



PEACH BOTTOM--THE POWER OF EXCELLENCE

PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION

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Delta, Pennsylvania 17314

(717) 456-7014

November 29, 1990

Docket No. 50-277

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

SUBJECT: Licensee Event Report
Peach Bottom Atomic Power Station - Unit 2

This LER concerns a missed Core Spray surveillance that resulted in a technical specification violation.

Reference: Docket No. 50-277
Report Number: 2-90-031
Revision Number: 00
Event Date: 03/14/89
Discovery Date: 10/26/90
Reportability Date: 11/2/90
Report Date: 11/29/90
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)(i)(B).

Sincerely,

cc: J. J. Lyash, USNRC Senior Resident Inspector
T. T. Martin, USNRC, Region I

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bcc: R. A. Burrice111, Public Service Electric & Gas
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Peach Bottom Atomic Power Station - Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 2 7 7	PAGE (3) 1 OF 0 4
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TITLE (4) **Missed Core Spray Surveillance Results in Technical Specification Violation Due to Inadequate Procedural Controls and Personnel Error**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)											
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES											
									DOCKET NUMBER(S)											
0	3	14	8	9	9	0	3	1	0	0	1	1	2	9	9	0	0	0	0	0

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5 (Check one or more of the following) (11)									
POWER LEVEL (10) 0 0 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.408(e)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(d)						
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Pa. 1 NRC Form 365A)						
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)								

LICENSEE CONTACT FOR THIS LER (12)

NAME A. A. Fulvio, Regulatory Engineer	TELEPHONE NUMBER
	AREA CODE: 7 1 7 4 NUMBER: 5 6 - 7 0 1 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC TURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFAC TURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

On 10/26/90, an NRC Resident Inspector identified that the data from Surveillance Test (ST) 6.6 F, "Core Spray 'A' Pump, Valve, Flow Cooler" for the quarter prior to the Unit 2 startup on 4/26/89 was missing from In-Service testing records. Further review by plant staff revealed that on 2/14/89 while performing ST 6.6 F, the 'A' Core Spray pump minimum flow valve failed to close as required by the test. The test was then aborted and maintenance was initiated on the minimum flow valve. The ST was erroneously logged as completed unsatisfactory. The minimum flow valve was verified to be operable following maintenance on 2/21/89. However, the remaining parts of the aborted test were not performed. The Unit 2 mode switch was moved from shutdown to refuel on 3/14/89. The causes of the event are inadequate procedural controls for appropriately rescheduling aborted tests and personnel error. Administrative procedures and the Operators Manual will be revised to control aborted tests. Operations personnel will be informed of this event. There were no safety consequences as a result of this event. There were no previous similar events.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Requirements for the Report

This report is being submitted pursuant to 10 CFR 50.73 (a)(2)(1)(B) as a result of a quarterly Technical Specification (Tech Spec) surveillance not being performed.

Unit Conditions at Time of Event (3/14/89)

Unit 2 was in the REFUEL mode, at 0 percent rated thermal power. Besides the minimum flow valve (EIIS:V) for the 'A' Core Spray (EIIS:BM) pump (EIIS:P), there were no structures, systems, or components that were inoperable that contributed to this event.

Description of Event

On 10/26/90, an NRC Resident Inspector reviewing In-Service Testing (IST) data identified that the data from quarterly ST 6.6 F "Core Spray 'A' Pump, Valve, Flow Cooler," for the quarter prior to the Unit 2 start-up on April 26, 1989 was missing. Review by the IST Coordinator and Site Regulatory personnel resulted in this event being determined to be reportable on 11/2/90.

Further review and investigation revealed that on 2/14/89 while performing Surveillance Test 6.6 F "Core Spray 'A' Pump, Valve, Flow Cooler," the 'A' Core Spray pump minimum flow valve failed to close as required by step 11 of the test. The test was subsequently aborted at step 13 due to the minimum flow valve not automatically closing and because continued performance of the test would result in erroneous data. Operations personnel followed the applicable requirements in the Operators Manual and indicated next to Step 13 that the test was aborted and the reason why the test was aborted. Operations personnel then signed off the test as unsatisfactory due to failure of the minimum flow valve to close.

Operations personnel initiated a Maintenance Request (MR) for the valve and indicated the MR number on the test cover sheet. The Shift Technical Advisor performed the plant staff review and signed off the applicable space believing that the test would be reissued when the minimum flow valve was repaired. The Shift Technical Advisor then forwarded the test to the Operations Cognizant Engineer who recognized that the test was signed off unsatisfactory but he believed that the surveillance test coordinator would reissue the test when the minimum flow valve was repaired. The Operations Cognizant Engineer coordinates operations activities to ensure surveillance tests are performed when required and is required per an Administrative Procedure to take corrective action for failed tests and schedule them to be reperformed.

The test was then forwarded to the IST Coordinator for review. The IST Coordinator also noticed the test was signed off unsatisfactory but he also believed that the Surveillance Test Coordinator would reissue the test. The test was then forwarded to the Surveillance Test Coordinator who is responsible for logging the information on the test cover sheet into the scheduling computer. Since there was no indication on the cover sheet indicating that the test was aborted, the Surveillance Test Coordinator logged the test as completed unsatisfactory. This was actually untrue because the test was never completed. Since the test was logged as completed

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

unsatisfactory, the Technical Specification surveillance requirements for Pump, Valve, Flow and Cooler operability were believed to have been fulfilled.

The minimum flow valve was stroked and declared operable on 2/21/89. Stroking was performed to verify operability of the minimum flow valve but the aborted portions of the test were not performed.

On 3/14/89 at 0240, the Unit 2 mode switch was moved from shutdown to refuel without performing the required 'A' loop Core Spray Pump, Valve, Flow, and Cooler Surveillance Testing as required by Technical Specification 4.5.A.d. Prior to moving the mode switch to refuel, Core Spray was not required to be operable. In addition, on 4/26/89 a Unit 2 reactor start-up was performed. On 5/20/89 the required Core Spray 'A' loop surveillance testing was completed as scheduled.

Cause of the Event

The cause of this event has been determined to be inadequate procedural controls for rescheduling of aborted tests. Although the shift involved followed applicable requirements in the Operators Manual at the time the test was aborted, no indication of this was made on the test cover sheet. In addition, Administrative Procedures provide no guidance for aborting a test nor methodologies to ensure proper rescheduling.

A secondary cause is personnel error. The cognizant engineer is required per Peach Bottom Administrative Procedures to take corrective action for failed tests and ensure they are scheduled to be reperfomed. Corrective action was taken to repair the minimum flow valve but the failed test was not properly verified to be rescheduled. It was erroneously believed by the cognizant engineer that the test would be rescheduled by the ST Coordinator after maintenance work was performed on the minimum flow valve.

Analysis of the Event

There were no safety consequences as a result of this event. The minimum flow valve was verified to be operable following maintenance work. The surveillance test was performed satisfactorily on the next scheduled performance of the test on May 20, 1989. This proved that the 'A' loop of Core Spray was operable although the aborted portions of the surveillance were not performed on 2/14/89.

Corrective Actions

Administrative Procedures will be revised to more clearly delineate the Cognizant Engineer responsibilities, including specific direction for aborting test procedures. Administrative Procedures will be revised in conjunction with existing corrective action plans that resulted from a task force analysis concerning previous missed surveillances. The Operators Manual will be revised to include specific direction for aborting test procedures.

The pertinent information contained in this LER will be routed to the appropriate Operations personnel. The current Cognizant Engineers will also be informed of this event.

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TEXT (If more space is required, use additional NRC Form 3696A's) (17)

Previous Similar Events

There were no previous similar events identified on which an aborted surveillance test was inappropriately rescheduled resulting in a technical specification violation.