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10CFR 50.73

July 1, 2003

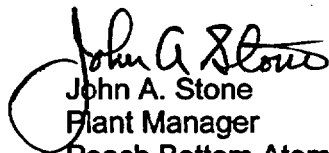
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Peach Bottom Atomic Power Station, Unit 3
Facility Operating License No. DPR-56
NRC Docket No. 50-278

Subject: Licensee Event Report (LER) 3-03-01

This LER reports a condition concerning the unavailability of the Unit 3 alternate control station in the event of certain 10CFR 50 Appendix R fires. This condition was discovered on 5/13/03 during the performance of a routine surveillance test. In accordance with NEI 99-04, the regulatory commitment contained in this correspondence is to restore compliance with the regulations. The specific methods that are planned to restore and maintain compliance are discussed in the LER. If you have any questions or require additional information, please do not hesitate to contact us.

Sincerely,


John A. Stone
Plant Manager
Peach Bottom Atomic Power Station

JAS/djf/CR158665

Attachment

cc: PSE&G, Financial Controls and Co-owner Affairs
R. R. Janati, Commonwealth of Pennsylvania
INPO Records Center
H. J. Miller, US NRC, Administrator, Region I
R. I. McLean, State of Maryland
A. C. McMurtray, US NRC, Senior Resident Inspector

CCN 03-14056

JE22

bcc:

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C. G. Pardee – KSA 3-N
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SUMMARY OF EXELON NUCLEAR COMMITMENTS

The following table identifies commitments made in this document by Exelon Nuclear. (Any other actions discussed in the submittal represent intended or planned actions by Exelon Nuclear. They are described to the NRC for the NRC's information and are not regulatory commitments.)

Commitment	Committed Date or "Outage"
In accordance with NEI 99-04, the regulatory commitment contained in this correspondence is to restore compliance with the regulations. The specific methods that are planned to restore and maintain compliance are discussed in the LER.	In accordance with the Corrective Action Program

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1) Peach Bottom Atomic Power Station, Unit 3	DOCKET NUMBER (2) 05000 278	PAGE (3) 1 OF 4
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TITLE (4)
Loss of Capability of the Unit 3 10CFR 50 Appendix R Alternate Control Station

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
5	5	03	03	001	00	07	1	03		

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)									
POWER LEVEL (10) 100	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input checked="" type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 73.71(a)(4)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(5)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	OTHER Specify in Abstract below or in NRC Form 366A						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(C)							
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(D)							
	<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(vii)							
	<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)								

LICENSEE CONTACT FOR THIS LER (12)

NAME Ellen Anderson - Regulatory Assurance Manager	TELEPHONE NUMBER (Include Area Code) (717) 456-3588
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO					

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On 5/14/03, at 0410 hours, an operability evaluation performed by a shift supervisor determined that the Unit 3 High Pressure Coolant Injection (HPCI) Alternate Control Station (ACS) for Fire Safe Shutdown was inoperable. This inoperability was due to the fact that multiple instruments were de-energized as a result of a failed wire on a power supply. This resulted in Operations personnel not having the capability to implement actions required for plant safe shutdown from the ACS if a 10CFR 50 Appendix R fire were to occur. The HPCI ACS is required if a significant fire were to occur in the Cable Spreading Room, Main Control Room or the Main Control Room Fan Room. Repairs to the broken wire were promptly made and the ACS was restored to an operable status on 5/14/03 by 1030 hours. There were no actual safety consequences as a result of this event. Investigation determined that the broken wire occurred during previous maintenance activities on 5/5/03. Further review of the post maintenance testing performed on 5/6/03 revealed that the I&C technicians involved with the work did not perform sufficient post maintenance testing as required. The involved I&C technicians have been counseled and expectations for strict compliance with the work order requirements have been reinforced. There were no previous similar events identified.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Peach Bottom Atomic Power Station, Unit 3	05000278	03	- 001	- 00	2 OF 4

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Unit Conditions Prior to the Event

Unit 3 was in Mode 1 operating at 100% rated thermal power when the event occurred. Although automatic initiation of carbon dioxide fire suppression in the Cable Spreading Room was inoperable at the time of the event, manual actuation capability of this equipment was available. Fire detection equipment was operable for the fire area involved with this event.

Description of the Event

On 5/14/03, at 0410 hours, an operability evaluation performed by a shift supervisor determined that the Unit 3 High Pressure Coolant Injection (HPCI) (EIIS: BJ) Alternate Control Station (ACS) for Fire Safe Shutdown was inoperable. This review was performed as a result of discontinuation of a routine surveillance test for flow instruments at the HPCI ACS. The purpose of the surveillance test is to calibrate instruments used to measure the flow rate of High Pressure Service Water (HPSW) through the Residual Heat Removal (RHR) Heat Exchanger required for Fire Safe Shutdown. The test had been aborted at approximately 1800 hours on 5/13/03 after the Instrumentation & Control (I&C) technicians noted that the instruments were not responsive during the test. The I&C technicians noted that the power supply for the Alternate Control Station (EIIS: XC) was not functioning properly due to a broken wire at the power supply (EIIS: JX).

The operability evaluation performed on 5/14/03 at 0410 hours determined that the HPCI ACS was not operable due to the fact that multiple instruments were de-energized as a result of the failed wire on the power supply. This resulted in Operations personnel not having the capability to implement actions required for plant safe shutdown from the HPCI ACS if a 10CFR 50 Appendix R fire were to occur. The HPCI ACS is required if a significant fire were to occur in the Cable Spreading Room, Main Control Room or the Main Control Room Fan Room.

Repairs to the broken wire were promptly made and the ACS was restored to an operable status on 5/14/03 by 1030 hours.

Investigation performed determined that the broken wire was the result of recent preventive maintenance work performed in the ACS on 5/5/03 (i.e. event date). The reportability date and time is 5/14/03 at 0410 hours when it was determined that the condition discovered on 5/13/03 at approximately 1800 hours resulted in the HPCI ACS being inoperable. Prompt notifications were completed by approximately 1145 hours on 5/14/03 (EN# 39844).

This report is being submitted pursuant to 10CFR50.73 (a)(2)(ii) due to the loss of Unit 3 Fire Safe Shutdown capability for certain 10CFR 50 Appendix R fires.

NRC FORM 366AU.S. NUCLEAR REGULATORY COMMISSION
(1-2001)

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Analysis of the Event

There were no actual safety consequences as a result of this event. Once identified, repairs were promptly completed and the U/3 HPCI ACS was returned to an operable status.

The purpose of the Unit 3 HPCI ACS is to provide the capability to bring the unit to a safe shutdown condition for significant fires that could occur in the Cable Spreading Room, Main Control Room or the Main Control Room Fan Room. Fires in these areas have the potential to prevent plant safe shutdown from the Main Control Room. The affected ACS is one of four ACS's for Unit 3 and allows for operation of High Pressure Coolant Injection (HPCI), Residual Heat Removal (RHR) and Main Steam Relief Valves (MSRVs). It also provides diagnostic instrumentation for HPCI, RHR, HPSW and Emergency Service Water (ESW) systems as well as reactor process monitoring instrumentation. The other three ACS's (which were unaffected by this event) allow operation of Emergency Switchgear, Diesel Generators, and Automatic Depressurization System (ADS) relief valves.

The power supply affected provides power to instrumentation associated with the HPCI ACS. The instrumentation is used to monitor the status of various reactor, primary containment (including suppression pool), HPCI, RHR, and ESW parameters. The HPCI turbine emergency speed control system was also affected resulting in not being able to use the HPCI system for level control. The emergency procedures recognize that the Reactor Cooling Isolation Control (RCIC) system may be able to be used for certain fire scenarios in lieu of HPCI. Operation of other required safe shut down equipment for Unit 3 was unaffected by this event. Also, Unit 2 Appendix R safe shutdown capability was unaffected by this event.

The duration of the unavailability of the affected equipment on the HPCI ACS was approximately 9 days. It was determined that this duration was not risk significant. PBAPS Technical Specifications allow HPCI to be out of service for up to 14 days prior to initiating plant actions. There was no affect on the ability for HPCI to perform its intended safety function for non-fire related design basis events. Control room instrumentation and the ability to monitor and operate plant equipment from the Main Control Room was unaffected by this event.

During the duration of this event, the ability to detect fires in the Main Control Room, Cable Spreading Room or Main Control Room Fan Room was maintained. Manual fire suppression capability was available during this time.

Cause of the Event

The cause of the event was due to a broken wire on the instrumentation power supply in the HPCI ACS. Investigation determined that the broken wire occurred during previous maintenance activities on 5/5/03. On 5/5/03, a routine calibration of the inverter associated with the power supply was being performed. The inverter had been removed to perform the calibration. To facilitate removal of the inverter, the I&C technician (utility, non-licensed personnel) moved the power supply about 1 inch to allow access to the inverter which was just below the power supply in the HPCI ACS. It was determined that when the power supply was moved, stress was placed on the positive wire feeding the power supply from the inverter. This stress caused the wire to break. Due to the tight location within the panel, the I&C technician did not notice that the wire had broken.

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION
(1-2001)

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Cause of the Event, (continued)

Further review of the post maintenance testing performed on 5/6/03 revealed that the I&C technicians involved with the work did not perform sufficient post maintenance testing as required. The post maintenance testing for the job required, in part, that a loop check to the power supply be performed. Contrary to this requirement, the loop check was not performed.

Corrective Actions

The involved I&C technicians have been counseled and expectations for strict compliance with the work order requirements have been reinforced.

Additionally, this event has been shared with the maintenance organization to highlight the importance of strict compliance to the post maintenance requirements of the work order.

Previous Similar Occurrences

There were no previous events identified involving the loss of fire safe shutdown capability due to post maintenance human performance issues.