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Alabama Power

The southern electric system

May 13, 1991

10 CFR 50.73

Docket No. 50-364

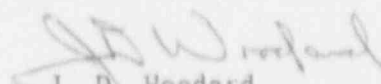
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

Joseph M. Farley Nuclear Plant - Unit 2
Licensee Event Report No. LER 91-003-00

Gentlemen:

Joseph M. Farley Nuclear Plant, Unit 2, Licensee Event Report No. LER 91-003-00 is being submitted in accordance with 10 CFR 50.73. If you have any questions, please advise.

Respectfully submitted,


J. D. Woodard

JDW/BHW:map 0185

Enclosure

cc: Mr. S. D. Ebnetter
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 4		
TITLE (4) Both Trains Of Ctl Rm Emer Air Cleanup Sys Inoperable Due To Both Trains Of U1 SW Being Inoperable														
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)			
											05000			
04	16	91	91	003	00	05	13	91			05000			
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)														
OPERATING MODE (9)		1		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)				
POWER LEVEL		100		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)				
				20.405(a)(1)(iii)		X 50.73(a)(2)(i)		50.73(a)(2)(viii)(A)						
				20.405(a)(1)(iv)		50.73(a)(2)(iii)		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 D. N. Morey, General Manager - Nuclear Plant										TELEPHONE NUMBER AREA CODE 205 899-5156				
COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)														
CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NFRDS	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NFRDS					
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)														

At 1747 on 4-16-91, Technical Specification 3.0.3 was entered because both trains of the shared control room emergency air cleanup system were inoperable. Both trains were inoperable because the respective Unit 1 service water trains supplying the air conditioners were inoperable.

The control room air conditioning units can obtain service water from Unit 1 only, which was in a refueling outage. The Unit 1 "B" train service water system had been removed from service for maintenance and modifications. Personnel working on motor-operated valves mistakenly closed the valve supplying Unit 1 "A" train service water to the Auxiliary Building. With both trains of Unit 1 Auxiliary Building service water inoperable, both trains of the shared control room emergency air cleanup system were inoperable.

Upon investigation, control room personnel determined the cause and the Unit 1 "A" train service water valve was opened. The "A" train emergency air cleanup system was returned to service at 1824 on 4-16-91, at which time Technical Specification 3.0.3 was no longer in effect.

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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

At 1747 on 4-16-91, Technical Specification 3.0.3 was entered because both trains of the control room emergency air cleanup system were inoperable. Both trains were inoperable because the respective Unit 1 service water trains supplying the air conditioner systems were inoperable.

Description of Event

On 4-16-91, Unit 2 was operating at approximately 100 percent power. Unit 1 was in a refueling outage and fuel had been removed from the reactor vessel. The "B" train control room emergency air cleanup system [VI] was inoperable because the Unit 1 "B" train service water system [BI] had been removed from service and drained for maintenance and modifications.

The shared control room air conditioners, which are components in the control room emergency air cleanup system, use service water for their chiller condensers. The "A" and "B" train air conditioners are supplied service water only from the respective Unit 1 service water trains. Technical Specification 3.7.7 requires both trains of the emergency air cleanup system to be operable during Modes 1 - 4.

At 1747, contract personnel working on motor-operated valves (MOVs) in a valve box mistakenly closed the valve supplying Unit 1 "A" train service water to the Auxiliary Building. Work was scheduled on both Unit 1 "B" train Turbine Building inlet service water isolation valves (MOVs 514 and 517). The Shift Supervisor was concerned that if both valves were opened at the same time leakage in the Turbine Building may occur. The Shift Supervisor requested that MOV 514 be verified closed by the workers prior to working on MOV 517. This was not in accordance with approved plant procedures which would have required Operations personnel to establish work boundaries.

To comply with the Shift Supervisor's request, the contract personnel located what they believed to be MOV 514 and closed it. However, they mistakenly operated the wrong valve resulting in isolating Unit 1 "A" train service water to the Auxiliary Building. With both trains of the Unit 1 Auxiliary Building service water inoperable, both trains of the shared control room emergency air cleanup system were inoperable and Technical Specification 3.0.3 was entered for Unit 2.

Control room annunciators immediately indicated the loss of the Unit 1 "A" train service water at 1747. Personnel were dispatched to determine the cause of the problem. At 1805 it was determined that the "A" train Auxiliary Building service water motor-operated isolation valve had been mistakenly closed. The valve was manually opened and the "A" train air conditioning unit was declared operational at 1824.

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Cause of Event

The Unit 1 "A" train service water system was rendered inoperable due to cognitive personnel error. Personnel mistakenly closed the valve supplying service water to the Unit 1 Auxiliary Building due to inattention to detail. Also, the Shift Supervisor failed to follow existing procedures for establishing work boundaries.

Reportability Analysis and Safety Assessment

This event is reportable because both control room emergency air cleanup systems were inoperable and Technical Specification 3.0.3 was entered. In addition, loss of both trains of Unit 1 Auxiliary Building service water caused both trains of the Unit 1 spent fuel pool cooling system to be inoperable. However, the cooling was restored after 37 minutes. Control room temperature remained acceptable and the Unit 1 spent fuel pool temperature only increased three degrees. Therefore, no adverse effects resulted from these systems being inoperable. The isolation function of the control room emergency air cleanup system was unaffected, and the control room pressurization units remained operable. Further, the control room emergency air cleanup system was not needed at this time. The health and safety of the public were not affected by this event.

Corrective Action

- The Unit 1 "A" train service water valve was opened.
- The "A" train emergency air cleanup system was returned to service at 1824 on 4-16-91, at which time Technical Specification 3.0.3 was no longer in effect.
- The Shift Supervisor involved has been disciplined for failure to follow procedure.
- All Shift Supervisors have been instructed to use only existing proceduralized controls when required to establish boundaries for work activities.
- All motor-operated valve project foremen have been retrained on their job responsibilities including identification and location of motor-operated valves.
- Appropriate plant and vendor personnel onsite at the time have been instructed on this event.
- A design change to provide service water to the control room air conditioners from either unit is scheduled to be implemented in 1992.

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Additional Information

No components failed during this event.

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

Unit 2 LER 86-011-00 reported a 10-15-86 event in which both control room emergency air cleanup systems were inoperable due to loss of both trains of Unit 1 service water during a Unit 1 refueling outage. However, in this previous event, the second train of service water had been intentionally secured because it was believed to be the source of a service water leak.