Engineer (SCRE) and the Shift Engineer provided the review and approval at approximately 0230 on 10/30/89. This OOS isolated S/G blowdown monitor R-19, rendering it inoperable. When this monitor is inoperable, shiftly grab samples of the S/Gs are required. The isolation of the Radiation Monitor was not discovered until the Chemistry Department was unable to pull the daily S/G leak rate sample at approximately 1500. Work was expedited, and the OOS was cleared at approximately 2200 on 10/30/89. The required samples were taken at that time. The S/G blowdown grab samples for the 0700 - 1500 shift were missed.

The cause of the event was personnel error in that the SCRE and Shift Engineer failed to recognize that the OOS would isolate R-19. CAUTION plaques will be added to various locally operated and Main Control Board operated valves to help prevent future occurrences.

There was no safety significance as there were two operable redundant radiation monitoring systems to detect S/G tube leakage.

A. CONDITION PRIOR TO EVENT

MODE 1 - Power RX Power 99% RCS [AB] Temperature/ Pressure 559 °F/2235 psig

B. DESCRIPTION OF EVENT

Unit 2 was at 99% power. The Mechanical Maintenance Department had Work Requests to work on two Steam Generators (S/G) Blowdown system valves. The Out Of Service (OOS) was written and brought to the Control Room for review and approval. The Shift Control Room Engineer (SCRE) and the Shift Engineer provided the review and approval at approximately 0230 on 10/30/89. The shift review did not catch the fact that this OOS isolated S/G blowdown monitor R-19, rendering it inoperable. When this monitor is inoperable, shiftly grab samples of the S/Gs are required. The isolation of the Radiation Monitor was not discovered until the Chemistry Department was unable to pull the daily S/G leak rate sample at approximately 1500. When the Chemist reported this fact to the Control Room, a review of the OOS was conducted, and the isolation of the Radiation Monitor was discovered. Maintenance expedited their work, completing only one valve. The OOS was cleared at approximately 2200 on 10/30/89. The required samples were taken at that time. The S/G blowdown grab samples for the 0700 - 1500 shift were missed.

C. APPARENT CAUSE OF EVENT

The root cause of the event was personnel error in that the SCRE and Shift Engineer failed to recognize that the OOS would isolate the blowdown radiation monitor.

D. SAFETY ANALYSIS OF EVENT

The purpose of the Blowdown Monitor is to detect a S/G tube leak or rupture. During this event, the steamline radiation monitors and the Offgas Radiation monitors were operable. These monitors provide redundant indication of a S/G tube leak. The grab samples taken at 2200 showed no abnormal indication of tube leakage.

Based upon these considerations, the event had no safety impact.

E. CORRECTIVE ACTIONS

The Mechanical Maintenance Department expedited the Work Requests, the OOS was cleared, and the required samples taken. To help prevent future occurrences, CAUTION plaques will be added to the local isolation valves 1(2)BD0001, 2, 3, 4, 5, 6, 7, and 8 to warn operators that closure of these valves will result in isolation of R-19. Similar CAUTION plaques will be added to 1(2)FCV-SS02, 03, 04, and 05 in the Control Room. These items will be tracked by Commitment #304-200-89-08001. The event was discussed with the individuals involved, and all operating crews will review this event as part of the required reading program.

F. PREVIOUS EVENTS

No events could be found where missed Radiation Monitor surveillances had been caused by inadequate review of an OOS. Thus, previous corrective actions would not have prevented this event.

G. COMPONENT FAILURE DATA

None