



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 8, 1991

Docket Nos. 50-277
50-278

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

SUBJECT: Licensee Event Report
Peach Bottom Atomic Power Station - Unit 2 and 3

This LER concerns having two Diesel Generators inoperable concurrently as a result of a mispositioned valve due to personnel error.

Reference:	Docket Nos. 50-277 50-278
Report Number:	2-91-020
Revision Number:	00
Event Date:	06/07/91
Report Date:	07/08/91
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) and 50.73(a)(2)(ii)(B).

Sincerely,

cc: J. J. Lyash, USNRC Senior Resident Inspector
T. T. Martin, USNRC, Region I

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bcc: R. A. Burricelli, Public Service Electric & Gas
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Peach Bottom Atomic Power Station - Unit 2 and 3										DOCKET NUMBER (2) 0 5 0 0 0 2 7 7										PAGE (3) 1 OF 0 3	
TITLE (4) Two Diesel Generators Inoperable Concurrently as a Result of a Mispositioned Valve due to Personnel Error																					
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)						
									Peach Bottom - Unit 3						0 5 0 0 0 2 7 8						
0 6	0 7	9 1	9 1	0 2	0 0	0 7	0 8	9 1							0 5 0 0 0						
OPERATING MODE (9) N		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																			
POWER LEVEL (10) 0 9 7		20.402(b)				20.405(e)				50.73(a)(2)(vi)				73.71(b)							
		20.405(a)(1)(i)				50.38(e)(1)				50.73(a)(2)(vi)				73.71(e)							
		20.405(a)(1)(ii)				50.38(e)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 385A)							
		20.405(a)(1)(iii)				<input checked="" type="checkbox"/> 50.73(a)(2)(i)				50.73(a)(2)(viii)(A)											
		20.405(a)(1)(iv)				<input checked="" type="checkbox"/> 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 Albert A. Pulvio, Regulatory Engineer										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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC												
SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)				MONTH	DAY	YEAR					
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)										<input checked="" type="checkbox"/> NO											

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

On 6/7/91 at 0930 hours, it was discovered that the E-4 Emergency Diesel Generator (D/G) was inoperable due to a fuel oil transfer valve being in the closed position which would have prevented the transfer of fuel oil from the E-4 Diesel Oil Storage Tank to the D/G Day Tank. Additionally, the E-3 D/G was out of service for minor maintenance. Since both the E-4 and E-3 D/Gs were inoperable at the same time, the plant was outside its design basis. Having two D/Gs inoperable concurrently is a condition prohibited by Technical Specifications. The cause of this event has been determined to be that the E-4 D/G fuel oil transfer pump discharge valve was inadvertently left in the locked closed position during a previous Surveillance Test. The valve was immediately opened and the other D/G fuel oil transfer systems were verified to be in the proper lineup. The involved individuals have been counselled. No actual safety consequences occurred as a result of this event. There have been no previous similar events identified.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/86

FACILITY NAME (1) Peach Bottom Atomic Power Station Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 2 7 7 9 J — 0 2 0 — 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 to satisfy the requirements of 10 CFR 50.73(a)(2)(ii)(B) and 50.73(a)(2)(i)(B) describing a condition which is outside the design basis of the plant due to two D/G being inoperable concurrently and entry into Technical Specification (Tech Spec) 3.0.C.

Unit Conditions at Time of Discovery

Unit 2 was in the RUN mode at 97% of thermal reactor (EIIS:EA) power and Unit 3 was in the RUN mode at 94%. There were no other systems, structures, or components that were inoperable that contributed to the event.

Description of Event

On 6/7/91 at 0930 hours, it was discovered that the E-4 Emergency Diesel Generator (D/G)(EIIS:ER) was inoperable due to a fuel oil (EIIS:DC) transfer valve (EIIS:V) being in the closed position which would have prevented the transfer of fuel oil from the E-4 Diesel Oil Storage Tank to the D/G Day Tank. Additionally, the E-3 D/G was out of service for minor maintenance. Since both the E-4 and E-3 D/Gs were inoperable at the same time, the plant was outside its design basis. Having two D/Gs inoperable concurrently is a condition prohibited by Tech Specs, therefore Tech Spec 3.0.C is applicable and requires Hot shutdown in 6 hours and Cold shutdown in 36 hours.

On 6/5/91 at 1210 hours during the performance of a D/G fuel oil analysis Surveillance Test (ST), the E-4 D/G fuel oil transfer pump discharge valve was inadvertently left in the locked closed position instead of the locked open position by the Plant Operator. A Chemist who was working with the Plant Operator subsequently incorrectly performed the Independent Verification (IV) of the valve position.

On 6/7/91 at 0730 hours, the E-3 D/G was taken out of service to support minor maintenance activity. Subsequently at 0840 hours, the required Tech Spec Limiting Condition for Operation (LCO) testing commenced on the other three D/Gs.

At 0930 hours, the System Engineer identified that the E-4 D/G fuel oil transfer valve was in the locked closed position instead of the locked open position. The Plant Operator and the Control Room Operator were informed and the valve was opened to the proper position at 940 hours. The other D/G fuel oil transfer systems were verified to be in the proper lineup. After a reportability determination was made, the NRC was notified via the ENS at 1050 hours.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/00

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

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

Cause of the Event

The cause of this event has been determined to be that the E-4 D/G fuel oil transfer pump discharge valve was inadvertently left in the locked closed position instead of the locked open position during a D/G fuel oil analysis ST. This has been attributed to personnel error and inadequate IV of the valve restoration after the ST.

Analysis of the Event

No actual safety consequences occurred as a result of this event. If a design basis event and loss of offsite power would have occurred with the E-3 D/G out of service and the E-4 D/G unavailable for long term operation, the High Pressure Coolant Injection System would be available for high pressure cooling. Low pressure Core Spray and Low Pressure Coolant Injection systems fed from the other D/Gs in conjunction with the Automatic Depressurization System would be available for low pressure cooling. The low pressure systems fed from the E-4 D/G would be available for approximately two and one half hours until the D/G fuel oil would have run out. Although the E-4 D/G fuel oil transfer system would have been unavailable, the D/G Day Tank Low Fuel Level alarm would have alerted the Operators that the Diesel Oil Storage tank makeup to the D/G Day Tank was not functioning properly. This alarm would have provided approximately two hours to initiate an investigation and open the valve prior to the E-4 D/G running out of fuel oil in the Day Tank.

Corrective Actions

The valve was immediately restored to the proper position and the other D/G fuel oil transfer systems were verified to be in the proper lineup.

The involved Operator and Chemist have been counselled concerning this event. The pertinent information from this event will be provided to other Operators and members of the technical staff.

A Temporary Change has been initiated on the ST to delete the note that allows a Chemist to perform the IV and a note was added to the ST requiring the person performing the IV to be qualified per the Operations Manual. This is an interim action until a permanent revision is approved.

Other surveillance procedures performed by Operations involving interfaces with other groups will be reviewed for appropriateness of IV responsibility. Additionally, a Common Nuclear Procedure is being generated which specifies process and qualifications required for the performance of an IV.

Previous Similar Events

There have been no previous similar events identified concerning an inoperable safety system as a result of mispositioned valve due to personnel error.