



Commonwealth Edison

Zion Generating Station
Shiloh Blvd. & Lake Michigan
Zion, Illinois 60099
Telephone 708 / 746-2084

May 20, 1991

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

Dear Sir:

The enclosed License Event Report Number 89-009-01, Docket No. 50-304/DPR-48 from Zion Generating Station is being transmitted to you to update the corrective actions taken.

Very truly yours,

W. R. Kuntz
for T. P. Joyce
Station Manager
Zion Generating Station

TPJ/dmg

Enclosure: Licensee Event Report

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

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PDR ADDCK 05000304
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LICENSEE EVENT REPORT (LER)															Form Rev 2.0										
Facility Name (1) Zion Unit 2										Docket Number (2) 0 5 0 0 0 3 0 4					Page (3) 1 of 0 3										
Title (4) Missed Radiation Monitor 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)												
0	9	0	3	8	9	8	9	0	0	9	0	1	0	5	2	0	9	1	N/A						
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)																						
POWER LEVEL (10) 9 9 %			<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										
			<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)				in Abstract										
			<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)				below and in										
			<input type="checkbox"/> 20.405(a)(1)(v)				<input type="checkbox"/> 50.73(a)(2)(iii)				<input type="checkbox"/> 50.73(a)(2)(x)				Text)										
LICENSEE CONTACT FOR THIS LER (12)																									
Name Suzanne Mika, Regulatory Assurance										ext. 2323							TELEPHONE NUMBER								
										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									
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO													
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																									

At 0630 hours on 9/3/89 the Vent Stack SPING flow monitor (2LP084) failed, rendering the Auxiliary Building Stack radiation monitor inoperable. The surveillance requirements (shiftly sample and blower check) were not performed for the 1500 - 2300 shift on 9/3/89. The cause of the event was due to personnel error. Corrective actions included procedural and organizational changes, and formation of a team to further evaluate these and other corrective actions. The health and safety of the general public were not compromised due to the fact that process monitoring devices located upstream of the inoperable monitor were operable throughout the event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION												Form Rev 2.0	
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						Page (3)					
		Year	///	Sequential Number	///	Revision Number							
Zion Unit 2	0 5 0 0 0 3 0 4	8 9	-	0 0 9	-	0 1	0 2	OF	0 3				

TEXT Energy Industry Identification System (EIIIS) codes are identified in the text as [XX]

A. CONDITION PRIOR TO EVENT

MODE 1 - Power Operation RX Power 99% RCS [AB] Temperature/ Pressure 558 °F/ 2235 psig

B. DESCRIPTION OF EVENT

At 0630 hours on 9/3/89, the Vent Stack Flow Monitor, 2LP084, failed, rendering the Auxiliary Building Stack SPING radiation monitor inoperable. The surveillance requirements (Technical Specification 3.12.3) are a shiftly grab sample and blower check of 20PR038. Contrary to this requirement the shiftly sample and blower check were not performed on the third shift (1500 - 2300) on 9/3/89.

C. APPARENT CAUSE OF EVENT

The cause of the event was a personnel error on the part of the Shift Control Room Engineer (SCRE) and the Chemistry Technician (CT). A contributing factor was the double shift (16 hours) that the CT was scheduled to work. The CT reviewed the log book which he initials, signifying completion of the surveillance, and noticed he had already initialed the required space. The CT assumed the required surveillance was complete. In reality, the surveillance was completed for the previous shift, but not for the 1500 - 2300 shift. The SCRE was also in error because he did not verify the completion of the surveillance requirements in accordance with Periodic Test (PT) -14, Inoperable Equipment Surveillance.

D. SAFETY ANALYSIS OF EVENT

The safety significance of this event was minimal because the Auxiliary Building Vent Stack Monitor, 2RT-PR25, was operable throughout the event. This monitor is located upstream of 2RIA-PR49 and monitors the vent stack for noble gases. The monitor would have alarmed if it had detected noble gases being released out of the vent stack. This monitor has an iodine cartridge that was later removed and analyzed for activity as part of the immediate corrective action. No activity was detected as a result of this analysis.

E. CORRECTIVE ACTIONS

The immediate corrective action was to perform the required surveillance.

The Human Performance Evaluation System (HPES) investigation committed to in the original LER was never performed. The HPES program was new, and the investigators were never directed to perform the evaluation. By the time the error was realized, it was too late to perform the investigation. The HPES program has now been integrated into the Root Cause Program. All events are discussed daily at the Root Cause Meeting, where disposition of events is determined. All HPES investigations associated with Licensee Event Reports are now given a commitment number to ensure their completion.

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Zion Unit 2	0	5	0	0	0	3	0	4	8	9	-	0	0	9	-	0	1	0	3	OF	0	3
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E. CORRECTIVE ACTIONS (con't)

Since this event, there have been a number of similar events, not necessarily related to radiation monitors. The corrective actions taken in response to these events should prevent recurrence. Corrective actions taken are:

1. Zion Radiation Procedure (ZRP) 1720-1 "Out of Service Surveillance for Radiation Monitors" was changed to include individual out of service sheets for radiation monitors. These sheets clearly spell out the requirements for a radiation monitor that is out of service, and will require face to face contact between the Operating shift personnel and Health Physics Department whenever a radiation monitor becomes inoperable.
2. A complete review of the SCRE's duties has been performed. The SCRE position has now been divided into two positions - the Unit 1 and Unit 2 Supervisor. This action has reduced the workload of administrative requirements for the position. One intended result is better followup by the Unit supervisors on non-routine surveillances.
3. Zion Station has instituted the Self Check program. The intent of this program is to reduce errors by reminding people to pay more attention to detail.
4. Because of the continuing problem with missed radiation monitor surveillances, a team consisting of representatives from the Operating, Chemistry, Radiation Protection, and Work Planning Departments was formed. This team reviewed the existing surveillance program administrative process for identification of departmental responsibilities, methods for transfer of responsibilities, accountability for surveillance program implementation, formal lines of communication, adequacy of shift turnovers, use of status keeping aids, and surveillance controls at other Commonwealth Edison Stations to formulate action plans to address the problem of missed surveillances at Zion Station. The action plans for these issues are being tracked by INPO commitments.

F. PREVIOUS EVENTS

A trend of missed surveillances on radiation monitors that have been declared inoperable was identified in both the DVR trend report and in the Fall 1990 INPO visit. The outlined corrective actions were designed to address this problem.

G. COMPONENT FAILURE DATA

None