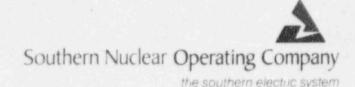
Southern Nuclear Operating Company Post Office Box 1295 Birmingham, Alabama 35201 Telephone (205) 868-5131

Dave Morey Vice President Farley Project



January 10, 1995

Docket No.: 50-364

10 CFR 50.73

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

> Joseph M. Farley Nuclear Plant—Unit 2 Licensee Event Report No. 94–002–00 Surveillance Not Performed On Service Water Pumps' Lube and Cooling Valves

Gentlemen:

Joseph M. Farley Nuclear Plant Licensee Event Report No. 94-002-00 is being submitted in accordance with 10 CFR 50.73. If you have any questions, please advise.

Respectfully submitted,

Dave Morey

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Enclosure

cc: Mr. S. D. Ebneter

Mr. B. L. Siegel Mr. T. M. Ross

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At 1652 on 12/14/94, with the Unit 2 reactor in mode 1 operating at 100 percent reactor power, it was determined during a surveillance schedule review, that the required surveillance for the Unit 2 service water pumps' lube and cooling valves had not been performed and had exceeded the allowable grace period. Failure to perform this inservice test within the specified surveillance interval required the A and B train service water systems to be declared inoperable. The missed surveillance test was performed satisfactorily and completed by 1747 on 12/14/94.

s event was caused by cognitive personnel error. The last date performed and the due date on the surveillance schedule was inadvertently changed during the transcription process and verification by an independent reviewer was not performed. Contributing to this was a misinterpretation of requirements by responsible personnel, in that they did not understand that all changes to the surveillance schedule, including transcriptions, required independent verification.

All surveillance schedules were reviewed to ensure correct schedules were in place. Although, additional transcription errors were noted, none of those errors resulted in a missed surveillance. This event has been discussed with personnel responsible for updating surveillance schedules. The requirement of independent verification for all changes, including transcriptions, has been communicated to the responsible personnel.

NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO CUMPLY WITH THIS INFORMATION COLLECTION REQUEST. 50.0 HRS. FORWARD LOMMENTS 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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TEXT (If more space is required, use additional NRC Form 386A'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 1652 on 12-14-94, it was determined during a surveillance schedule review, that the last date performed and the due date as listed on the Unit 2 surveillance schedule for FNP-2-STP-24.11 (Service Water Cyclone Separator Valves Inservice Test) [BI] were incorrect. FNP-2-STP-24.11 had not been performed within its specified surveillance interval and had exceeded its grace period ending on 11/26/94.

The actions required by Technical Specification 4.0.3 resulted in declaring both the A and B train service water systems inoperable. This caused entry into Technical Specification 3.0.3. Immediate action was taken to perform the missed surveillance test. At 1747 on 12/14/94, the surveillance was completed satisfactorily.

The surveillance test had been last performed on 8/3/94 and had a scheduled next quarterly due date of 11/3/94. The last date performed and the due date had been correctly calculated, entered into the schedule and verified by an independent reviewer. When the schedule sheet containing FNP-2-STP-24.11 and other scheduled surveillances required replacement, the information was transcribed to a new sheet. The dates for FNP-2-STP-24.11 were inadvertently changed during this transcription process. The transcription was not verified by an independent reviewer.

The corrective action that had been communicated to personnel, per LER 89-016(U2), had been that independent reviews were required for updates to the surveillance schedule.

Cause of Event

This event was caused by cognitive personnel error. The last date performed and the due date on the surveillance schedule were inadvertently changed during the transcription process and verification by an independent reviewer was not performed. Contributing to this was a misinterpretation of requirements by responsible personnel, in that they did not understand that all changes to the surveillance schedule, including transcriptions, were considered updates that required independent verification.

NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

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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TEXT (If more space is required, use additional NRC Form 365A's)(17)

Safety Assessment

This event was reportable because of entry into Technical Specifications 3.0.3.

Although the surveillance was overdue, it was completed satisfactorily, demonstrating that the equipment had remained operable during this period. There was no effect on plant operation. The health and safety of the public were not affected by this event.

Corrective Action

The actions required by Technical Specification 4.0.3 were performed. Immediate action was taken to perform the missed surveillance test. At 1747 on 12/14/94, the surveillance was completed satisfactorily.

All surveillance schedules were reviewed to ensure correct schedules were in place. Although, additional transcription errors were noted, none of those errors resulted in a missed surveillance. This event has been discussed with personnel responsible for updating surveillance schedules. The requirement of independent verification for all changes, including transcriptions, has been communicated to the responsible personnel.

Additional Information

LER 89-016(2) involved cognitive personnel error in the miscalculation of a surveillance due date associated with the completion of the surveillance schedule.

No component failures occurred during this event.

The unit was available for power operation during the period from 11-26-94 through 12-14-94.

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