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Southern Nuclear Operating Company  
*the southern electric system*

Dave Morey  
Vice President  
Farley Project

December 8, 1995

10 CFR 50.73

Docket Number: 50-348

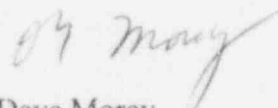
U. S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, DC 20555

Joseph M. Farley Nuclear Plant – Unit 1  
Licensee Event Report Number 95-011-00  
Unplanned Manual Actuation of Engineered Safety Feature Equipment

Ladies and Gentlemen:

Joseph M. Farley Nuclear Plant Licensee Event Report Number 95-011-00 is being submitted in accordance with 10 CFR 50.73(a)(2)(iv). If you have any questions, please advise.

Respectfully submitted,

  
Dave Morey

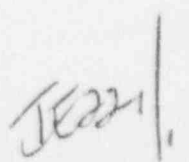
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Enclosure

cc: Mr. S. D. Ebnetter, Region II Administrator  
Mr. B. L. Siegel, NRR Senior Project Manager  
Mr. T. M. Ross, FNP Resident Inspector

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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, 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 1							DOCKET NUMBER (2) 05000348			PAGE (3) 1 OF 4	
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TITLE (4)  
Unplanned Manual Actuation of Engineered Safety Feature Equipment

EVENT DATE (8)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME		
11	14	95	95	011	00	12	08	95			

OPERATING MODE (9) 1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 1: (Check one or more) (11)									
POWER LEVEL (10) 95	20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)							
	20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)							
	20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71							
	20.2203(a)(2)(ii)	20.2203(a)(4)	X 50.73(a)(2)(iv)	OTHER							
	20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below							
	20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	or in NRC Form 366A							

LICENSEE CONTACT FOR THIS LER (12)

NAME R.D. Hill, General Manager - Nuclear Plant	TELEPHONE NUMBER		
	AREA CODE 334	899-5156	

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)  X<sup>10</sup>

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

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

At 0936 on November 14, 1995, with Unit 1 in Mode 1 operating at 95 percent power, an unplanned manual actuation of an engineered safety feature (ESF) [JE] occurred when the 1B motor driven auxiliary feedwater (MDAFW) pump [BA] was manually started during simulated troubleshooting activities associated with an emergency drill. The manual start occurred when an electrician manually closed the supply breaker associated with the 1B MDAFW pump.

The cause of this event was cognitive personnel error due to inadequate communication between the drill shift supervisor and the electrician troubleshooting the supply breaker as part of the emergency drill. A contributing cause was inadequate guidance provided to the drill monitors which resulted in the failure of a drill monitor being dispatched to monitor the emergency drill activity.

Personnel associated with this event have been coached concerning the simulation of activities associated with emergency drills. Additional criteria have been developed for determining emergency drill activities that require the presence of a drill monitor. This event will be included in 1996 maintenance and operations retraining.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET.

FACILITY NAME (1)  Joseph M. Farley Nuclear Plant - Unit 1	DOCKET NUMBER (2)  0   5   0   0   0   3   4   8	LER NUMBER (6)			PAGE (3)		
		YEAR 9   5	SEQUENTIAL YEAR -   0   1   1	REVISION NUMBER -   0   0			

TEXT (If more space is required, use additional NRC Form 366) (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 0936 on November 14, 1995, with Unit 1 in Mode 1 operating at 95 percent power, an unplanned manual actuation of an engineered safety feature (ESF) [JE] occurred when the 1B motor driven auxiliary feedwater (MDAFW) pump [BA] was manually started during simulated troubleshooting activities associated with an emergency drill. The manual start occurred when an electrician manually closed the supply breaker associated with the 1B MDAFW pump.

While training to support readiness for the FNP emergency plan, a practice drill was being held. During this practice drill the emergency organization responded to a simulated loss of all auxiliary feedwater. An electrician was assigned to report to the Operations Support Center (OSC) to receive instructions for troubleshooting and locally operating the 1B MDAFW pump. Part of the instructions provided to the electrician in the OSC included information to simulate activities associated with troubleshooting, closing, and opening the breaker. Further instructions provided the phone number of the shift supervisor and instructions to proceed to the supply breaker and perform actions as requested by the shift supervisor and drill monitor. Drill monitors in the OSC monitored these instructions and decided that this activity could proceed without a drill monitor.

When contacting the drill shift supervisor from the area of the supply breaker the electrician and drill shift supervisor briefly discussed the lack of an drill monitor at the supply breaker and proceeded to discuss troubleshooting activities which included local breaker operation. Although the drill shift supervisor indicated at the beginning of their communications that this was a drill message, discussions did not include that activities should be simulated. During the course of the discussions the electrician was instructed by the drill shift supervisor to close the supply breaker. At this time, the electricians perspective changed concerning the simulation of breaker closure. The electrician concluded that part of the drill involved the actual manual closing of the supply breaker. Following supply breaker closure, the breaker was opened locally and the Unit 1 control room informed of the conditions associated with the starting of 1B MDAFW pump.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (7-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET.

FACILITY NAME (1)  Joseph M. Farley Nuclear Plant - Unit 1	DOCKET NUMBER (2)  0   5   0   0   0   3   4   8	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL YEAR	REVISION NUMBER			
		9   5	-   0   1   1	-   0   0	3	OF	4

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

Cause of Event

The cause of this event was cognitive personnel error due to inadequate communication between the drill shift supervisor and the electrician troubleshooting the supply breaker as part of the emergency drill. A contributing cause was inadequate guidance provided to the drill monitors which resulted in the failure of a drill monitor being dispatched to monitor the emergency drill activity.

Safety Assessment

This event is reportable since the MDAFW pumps are an Engineered Safety Feature (ESF) whose actuation is reportable under 10CFR50.73(a)(2)(iv).

The 1B MDAFW pump and associated systems operated as designed during this event.

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

Corrective Action

Personnel associated with this event have been coached concerning the simulation of activities associated with emergency drills.

Additional criteria have been developed for determining emergency drill activities that require the presence of a drill monitor.

This event will be included in 1996 maintenance and operations retraining.

Corrective actions will be completed by April 5, 1996.

Additional Information

A four-hour notification was made to the NRC at 1259 hours on November 14, 1995 pursuant to 10CFR50.72.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 500 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001 AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET.

FACILITY NAME (1)  Joseph M. Farley Nuclear Plant - Unit 1	DOCKET NUMBER (2)  0   5   0   0   0   3   4   8	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL YEAR	REVISION NUMBER			
		9   5	-   0   1   1	-   0   0	4	OF	4

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

The following LER's involved unplanned actuations of ESF equipment:

- LER 95-010-00 (Unit 1) - Actuation of Engineered Safety Feature Equipment Due to Loss of Main Feedwater
- LER 95-004-00 (Unit 1) - Actuation of Engineered Safety Feature Equipment Due to Inadvertent Contact While Installing a Test Lead
- LER 92-006-00 (Unit 1) - LOSP Actuation Due to Inadvertent Contact While Installing Jumper
- LER 92-003-00 (Unit 1) - Inadvertent Actuation of ESF Equipment
- LER 92-003-00 (Unit 2) - Actuation of ESF Equipment Caused by Inadequate Procedural Guidance
- LER 90-004-00 (Unit 2) - Actuation of ESF Equipment Caused by an Electrical Ground in the Solid State Protection System