



PECO ENERGY

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U. S. Nuclear Regulatory Commission
Washington, DC 20555

Docket Nos. 50-277 & 278

SUBJECT: Licensee Event Report, Peach Bottom Atomic Power Station
Unit 2 & 3

This LER concerns an unplanned Engineered Safety Feature actuation during a fast transfer.

Reference:	Docket No. 50-277 & 278
Report Number:	2-95-003
Revision Number:	00
Event Date:	08/15/95
Report Date:	09/13/95
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)(iv).

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

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CCN 95-14081

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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 Units 2 & 3										DOCKET NUMBER (2) 0 5 0 0 0 2 7 7				PAGE (3) 1 OF 0 4		
TITLE (4) Unplanned ESF Actuation when a wire was out in a junction box																
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	15	95	0	03	0	9	13	Peach Bottom				0 5 0 0 0 2 7 8			
OPERATING MODE (9) N			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)													
POWER LEVEL (10) 11010			20.402(b)				20.405(c)				<input checked="" type="checkbox"/> 50.73(a)(2)(iv)				73.71(b)	
			20.405(a)(1)(i)				50.36(c)(1)				<input type="checkbox"/> 50.73(a)(2)(v)				73.71(c)	
			20.405(a)(1)(ii)				50.36(c)(2)				<input type="checkbox"/> 50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 365A)	
			20.405(a)(1)(iii)				50.73(a)(2)(i)				<input type="checkbox"/> 50.73(a)(2)(viii)(A)					
			20.405(a)(1)(iv)				50.73(a)(2)(ii)				<input type="checkbox"/> 50.73(a)(2)(viii)(B)					
			20.405(a)(1)(v)				50.73(a)(2)(iii)				<input type="checkbox"/> 50.73(a)(2)(ix)					
LICENSEE CONTACT FOR THIS LER (12)																
NAME Anthony J. Wasong, Manager-Experience Assessment										TELEPHONE NUMBER 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 8/15/95, the #2 Startup feed was lost when an electrical distribution breaker (SU-25) tripped open. Four 4KV busses fed from the #2 Startup feed automatically fast transferred to the #343 Startup feed per design causing Unit 2 & 3 Group II/III half isolations. Following the event, the Group II/III isolation logics were reset. Affected systems were restored to appropriate conditions as necessary. The cause of the isolations has been determined to be the loss of the #2 Startup feed. An investigation has determined that the cause of the #2 Startup feed loss was that the SU-25 breaker tripped open when a wire was cut in a junction box near the decommissioned Unit 1 facility. The wire, which was cut, was in protective relay logic associated with the 220-08 off site electrical power line. The cut wire has been repaired. The cut wire has been repaired and the yard area electrical prints will be revised. Access to this junction box has been minimized since the box is now buried underground. In addition, the Unit 1 facility will be reviewed to identify if other junction boxes are not adequately labelled or referenced on the appropriate yard area prints. Corrective actions including additional labelling and print revisions will be evaluated and implemented as needed. The involved supervisor has been coached regarding his actions. Lessons learned from this event will be communicated to appropriate station personnel. No previous similar events have been identified.

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 (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
Units 2 & 3

DOCKET NUMBER (2)

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LER NUMBER (5)

YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
9 5	- 0 0 3	- 0 0

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

Requirements for the Report

This report is submitted to satisfy the requirements of 10 CFR 50.73(a)(2)(iv) because of unplanned Engineered Safety Feature Actuations.

Unit Conditions at Time of Event

Unit 2 was in the RUN mode at 100% of rated thermal reactor (EIIIS:RPV) power and Unit 3 was in the RUN mode at 66% power. There were no systems, structures, or components that were inoperable that contributed to the event.

Description of Event

On 8/15/95 at 1035 hours, the #2 Startup feed was lost when an electrical distribution breaker (SU-25) tripped open. The four 4KV busses fed from the #2 Startup feed automatically fast transferred to the #343 Startup feed per design. Transfer of the Startup feeds resulted in Unit 2 & 3 Primary Containment Isolation System (EIIIS:JM)(PCIS) Group II/III half isolations. These isolations caused the Standby Gas Treatment System (EIIIS:BH) to initiate, the Reactor Water Clean Up system (EIIIS:CE) to isolate, and several containment isolation valves (EIIIS:JM) to close. The isolations occurred due to the momentary de-energization of several electrical distribution panels on each unit during the fast transfer. In addition, one Reactor Protection System (RPS) Motor Generator (M/G) set on each unit tripped thus causing a half scram signal on each unit. Appropriate actions were immediately taken to stabilize the units and the NRC was notified of the event at 1423 hours. Following the event, the PCIS Group II/III isolation logics were reset. Affected systems were restored to appropriate conditions as necessary.

Cause of Event

The cause of the PCIS isolations has been determined to be the loss of the #2 Startup feed. An investigation has determined that the cause of the #2 Startup feed loss was that the SU-25 breaker tripped open when a wire was cut in a junction box near the decommissioned Unit 1 facility. The wire, which was cut, was in protective relay logic associated with the 220-08 off site electrical power line.

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 (P-630), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

The wire was cut by a Station Support individual (Utility : Non-Licensed) during Unit 1 exterior renovation activities. This individual conferred with his supervisor prior to cutting the wire. The Station Support Supervisor (Utility : Non-Licensed) believed that the wire and associated junction box were abandoned, and therefore, would not impact any plant systems or electrical distribution systems. The decision by the supervisor to cut the wire was based on several factors.

Voltage monitoring was performed prior to cutting the wire but the low voltage readings obtained were believed to be induced by the nearby 500 KV electrical power lines.

In addition, the abandoned Unit 1 Main Generator electrical distribution output tower was just recently removed and this junction box was located directly underneath the tower. This made the supervisor believe the junction box was also abandoned.

The junction box and protective relay logic cables were not clearly identified on the Unit 1 yard area electrical prints. In addition, the junction box was not labeled to identify its function or assist in locating the appropriate electrical drawing.

Although these factors contributed to the supervisor's decision, the supervisor did not meet Management's expectations with respect to confirming the function of the wire. It is the Management's expectation that employees stop, seek assistance, and totally resolve any questions before proceeding with any work activity that is not fully understood. This expectation has been communicated to station personnel in various station programs.

Analysis of Event

No actual safety consequences occurred as a result of this event. All automatic PCIS isolations functioned as designed.

Corrective Action

Following the event, the PCIS Group II/III isolation logics were reset. Affected systems were restored to appropriate conditions as necessary.

The cut wire has been repaired. The yard area electrical prints will be revised to reference the location of this junction box. Access to this junction box has been minimized since the box is now buried underground.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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.

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

The involved supervisor has been coached regarding his actions during the event. Lessons learned from this event will be communicated to appropriate station personnel.

In addition, the Unit 1 facility will be reviewed to identify if other junction boxes are not adequately labelled or referenced on the appropriate yard area prints. Corrective actions including additional labelling and print revisions will be evaluated and implemented as needed.

Previous Similar Events

No previous similar events have been identified which involved Station Support individuals