

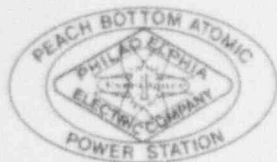
PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION

R. D. 1, Box 208

DELTA, PA 17314

(717) 456-7014



KEN POWERS
PLANT MANAGER

April 7, 1993

Docket Nos. 50-278

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

SUBJECT: Licensee Event Report
Peach Bottom Atomic Power Station - Unit 3

This LER concerns a Technical Specification violation when the Reactor was unvented and pressure - temperature data was not obtained.

Reference:	Docket No. 50-278
Report Number:	3-93-003
Revision Number:	00
Event Date:	03/10/93
Report Date:	04/07/93
Facility:	Peach Bottom Atomic Power Station RD1, Box 208, Delta, PA 17314

This LER is being submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(i)(B).

Sincerely,

cc: R. A. Burricelli, Public Service Electric & Gas
W. P. Dornsife, Commonwealth of Pennsylvania
INPO Records Center
J. J. Lyash, US NRC Senior Resident Inspector
T. T. Martin, US NRC, Region I
R. I. McLean, State of Maryland
C. D. Schaefer, DelMarVa Power
H. C. Schwemm, VP-Atlantic Electric

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ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-550), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET WASHINGTON DC 20503

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LICENSEE CONTACT FOR THIS LER (12)

TELEPHONE NUMBER

AREA CODE

7 | 1 | 7 | 4 | 5 | 6 | - | 7 | 0 | 1 | 4

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	
	1	1 1 1	1 1 1				1	1 1 1	1 1 1		
	1	1 1 1	1 1 1				1	1 1 1	1 1 1		

SUPPLEMENTAL REPORT EXPECTED (54)

ABSTRACT Limit to 3400 spaces (i.e. approximately fifteen single space typewritten lines) (56)

NRC Form 306 (6-89)

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Peach Bottom Atomic Power Station Unit 3	DOCKET NUMBER (2) 0 5 0 0 0 2 7 8	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 3	— 0 0 3	— 0 0	0 2	OF	0 5

TEXT (If more space is required, use additional NRC Form 305A's) (17)

Requirements of the Report

This report is submitted pursuant to 10 CFR 50.73 (a)(2)(i)(B) as a result of a Technical Specification (Tech Spec) violation due to missed Surveillance Requirements.

Unit Conditions at Time of Event

Unit 3 was in the "REFUEL" mode at 0% of thermal reactor (EIIIS:EA) power. There were no systems, structures, or components that were inoperable that contributed to the event.

Description of the Event

On 03/10/93 at approximately 2245 hours, during the shift turnover process by the Reactor Operator (RO) (Utility:Licensed), it was discovered that the Reactor vessel head vents (AO-17 & 18) (see attached diagram) were closed. A Nuclear Plant Operator (NPO) was immediately dispatched to investigate the problem. The NPO identified that the backup Instrument Air Supply Valves (AO-5230A & B) (EIIIS:V) (EIIIS:LD) which provide an instrument air supply to the head vents were closed. Since AO-5230A & B were found closed, the head vents eventually drifted shut as pressure in the supply lines decayed away. While the plant is shutdown, the primary air supply is the backup Instrument Air Supply system and the Instrument Nitrogen Supply system is out of service. The instrument air supply valves and the Reactor vessel head vents were immediately restored to their proper position. Tech Spec 4.6.A.2 specifies that "Reactor vessel temperature and reactor coolant pressure shall be permanently logged every 15 minutes whenever the shell temperature is below 220 degrees F and the reactor is not vented". Therefore, this condition resulted in a violation of Tech Spec because the appropriate 15 minute Surveillance Requirements were not performed for several hours when the reactor was not vented. Further investigations have determined that during the performance of General Procedure (GP)-2 "NORMAL PLANT START-UP" on 03/10/93 at approximately 0930 hours, an NPO did not fully move the control switches (HS-3-36B-5230A & B) for AO-5230A & B to the "AUTO" position. During normal power operation, AO-5230A & B are maintained in the "AUTO" positions to provide an instrument air supply to the head vents in the event that the normal instrument nitrogen supply is lost. In this condition, the instrument air supply valves will automatically open to supply instrument air if the pressure in the instrument nitrogen tank drops below a specified value.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 60.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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Unit 3

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Cause of the Event

The cause of the event has been determined to be that AO-5230A & B were found closed which provide an instrument air supply to the head vents. AO-5230A & B were closed due to a sluggish control switches (EHS:HC) and the misalignment of the labels on the control box. When the NPO (Utility:Non-Licensed) positioned the switches during GP-2, it was believed that the control switches were placed in the "AUTO" position. However, because of the sluggishness of the switch and the labeling misalignment deficiencies, the switches had not made up in the "AUTO" position and were still in the "CLOSED" position. Additional investigation determined that the same switches on the other unit were also sluggish and also had a labelling misalignment concern. These switches are General Electric model CR2940 and are used in various applications throughout the plant. However, given the fact that this is the only event identified to date, and the large number of positive checks of switch operations (Check-Off-Lists, Surveillance Test performance, system operations, blocking, etc), this error is considered an isolated occurrence at this time.

Analysis of the Event

No actual safety consequences occurred as a result of this event.

The consequences are considered minimal due to the fact that the pressure and temperature conditions of the Reactor vessel had remained within the regions specified in the Tech Specs. In addition, no activities were in progress that could have significantly affected vessel conditions.

Corrections Actions

After discovery of the event, the instrument air supply valves and the Reactor vessel head vents were immediately restored to their proper position.

The control switch labels for AO-5230A & B and the same valves on the other unit will be better human factored. In addition, the sluggish switches will be inspected and corrective actions will be implemented as appropriate.

The event has been discussed with the involved individuals. The pertinent information from the event will be provided to the appropriate Operations personnel.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 600 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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DOCKET NUMBER (2)

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Unit 3YEAR SEQUENTIAL
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Previous Similar Events

No previous similar events have been identified which involved improper positioning of control switches due to labelling misalignment or events which involved missed Surveillance Requirements due to the Reactor head vents.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)
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Unit 3

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