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Southern Nuclear Operating Company
the southern electric system

June 6, 1995

Docket No: 50-364

10 CFR 50.73

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

Joseph M. Farley Nuclear Plant - Unit 2
Licensee Event Report No. 95-003-00
Loop 2A Overtemperature Delta Temperature
Channel Inoperable Due to Personnel Error

Ladies and Gentlemen:

Joseph M. Farley Nuclear Plant Licensee Event Report No. 95-003-00 is being submitted in accordance with 10 CFR 50.73. If you have any questions, please advise.

Respectfully submitted,

Dave Morey

DPH:maf LOOPD.DOC

Enclosure

cc: Mr. S. D. Ebner
Mr. B. L. Siegel
Mr. T. M. Ross

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PDR ADOCK 05000364
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Joseph M. Farley Nuclear Plant - Unit 2

DOCKET NUMBER (2)

05000364103

PAGE (3)

3

TITLE (4)

Loop 2A Overtemperature Delta Temperature Channel Inoperable Due to Personnel Error

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 NAMES											
0	5	0	7	9	5	9	5	0	0	3	0	0	6	0	6	9	5	N/A		

OPERATING
MODE (9)

1

POWER

LEVEL (10)

94

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 2.201 (Check one or more of the following) (11)

20.402(b)

20.405(a)(1)(i)

20.405(a)(1)(ii)

20.405(a)(1)(iii)

20.405(a)(1)(iv)

20.405(a)(1)(v)

20.405(c)

50.36(c)(1)

50.36(c)(2)

50.73(a)(2)(i)

50.73(a)(2)(ii)

50.73(a)(2)(iii)

50.73(a)(2)(iv)

50.73(a)(2)(v)

50.73(a)(2)(vi)

50.73(a)(2)(vii)(A)

50.73(a)(2)(vii)(B)

50.73(a)(2)(x)

73.71(b)

73.71(c)

OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME

R.D. Hill, General Manager - Nuclear Plant

TELEPHONE NUMBER

AREA CODE

334899-5156

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED

SUBMISSION

DATE (15)

MONTH

DAY

YEAR

YES (If yes, complete EXPECTED SUBMISSION DATE)

X NO

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 0130, on May 7, 1995, with Unit 2 in Mode 1 operating at 94 percent the Loop 2A Overtemperature Delta Temperature (OTΔT) channel [JC] was determined to be inoperable during the performance of a channel check in that the maximum acceptable deviation between Loop OTΔT channels had been exceeded. The Loop 2A OTΔT channel was declared inoperable and placed in a tripped condition. The as-found setting for the Loop 2A OTΔT channel indicated that the associated pressurizer pressure input potentiometer had apparently been inadvertently adjusted to an out of tolerance setting during a nuclear instrumentation calibration performed during post-refueling adjustments on 4/29/95. This inadvertent adjustment resulted in the 2A OTΔT channel having a reactor trip setpoint outside the limitations for operability. However, for the plant conditions that existed at that time, it was not recognizable as being inoperable using normal control room indications. Therefore, the inoperable channel was not placed in the trip condition within 6 hours as required by Technical Specifications 3.3.1.

An investigation determined that the deviation was attributable to personnel error. The channel was adjusted and returned to service 5/7/95 at 0430 hours. In addition, subsequent to 4/29/95, nuclear instrumentation calibrations were completed satisfactorily. The individual that apparently inadvertently adjusted an inappropriate potentiometer has been coached concerning this incident. Lessons learned have been addressed to personnel in shop information meetings.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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Joseph M. Farley Nuclear Plant - Unit 2	05000364	95	-003	-00	2	OF	3

TEXT (If more space is required, use additional NRC Form 366A's)(17)

Plant and System Identification

Westinghouse - Pressurized Water Reactor

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

Description of Event

At 0130, on May 7, 1995, with Unit 2 in Mode 1 operating at 94 percent the Loop 2A Overtemperature Delta Temperature (OTΔT) channel [JC] was determined to be inoperable during the performance of a channel check in that the maximum acceptable deviation between Loop OTΔT channels had been exceeded. The Loop 2A OTΔT channel was declared inoperable and placed in a tripped condition. The as-found setting for the Loop 2A OTΔT channel indicated that the associated pressurizer pressure input potentiometer had apparently been inadvertently adjusted to an out of tolerance setting during a nuclear instrumentation calibration performed during post-refueling adjustments on 4/29/95 when Unit 2 was operating at approximately 33 percent power. The pressurizer pressure input potentiometer associated with the Loop 2A OTΔT channel is located on a common card and adjacent to the potentiometer which should have been adjusted during nuclear instrumentation adjustments. This inadvertent adjustment resulted in the 2A OTΔT channel having a reactor trip setpoint outside the limitations for operability. However, for the plant conditions that existed at that time, it was not recognizable as being inoperable using normal control room indications. Control room channel indicators for the Loop OTΔT channels indicate approximately 150% of ΔT (upper end of the indication band) at 33 percent power. Therefore, the inoperable channel was not placed in the trip condition within 6 hours as required by Technical Specifications 3.3.1. The channel was adjusted and returned to service 5/7/95 at 0430 hours. In addition, subsequent to 4/29/95, nuclear instrumentation calibrations were completed satisfactorily.

Cause of Event

An investigation determined that the deviation was attributable to personnel error in that an individual apparently inadvertently adjusted an inappropriate potentiometer while performing a nuclear instrumentation calibration.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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		9 5	- 0 0 3	- 0 0	3	OF	3

TEXT (If more space is required, use additional NRC Form 366A's)(17)

Safety Assessment

This event is reportable in that the action statement associated with Technical Specification 3.3.1 for an inoperable OTAT channel was not met. Loops 2B and 2C OTAT reactor trip inputs remained capable of performing their reactor trip function during the time period in which Loop 2A was outside of its acceptable limits for operability.

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

Corrective Action

The channel was adjusted and returned to service 5/7/95 at 0430 hours.

Subsequent to 4/29/95, nuclear instrumentation calibrations were completed satisfactorily.

The individual that apparently inadvertently adjusted an inappropriate potentiometer has been coached concerning this incident.

The lessons learned from this incident concerning adjustments of potentiometers have been addressed to other technicians in shop information meetings.

Additional Information

No similar LERs have been reported by Farley Nuclear Plant.

As power level was increased on May 6, 1995, evening shift control room personnel had an opportunity to identify the abnormal response of the Loop 2A OTAT channel prior to the indicated maximum acceptable deviation being exceeded. Additional corrective action will be taken relative to the untimely identification of this deviation. This corrective action will be documented in Farley Nuclear Plant's response to NRC Inspection Report 95-10.