CCN 90-14239

PEACH BOTTOM—THE POWER OF EXCELLENCE

PHILADELPHIA ELECTRIC COMPANY
PEACH BOTTOM ATOMIC POWER STATION
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December 24, 1990

Docket No. 50-278

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

SUBJECT: Licensee Event Report
Peach Bottom Atomic Power Station - Unit 3

This LER concerns the inadvertent opening of a safety relief valve due to failure to follow procedure.

Reference:	Docket No. 50-278
Report Number:	3-90-016
Revision Number:	00
Event Date:	12/02/90
Report Date:	12/24/90
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,

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

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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Peach Bottom Atomic Power Station - Unit 3	0 5 0 0 0 2 7 8	1 OF 0 3

TITLE (4) Inadvertent Opening of a Safety Relief Valve due to Failure to Follow Procedure

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 5 0 0 0
1 2	0 2	9 0	9 0	0 1 6	0 0	1 2	2 4 9	0		0 5 0 0 0

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 0 0	20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

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

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On December 2, 1990, with Unit 3 at 100% power, a team of I&C technicians were performing Automatic Depressurization System "B" Logic System Functional Test. During the test, a jumper was installed in the wrong panel. This resulted in the 71J Main Steam Relief Valve opening for approximately 3/4 of a second. The cause of the event was failure to follow procedure with two contributing factors: inadequate understanding of double verification and inadequate pre-job briefing. One previous similar event was identified.

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

Requirements for the Report

This LER is being submitted pursuant to 10CFR 50.73(a)(2)(iv) to report the inadvertent actuation of an Engineered Safety Feature (ESF).

Unit Condition at the Time of the Event

Unit 3 was in the Run Mode at 100% power. There were no systems, structures or components that were inoperable that contributed to this event.

Description of Event

On December 2, 1990 at 11:00 AM with Unit 3 at 100% power, a team of four I&C technicians (utility, non-licensed) were performing a Logic System Functional Test on the "B" Automatic Depressurization System (EIIS:RV). They had successfully completed the "A" logic test earlier that day.

One step in the test states "Momentarily jumper between two terminal points in the C33 panel". This step requires double verification. Just prior to the step is a Caution Statement which reads "The next step is performed in panel C33". The technicians performing the test did not read the caution statement and remained in the C32 panel. The momentary jumper being placed in the wrong panel generated an open signal to the 71J Main Steam Relief Valve. The relief valve remained open for approximately 3/4 of a second and then closed.

The "A" logic test was performed entirely in the C32 panel. The "B" logic test starts in the C32 panel then moves to the C33 panel. This crew had not performed the "B" logic test before.

One technician was reading the test while the other performed the test, repeating the steps prior to performing them.

The NRC was notified of the event through the Emergency Notification System at 12:30 on December 2, 1990.

Cause of the Event

The cause of the event was a failure to follow procedure. In addition, the technicians' understanding of the term double verification was inadequate. Guidance for double verification is not consistent in Administrative Procedures. The pre-job briefing did not include a discussion of the consequences of an error.

Analysis of Event

There were no actual safety consequences that occurred as a result of this event. The relief valve was opened less than one second. All systems responded as designed. Reactor pressure decreased 5 psig and then returned to normal.

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

Corrective Actions

The technicians involved were formally counselled concerning the importance of following procedures and the incident has also been reviewed with I&C technicians. Appropriate procedures will be revised to clarify the definition of Double Verification.

The logic system functional tests will be reviewed. Written pre-job briefings will be developed from the review and I&C personnel training will be enhanced as necessary.

Previous Similar Events

One previous similar event was identified. Relief valve 71J lifted on Unit 2 on August 9, 1989 due to a momentary jumper being placed in the wrong panel. The corrective action for his event was to place a caution statement immediately before the test step which installs the jumper. The correction did not prevent the event since the technician did not read the caution statement.