DESIGNATED ORIGINAL

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PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION
R. D. 1, BOX 208
DELTA, PENNSYLVANIA 17314

January 20, 1983

Mr. R. C. Haynes
Administrator
U.S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

SUBJECT: REPORTABLE OCCURRENCE - PROMPT NOTIFICATION

Confirming S. R. Roberts' telephone conversation with A. R. Blough, Region I, United States Nuclear Regulatory Commission on 1/20/83.

Reference: Docket No. 50-277
Peach Bottom Unit 2
Technical Specification 3.7.D.3

Report No. 2-83-2/1P
Occurrence Date: 1/20/83

Identification of Occurrence:

During a routine surveillance in the control room, the indicating lights for the RCIC inboard steam supply isolation valve were found not lit. Immediate investigation determined that the feed breaker for the valve had been mistakenly opened during the application of a block. The breaker was then closed to restore power and indication to the valve. Since the valve was in the open position during the time the feed breaker was open, it was not capable of closing if it had received an isolation signal. During that time, the redundant isolation valve was not in the closed position as required when an isolation valve is inoperable. The Technical Specifications require that if the redundant isolation valve is not closed that an orderly shutdown be initiated. An orderly shutdown was not begun because the condition was not found for approximately one hour.

Conditions Prior to Occurrence:

Unit 2 operating at full power.

Apparent Cause of Occurrence:

An Operator was applying a block to remove the Reactor Water Clean-Up System from service. He mistakenly removed the feed from the RCIC steam supply valve during the application of that block.

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Analysis of Occurrence:

While the inboard steam supply valve on RCIC was inoperable due to the feed breaker being open, the outboard steam supply valve was fully operable and would have performed the isolation function if an isolation signal had been received. That fact, coupled with the short duration that the inboard valve did not have isolation capability, makes the safety significance of this event minimal.

Corrective Action:

When the control room operator found the indicating lights on the RCIC steam supply valve not lit, an immediate investigation was undertaken and the feed breaker was immediately reclosed.

Previous Occurrence:

None.

Very truly yours,

W. T. Ullrich
Station Superintendent