



PEACH BOTTOM--THE POWER OF EXCELLENCE

PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION

R. D. 1, Box 208
Delta, Pennsylvania 17314

(717) 456-7014

November 29, 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 the 'A' Waste Sample Tank being released without proper sampling resulting in a Tech Spec violation due to failure to follow procedure.

Reference:	Docket Nos. 50-277 50-278
Report Number:	2-91-036
Revision Number:	00
Event Date:	11/03/91
Report Date:	11/29/91
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).

Sincerely,

Ken Powers

cc: J. J. Lyash, USNRC Senior Resident Inspector
T. T. Martin, USNRC, Region 1

FE22

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 30.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P&30), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545, AND TO THE PAPERWORK REDUCTION PROJECT (3160-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Peach Bottom Atomic Power Station - Unit 2 and 3

DOCKET NUMBER (2)

050002177

PAGE (3)

1 OF 3

TITLE (4)

Technical Specification Violation Occurred when the 'A' Waste Sample Tank was Released Without Proper Sampling due to Failure to Follow Procedure

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 (5)

1

1

03

91

91

03

6

00

11

29

91

Peach Bottom - Unit 3

050002177

OPERATING MODE (9)

N

20.402(b)

20.405(a)

50.73(a)(2)(iv)

73.71(b)

POWER LEVEL (10)

1.00

20.405(a)(1)(i)

50.36(a)(1)

50.73(a)(2)(v)

73.71(c)

20.405(a)(1)(ii)

50.36(a)(2)

50.73(a)(2)(vi)

OTHER (Specify if Abnormal Data and in Text NRC Form 366A)

20.405(a)(1)(iii)

X 50.73(a)(2)(vii)

50.73(a)(2)(viii)(A)

20.405(a)(1)(iv)

50.73(a)(2)(viii)(B)

50.73(a)(2)(ix)

20.405(a)(1)(v)

50.73(a)(2)(x)

50.73(a)(2)(xi)

LICENSEE CONTACT FOR THIS LER (12)

NAME

Albert A. Fulvio, Regulatory Engineer

TELEPHONE NUMBER

AREA CODE

717456-7014

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)

X NO

ABSTRACT (Limit to 1000 spaces, i.e., approximately fifteen single spaced typewritten lines) (16)

On 11/03/91 at 0530 hours, it was discovered that the "A" Waste Sample Tank (WST) treated liquid was released without the appropriate sample and release approval. The "B" WST was sampled instead of the "A" WST. This condition resulted in a violation of Technical Specification 4.8.B.1b because the Surveillance Requirements were not performed. The cause of the event has been determined to be that the Radwaste Plant Operator (PO) failed to properly follow the Surveillance Test (ST) used to sample and release the WST contents. Additionally, miscommunication between the Radwaste PO and the Shift Chemist led to the wrong WST being sampled. No actual safety consequences occurred as a result of this event. The release was terminated and a liquid sample was obtained from the "A" WST. The pertinent information from this event will be provided to the appropriate personnel. The ST will be revised with focus on human factors considerations. There was one previous similar LER identified.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 800 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 (315-0104) OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (3)

PAGE (3)

Peach Bottom Atomic Power Station
Unit 2 and 3

0 5 0 0 0 2 7 7 9 1 — 0 3 6 — 0 0 0 2 OF 0 3

TEXT (If more space is required, use additional NRC Form 386A's) (17)

Requirements of the Report

This report is being submitted pursuant to 10 CFR 50.73 (a)(2)(i) as a result of Technical Specification (Tech Spec) 4.8.B.1b violation when the "A" Waste Sample Tank (WS) was released without performance of the appropriate surveillance requirement.

Unit Conditions at Time of Event

Unit 2 was in the "RUN" mode at 100% of thermal reactor (E11S:EA) power. Unit 3 was in the "REFUEL" mode. There were no systems, structures, or components that were inoperable that contributed to this event.

Description of the Event

On 11/03/91 at 0530 hours, it was discovered that the "A" WST treated liquid was release without the appropriate sample and release approval. The "B" WST was sampled instead of the "A" WST. This condition resulted in a violation of Tech Spec 4.8.B.1b because the Surveillance Requirements were not performed. The release was started at 0130 hours with tank level at 94%.

After discovery of the event, the release was terminated at 0530 hours at a tank level of 14%. Approximately 20,000 gallons was released from the "A" WST. A liquid sample was obtained from the "A" WST and this sample is assumed to be a representative of the effluent released from the "A" WST since no water had been added to the tank prior to the sample. This sample indicated that the actual activity levels released from the "A" WST were below the limits specified in the Tech Specs and the Offsite Dose Calculation Manual. The actual activity levels were approximately the same as originally recorded and approved for the "B" WST release.

Cause of the Event

The cause of the event has been determined to be that the Radwaste Plant Operator (PO)(Utility:Non-Licensed) failed to properly follow the ST used to sample and release the WST contents. The ST specified that the "B" WST be released but the "A" WST was inadvertently released.

Additionally, miscommunication between the Radwaste PO and the Shift Chemist regarding which tank was ready for release led to the wrong WST being sampled. The communication problem occurred when the Shift Chemist believed that the "B" WST was to be sampled for release while the PO was certain that the "A" WST was requested to be sampled.

A contributing factor to this event was that the WST to be released was only identified one place in the ST. If the source of the release was more obvious, this could have been helpful to prevent this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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 (F-500) U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 20545, AND TO THE PAPERWORK REDUCTION PROJECT (3160-0104) OFFICE OF MANAGEMENT AND BUDGET WASHINGTON, DC 20503.

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

TEXT (if more space is required, use additional NRC Form 306A's) (17)

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 actual activity levels released from the "A" WST were below the limits specified in the Tech Spec and the Offsite Dose Calculation Manual. After discovery of the event, a liquid sample was obtained from the "A" WST and this sample is assumed to be a representative of the effluent released from the "A" WST since no water had been added to the tank prior to the sample. The actual activity levels were approximately the same as originally recorded and approved for the "B" WST release. The effluent released was treated prior to discharge and the components involved in the treatment were functioning properly.

Additionally, a radiation monitor is located on the discharge header and the alarm setpoint was operable to monitor effluent release. If the setpoint is reached, it is annunciated in the Radwaste Control Room and the Main Control Room, and the discharge header valve will automatically close, thus aborting the release. For this event, the activity levels actually released were approximately the same as the "B" WST, and consequently below the alarm setpoints.

Corrective Actions

After discovery of the event, the release was terminated and a liquid sample was obtained from the "A" WST. This sample indicated that the actual activity levels released from the "A" WST were below the limits specified in the Tech Spec and the Offsite Dose Calculation Manual.

The involved Radwaste PO has been counselled and coached by Shift Management on attention to detail and self checking. The pertinent information from this event will be provided to the appropriate Operations and Chemistry personnel to reinforce the importance of accurate communication and attention to detail.

The ST will be revised for other human factor considerations as part of the ST Rewrite Program.

Previous Similar Events

There was one previous similar LER (2-88-009) identified which involved the release of a Radwaste sample tank without the completion of the appropriate Tech Spec Surveillance Requirement. The corrective actions taken as a result of the previous LER involved counselling the chemistry technician and a discussion at the Chemistry staff meeting. Since the corrective action taken involved the Chemistry staff only and did not involve ST enhancements, it could not have been expected to prevent this event.