

LICENSEE EVENT REPORT (LER)

| | | | | | | | | | | | | | | | | |
|--|--------|--|----------------|---------------------|-----------------|------------------|-----------------|-----------|----------------|--|--|--|------------------|--|-----|------|
| FACILITY NAME (1) Joseph M. Farley - Unit 1 | | | | | | | | | | DOCKET NUMBER (2) 0 5 0 0 0 3 4 8 | | | | PAGE (3) 1 OF 02 | | |
| TITLE (4) Isolation of A and B Train RHR Suction Valves Due to Single Cause | | | | | | | | | | | | | | | | |
| 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 | | | | DOCKET NUMBER(S) | | | |
| 0 5 | 0 6 | 8 5 | 8 5 | 0 0 8 | 0 0 | 0 6 | 0 5 | 8 5 | | | | | 0 5 0 0 0 | | | |
| OPERATING MODE (9) | | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11) | | | | | | | | | | | | | | |
| 5 | | 20.402(b) | | | | 20.406(c) | | | | 50.73(a)(2)(iv) | | | | 73.71(b) | | |
| POWER LEVEL (10) | | 20.406(a)(1)(i) | | | | 50.36(e)(1) | | | | <input checked="" type="checkbox"/> 50.73(a)(2)(v) | | | | 73.71(e) | | |
| 0 0 0 | | 20.406(a)(1)(ii) | | | | 50.36(e)(2) | | | | <input checked="" type="checkbox"/> 50.73(a)(2)(vii) | | | | OTHER (Specify in Abstract below and in Text, NRC Form 365A) | | |
| | | 20.406(a)(1)(iii) | | | | 50.73(a)(2)(i) | | | | 50.73(a)(2)(viii)(A) | | | | | | |
| | | 20.406(a)(1)(iv) | | | | 50.73(a)(2)(ii) | | | | 50.73(a)(2)(viii)(B) | | | | | | |
| | | 20.406(a)(1)(v) | | | | 50.73(a)(2)(iii) | | | | 50.73(a)(2)(ix) | | | | | | |
| LICENSEE CONTACT FOR THIS LER (12) | | | | | | | | | | | | | | | | |
| NAME | | | | | | | | | | TELEPHONE NUMBER | | | | | | |
| J. D. Woodard | | | | | | | | | | 2 0 5 8 9 9 - 5 1 5 6 | | | | | | |
| COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13) | | | | | | | | | | | | | | | | |
| CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NPD'S | | CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NPD'S | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 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 (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 0925 on 5-6-85, both trains of the Residual Heat Removal System (RHR) and the Overpressure Mitigation System (OMS) were made inoperable by a common cause. At 0920 on 5-6-85, the suction valve for the "A" train RHR system closed. Attempts to open the valve from the main control board were unsuccessful and the operators stopped the "A" train RHR pump.

Similarly, the suction valve for the "B" train RHR system closed. Attempts to open this valve from the main control board were unsuccessful and the operators stopped the "B" train RHR pump at 0925. Closing of these valves also isolated the OMS relief valves. Power was removed from the two valves and they were manually opened allowing the "A" train RHR pump to be re-started at 1012 on 5-6-85 and the "B" train RHR pump to be restarted at 1020. This restored both trains of RHR and OMS to operability.

This event was caused by procedural inadequacy and personnel error. Power which had been procedurally removed from the valves was incorrectly restored while an auto close signal from the RCS pressure transmitters was present.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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| FACILITY NAME (1) J. M. Farley - Unit 1 | DOCKET NUMBER (2) 0 5 0 0 0 3 4 8 | LER NUMBER (6) | | | PAGE (3) | | |
| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | | | |
| | | 8 5 | 0 0 8 | 0 0 | 0 2 | OF | 0 2 |

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

At 0925 on 5-6-85, both trains of the Residual Heat Removal System (RHR) and the Overpressure Mitigation System (OMS) were made inoperable by a common cause. The unit was in Mode 5 with a Reactor Coolant System temperature of 111 degrees and at atmospheric pressure. During the unit cooldown, the breakers which supply power to MOV-8701B (the suction valve for the "A" train RHR system from the "C" RCS loop) and MOV-8702B (the suction valve for the "B" train RHR system from the "A" RCS loop) had been opened as required by procedure to prevent closing of these valves on an inadvertent isolation signal. This is to prevent inadvertent isolation of the OMS relief valves from the RCS. Work was later initiated on a containment electrical penetration which also required these breakers to be open. Hold tags were placed on the already open breakers for this work.

Subsequently, a modification was started on RCS pressure transmitters PT-402 and PT-403. This work required the transmitters to be placed in "test" generating an auto close signal for the RHR suction motor operated valves. The procedure for work on the transmitters contained a precaution to install jumpers to defeat this auto close signal. Because power was removed from the valves, the maintenance personnel involved incorrectly assumed that it was not necessary to follow the precaution.

Work was completed on the electrical penetration. In clearing the tagging order for this work, operations personnel referred to the system operating procedure. This procedure only recognized the condition for normal operation and did not specify that the breaker could be open when RCS temperature was below 180°F. Hence, the operations personnel failed to recognize that the breakers should be left open and the electrician was directed to close the breakers. The electrician closed the breaker that supplies power to MOV-8701B at 0920 on 5-6-85. Since the auto close signal from the RCS pressure transmitters was present, the valve closed isolating the "A" train RHR suction and isolating one of the two OMS relief valves from the RCS. Attempts to open the valve from the main control board were unsuccessful due to the presence of the auto close signal and the operators stopped the "A" train RHR pump to prevent damage to the pump. In accordance with the tagging order, the electrician closed the breaker for MOV-8702B at 0924 and this valve closed isolating "B" train RHR suction and isolating the remaining OMS relief valve. Attempts to open this valve from the main control board were unsuccessful and the operators stopped the "B" train RHR pump at 0925.

Power was removed from MOV-8701B and MOV-8702B and the valves were opened using the local manual operators. The "A" train RHR pump was restarted at 1012 on 5-6-85 and the "B" train RHR pump was restarted at 1020. This restored both trains of RHR and OMS to operability. During the period that RHR was isolated, the core outlet temperature increased from 111°F to 128°F and no pressure transients occurred.

This event was caused by procedural inadequacy and personnel error. The procedure for working on the RCS pressure transmitters has been changed to require that the auto close signal be defeated and signed off instead of just stating this as a precaution. The system operating procedure that operators referenced when clearing the tagging order has been changed to say that the breakers may be open when the RCS temperature is less than 180°F. Further, the unit operating procedures have been revised to require a caution tag to be placed on the breakers when the RCS temperature is less than 180°F. The personnel involved will be reinstructed concerning procedural adherence.

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Flintridge Building



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Docket No. 348

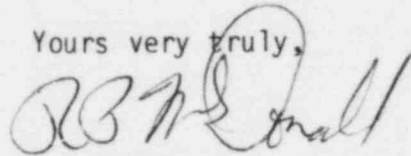
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Dear Sir:

Joseph M. Farley Nuclear Plant, Unit 1, Licensee Event Report No. LER 85-008-00 is forwarded in accordance with 10CFR50.73 to provide 30 day written notification of the occurrence.

If you have any questions, please advise.

Yours very truly,



R. P. McDonald

RPM/DSM:sam

Enclosure

xc: IE, Region II

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11