

PHILADELPHIA ELECTRIC COMPANY

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PHILADELPHIA, PA. 19101

(215) 841-4000

November 4, 1981

Mr. R. C. Haynes, Administrator
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

SUBJECT: LICENSEE EVENT REPORT NARRATIVE DESCRIPTION

Dear Mr. Haynes:

The following occurrence was reported to Mr. R. Blough,
Region I, United States Nuclear Regulatory Commission on October
24, 1982.

Reference:	Docket No. 50-277/278
Report No.:	2-82-35/1T
Event Date:	November 4, 1982
Report Date:	October 21, 1982
Facility:	Peach Bottom Atomic Power Station RD #1, Box 208, Delta, PA 17314

Technical Specification Reference:

Tech. Specs. 3.14.B.3 and 3.14.B.4 require, among other things,
that a firewatch be posted and a report filed pursuant to Tech.
Spec. 6.9.2 if the pressure in the Cardox Storage Tank is below
280 psig when the Diesels are required to be operable.

Description of the Event

At about 4 p.m. on October 21, 1982, it was discovered that the Diesel Generator Cardox Tank pressure was below the technical specification limit of 280 psi.

Immediate Corrective Action

As required by Technical Specifications, a firewatch was posted and remained on location until the pressure had returned to within Tech. Spec. limits.

Consequences of the Event

The quantity of carbon dioxide available exceeded Tech. Spec. requirement of 2200 pounds. The pressure in the tank was 260 psig or seven percent below the Tech. Spec. limit of 280 psi. The pressure in the tank would have been sufficient for system activation had an initiation signal been received. The amount of time which elapsed during the period in which the pressure was below the Tech. Spec. limit and no firewatch was posted was approximately six and one-half hours.

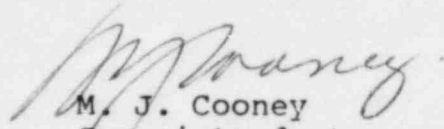
Cause of the Event

The Cardox System was removed from service and blocked for minor maintenance activities at 8:35 a.m. on October 21. As required, a firewatch was posted. Maintenance work was completed and the blocking cleared at approximately 9:35 a.m. At this time, the firewatch was mistakenly released by the operator who had cleared the mechanical blocking.

Action Taken to Prevent Recurrence

Responsible operator was counselled on the requirement for a firewatch. This incident will be discussed during upcoming shift meeting.

Very truly yours,



M. J. Cooney
Superintendent
Generation Division - Nuclear

cc: Mr. Victor Stello, Director
Office of Inspection & Enforcement
U.S. Nuclear Regulatory Commission
Washington, DC 20555

Mr. Norman M. Haller, Director
Office of Management & Program Analysis
U.S. Nuclear Regulatory Commission
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R. Blough
Site Inspector
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