

PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION

R. D. 1, Box 208

DELTA, PA 17314

(717) 456-7014



KEN POWERS  
PLANT MANAGER

January 14, 1992

Docket No. 50-278

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

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

This LER concerns an Engineering Safeguard Feature Actuation as a result of less than adequate programmatic guidance.

Reference:	Docket No. 50-278
Report Number:	3-91-018
Revision Number:	00
Event Date:	12/16/91
Report Date:	01/14/92
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)(iv).

Sincerely,

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

9201230031 920114  
PDR ADOCK 05000278  
S PDR

TE22  
111

## LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.8 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 3										DOCKET NUMBER (2) 0 5 0 0 0 2 7 8				PAGE (3) 1 OF 0 3		
TITLE (4) Engineering Safeguard Feature Actuation as a Result of Less Than Adequate Programmatic Guidance																
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)			
1 2	1 6	9 1	9 1	0 1 8	0 0 0	1 1	4	9 2					0 5 0 0 0			
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11):														
N		20.402(b)				20.405(c)				<input checked="" type="checkbox"/> 50.73(a)(2)(iv)		73.71(b)				
POWER LEVEL (10)		20.405(a)(1)(i)				50.38(c)(1)				50.73(a)(2)(v)		73.71(c)				
0 1 0 0		20.405(a)(1)(ii)				50.38(c)(2)				50.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)				
		20.405(a)(1)(iii)				50.73(a)(2)(iii)				50.73(a)(2)(vii)(A)						
		20.405(a)(1)(iv)				50.73(a)(2)(iv)				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 4 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 12/16/91 at 2205 hours, an isolation of the Main Steam Line Drain and the Recirculation System Sample Valves occurred unexpectedly during the performance of an in-service leak test. At the time of the event, Operations personnel were valving into service the instrument valves on a Feedwater Control system flow transmitter. The cause of the event has been determined to be a pressure transient in the instrument line. This was a result of the instrument line not being backfilled prior to the instrument being returned to service. No documented station guidance existed to address operation of instrument valves and responsibilities. A contributing factor to this event was less than adequate communication. After the Group I Primary Containment Isolation System (PCIS) isolation occurred, the PCIS logic was reset at 2220 hours and the affected valves were restored to the proper position. Station guidance will be developed. The event will be reviewed to determine adequacy of the present methods used to perform in-service leak testing. No actual safety consequences occurred as a result of this event. There were no previous similar events identified.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN FOR 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 Unit 3	DOCKET NUMBER (2)  0 5 0 0 0 2 7 8	LER NUMBER (6) <table border="1"><thead><tr><th data-bbox="1093 313 1173 347">YEAR</th><th data-bbox="1173 313 1331 347">SEQUENTIAL NUMBER</th><th data-bbox="1331 313 1437 347">REVISION NUMBER</th></tr></thead><tbody><tr><td data-bbox="1093 347 1173 416">91</td><td data-bbox="1173 347 1331 416">— 0 1 8</td><td data-bbox="1331 347 1437 416">— 0 0</td></tr></tbody></table>	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	91	— 0 1 8	— 0 0	PAGE (3)  0 2 OF 0 3
YEAR	SEQUENTIAL NUMBER	REVISION NUMBER							
91	— 0 1 8	— 0 0							

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

Requirements of the Report

This report is being submitted pursuant to 10 CFR 50.73(a)(2)(iv) due to an Engineering Safeguard Feature (ESF) actuation.

Unit Conditions at Time of Event

Unit 3 was in the "REFUEL" mode with the reactor at 1000 psig and 199 degrees F during the Reactor Pressure Vessel (RPV) hydrostatic test. There were no systems, structures, or components that were inoperable that contributed to the event.

Description of the Event

On 12/16/91 at 2205 hours, an isolation of the Main Steam Line Drain and the Recirculation System Sample Valves occurred unexpectedly during the performance of an in-service leak test associated with a modification. This was the result of a Group I Primary Containment Isolation System (PCIS)(EIIS:JM) actuation. At the time of the event, Operations personnel were valving into service the instrument valves (EIIS:ISV) on a Feedwater Control system flow transmitter (EIIS:FT) (FT-3-06-051D). This action produced a pressure transient in the instrument line which impacted other instrumentation and resulted in the PCIS isolation. The PCIS logic was reset at 2220 hours and the affected valves were restored to the proper position. The NRC was notified of the event via ENS at 0020 hours on 12/17/91.

Cause of the Event

The cause of the event has been determined to be a pressure transient in the instrument line. This transient produced a Group I PCIS isolation and subsequent valve isolations. This was a result of the instrument line not being backfilled prior to the instrument being returned to service.

The valve manipulations were done by a Station Operator. Normally, instrument valve operations are accomplished by Instrument & Control (I&C) technicians. No documented station guidance existed to address operation of instrument valves and responsibilities. An I&C technician would have been more likely to identify that the instrument line was in need of backfilling.

A contributing factor to this event was less than adequate communication between the installation personnel and the operator. The installation individual failed to inform the operator that an I&C technician was requested to perform the instrument valving. Had the operator been informed of this, he would probably have waited for the I&C technician. The I&C technician would have been more likely to identify the need of backfilling and therefore prevent the event.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 60.0 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)  Peach Bottom Atomic Power Station Unit 3	DOCKET NUMBER (2)  0 5 0 0 0 2 7 8 9 1	LER NUMBER (6) <table border="1"><thead><tr><th data-bbox="1023 266 1104 297">YEAR</th><th data-bbox="1104 266 1266 297">SEQUENTIAL NUMBER</th><th data-bbox="1266 266 1364 297">REVISION NUMBER</th></tr></thead><tbody><tr><td data-bbox="1023 297 1104 370">— 0 1</td><td data-bbox="1104 297 1266 370">8 — 0 0</td><td data-bbox="1266 297 1364 370">0 3</td></tr></tbody></table>	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	— 0 1	8 — 0 0	0 3	PAGE (3)  0 3 OF 0 3
YEAR	SEQUENTIAL NUMBER	REVISION NUMBER							
— 0 1	8 — 0 0	0 3							

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

Analysis of Event

No actual safety consequences occurred as a result of this event.

The isolation functioned per design. The Main Steam Isolation valves were already closed to support the RPV hydrostatic testing and the PCIS Group I isolation capabilities were not required at the time of the event per the Technical Specifications. In the event that the PCIS Group I isolation would have occurred with the plant at power, the reactor would have shutdown safely as designed.

Corrective Actions

After the Group I PCIS isolation occurred, the PCIS logic was reset at 2220 hours and the affected valves were restored to the proper position.

The event has been discussed with the involved individuals. The pertinent information from this event will be provided to the appropriate Operations and Installations personnel.

Station guidance will be developed which will address operation of instrument valves and responsibilities.

The event will be reviewed to determine adequacy of the present methods used to perform in-service leak testing associated with modifications. Based on this evaluation, the existing guidance involving in-service leak testing will be reviewed and revised as necessary to prevent future occurrences of similar type.

Previous Similar Events

There were no previous similar events identified which involved an ESF actuation caused by lack of instrument backfilling associated with a modification.