Garrett D. Edwards
Plant Manager
Peach Bottom Atomic Power Station

PECO NUCLEAR
A Unit of PECO Energy

PECO Energy Company
1848 Lay Road
Delta, PA 17314-9032
717 456 4244
Fax 717 456 4232

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

Docket Nos. 50-277

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

This LER concerns Engineered Safety Features actuations due to personnel performance.

Reference:	Docket No. 50-277
Report Number:	2-96-006
Revision Number:	00
Event Date:	5/22/96
Report Date:	6/21/96
Facility:	Peach Bottom Atomic Power Station 1848 Lay Road, Delta, PA 17314

This LER is being submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(iv).

Sincerely,

for Garrett Edwards

GDE\JHG:jhg

enclosure

1/1
IE22

cc: B. Gorman, Public Service Electric & Gas
R. R. Janati, Commonwealth of Pennsylvania
INPO Records Center
T. T. Martin, US NRC, Administrator, Region I
R. I. McLean, State of Maryland
W. L. Schmidt, US NRC, Senior Resident Inspector
A. F. Kirby III, DelMarVa Power
H. C. Schwemm, VP - Atlantic Electric

NRC FORM 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

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

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

TITLE (4)

Engineered Safety Systems Actuation due to Personnel Performance

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	2 2	9 6	9 6	—	0 0 6	—	0 0	0 6	2 1	9 6		0 5 0 0 0
												0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	9 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
George Lengyel	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 5/22/96, at approximately 1305 hours, the Unit 2 'B' Reactor Protection System (RPS) power supply was unexpectedly lost. The loss of the 'B' RPS power supply initiated an outboard group III Primary Containment Isolation System (PCIS) isolation signal. As a result, the instrument nitrogen compressor outboard suction and the containment atmospheric control sample valves automatically closed. The cause of this event was human performance. No other procedural or human factors deficiencies were identified which could have contributed to this event. No actual safety consequences occurred as a result of this event. The RPS bus power supply was restored and the PCIS isolation signal was reset. The operator involved in this event was coached on self-checking practices and the need to remain focused on the task at hand. This event will be communicated to other operations personnel. Ten previous LERs were identified which concerned RPS bus trips and subsequent PCIS actuations. However, these events were the result of equipment deficiencies. Since the event described in this LER was the result of human performance, the corrective actions associated with the previous events could not have been expected to have prevented this event.

Requirements of the Report

This report is submitted pursuant to 10 CFR 50.73(a)(2)(iv) due to unplanned Engineered Safety Feature Actuation (ESF).

Unit Conditions at Time of Discovery

Unit 2 was in Mode 1 (RUN) at approximately 90% thermal reactor power. There were no other systems, structures, or components that were inoperable that contributed to the event.

Description of the Event

On 5/22/96, at approximately 1305 hours, the Unit 2 'B' Reactor Protection System (RPS) power supply was unexpectedly lost. The loss of the 'B' RPS power supply initiated an outboard group III Primary Containment Isolation System (PCIS) isolation signal. As a result, the instrument nitrogen compressor outboard suction and the containment atmospheric control sample valves automatically closed.

Cause of the Event

The cause of this event was human performance. At the time of this event, the 'B' RPS bus was being supplied by an alternate power supply and restoration activities were in progress to restore the normal 'B' RPS power source. During these restoration activities, the plant operator (utility:non-licensed) mistakenly operated the voltage regulator on the in-service alternate power supply instead of the out of service normal supply. A contributing factor which lead to this misoperation was a temporary delay in the restoration activities. During the delay, the plant operator began to pre-stage equipment required for the later steps in the restoration procedure associated with the alternate RPS power supply. When restoration activities were resumed, the plant operator had become focused on the alternate supply, and therefore mistakenly performed the voltage regulator adjustment on alternate supply instead of the normal supply as specified by the restoration procedure. No other procedural or human factors deficiencies were identified which could have contributed to this event.

Analysis of the Event

No actual safety consequences occurred as a result of this event. The PCIS occurred as designed. There was no adverse impact on the operation of Unit 2 as a result of this event.

Corrective Actions

The RPS bus power supply was restored and the PCIS isolation signal was reset.

The operator involved in this event was coached on self-checking practices and the need to remain focused on the task at hand.

This event will be communicated to other operations personnel.

Previous Similar Events

Ten previous LERs were identified which concerned RPS bus trips and subsequent PCIS actuations. However, these events were the result of equipment deficiencies. Since the event described in this LER was the result of human performance, the corrective actions associated with the previous events could not have been expected to have prevented this event.