

PHILADELPHIA ELECTRIC COMPANY

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June 22, 1979

Mr. Boyce H. Grier, Director
Office of Inspection and Enforcement
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Grier:

SUBJECT: Licensee Event Report Narrative Description

The following occurrence was reported to Mr. Greenman,
Region I, Office of Inspection and Enforcement on May 24, 1979.

Reference: Docket Number 50-277

Report No: LER 2-79-28/3L

Report Date: June 22, 1979

Occurrence Date: May 24, 1979

Facility: Peach Bottom Atomic Power Station
R.D. 1, Delta, PA 17314

Technical Specification Reference:

The applicable Technical Specification is Table 3.2.B.

Description of the Event:

During the performance of a routine surveillance test on
electronic instrument LSL-2-3-72C on 5/24/79, the redundant start
signal to the HPCI system was found to be inoperable.

Consequences of Event:

The initiation of the HPCI was not inhibited by the
inoperable channel because the HPCI receives a redundant start
signal from three other channels, therefore, the safety
significance is minimal.

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Cause of Event:

The cause of the occurrence was human error. During electrical drawing preparation for a cable rerouting modification, the draftsman accidentally removed a wire to a relay which provides a start signal to the HPCI. The independent review performed by the drawing checker failed to discover the error. The wire to the HPCI start relay was physically disconnected during the modification work performed on 5/21/79. The error was beyond the scope of the modification work and was therefore not found during post-modification testing.

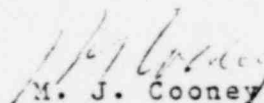
Corrective Action:

Immediately following the identification of the disconnected wire, a jumper was placed in the circuit to place the initiation input in the tripped position. Subsequently, the drawing has been corrected, rechecked and reissued. The wiring error has been corrected and the surveillance test performed successfully. Additionally, all logic system functional tests of systems in C32 panel (where the relay is located) were satisfactorily completed by 5/25/79. All instrument surveillance tests of systems which interface with C32 panel were successfully completed by 5/26/79.

The importance of accuracy in performing drafting and review work on safety system drawings was stressed to the draftsman and checker responsible for the error. The seriousness and potential consequences of such errors were emphasized.

The Engineering Quality Assurance Group is conducting a review of the circumstances and procedures pertaining to the event and will provide, if appropriate, recommendations to prevent the recurrence of similar mistakes.

Yours truly,


M. J. Cooney
Superintendent
Generation Division-Nuclear

Attachment

cc: Director, NRC - Office of Inspection and Enforcement
Mr. Norman M. Haller, NRC - Office of Management &
Program Analysis

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