



PECO ENERGY

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September 8, 1994

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

Docket No. 50-277

SUBJECT: Licensee Event Report,
Peach Bottom Atomic Power Station-Unit 2

This LER concerns making the Secondary Containment system inoperable for a short period of time when fire hoses were ran through a hatch.

Reference:	Docket No. 50-277
Report Number:	2-94-007
Revision Number:	00
Event Date:	08/10/94
Report Date:	09/08/94
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)(v).

Sincerely,

GDE/GAJ:gaj

enclosure

cc: R. A. Burricelli, Public Service Electric & Gas
R. R. Janati, Commonwealth of Pennsylvania
INPO Records Center
T. T. Martin, US NRC, Administrator, Region I
R. I. McLean, State of Maryland
W. L. Schmidt, US NRC, Senior Resident Inspector
A. F. Kirby III, DelMarVa Power
H. C. Schwemm, VP - Atlantic Electric

CCN 94-14136

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LICENSEE EVENT REPORT (LER)

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 (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.

FACILITY NAME (1)

Peach Bottom Atomic Power Station Unit 2

DOCKET NUMBER (2)

0 5 0 0 0 2 7 7

PAGE (3)

1 OF 0 4

TITLE (4)

Secondary Containment Breached to Fight Fire

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)	
08	10	94	94	007	00	09	08	94			0 5 0 0 0	
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)									
N			20.402(b)			20.405(c)			50.73(a)(2)(iv)			73.71(b)
POWER LEVEL (10)			20.405(a)(1)(i)			50.38(c)(1)			X 50.73(a)(2)(v)			73.71(c)
01810			20.405(a)(1)(ii)			50.38(c)(2)			50.73(a)(2)(vii)			OTHER (Specify in Abstract below and in Text, NRC Form 366A)
			20.405(a)(1)(iii)			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)(ix)			

LICENSEE CONTACT FOR THIS LER (12)

NAME

Anthony J. Wasong, Manager-Experience Assessment Group

TELEPHONE NUMBER

AREA CODE

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

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO
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EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

On 8/10/94, a fire occurred inside the Unit 2 vent stack protective siding during modification activities. Hangers were being welded within the vent stack walls. The welding cloth was removed and smoke started coming from the opening. The fire brigade leader in conjunction with Shift Supervision directed that the hatch on the Reactor Building (R/B) roof be opened to allow a fire hose to be run through it. Once the fire hose arrived at the vent stack, water was sprayed into the opening until the steam/smoke mixture stopped. The Secondary Containment hatch was closed. The cause of this event was that a Secondary Containment hatch was opened on the R/B roof to allow a fire hose to be run through it. The cause of the fire has been determined to be that the work area was not properly staged. The Welder did not properly install the welding cloth in a manner which would prevent sparks from dropping between the inner and outer walls of the vent stack. In addition, the Work Supervisor had not properly inspected the welding area in accordance with the Hot Work Permit (HWP). An evaluation will be performed on the A-12 "IGNITION SOURCE CONTROL" and HWP Processes to identify if additional corrective actions are needed to prevent future events. The event has been discussed with the Welding Crew and the Supervisor has been coached regarding this event. No previous similar events have been identified.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)						
Peach Bottom Atomic Power Station Unit 2	0 5 0 0 0 2 7 7 9 4	<table border="1"><tr><th data-bbox="1047 270 1125 293">YEAR</th><th data-bbox="1129 270 1273 293">SEQUENTIAL NUMBER</th><th data-bbox="1278 270 1384 293">REVISION NUMBER</th></tr><tr><td data-bbox="1047 300 1125 357">— 0</td><td data-bbox="1129 300 1273 357">0 7</td><td data-bbox="1278 300 1384 357">— 0 0</td></tr></table>	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	— 0	0 7	— 0 0	0 2 OF 0 4
YEAR	SEQUENTIAL NUMBER	REVISION NUMBER							
— 0	0 7	— 0 0							

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

Requirements for the Report

This report is submitted to satisfy the requirements of 10CFR50.73(a)(2)(v) describing conditions that alone could have prevented the fulfillment of the Secondary Containment safety function when a hatch was opened.

Unit Conditions at Time of Discovery

Unit 2 was in the "RUN" mode at approximately 80 % of rated thermal reactor (EII:EA) power. There were no systems, structures, or components that were inoperable that contributed to the event.

Description of the Event

On 8/10/94 at approximately 1330 hours, a fire occurred inside the Unit 2 vent stack protective siding during modification activities associated with a vent stack radiation monitoring system upgrade. Hangers were being welded within the vent stack walls. Twelve hangers were successfully installed. The welder proceeded to tack the thirteenth hanger to a beam. The welder noticed a burning odor coming from within the Unit 2 vent stack siding. The welding cloth was removed and smoke started coming from the opening. The fire watch immediately discharged the fire extinguisher into the opening in the vent stack. Due to an updraft in between the inner and outer walls of the stack, the firewatch was unsuccessful in extinguishing the fire. At 1335 hours, the firewatch notified the control room of the situation and the Chief Operator (CO) immediately dispatched the fire brigade. The fire brigade proceeded to the scene with fire extinguishers and realized that the extinguishers were not going to be enough to extinguish the fire. Therefore, the fire brigade leader in conjunction with Shift Supervision directed that the hatch on the Unit 2 Reactor Building roof be opened to allow a fire hose to be run through it. In accordance with Technical Specification 3.7.C, Control Room supervision entered a 12 hour hot shutdown LCO at 1353 hours when the Reactor Building roof hatch was opened. Once the fire hose arrived at the vent stack, water was sprayed into the opening until the steam/smoke mixture stopped. A heat gun was used to determine that the fire was completely extinguished. The fire brigade leader informed the CO that the fire was out and cleanup efforts were then started to remove the hosing from the Reactor Building roof in order to reestablish secondary containment. Shift Management classified the event as an Unusual Event for a fire in the protected area lasting 10 minutes or more after initial attempts to extinguish it. Therefore, the local and state agencies were notified of the Unusual Event classification. In addition, the NRC was notified of the event at 1431 hours. At 1454 hours, the fire brigade leader notified the Control Room that the Secondary Containment hatch was closed. Shift Supervision exited the LCO for the Secondary Containment breach. In addition, at 1842 hours, the NRC was notified of the loss of Secondary Containment while having the hatch opened. This breach resulted in

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
Peach Bottom Atomic Power Station		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Unit 2	0 5 0 0 0 2 7 7	9 4	— 0 0 7	— 0 0	0 3	OF 0 4

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

a condition that could have prevented the fulfillment of a safety function.

Cause of the Event

The cause of this event was that a Secondary Containment hatch was opened on the Unit 2 Reactor Building roof to allow a fire hose to be run through it. The cause of the fire has been determined to be that the work area was not properly staged prior to commencing work. The Welder (Non Utility : Non Licensed) did not properly install the welding cloth in a manner which would prevent sparks from dropping between the inner and outer walls of the Unit 2 vent stack. A contributing factor to this event was that the hanger location was different than the previous hangers installed. Twelve hangers were successfully installed and the work environments on these hangers were identical. On the thirteenth hanger, the hanger on which the fire occurred, the work environment was different. The beam was on an angle and it was recessed approximately three inches further inside the vent stack outer wall. This required the welding crew to expand the opening in the outer wall due to the tight work space. The welding crew installed the weld cloth but apparently not all openings to the vent stack shaft were completely sealed with welding cloth.

In addition, the Work Supervisor (Non Utility : Non Licensed) had not properly inspected the welding area in accordance with the Hot Work Permit (HWP) prior to commencing work on the thirteenth hanger. The HWP had instructions in the setup / staging instructions section to use welding cloth and sheet metal as required to prevent sparks from entering the space between the metal skins of the vent stack. Procedure A-12 "IGNITION SOURCE CONTROL" requires that the Work Supervisor inspect the job area prior to commencing work and at least once per 24 hours during work activities to ensure work area setup / staging instructions have been completed and are maintained. The Work Supervisor did an initial inspection on the first hanger and an area inspection every 24 hours thereafter. An individual inspection was not performed on each hanger after the first hanger prior to commencing welding. This was due to a misinterpretation of the instructions by the Work Supervisor.

Analysis of Event

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

Since Unit 2 was operating at the time of the event, a fuel handling accident and a pipe break accident are the bounding accidents. No fuel handling activities were in progress during the time that the Secondary Containment hatch was opened and had a pipe break occurred, isolation valves were operable to minimize the leakage to the Secondary Containment. In addition, the Secondary Containment system could have been returned to an operable status in a very minimal amount of time and the Standby Gas Treatment System was operable during the time that the hatch was opened.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
Peach Bottom Atomic Power Station Unit 2	05000277	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	04	OF	04
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Corrective Actions

Following discovery of the fire, measures were taken to promptly extinguish the fire and to restore the Secondary Containment hatch.

An evaluation will be performed on the A-12 and HWP Processes to identify if additional corrective actions are needed to prevent future events.

The event has been discussed with the Welding Crew and the Supervisor has been coached regarding this event. The pertinent information from this event will be provided to the appropriate station personnel to re-emphasize the importance of proper setup and inspections of fire prevention devices prior to welding.

Previous Similar Events

No previous similar events have been identified which involved a fire due to welding activities.