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prior to being allowed to supervise another work crew or request

IF

another blocking permit.

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Unit Conditions Prior to the Event

Unit 2 and Unit 3 Shutdown For Environmental Qualification Inspection of Valve Motor-Operators

Description of the Event:

On August 13, 1986 at approximately 2345 hours, personnel error rendered the Unit 2 Core Spray System 'A' loop incapable of fulfilling its safety design basis. However, at the time, the Core Spray System was not required to be operable. The 'B' loop of the Core Spray System was blocked for the ongoing Environmental Qualification (EQ) inspections of valve motoroperators; however, the 'A' loop of the Core Spray System was not blocked. The minimum flow valves on both loops were not blocked; however, electrical construction personnel performed EQ inspections and wiring replacements on the minimum flow valve operators without authorization and blocking permits from Operations. During the course of their work, the construction personnel did not realize that they were working on unblocked equipment.

At approximately 2345 hours on August 13, 1986, control room personnel noticed that no Core Spray minimum flow valve position indication lights were on. Investigation revealed that the lights were off because of inadvertent control circuitry grounding during the unauthorized wiring replacements. This caused the motor control center valve control circuit fuses to fail, causing the minimum flow valves to fail in their normally closed position. If this event had occurred with the reactor at power, the Core Spray System could have been prevented from fulfilling its safety function because minimum flow pump protection was defeated.

The EIIS code for the affected system is BM, Low Pressure Core Spray.

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Consequences of the Event:

There were no adverse safety consequences in this case; however, this personnel error is considered to be serious. The Core Spray System was not required by the Technical Specifications to be operable because Unit 2 was in the cold shutdown condition and no work was being performed with the potential to drain the reactor vessel. Had a valid loss-of-coolant accident (LOCA) signal occurred, the 'A' loop of the Core Spray System would have performed its safety function because the reactor vessel was depressurized. However, if this event had occurred with reactor vessel pressure above Core Spray pump discharge pressure and a valid LOCA signal occurred, pump damage could have occurred because minimum flow pump protection was not available.

Considering the reduced scope of inspection and maintenance activities while the reactor is at power, and the allowable out-of-service operating restraints on safety related equipment imposed by the Technical Specifications, the probability of this error occurring at power is substantially lower than during a plant outage.

Cause of the Event:

The cause of this event was an error by an upgraded construction supervisor who was aware of the rules and controls in place to prevent this type of occurrence, but unintentionally failed to carry them out. At the time, this individual was upgraded to the position of crew supervisor (sub-foreman). He was fully qualified to hold that position.

To aid in the planning and scheduling of the EQ inspection a list of valves was being used, with markings to indicate which valves had been blocked and which valves had not yet been blocked. The individual supervising the work misinterpreted the list and, consequently, directed work to begin on the minimum flow valves (MO-2-14-05A thru D) without authorization and the proper safety blocking. The upgraded supervisor failed to verify that blocking permits for the minimum flow valves were issued prior to starting work.

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Corrective Actions:

Upon discovery, the partially complete EQ inspection work was immediately stopped. The Core Spray minimum flow valves were returned to normal and verified to be operable by 0600 hours on August 14, 1986. Permits were subsequently issued on August 14 for the minimum flow valves and the EQ inspection work was completed on August 17.

A meeting between station management and construction supervisors was held on August 14, 1986 prior to resuming the EQ inspection work to discuss the incident and identify measures to prevent recurrence. It was concluded that the blocking procedures were adequate.

The upgraded supervisor involved was counseled regarding his error and reminded of the need to verify that the necessary blocking permits have been issued for equipment prior to starting work. This individual will be required to successfully repeat the blocking permit test before he is allowed to request a blocking permit again. In addition, he is being denied the opportunity to supervise a work crew for 6 months.

Previous Similar Occurrences:

None.

PHILADELPHIA ELECTRIC COMPANY

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September 12, 1986

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 unauthorized work which disabled the Core Spray System minimum flow valves.

Reference:

Docket No. 50-277

Report Number: 2-86-21

Revision Number: 00

Event Date: Report Date:

August 13, 1986 September 12, 1986

Facility:

Peach Bottom Atomic Power Station

RD 1, Box 208, Delta, PA 17314

This LER is being submitted pursuant to the requirements of 10 CF: 50.73(a)(2)(v).

Very truly yours,

G. M. Leitch

Superintendent Nuclear Generation Division

co: Dr. Thomas E. Murley, Administrator, Region I, USNRC T. P. Johnson, NRC Resident Inspector