# PHILADELPHIA ELECTRIC COMPANY

### PEACH BOTTOM ATOMIC POWER STATION

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May 20, 1993

Docket Nos. 50-277

50-278

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

SUBJECT: Licensee Event Report

Peach Bottom Atomic Power Station - Units 2 and 3

This LER concerns a Technical Specification violation when the Unit 2 Fire Suppression Carbon Dioxide Storage Tank pressure dropped below the minimum limit and compensatory actions were not implemented on time.

Reference:

Docket Nos. 50-277

50-278

Report Number:

2-93-008

Revision Number: 00

Discovery Date: 04/09/93

Reportability Date: 04/22/93

Report Date:

05/20/93

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)(B).

Kan Power Sincerely

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

YES IT yes, complete EXPECTED SUBMISSION DATE!

SUPPLEMENTAL REPORT EXPECTED (14)

On 04/09/93, a Technical Specification (Tech Spec) violation occurred when the appropriate compensatory actions were not established when the Unit 2 Fire Suppression Carbon Dioxide Storage Tank pressure went below the Tech Specs limit. The CO2 tank low pressure condition was identified by a Nuclear Plant Operator (NPO) during the performance of a Surveillance Test (ST). The NPO notified the Chief Operator (CO) that the ST was going to fail, however, the required compensatory actions were not implemented. Testing identified that the tank pressure switch setpoint had drifted. Following as found tank instrumentation testing, this event was determined to be reportable on 04/22/93. The cause of the event was setpoint drift of a pressure switch in conjunction with less than adequate communication. The NPO notified the CO that the ST was going to fail but did not specifically communicate that the failure involved a Tech Spec step in the ST. After discovery of the event, the Shift Technical Advisor verified that tank pressure had recovered. The tank pressure switches have been properly calibrated. An investigation is currently being performed on this pressure switch problem and corrective actions will be implemented. The event has been discussed with the involved individuals. The information will be provided to the appropriate Operations personnel.

X NO

YEAR

EXPECTED

# NRC FORM 386A

#### U.S. W. ICLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

APPROVED DMB NO. 3150-0104 EXPIRES 4/30/92

ESTIMATED BURDEN PER RESPONSE TO DOMPLY WITH THIS INFORMATION COLLECTION REQUEST 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F-53), U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 2055. AND TO THE PAPERWORK REDUCTION PROJECT (3155-0104). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	KET NUMBER (2) LER NUMBER (6)								
Peach Bottom Atomic Power Station Unit 2 and 3		YEAR SEQUENTIAL REVISION NUMBER								
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# Requirements of the Report

This report is submitted pursuant to 10 CFR 50.73 (a)(2)(i)(B) as a result of a Technical Specification (Tech Spec) violation when the Unit 2 Fire Suppression Carbon Dioxide Storage Tank pressure was found low and the appropriate Tech Spec Limiting Condition of Operation was not implemented.

# Unit Conditions at Time of Event

Unit 2 and 3 were in the "RUN" mode at approximately 100% of thermal reactor (EIIS:EA) power.

# Description of the Event

On 04/09/93 at approximately 1330 hours, a Tech Spec violation occurred when the appropriate compensatory actions were not established when the Unit 2 Fire Suppression (EIIS:KP) Carbon Dioxide (CO2) Storage Tank pressure went below the 280 psig value specified in the Tech Specs. Tech Spec 3.14.B.1.a specifies that "a minimum inventory of 2400 pounds of CO2 and a minimum pressure of 280 psig in the CO2 storage tank" be maintained and Tech Spec 3.14.B.4.a specifies that if this requirement cannot be met, then "establish a continuous fire watch with back-up fire suppression equipment for unprotected areas within 1 hour".

The CO2 tank low pressure condition was identified by a Nuclear Plant Operator (NPO), at approximately 1230 hours, during the performance of a weekly Surveillance Test (ST)-O-037-340-2 "Fire System Weekly Check". The NPO notified the Chief Operator (CO) that the ST was going to fail, however, the Tech Spec required compensatory actions were not implemented. At approximately 1700 hours, the Shift Technical Advisor (STA) reidentified the concern during a review of the ST after test completion. The STA immediately verified that tank pressure had recovered and was greater than the 280 psig Tech Spec limit.

Subsequently, the tank pressure was closely monitored for several days and tank instrumentation was tested for proper function. Testing identified that the CO2 tank pressure switch (EIIS:PS) (PS-8329A) setpoint had drifted to approximately 250 psig thus allowing the 280 psig Tech Spec limit to be violated. Based on as found Unit 2 CO2 Tank instrumentation testing, this event was determined to be reportable on 04/22/93.

# NRC FORM 366A

#### U.S. NUCLEAR REGULATORY COMMISSION

#### APPROVED OMB NO. 3150-0104 EXPIRES 4/30/82

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 REPORTE MANAGEMENT BRANCH IP-S20, U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20055, AND TO THE PAPERWORK REDUCTION PROJECT (3/1907/104). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)			
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## Cause of the Event

The cause of the event was setpoint drift of PS-8329A in conjunction with less than adequate communication between the NPO (Utility: Non Licensed) and the CO following discovery of the event. The NPO notified the CO that the ST was going to fail but did not specifically communicate to the CO that the failure was due to a low tank pressure condition or that it involved a Tech Spec step in the ST. Therefore, the CO did not realize that this condition involved the need for any compensatory actions. Communication which is not clear and understood by all individuals does not meet the expectation of Management as specified in the Operations Manual.

# Analysis of the Event

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

The consequences are considered minimal due to the fact that the Unit 2 CO2 Tank pressure was restored to its proper pressure in a short period of time. With the Unit 2 CO2 Tank at 250 psig, adequate pressure was available to ensure that the CO2 in the Tank could be discharged to the Unit 2 High Pressure Coolant Injection (EIIS:BJ) and the Cable Spreading Rooms in case of a fire. In addition, the Unit 3 CO2 Tank could have been aligned to provide adequate CO2 fire protection to the affected areas.

# Corrections Actions

After discovery of the event, the STA immediately verified that tank pressure had recovered and was greater than the Tech Spec limit.

The CO2 Tank pressure switches have been properly calibrated to ensure the refrigeration unit stops prior to tank pressure dropping below the 280 psig Tech Spec limit. An investigation is currently being performed on this pressure switch problem. Corrective actions will be implemented as appropriate. Any significant additional causes and associated corrective actions will be submitted in a revision to this report as necessary.

The event has been discussed with the involved individuals. The pertinent information from the event will be provided to the appropriate Operations personnel to re-emphasize the importance of clear communication.

# SHC FORM 386A

U.S. AUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104 EXPIRES. 4/30/92

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P.330), U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 20565, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)			DOCKET NUMBER (2) LER NUM										NUMBER (6)	-			PAGE (3)			
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# Previous Similar Events

No previous similar events have been identified which involved Tech Spec violation when the appropriate compensatory action was not implemented on low CO2 Tank pressures.