

PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION R. D. 1, Box 208 Delta, Pennsylvania 17314 (717) 456-7014

November 21, 1990

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 & 3

This LER concerns a control room emergency ventilation actuation due to inadvertent opening of a 480 volt breaker.

Reference:

Docket Nos. 50-277

50-278

Report Number:

2-90-030

Revision Number:

00

Event Date:

10/24/90

Report Date:

11/21/90

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).

Sincerely.

John Tran

cc: J. J. Lyash, USNRC Senior Resident Inspector

T. T. Martin, USNRC, Region I

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On 10/24/90, at 2205 hours, the Control Room Ventilation System (CRVS) transferred to the Emergency Ventilation mode due to a false high radiation signal from the 'B' radiation monitor caused by a loss of power. The loss of power was a result of a two-way, radio which was attached to the belt of a Plant Operator, contacting the handle of a 480 Volt breaker and causing it to open. Initiation of Control Room Emergency Ventilation is an Engineered Safety Feature actuation. The CRVS serves the PBAPS Control Room which is common to both units. Following reclosure of the breaker, the system was restored to is normal standby alignment. The Plant Operator involved in the incident was counseled. No previous similar LERs were identified.

YES III VES complete EXPECTED SUBMISSION DATE!

ABSTRACT (Limit to 1400 spaces, i.e. approximately lifteen single space typeveritten lines) (16)

NRC	Form	366A
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

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

Requirements for the Report

This report is submitted to satisfy the requirements of 10 CFR 50.73 (a)(2)(iv) which requires reporting any unplanned actuation of an Engineered Safety Feature.

Unit Conditions at Time of Discovery

Unit 2 was in the RUN mode at 99% of rated thermal reactor power. Unit 3 was in the RUN mode at 80% of rated thermal reactor power. There were no systems, structures, or components that were inoperable that contributed to this event.

Description of Event

On 10/24/90, at 2205 hours, the Control Room Ventilation System (CRVS) transferred to the Emergency Ventilation mode due to a false high radiation signal from the 'B' radiation monitor (RIS-0760B) (EIIS:MON) caused by a loss of power. The loss of power was a result of a two-way radio, which was attached to the belt of a Plant Operator (Utility, non-Licensed), contacting the handle of a 480 Volt Breaker (EIIS:BKR) and causing it to open. The Plant Operator was performing blocking of the 3D Residual Heat Removal (RHR) (EIIS:BO) pump in the vicinity of the breaker which supplied power to the CRVS. The Plant Operator immediately recognized the error, reclosed the breaker, and contacted the control room.

The opening of the breaker also caused several alarms to annunciate along with closure of several valves in the Backup Instrument Nitrogen to Automatic Depressurization System (ADS). Two of the alarms required troubleshooting prior to being reset.

Control Room Ventilation was restored to is normal lireup at 2220 hours. The NRC was notified at 2307 hours.

Cause of Event

The cause of the event was due to a two way radio, attached to a Plant Operator's belt, coming into contact with the arm of a 480 Volt breaker and causing it to open.

Analysis of Event

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

The CRVS serves the PBAPS control room which is common to both units. The system's safety design basis is to maintain the control room habitable under design basis accident conditions including loss of off-site power. Fresh air is filtered when necessary to prevent contamination of the control room.

Two radiation monitors ("A" & "B") continuously sample air from the CRVS supply duct (EIIS:DUCT). With a high radiation signal present from either radiation monitor, the CRVS realigns to the Emergency Mode of Operation and supplies filtered fresh air to the control room. Upon actuation, the normal fresh air supply fans (EIIS:FAN) trip and isolate. The Emergency fans then start supplying fresh air to the control room through the Emergency Filters (EIIS:FLT).

NAC Form 366A (9-83) LICENSEE EVENT	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION O.S. NUCLEAR REGULATORY OF APPROVED OMB NO. 3150 EXPIRES. 8/31/88									
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The "B" radiation monitor high radiation signal only existed for a short duration. The "A" monitor indicated normal background radiation condition. No other plant condition indicated the potential for the indicated high radiation condition. The realignment of the CRVS to the Emergency Mode of operation initiated as designed. This realignment was conservative and had no adverse effect on safety. The effect of this event under other plant conditions would be no more severe.

Corrective Actions

Following reclosure of the breaker, the system was restored to its normal standby alignment. The Plant Operator involved in the incident was counseled. The pertinent information contained in this report will be routed to appropriate Operations personnel.

Previous Similar Events

No previous similar LERs were identified which involved manual opening of breakers causing ESF actuations.