

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)  
Peach Bottom Atomic Power Station - Unit 2

DOCKET NUMBER (2)

0 5 0 0 0 2 7 7 1 OF 0 3

PAGE (3)

TITLE (4)

Operator Error During Performance of Approved Procedure Causes Reactor Scram

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(S)	DOCKET NUMBER(S)					
0	3	0	1	8	8	8	0	0	2	0	0	0	0	0	0
0	3	0	1	8	8	8	0	0	0	3	2	5	8	8	8

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
N	0 10 10	20.402(b)	20.405(e)	X	50.73(a)(2)(iv)	73.71(b)					
		20.405(a)(1)(i)	50.38(a)(1)		50.73(a)(2)(v)	73.71(e)					
		20.405(a)(1)(ii)	50.38(a)(2)		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)		50.73(a)(2)(viii)(A)						
		20.405(a)(1)(iv)	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	TELEPHONE NUMBER
W. C. Birely, Senior Engineer - Licensing Section	2 1 5 8 4 1 - 5 0 4 8

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)	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
X					

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

## Abstract:

At 0400 hours on March 1, 1988 while resetting a scram signal following completion of the reactor vessel hydrostatic test, a licensed operator's error resulted in another reactor scram signal. The operator operated the wrong control switch while performing the scram reset procedure. Unit 2 was in the shutdown mode with all control rods fully inserted, and no control rod motion resulted. The consequences, both actual and potential, were determined to be minimal, and the scram signal was reset by 0420 hours. The operating crew discussed the event and emphasized the importance of attention to detail. The operator involved received additional counseling regarding the importance of attention to detail. The Superintendent - Operations has written a letter to all shifts re-emphasizing the importance of attention to detail. The letter includes a copy of this LER as an attachment. This event is reported pursuant to 10CFR50.73(a)(2)(iv).

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104  
EXPIRES 8/31/85

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

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

Unit Conditions Prior to the Event:

Unit 2 was in the Refuel mode, and the reactor vessel hydrostatic test was complete. Reactor coolant temperature was 190 degrees F, with system pressure at 986 psi.

Description of the Event:

At 0400 hours on March 1, 1988 during performance of procedure GP-11.E, "Reactor Protection System (RPS) - Scram Reset", the Unit 2 RPS initiated a full reactor scram signal. Unit 2 was in the Shutdown mode with all control rods inserted and no control rod motion resulted. The events leading to and following the scram are described below.

At 0335 hours on March 1, 1988, upon completion of the reactor vessel hydrostatic test, the mode switch was moved from the Refuel to the Shutdown position, initiating a planned scram. The licensed operator proceeded to reset the scram in accordance with procedure GP.11.E, "Reactor Protection System-Scram Reset". Following the procedure, the operator had placed the scram discharge volume (SDV) high water level bypass switch in the BYPASS position and reset the RPS logic. Step 3.11 instructs the operator to open the SDV inboard vent and drain valves and to verify the OPEN indication. The operator received shift management approval to drain the SDV, then mistakenly moved the "SDV high water level bypass" switch from BYPASS to NORMAL rather than the "SDV inboard vent and drain valves" switch. This mistake caused the RPS to generate a full scram on "SDV high level". The operator immediately recognized his mistake. The scram was reset through the successful performance of GP-11.E at 0420 hours.

Consequences of the Event:

The actual and potential consequences of this event are determined to be minimal. The fail safe design of the RPS was demonstrated, the RPS functioned as designed, and no control rod motion occurred. This event would not have any adverse effects at power, since the operation is an RPS reset function and the SDV high water level bypass function is removed when the mode switch is in the Startup or Run positions.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 365A's) (17)

Cause of the Event:

The licensed operator initiated the scram by operating the incorrect switch. The two switches involved are eight inches apart and are not similar in appearance: human factors was not a contributing cause. The mistake was discussed among the licensed operator, shift supervisor, shift technical advisor and shift manager, and no other contributing factors were determined.

Corrective Actions:

The scram was reset through the successful performance of GP-11.E. The operating crew discussed the event and agreed that routine operations, such as this one, may be especially prone to errors, and a high level of attention must be maintained at all times.

Actions to Prevent Recurrence:

The operator was counseled regarding the importance of attention to detail. The Superintendent-Operations has written a letter to all shifts which re-emphasizes the importance of attention to detail. The letter includes a copy of this LER as an attachment.

EIIS Codes:

HS - Hand Switch; VTV - vent valve; ROD - rod; AA - Control Rod Drive System;; JC-Plant Protection System (RPS); CBD-control board.

Previous Similar Events:

Cause Code: A - Personnel Error

Peach Bottom LERs 3-86-12, 3-86-21, 2-85-2, 2-85-12, 2-85-14, 2-85-17, 2-85-20, and 3-84-7 were also caused by operator error.

PHILADELPHIA ELECTRIC COMPANY

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March 25, 1988

Docket No. 50-277

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

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

This LER concerns the inadvertent reactor scram signal caused by operator error. No control rod motion resulted.

Reference:	Docket No. 50-277
Report Number:	2-88-02
Revision Number:	00
Event Date:	March 1, 1988
Report Date:	March 25, 1988
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).

Very truly yours,



R. H. Logue  
Assistant to the Manager  
Nuclear Support Department

cc: W. T. Russell, Administrator, Region I, USNRC  
T. P. Johnson, NRC Resident Inspector

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