



PECO ENERGY

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U. S. Nuclear Regulatory Commission
Washington, DC 20555

Docket No. 50-277 & 50-278

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

This LER concerns a Technical Specifications violation when an instrument channel check was not being performed on a Drywell Pressure instrument.

Reference:	Docket No. 50-277 & 50-278
Report Number:	2-95-005
Revision Number:	00
Discovery Date:	09/22/95
Report Date:	10/20/95
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)(i).

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 95-14094

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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 Unit 2

DOCKET NUMBER (2)

0 5 0 0 0 2 7 7

PAGE (3)

1 OF 0 3

TITLE (4)

Technical Specification Violation Associated with Drywell Pressure Recorders

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 9	2 2	9 5	9 5	0 0 5	0 0 1	0 2	0 9	5	Peach Bottom Unit 3	0 5 0 0 0 2 7 8
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 8 (Check one or more of the following) (11)										
OPERATING MODE (9)		N		20.402(b)		20.406(c)		50.73(a)(2)(iv)		73.71(b)
POWER LEVEL (10)		1 1 0 1 0		20.406(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
				20.406(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)
				20.406(a)(1)(iii)		X 50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
				20.406(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
				20.406(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(ix)		

LICENSEE CONTACT FOR THIS LER (12)

NAME

Anthony J. Wasong, Manager-Experience Assessment

TELEPHONE NUMBER

AREA CODE

7 1 1 7 4 5 6 1 - 7 1 0 1 1 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

On 9/22/95, it was discovered that the narrow range indication on Drywell pressure recorder (PR-2(3)508) was being checked each shift instead of the wide range indicator required by the Tech Specs. Tech Spec table 4.2.F requires that an instrument check be performed on pressure instrumentation once each shift. The cause of this event was that the ST directed the operators to record the Red pen reading, which is associated with Drywell narrow range pressure instrumentation, instead of the Black pen which is associated with the Drywell wide range pressure instrument. The STs used to perform this instrument check, have referenced the Red pen on PR-2(3)508 since a procedure revision in 1989. Prior to that time, there were no references to pen colors on the ST. Following discovery of the condition, immediate actions were taken to ensure that the correct pen was being monitored. The STs associated with monitoring these parameters were subsequently changed on both units to reference the correct pen. Other instruments involved in the Control Room rounds were also reviewed for similar discrepancies and no other Tech Spec violations were discovered. The review process associated with surveillance tests has significantly improved since this error was made due to the incorporation of the Station Qualified Review (SQR) program in 1992. This process heightens the accountability of reviewers to ensure that requirements are properly incorporated into procedures. Appropriate cross-discipline reviews are also required as part of the SQR program. One previous similar event was identified.

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 (F-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)

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Peach Bottom Atomic Power Station
Units 2 & 3

0 5 0 0 0 2 7 8

YEAR

SEQUENTIAL
NUMBERREVISION
NUMBER

9 5

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2 OF

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

Requirements for the Report

This LER is being submitted pursuant to the requirements of 10 CFR 50.73 (a)(2)(i)(B) due to a violation of the Unit 2 & 3 Technical Specification (Tech Spec) 4.2.F and Table 4.2.F when an instrument channel check was not performed on a Drywell Pressure instrument.

Unit Conditions at the time of the Event

Unit 2 was in the "RUN" mode at approximately 100 % power and Unit 3 was in the "REFUEL" mode. There were no inoperable structures, systems or components that contributed to this event.

Description of the Event

On 9/22/95, during a review of the Unit 2 daily Surveillance Test {(ST)-O-098-01D-2(3)}, a Shift Supervisor (Utility : Licensed) discovered that the narrow range indication on Drywell pressure recorder (PR-2(3)508) (EHS:LT) was being checked each shift instead of the wide range indicator required by the Tech Specs. Tech Spec 4.2.F specifies that "Instrumentation shall be calibrated and checked as indicated in Table 4.2.F." Tech Spec table 4.2.F item 5 requires that an instrument check be performed on pressure instrumentation once each shift. The daily surveillance test was written with the intent to satisfy this surveillance requirement. This surveillance requirement does not specify which range to check. The Limiting Condition for Operation requirement states that PR-2(3)508 'Pen 2' is required to be operable. However, this pressure recorder has two pens, a Red pen (Pen 1) and a Black pen (Pen 2). The ST directed the operators to record the Red pen reading, which is associated with the Drywell narrow range pressure instrument loop on PR-2(3)508. It should have directed the operators to record the Black pen (i.e. Pen 2) which is associated with the Drywell wide range pressure instrument loop. The same problem was found with the Unit 3 surveillance test.

It should be noted that Pen 1 and Pen 2 are the only 2 pens on the recorder. Both pens are clearly labeled. Interviews with operations personnel have confirmed that when performing the instrument check on Pen 1, the status of Pen 2 was self-evident as well. However, only Pen 1 was documented on the ST.

Following discovery of this condition, immediate actions were taken to ensure that the correct pen was being monitored and the STs associated with monitoring these parameters were subsequently changed on both units to reference the correct pen.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.9 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.

FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (6)

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Peach Bottom Atomic Power Station
Units 2 & 3

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

Cause of the Event

The cause of this event was that the ST directed the operators to record the Red pen reading, which is associated with Drywell narrow range pressure instrumentation, instead of the Black pen which is associated with the Drywell wide range pressure instrument. The STs used to perform this instrument check, have referenced the Red pen on PR-2(3)508 since a procedure revision in 1989. Prior to that time, there were no references to pen colors on the ST.

Analysis of the Event

There were no actual safety consequences as a result of this event. The wide range pressure indication on PR-2(3)508 was operable on both units. Had a design bases accident occurred and this instrument was not operable, redundant Drywell pressure indication was available to allow operators to know the status of the containment pressure. This instrument does not provide compliance with Regulatory Guide 1.97.

Corrective Actions

Following discovery of the condition, immediate actions were taken to ensure that the correct pen was being monitored. The STs associated with monitoring these parameters were subsequently changed on both units to reference the correct pen.

Generic implications were considered as part of this event. Other instruments involved in the Control Room rounds were also reviewed for similar discrepancies and no other Tech Spec violations were discovered. The review process associated with surveillance tests has significantly improved since this error was made due to the incorporation of the Station Qualified Review (SQR) program in 1992. This process heightens the accountability of reviewers to ensure that requirements are properly incorporated into procedures. Appropriate cross-discipline reviews are also required as part of the SQR program.

Previous Similar Events

One previous similar event (LER 2-90-24) was identified which involved a missed daily instrument check on other instruments. This event was due to a less than adequate technical review of an ST revision due to an incorrect interpretation of Tech Specs. Corrective actions for this event involved reviewing the instrument check surveillances. However, this review focused on potential omissions associated with particular modes of operation and, therefore, did not identify the discrepancy identified in this LER.