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Southern Nuclear Operating Company
the southern electric system

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Docket Nos. 50-348
50-364

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

Joseph M. Farley Nuclear Plant
Reply to Notice of Violation
Report Number 50-348/93-04-01 and 50-364/93-04-01
NRC Inspection of February 10 - March 22, 1993

Gentlemen:

This letter refers to a two part Notice of Violation in the subject inspection report. The violation states:

> Technical Specification 6.8.1 requires that applicable written procedures recommended in Appendix A of Regulatory Guide (RG) 1.33, Revision 2, 1978 shall be established, implemented and maintained.
>
> Administrative Procedure FNP-0-AP-5, Surveillance Program Administrative Control, Revision 16, Step 3.4.4, requires tests to be performed as written by qualified personnel. Step 3.4.3 requires notification to the Operations Shift Supervisor of failures to comply with surveillance test acceptance criteria.
>
> Surveillance test procedure FNP-2-STP-45.4, ECCS Valve ISI Test During Cold Shutdown, Revision 7, step 5.8 requires the reactor coolant system hot leg isolation valve to be "cycled" (opened then reclosed). Step 5.9.1 and 5.9.2 requires the opening of the charging pump discharge header isolation valves subsequent to the completion of step 5.8.
>
> Surveillance test procedure FNP-2-STP-33.0A, Solid State Protection System Train A Operability Test, Revision 12, Step 5.7.5, requires the "block-reset" switches for the "pressurizer pressure safety injection" circuitry and the "steamline pressure safety injection" circuitry to be placed in the "block" position. A caution statement proceeding step 5.7.6 states that step 5.7.5 must be accomplished before returning the "input error inhibit" switch to the "normal" position, and Step 5.7.6 states that the "input error inhibit" switch is to be returned to the "normal" position.

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a) Contrary to the above, on February 2 while operators were conducting FNP-2-STP-45.4, the "operator-at-the-controls" failed to properly follow STP-45.4 in that he opened the charging pump discharge header valves (Step 5.9.1 and 5.9.2) prior to closing the reactor coolant system hot leg isolation valve (Step 5.8). This failure resulted in an emergency core cooling system valve misalignment and an injection of 1,384 gallons of water into the reactor coolant system.

b) Contrary to the above, on February 5 while operations was performing FNP-2-STP-33.0A; during the performance of step 5.7.5 the operator failed to respond to the "lack of proper illuminated light" feedback indication while placing the "block-reset" switches in the block position. The operator then proceeded to step 5.7.6 without communicating this observation to other crew members or to the shift supervisor. As a result, a safety injection occurred.

This is a Severity Level IV violation (Supplement 1).

Admission or Denial

The above violation occurred as described in the subject report.

Reason for Violation

a) This violation was caused by personnel error. The OATC did not self-check his operation of MOV8886 and did not sign off step 5.8 before proceeding to step 5.9. A contributing factor was that multiple actions were included in step 5.8.

b) This violation was caused by personnel error. The operator did not self-check his action and did not report an unexpected condition to the shift supervisor.

Corrective Action Taken and Results Achieved

a) The flow was stopped by the operator closing MOV8886.

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

Corrective Steps To Avoid Further Violations

The following actions have been taken to prevent recurrence of this event:

a) The operator involved has been coached on self-check and procedure compliance. Event information has been discussed with on-shift Operations personnel. The procedure has been revised removing multiple steps in step 5.8 of STP-45.4

b) The individual involved in this event has been disciplined for failure to use self-check techniques and to effectively communicate with other members of his crew. Also, 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. A training change notice has been issued to all licensed personnel concerning this incident.

FNP is continuing to support the STAR program. This includes periodic news letters that inform personnel of potential plant events that were prevented through the use of STAR techniques, and other periodic promotional activities.

Date of Full Compliance

April 16, 1993

Confirmation

I affirm that this response is true and complete to the best of my knowledge, information, and belief. The information contained in this letter is not considered to be of a proprietary nature.

In response to concerns stated in the March 26, 1993 NOV transmittal letter, attached is an outline of additional initiatives which have been introduced at FNP to enhance personnel performance and reduce human error events.

Respectfully submitted,

SOUTHERN NUCLEAR OPERATING COMPANY

J. D. Woodard

BHW:cht-NOV93-04.bhw

cc: Mr. S. D. Ebneter
Mr. T. A. Reed
Mr. G. F. Maxwell

Attachment

Supplemental Information

SNC recognizes that the incorporation of the STAR program into FNP's culture will take some time, and that the attention it has received as a new program might have been reduced slightly by the timing of the forced outage on Unit 1. Increased attention was given as we entered the forced outage that followed these events and no similar incidents have occurred since. FNP will be working on ways to enhance the STAR program awareness level until it becomes an established part of our culture and day-to-day business.

In addition, FNP has implemented other programs designed to improve personnel performance, communication and team work that are not specifically part of the STAR program. These programs include the following:

* **Team Building Sessions:** Plant personnel are sent to a three day program on team building. There have been approximately 245 people included in the program so far, and all Operations personnel will have attended by June 30, 1993. This program promotes improved communication and working as a team.

* **Operations Weekly Newsletter:** A weekly newsletter is distributed to Operations personnel containing lessons learned from events, policy changes made by the Operations department, and other items of interest.

* **Control Room Formality and Communication:** Two new procedures have been developed that improve and standardize plant communication and control room formality. To ensure consistent philosophy and commitment, approximately 112 man-hours have been spent with the General Manager, Assistant General Manager - Operations, Operations Manager, and the four Operations Superintendents collectively talking with each Shift Supervisor on an individual basis.