

PHILADELPHIA ELECTRIC COMPANY

2301 MARKET STREET
P.O. BOX 8699
PHILADELPHIA, PA. 19101
(215) 841-4000

September 24, 1982

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

SUBJECT: Licensee Event Report Narrative Description

Dear Mr. Haynes:

The following occurrence was reported to Mr. Blough, Region I, United States Nuclear Regulatory Commission on September 10, 1982.

| | |
|------------------|--|
| Reference: | Docket No. 50-277 |
| Report No.: | 2-82-27/1T |
| Report Date.: | September 24, 1982 |
| Occurrence Date: | September 10, 1982 |
| Facility: | Peach Bottom Atomic Power Station RD#1, Delta, PA 17314 |

Technical Specification Reference:

Technical Specification 3.7.A.2.

Description of Event:

During the Unit 2 operational period from August 12 through September 10, 1982, oxygen content in the primary containment was within technical specifications, but higher than normal. Purging requirements to maintain drywell pressure were also significantly less than normal. An investigation identified an open service air manual outer isolation valve. The service air system normally operates at 100 psig, and therefore provided a source of in leakage of air to the containment through leaking individual service air connection valves in the drywell.

Probable Consequences of Occurrence:

The line in question is provided with an outer isolation valve and a check valve prior to entering containment. Inside containment the line has a second manual isolation valve as well as several valves where users of service air are normally connected. Since drywell pressure was maintained at 0.5 psig without frequent venting to control pressure, in leakage is believed to have been minimal. The service air system normally operates above even the maximum drywell pressure that would occur during a LOCA. That pressure difference would prevent leakage from the drywell, provided there is electrical power to the air compressors, and the service air piping is intact. The check valve in this line inboard of the outer isolation valve, although not routinely tested, is an isolation boundary which also provides resistance to out-flow from the containment if the service air pressure was less than containment pressure. The inner closed service air valves also would prevent out-leakage from containment, unless the service air piping within the drywell failed. Based on the remote probability of simultaneous high pressure transients in containment, release of fission products to containment, and a failure of the air piping both inside and outside containment, safety significance is considered minimal. Even in this event, the check valve in the line outside containment would restrict out leakage.

Cause of the Event:

During a Unit 2 planned maintenance outage, the service air to the containment was placed in service. This involved opening both the inner and outer locked closed isolation valves on this line. At the end of the planned maintenance outage, the unit was started up without returning these valves to the closed and

locked position. Based on the primary containment integrity definition in paragraph 1.0 of the technical specifications, primary containment integrity was therefore not established during reactor operation. Investigation indicated that the cause of this event was due to the failure of operations personnel to make an entry in the locked valve log book upon unlocking the valves. As a result, review of the locked valve log book by operations personnel prior to start up did not indicate that these valves were not in the proper position.

Corrective Action:

The outer isolation valve was closed and locked shortly after it was identified as being opened. In order to determine the status of the inner isolation valve, a plant shutdown was initiated on 9/10/82. Containment entry was made, and the inner isolation valve which was found open, was closed and locked. With primary containment re-established, reactor startup was initiated. Additional corrective action undertaken to this event is a repeat of the locked valve check-off list for Unit 2.

The importance of adhering to Administrative Procedures concerning locked valves was re-emphasized with operations personnel. In addition, steps are being taken to highlight the locked valves so that the importance is more easily recognized by plant personnel. This effort will be completed for accessible valves by 11/1/82 and for inaccessible valves during the next outage with a planned duration of more than 5 days.

Valving problems at Peach Bottom have been reviewed and additional actions in the areas of training and controls are being considered.

Very truly yours,



M. J. Cooney
Superintendent
Generation Division - Nuclear

cc: Director, NRC - Office of Inspection & Enforcement
Mr. Norman M. Haller, NRC - Off. of Mgmt & Prog. Anal.
R. Blough, Site Inspector