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Southern Nuclear Operating Company
the southern electric system

J. D. Woodard
Vice President
Farley Project

10 CFR 50.73

March 4, 1993

Docket No. 50-364

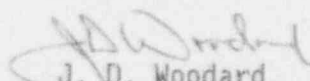
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

Joseph M. Farley Nuclear Plant - Unit 2
Licensee Event Report No. LER 93-001-00

Gentlemen:

Joseph M. Farley Nuclear Plant, Unit 2 Licensee Event Report Number
LER 93-001-00 is being submitted in accordance with 10 CFR 50.73. If you
have any questions, please advise.

Respectfully submitted,


J. D. Woodard

BHW:cht-licevent.nrc

Enclosure

cc: Mr. S. D. Ebner
Mr. G. F. Maxwell

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Joseph M. Farley Nuclear Plant - Unit 2										DOCKET NUMBER (2) 05000364		PAGE (3) 1 OF 3		
TITLE (4) Inadvertent Safety Injection Due To Personnel Error														
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)				
MONTH	DAY	YEAR	YEAR	SEQ NUM	REV	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)			
02	05	93	93	001	00	03	04	93			05000			
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)												
5		20.402(b)				20.405(c)				X 50.73(a)(2)(iv)		73.71(b)		
POWER LEVEL		000				20.405(a)(1)(i)				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)		
		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				
R. D. Hill, General Manager - Nuclear Plant										AREA CODE		899-5156		
205														
COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)														
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRPDS
SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)										<input checked="" type="checkbox"/> NO				
ABSTRACT (16)														

On 2-5-93, preparations were being made for Unit 2 entry into mode 4 after a cold shutdown outage. At 0344 on 2-5-93, an inadvertent 'A' train safety injection (SI) occurred during the performance of FNP-2-STP-33.0A, "Solid State Protection System Train A Operability Test". The control room responded to the inadvertent actuation and subsequently terminated the SI and returned the Engineered Safety Features (ESF) systems to their pre-SI alignment. All ESF equipment functioned properly in response to the 'A' train SI signal.

During performance of the surveillance test procedure (STP) with the plant in Mode 5, the lights on the Bypass and Permissive panel should illuminate when the low pressurizer pressure safety injection and low steamline pressure safety injection signals are blocked. When attempting to block these signals the operator noted the lights did not illuminate. He incorrectly concluded this was the correct response and failed to communicate this observation to other crew members and correct the problem before proceeding to the next step of the procedure. FNP has concluded that the failure to block the safety injection signals as designed was due to the misoperation of the block-reset hand switches.

This event was caused by cognitive personnel error. The individual involved in this event has been disciplined for failure to use self-verification techniques and to effectively communicate with other members of his crew. As an enhancement all STP-33.0 series procedures have been revised to include the expected Bypass and Permissive Panel lamp indication based on plant conditions. This incident will be covered in licensed operator requalification training.

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TEXT

Plant and System Identification

Westinghouse - Pressurized Water Reactor

Energy Industry Identification System codes are identified in the text as [XX].

Summary of Event

On 2-5-93, preparations were being made for Unit 2 entry into mode 4 after a cold shutdown outage. At 0344 on 2-5-93, an inadvertent 'A' train safety injection (SI) [JG] occurred during the performance of FNP-2-STP-33.0A, "Solid State Protection System Train A Operability Test" due to cognitive personnel error. The control room responded to the inadvertent actuation and subsequently terminated the SI and returned the Engineered Safety Features (ESF) systems to their pre-SI alignment. All ESF equipment functioned properly in response to the 'A' train SI signal.

Description of Event

On 2-5-93 at 0300, preparations were being made for Unit 2 entry into mode 4 following a cold shutdown outage.

Operations personnel were performing FNP-2-STP-33.0A, "Solid State Protection System Train A Operability Test". The test was successfully completed up to the step in which the operator blocks the low pressurizer pressure and low steamline pressure safety injection signals. When these signals are blocked with the plant in these conditions (Mode 5), lights on the Bypass and Permissive panel illuminate. When the operator attempted to block the low pressurizer pressure and low steamline pressure safety injection signals, the lights did not illuminate. He noted these lights did not illuminate and incorrectly concluded this was the correct response. He failed to communicate this observation to other crew members and to correct the problem before proceeding to the next step of the procedure. At approximately 0344, SSPS was returned to normal which resulted in a safety injection on 'A' train.

All ESF equipment functioned properly in response to the 'A' train SI signal.

The control room responded to the inadvertent actuation and subsequently terminated the SI and returned the ESF systems to their pre-SI alignment.

FNP has concluded that the failure to block the safety injection signals as designed was due to the misoperation of the block-reset hand switches. The operator mistakenly placed the block-reset switches to the reset position vice the block position. Had he positioned the switches to block, the bypass and permissive panel lights would have illuminated, signifying that the low pressurizer pressure and the low steamline pressure SI signals were blocked.

Subsequent to the event, the SSPS was extensively tested to verify that there was no equipment malfunction and STP-33.0A was performed successfully prior to returning to power.

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TEXT

Cause of Event

This event was caused by cognitive personnel error. At this step in the surveillance test procedure (STP) and the plant in this condition (Mode 5), the lights on the Bypass and Permissive panel illuminate when the low pressurizer pressure safety injection and low steamline pressure safety injection signals are blocked. The operator noted these lights did not illuminate. He incorrectly concluded this was the correct response and failed to communicate this observation to other crew members and correct the problem before proceeding to the next step of the procedure. FNP has concluded that the failure to block the safety injection signals as designed was due to the misoperation of the block-reset hand switches.

Reportability Analysis and Safety Assessment

This event is reportable due to the actuation of ESF equipment.

All 'A' train ESF equipment functioned properly in response to this event.

The health and safety of the public was not affected.

Corrective Action

The individual involved in this event has been disciplined for failure to use self-verification techniques and to effectively communicate with other members of his crew. As an enhancement all STP-33.0 series procedures have been revised to include the expected Bypass and Permissive Panel lamp indication based on plant conditions. This incident will be covered in the licensed operator requalification training program.

Additional Information

Similar events involving safety injections caused by personnel error were reported in Units 1 LER 89-006-00, 88-024-00, 92-003-00 and Unit 2 LER 89-005-00.

No components failed during this event.

This event would not have been more severe if it had occurred under different operating conditions.