

L. M. Stinson (Mike)
Vice President

Southern Nuclear
Operating Company, Inc.
40 Inverness Center Parkway
Post Office Box 1295
Birmingham, Alabama 35201

Tel 205.992.5181
Fax 205.992.0341



Energy to Serve Your WorldSM
NL-04-0930

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Docket No.: 50-364

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555-0001

Joseph M. Farley Nuclear Plant – Unit 2
Licensee Event Report 2004-002-00
Plant Entered Mode 3 with One Train of Component Cooling Water Inoperable

Ladies and Gentlemen:

Joseph M. Farley Nuclear Plant – Licensee Event Report (LER) No. 2004-002-00 is being submitted in accordance with 10 CFR 50.73(a)(2)(i)(B).

This letter contains no NRC commitments. If you have any questions, please advise.

Sincerely,

A handwritten signature in black ink, appearing to read "L. M. Stinson".

L. M. Stinson

LMS/WAS/sdl

Enclosure: Licensee Event Report 2004-002-00

cc: Southern Nuclear Operating Company
Mr. J. B. Beasley, Jr., Executive Vice President
Mr. D. E. Grissette, General Manager – Plant Farley
Document Services RTYPE: CFA04.054; LC# 14042

U. S. Nuclear Regulatory Commission
Dr. W. D. Travers, Regional Administrator
Mr. S. E. Peters, NRR Project Manager – Farley
Mr. C. A. Patterson, Senior Resident Inspector – Farley

JE22

Estimated burden per response to comply with this mandatory information collection request, 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)

Joseph M. Farley Nuclear Plant - Unit 2

DOCKET NUMBER (2)

05000364

PAGE (3)

1 OF 3

TITLE (4) Plant Entered Mode 3 with One Train of Component Cooling Water Inoperable

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
04	09	2004	2004	- 002 -	00	06	01	2004	FACILITY NAME	DOCKET NUMBER
OPERATING MODE (9)		3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)							
POWER LEVEL (10)		00	20.2201(b)			20.2203(a)(3)(ii)			50.73(a)(2)(ii)(B)	50.73(a)(2)(ix)(A)
			20.2201(d)			20.2203(a)(4)			50.73(a)(2)(iii)	50.73(a)(2)(x)
			20.2203(a)(1)			50.36(c)(1)(i)(A)			50.73(a)(2)(iv)(A)	73.71(a)(4)
			20.2203(a)(2)(i)			50.36(c)(1)(ii)(A)			50.73(a)(2)(v)(A)	73.71(a)(5)
			20.2203(a)(2)(ii)			50.36(c)(2)			50.73(a)(2)(v)(B)	OTHER Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iii)			50.46(a)(3)(ii)			50.73(a)(2)(v)(C)	
			20.2203(a)(2)(iv)			50.73(a)(2)(i)(A)			50.73(a)(2)(v)(D)	
			20.2203(a)(2)(v)		X	50.73(a)(2)(i)(B)			50.73(a)(2)(vii)	
			20.2203(a)(2)(vi)			50.73(a)(2)(i)(C)			50.73(a)(2)(viii)(A)	
			20.2203(a)(3)(i)			50.73(a)(2)(ii)(A)			50.73(a)(2)(viii)(B)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
D. E. Grissette, General Manager Nuclear Plant	334-899-5156

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On April 8, 2004, at 2200, with Unit 2 in Mode 4, it was determined that Unit 2 was operated contrary to Technical Specification 3.0.4 in that the unit had entered Mode 4 on April 8, 2004 at 1729, with one train of Component Cooling Water (CCW) inoperable. On the previous day, April 7, 2004, with Unit 2 in Mode 5, HV3096A, CCW from Evaporator Packages and H2 Recombiners, would not open from the Main Control Board and was opened using its manual operator. The fail safe position of this valve is closed to isolate the non-seismic portion of the CCW system from the safety related portion. A caution tag was placed on the valve documenting the abnormal position, and a work order was written for failure of the valve to open. Personnel reviewing readiness for Mode 4 entry failed to recognize the significance of this off normal condition. On April 8, 2004, at 2200, during review of readiness for Mode 3 entry, this condition was identified. The valve was taken off the manual actuator and closed.

This event was due to cognitive personnel error. Personnel who authorized placing the valve on the manual operator did not recognize that the condition made the on service train of CCW inoperable, and therefore did not generate an LCO tracking sheet for the upcoming Mode 4 entry. Personnel reviewing tagging order status for Mode 4 entry erroneously determined that the valve status given on the tagging order would not constitute an LCO when Mode 4 was entered.

Personnel involved have been coached. A Training Advisory Notice has been sent to Operations personnel informing them of the details of this event. The Operations staff will be counseled concerning this event during the next training cycle by August 31, 2004. More specific guidance will be provided for reviewing tagging orders prior to Mode changes. This action will be completed by July 31, 2004.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2) NUMBER	LER NUMBER (6)			PAGE (3)	
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Joseph M. Farley Nuclear Plant - Unit 2	05000364	2004	- 002	- 00	2	OF 3

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Westinghouse -- Pressurized Water Reactor
 Energy Industry Identification Codes are identified in the text as [XX]

Description of Event

The design function of HV3096A, CCW from Evaporator Packages and H2 Recombiners, is to automatically close on a low-low CCW surge tank level and to isolate the safety related portion of the system from the non-seismic, non-safety related portion of the system. On April 7, 2004, with Unit 2 in Mode 5, HV3096A would not open from the Main Control Board and was opened using its manual operator. A caution tag was placed on the valve documenting the abnormal position, and a work order was written for failure of the valve to open. In Mode 5, an actual LCO Action requirement did not then exist. Personnel who authorized placing the valve on the manual operator did not recognize that the condition made the on service train of CCW inoperable, and therefore did not generate an administrative LCO tracking sheet for the upcoming Mode 4 entry.

Work order review for Mode 4 entry did not detect the condition since the work order did not note that the valve had been placed on its manual operator and opened. Personnel reviewing tagging order status for Mode 4 entry erroneously determined that the valve status given on the tagging order would not constitute an LCO when Mode 4 was entered. Performance of this review is required by procedure, but the process for performing it is not formally defined.

Mode 4 was entered on April 8, 2004, at 1729. The condition was detected on April 8, 2004 at 2200 during the tagging order review for the upcoming Mode 3 entry. The valve was taken off its manual operator and closed, returning it to its fail safe condition.

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Joseph M. Farley Nuclear Plant - Unit 2	05000364	2004	- 002	- 00	3 OF 3

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Cause of Event

This event was due to cognitive personnel error. Personnel who authorized placing the valve on the manual operator did not recognize that the condition made the on service train of CCW inoperable, and therefore did not generate an administrative LCO tracking sheet for the upcoming Mode 4 entry. Personnel reviewing tagging order status for Mode 4 entry erroneously determined that the valve status given on the tagging order would not constitute an LCO when Mode 4 was entered.

Safety Assessment

The other train of CCW remained operable throughout this event.
 The health and safety of the public were unaffected by this event.
 This event does not represent a Safety System Functional Failure.

Corrective Action

Personnel involved have been coached.
 A Training Advisory Notice has been sent to Operations personnel informing them of the details of this event.
 The Operations staff will be counseled concerning this event during the next training cycle by August 31, 2004.
 A formal Mode change tagging order review process will be instituted by July 31, 2004.

Additional Information

The following LERs have been submitted in the past two years concerning Technical Specification violations:

LER 2003-002-00 Unit 1, Reactor Pressure Vessel Head Set in Place with Technical Specification 3.4.12 Not Met.

LER 2002-003-00 Unit 1, Technical Specification Violation due to Section of Condensate Storage Tank Missile Barrier Not in Place.