



PECO ENERGY

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September 12, 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 3

This LER concerns the High Pressure Coolant Injection system being made inoperable during maintenance activities.

Reference:	Docket No. 50-278
Report Number:	3-94-003
Revision Number:	00
Event Date:	08/11/94
Report Date:	09/12/94
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 94-14137

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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)

DOCKET NUMBER (2)

PAGE (3)

Peach Bottom Atomic Power Station Unit 3

0 | 5 | 0 | 0 | 0 | 2 | 7 | 8 | 1 | OF | 0 | 3

TITLE (4)

HPCI Inoperable During Maintenance Activities

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	8	1	1	9	4	9	4	0	0	3	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)			50.36(c)(1)			X 50.73(a)(2)(v)			73.71(c)					
0 8 10			20.405(a)(1)(ii)			50.36(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)(x)								

LICENSEE CONTACT FOR THIS LER (12)

NAME

TELEPHONE NUMBER

Anthony J. Wasong, Manager-Experience Assessment Group

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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

☐ YES (If yes, complete EXPECTED SUBMISSION DATE)☒ NO

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

On 08/11/94, the High Pressure Coolant Injection (HPCI) system was considered inoperable and was placed in the secured condition by the Reactor Operator. This was done due to a spurious annunciation of the "Auxiliary Oil Pump Running" (AOP) alarm and lighting of the red status light associated with AOP. The cause of this event has been determined to be that Maintenance Technicians working in a electrical panel in the HPCI Room inadvertently worked on a relay associated with the AOP circuit. Following identification of the cause of the event, the HPCI system was restored to its normal condition and the associated Technical Specification LCO was exited. The involved individuals have been coached regarding this event. The pertinent information from this event will be provided to the appropriate Maintenance personnel. In addition, labels will be provided for these relays to minimize future concerns. An evaluation will be performed to determine if additional labelling is required for relays with similar type component configurations. Corrective actions will be implemented as appropriate pending the results of the evaluation. No previous similar events have been identified.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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Peach Bottom Atomic Power Station
Unit 3

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YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
94	003	00

02 OF 03

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 a safety function.

Unit Conditions at Time of Discovery

Unit 3 was in the "RUN" mode at approximately 80 % of rated thermal reactor (EIS:EA) power. There were no systems, structures, or components that were inoperable that contributed to the event.

Description of the Event

On 08/11/94 at 1004 hours, the High Pressure Coolant Injection (HPCI) system (EIS:BJ) was considered inoperable and was placed in the secured condition by the Reactor Operator (RO). This was done due to a spurious annunciation of the "Auxiliary Oil Pump Running" (AOP) alarm and lighting of the red status light associated with AOP. After verification that the condition was spurious and not actually an initiation signal, the RO secured the HPCI system to ensure the safety of the personnel working in the HPCI room. Securing the system would have prevented HPCI from being able to automatically inject per its intended design. Therefore, the applicable Tech Spec Limiting Condition for Operation (LCO) was entered. It was not known at that time the exact cause of the problem but it was known that Maintenance personnel were working in the HPCI room. An investigation was initiated which revealed that Maintenance Technicians were working in a electrical panel where the alarm and red status light circuits are located. The Maintenance Technicians were performing a Preventive Maintenance (PM) task on HPCI Vacuum Pump control circuit relays, however, the individuals inadvertently worked on the relay associated with the AOP circuit. Following identification of the cause of the event, the HPCI system was restored to its normal condition and the associated Tech Spec LCO was exited at 1025 hours. The NRC was notified via ENS at 1322 hours.

Cause of the Event

The cause of this event has been determined to be that Maintenance Technicians (Utility : Non-Licensed) working in a electrical panel in the HPCI Room inadvertently worked on a relay associated with the AOP circuit. The individuals were to perform a PM on the "CR" and the "UV" relays in the HPCI Vacuum Pump circuit. In the panel where the work was to be performed, there are seven relays. Two associated with the HPCI Vacuum Pump, two associated with the HPCI Condensate Pump, and three associated with the AOP. There is a "CR" relay associated with all three pumps, however, only the AOP was marked as a "CR" relay. Based on discussion between the Maintenance Technicians and review of the electrical prints, the individuals incorrectly decided to work on AOP "CR" relay. This

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Unit 3

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

decision was based on a less than adequate review of the electrical prints. In addition, the AOP had a label because the relays were replaced via a modification in 1990. The new AOP "CR" relay was labelled at that time with the current labeling practice, however, the relays associated with the Vacuum Pump and Condensate Pump were original installation and no labels were provided. Therefore, the Maintenance Technicians were incorrectly lead to the AOP "CR" relay.

Analysis of Event

No actual safety consequences occurred as a result of this event. Prior to manually securing HPCI, HPCI was operable to inject per its design. After the HPCI system was manually secured, if a design basis accident or transient would have occurred, the Automatic Depressurization System (EIS:RV) was operable, if required, to reduce reactor (EIS:RPV) pressure to allow the Low Pressure Coolant Injection (EIS:BO) Systems to inject. The Reactor Core Isolation Cooling (RCIC) system was also operable to provide core cooling. In addition, the HPCI system could have been returned to service at any time via the control switch located in the Main Control Room.

Corrective Actions

Following identification of the cause of the event, the HPCI system was restored to its normal condition and the associated Tech Spec LCO was exited.

The involved individuals have been coached regarding this event. The pertinent information from this event will be provided to the appropriate Maintenance personnel.

In addition, labels will be provided for these relays to minimize future concerns.

An evaluation will be performed to determine if additional labelling is required for relays with similar type component configurations. Corrective actions will be implemented as appropriate pending the results of the evaluation.

Previous Similar Events

No previous similar events have been identified which involved the maintenance or testing of the incorrect relay due to similar type causes.