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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1) Peach Bottom Atomic Power Station Unit 3	DOCKET NUMBER (2) 0500 278	PAGE (3) 1 of 3
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TITLE (4)
 This LER reports multiple unplanned Engineered Safety Feature (ESF) actuations during planned modification activities in the Main Control Room.

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 Name	Docket Number
09	01	99	99	064	00	10	01	99	Facility Name	Docket Number

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more) (11)	20.2201(B)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
POWER LEVEL (10) 89		20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	X 50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 336A
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Steven C. Beck	TELEPHONE NUMBER (include area code) 717.456.3243
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

Cause	System	Component	Manufacturer	Reportable to EPIX	Cause	System	Component	Manufacturer	Reportable to EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if yes, complete EXPECTED SUBMISSION DATE)	X	NO	EXPECTED Submission Date (15)	Month	Day	Year
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On Wednesday, September 1, 1999 at approximately 0850 hours, during planned modification activities on a Main Control Room panel, the 3A Reactor Protection System (RPS) bus was inadvertently deenergized. An electrician inadvertently repositioned the RPS Alternate Power Transfer switch which caused the deenergization of the 3A RPS bus. This caused the inboard PCIS Group III isolation valves to close and initiated the Unit 3 Standby Gas Treatment (SGT) system. This constituted an unplanned Engineering Safety Feature (ESF) actuation and resulted in a non-emergency four hour notification to the NRC per 10 CFR 50.72 (b) (2) (ii).

The operating crew responded to the loss of power to the 3A RPS bus per appropriate plant procedures and restored all PCIS Group III isolation valves systems and SGT system to their normal configurations. This condition is reportable per 10 CFR 50.73 (a) (2) (iv).

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FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Peach Bottom Atomic Power Station Unit 3	0500-278	Year	Sequential Number	Revision Number	2 of 3
		99	004	00	

TEXT (If more space is required, use additional copies of NRC form 336A) (17)

Requirements of the Report

This LER is being submitted in accordance with 10 CFR 50.73(a)(2)(iv) as a result of unplanned Engineered Safety Feature (ESF) actuations: Unit 3 Inboard PCIS Group III isolation valve closure (EIIS:JM) and actuation of the Standby Gas Treatment (SGT) System

Unit Conditions at Time of Event

Unit 3 was operating at approximately 89 percent reactor power (EIIS: RCT) with unit coastdown in progress. An electrician (vendor) was performing scheduled work on a Main Control Room panel.

Description of the Event

During the morning of 9/1/99, an electrician (vendor) was installing a switch in a Main Control Room panel to support the Recirculation Pump Trip (EOC-RPT) plant modification. The modification requires installation of an EOC-RPT switch in a location adjacent to the 3A RPS M-G Set Alt Feed Transfer Switch.

The lower mounting screw for this switch was located under the switch handle. In order to access this lower mounting screw, the electrician repositioned the new switch, which is located six inches below the RPS MG Set transfer switch. The new switch was not electrically connected to any plant equipment. After tightening the lower mounting screw, the electrician descended one step on a small stepladder, losing physical and visual contact of the new switch. The electrician then proceeded to place the new switch in its original position, but inadvertently placed the 'A' RPS MG Set transfer switch from 'NORMAL' to 'OFF'. Upon hearing annunciators alarming in the control room, the electrician realized that he had repositioned the 3A RPS M-G Set Alt Feed Transfer Switch instead of the EOC-RPT switch. The electrician stopped all work and informed the Shift Supervisor of the mistake.

Repositioning of the 3A RPS M-G Set Alt Feed Transfer Switch resulted in a loss of power to the 3A RPS bus. As a result, the following ESF actuations occurred: Group III inboard PCIS valves closed and the SGT system started per plant design.

After verifying that all appropriate automatic actions had taken place, the operating crew restored power to the 3A RPS bus and returned all ESFs to the appropriate configuration per plant procedures.

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Causes of the Event

This event was primarily caused by the electrician failing to self check his work. The electrician selected a switch and repositioned it without first verifying that the correct switch had been selected.

Less than adequate physical barriers to protect sensitive and critical equipment during plant work was a secondary cause to the event.

Analysis of the Event

There were no safety consequences due to this event. With the loss of the 3A RPS bus, if an actual event would have occurred during the loss of power, the capability to manually or automatically scram the reactor and place the plant in a safe shutdown condition still existed.

PCIS Inboard Group III isolation valves closed and the SGT system initiated per plant design. The unit continued operation at 89 percent power during the recovery from the event. The 3A RPS Bus was returned to the normal lineup.

Corrective Actions

All control room work was ceased immediately and a standdown meeting was held to reinforce management expectations for self-verification and component manipulation.

All remaining modification work was reviewed to identify potential similar conditions.

The work was evaluated to determine if additional barriers could be used to prevent inadvertent switch manipulation. Additional barriers such as physical barriers to sensitive equipment, and enhanced pre-job briefs are now being used to enhance human performance.

Previous Events

There were no previous events noted where a loss of RPS power caused an ESF actuation. However, there was an instance where ESF actuations occurred due to a loss of power because of inadequate self checking:

LER 3-98-005, Inadvertent Unit 3 Electrical Bus E33 Trip (Engineered Safety Feature Actuation) During Performance of Unit 2 Electrical Bus E32 Surveillance Test, occurred on October 25, 1998. During a surveillance, the E33 bus was inadvertently deenergized when a technician and peer checker performed an action on an incorrect relay. This event caused an ESF actuation due to the momentary interruption of power to E33.