



PEACH BOTTOM—THE POWER OF EXCELLENCE

**PHILADELPHIA ELECTRIC COMPANY**

PEACH BOTTOM ATOMIC POWER STATION

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Delta, Pennsylvania 17314

(717) 456-7014

July 3, 1991

Docket No. 50-277

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

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

This LER concerns Primary Containment Isolation Valve logging not being performed as required by Technical Specifications due to personnel error.

Reference:	Docket No. 50-277
Report Number:	2-91-019
Revision Number:	00
Event Date:	06/03/91
Report Date:	07/03/91
Facility:	Peach Bottom Atomic Power Station RD 1, 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: J. J. Lyash, USNRC Senior Resident Inspector  
T. T. Martin, USNRC, Region I

5001

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <b>Peach Bottom Atomic Power Station - Unit 2</b>										DOCKET NUMBER (2) <b>0 5 0 0 0 2 7 7 1</b>										PAGE (3) <b>OF 0 3</b>															
TITLE (4) <b>Primary Containment Isolation Valve Logging Not Being Performed as Required by Technical Specifications due to Personnel Error</b>																																			
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 NAME										DOCKET NUMBER(S)																
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0 6	0 3	9 1	9 1	0 1	9	0 0	0 7	0 3	9 1											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(e)										50.73(a)(2)(iv)		73.71(b)											
POWER LEVEL (10)		0 8 0										20.405(a)(1)(i)										50.36(e)(1)										60.73(a)(2)(v)		73.71(c)	
		20.405(a)(1)(ii)										50.36(e)(2)										60.73(a)(2)(vi)										OTHER (Specify in Abstract below and in Text, NRC Form 386A)			
		20.405(a)(1)(iii)										X 50.73(a)(2)(i)										60.73(a)(2)(vii)(A)													
		20.405(a)(1)(iv)										50.73(a)(2)(ii)										60.73(a)(2)(vii)(B)													
		20.405(a)(1)(v)										50.73(a)(2)(iii)										50.73(a)(2)(k)													
LICENSEE CONTACT FOR THIS LER (12)																																			
NAME <b>Albert A. Fulvio, Regulatory Engineer</b>										TELEPHONE NUMBER AREA CODE <b>7 1 7 4 5 6 - 7 0 1 4</b>																									
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	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	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 not, complete EXPECTED SUBMISSION DATE)										X NO																									

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

On 6/3/91, a Technical Specification (Tech Spec) violation occurred when the Unit 2 Reactor Operator (RO) failed to initial Surveillance Test (ST) 5.3, "Inoperable Isolation Valve Position Daily Log", which signifies that containment penetrations with inoperable isolation valves are still isolated as required by Tech Specs. The cause of this event is personnel error due to failure to follow procedure. The ST requires the RO to initial daily to verify that the penetration is isolated. The individuals involved in this event were counseled and coached following the incident on the performance of administrative tasks associated with the RO's responsibilities. Additional corrective action included development of a Reactor Operator task list to be posted at the Reactor Operator's console. Pertinent information from this LER will also be routed to the appropriate Operations personnel. There were no safety consequences as a result of this event.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104  
EXPIRES 8/31/88

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

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

Requirements for the Report

This report is being submitted pursuant to 10 CFR 50.73 (a)(2)(i)(B) as a result of Technical Specification (Tech Spec) required inoperable isolation valve positions not being recorded daily.

Unit Conditions at Time of Event

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

Description of the Event

On 6/3/91, a Tech Spec violation occurred when the Unit 2 Reactor Operator (RO) failed to initial Surveillance Test (ST) 5.3, "Inoperable Isolation Valve Position Daily Log", which signifies that containment penetrations with inoperable isolation valves are still isolated. Tech Spec 4.7.D.2 requires that the position of at least one other valve in each line having an inoperable isolation valve be recorded daily. The inoperable isolation valves in question were the Oxygen Analyzer Sample Valve SV-2671C, RHR Shutdown Cooling Suction Valve MO-2-10-017, and the Head Spray Isolation Valves MO-2-10-32 and MO-2-10-33. A review indicated that SV-2671C penetration was isolated by hand valve HV-2-7D-40135 under shift permit 2-91-0494, the shutdown cooling penetration was isolated by MO-2-10-017 and MO-2-10-018 under shift permit 2-91-0450. The head spray penetration was isolated by MO-2-10-32 and MO-2-10-33 under shift permit 2-91-0324.

The day shift RO on 6/4/91 discovered that the ST had not been initialed on 6/3/91. The position of the valves were verified closed on the day the ST had not been initialed. The RO who missed the sign-offs indicated that he had verified the position of the valves during his shift but failed to initial the ST.

Cause of the Event

The cause of this event was determined to be personnel error. The day shift RO (Utility, Licensed) failed to record the position of the inoperable isolation valves daily as required by the ST and Tech Spec 4.7.D.2.

Analysis of the Event

No actual safety consequences occurred as result of this event. Tech Spec 4.7.D.2 requires that the position of the valve used to isolate a primary containment penetration with an inoperable isolation valve be recorded daily. Per the ST, if the position of the valve cannot be determined from the Control Room, verifying that the Shift permit is still applied is adequate. Therefore, a review of the Shift Permits has indicated that the position of the valves were isolated on 6/3/91.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (5)

PAGE (3)

Peach Bottom Atomic Power Station  
Unit 2

0 5 0 0 0 2 7 7 9 1 - 0 1 9 - 0 0 0 3 OF 0 3

TEXT (If more space is required, use additional NRC Form 308A's) (17)

Corrective Actions

A Task Analysis will be performed for Operations positions to identify tasks that personnel perform and the requirements or knowledge necessary to perform those tasks. The results of this analysis will then be incorporated into appropriate training programs and a task list will be posted at the RO's console.

The pertinent information contained in this LER will be routed to the appropriate Operations personnel.

The Reactor Operator and Shift Supervisor involved in this event were counseled and coached by Shift Management following the incident on the performance of administrative tasks associated with the RO's responsibilities.

Previous Similar Events

There were four previous similar events identified. LER 2-89-027 concerned not logging the Suppression Pool Temperature, LER 3-90-009 involved not logging the 'B' Recirculation loop temperature, LER 3-90-015 concerned not logging Drywell sump flow readings, and LER 3-91-004 which involved the same surveillance test (ST 5.3).

Corrective actions taken as a result of these previous LERs could not have prevented this event, since they concerned informing Operations personnel of the specific events, programmatic corrective actions pertaining specifically to the events or have not been fully implemented yet. The corrective actions for this event concerning job task analysis, posting of required activities, and training are expected to more generically address data logging problems.