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Southern Nuclear Operating Company
the southern electric system

J. D. Woodard
Vice President
Farley Project

April 24, 1992

10 CFR 50.73

Docket No. 50-348

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

Joseph M. Farley Nuclear Plant - Unit 1
Licensee Event Report No. LER 92-002-00

Gentlemen:

Joseph M. Farley Nuclear Plant, Unit 1, Licensee Event Report No. LER 92-002-00 is being submitted in accordance with 10 CFR 50.73. If you have any questions, please advise.

Respectfully submitted,

J. D. Woodard

JDW/EFB:map 2182

Enclosure

cc: Mr. S. D. Ebneter
Mr. G. F. Maxwell

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PDR ADOCK 05000348
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NRC Form 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

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

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Joseph M. Farley Nuclear Plant	0 5 0 0 0 3 4 8	1 OF 3

TITLE (4)
Missed Fire Watch Due To Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQ NUM	REV	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
									J.M.Farley - Unit 2	0 5 0 0 0 3 6 4
0 3	3 0	9 2	9 2	0 0 2	0 0	0 4	2 4	9 2		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)			
POWER LEVEL	1 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	X 50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER	
	AREA CODE	
D. N. Morey, General Manager - Nuclear Plant	205	899-5156

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

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TUKER	REPORT TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

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

ABSTRACT (16)

At approximately 1000 on 3-30-92, a Shift Foreman Operating (SFO) recognized that an hourly fire watch patrol required by Technical Specification 3.3.3.9 was not being performed. The fire detection system, 1SW-111, for the Service Water Intake Structure (SWIS) went into spurious alarm at 0846 and was therefore inoperable. The required hourly fire watch was not established until 1025.

Detection System 1SW-111 had been declared inoperable prior to this event on 3-18-92 at 1715. This LCO and the required fire watch on 1SW-111 were cleared at 1850 on 3-19-92. The Unit 1 Unit Operator (UO) properly removed this LCO from his relief checksheet. However, he did not relay this information to the Operator At The Controls (OATC), and subsequently, the OATC continued to record 1SW-111 as being inoperable. When 1SW-111 alarmed on 3-30-92 at 0846, the OATC did not initiate an investigation nor did he inform the SFO of the alarm because he believed the system was already inoperable and that the required fire watches were established.

This event was caused by personnel error due to inadequate communication between the control room operators regarding the operability of 1SW-111.

A fire watch was established within one hour of the SFO's discovery that the system was inoperable. The personnel involved in this incident have been reinstructed on the importance of proper communication. In addition, the incident will be discussed with all on-shift operations personnel.

Plant and System Identification:

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

Summary of Event

At approximately 1000 on 03-30-92, it was recognized that an hourly fire watch patrol required by Technical Specification 3.3.3.9 was not being performed on SWIS detection system 1SW-111 [IC].

Description of Event

At approximately 1000 on 3-30-92, the SFO discovered that fire detection system 1SW-111, at the SWIS, was in spurious alarm without the required established fire watch. It was determined that it had been alarming since 0846. The OATC had not informed the SFO because his turnover sheet incorrectly reflected that the system was inoperable and was being covered by a fire watch.

1SW-111 was inoperable and the fire watch required by Technical Specification 3.3.3.9 was not established within the one hour required from the spurious alarm at 0846.

Further investigation revealed that a prior LCO and fire watch on 1SW-111 was cleared at 1850 on 3-19-92. The Unit 1 UO had properly removed this LCO from his relief checksheet. However, he did not relay this information to the OATC, and subsequently, the OATC continued to record 1SW-111 as being an LCO until the problem was identified on 3-30-92.

The required fire watch was established within one hour of discovering that the system was inoperable. System 1SW-111 was returned to service at 0016 on 4-4-92.

Cause of Event

This event was caused by personnel error in that the control room operators failed to communicate revised equipment/system operability status.

Reportability Analysis and Safety Assessment

This event is reportable because the hourly fire watch required by Technical Specification 3.3.3.9 was not performed.

This area is normally inspected every four hours by the operations systems operator; and a systems operator had completed a tour of the structure at 0815 on the day of this event.

This event had no effect on plant operation. No fire occurred during the time that the fire watch was not performed. The health and safety of the public was not affected by this event.

Corrective Action

The fire watch was established within one hour of discovering that the system was inoperable.

In addition, the personnel involved in this incident have been reinstructed on the importance of proper communication and this event will be discussed with all on-shift operations personnel.

Additional Information

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

Unit 1 was operating at approximately 100% power at the time of this event. Unit 2 was shutdown for the 8th Refueling Outage.

No components failed during this event.

The following LERs involved personnel errors in establishing and maintaining fire watches:

Unit 1 (Docket Number 05000348): LERs 84-013-00, 84-015-00, 84-022-00, 86-013-00, 87-006-00, 88-004-00, 90-001-00, 91-001-00

Unit 2 (Docket Number 05000364): LERs 84-007-00, 85-007-00, 85-013-00, 88-004-00, 88-005-00, 90-002-00