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Southern Nuclear Operating Company

*the southern electric system*

J. D. Woodard  
Vice President  
Farley Project

June 8, 1992

10 CFR 50.73

Docket No. 50-364

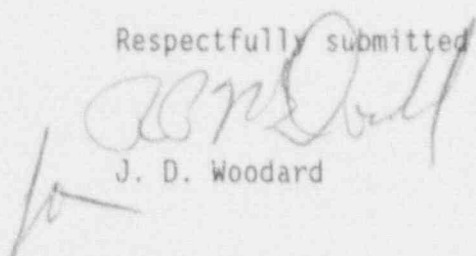
U. S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, DC 20555

Joseph M. Farley Nuclear Plant - Unit 2  
Licensee Event Report No. LER 92-004-00

Gentlemen:

Joseph M. Farley Nuclear Plant, Unit 2, Licensee Event Report No. LER 92-004-00 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 2580

Enclosure

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

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LICENSEE EVENT REPORT (LER)

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

TITLE (4) Missed Technical Specification Actions 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)
05	09	92	92	004	00	06	08	92		05000
										05000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)

OPERATING MODE (9)	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
0	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)	X 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
D. Hill, General Manager - Nuclear Plant	AREA CODE 205, NUMBER 899-5156

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

G. USE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if yes, complete EXPECTED SUBMISSION DATE)  NO  X

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (16)

At 1145 on 5-9-92, it was recognized that an inoperable pressurizer pressure channel, PT-455, had not been placed in the tripped condition as required by Technical Specifications 3.3.1 and 3.3.2. At 0308 on 5-9-92, PT-455 had been channel checked and found to be reading low and outside the maximum channel deviation of 48 psig, rendering it inoperable. The channel was placed in trip at 1243 on 5-9-92. Investigation determined the transmitter to be out of tolerance low. It was returned to service following calibration and declared operable at 2018 on 5-9-92.

The failure to meet the action statements of Technical Specifications 3.3.1 and 3.3.2 was caused by personnel error. The Plant Operators performing the surveillance failed to inform the Shift Supervisor that PT-455 was inoperable because, through miscommunications during shift turnover, the Plant Operators assumed that the transmitter had been declared inoperable and that the required actions had been met for an inoperable pressurizer pressure transmitter. The Shift Supervisor reviewing the completed surveillance data did not recognize that PT-455 had become inoperable. A subsequent review by the Shift Supervisor on the following shift identified that PT-455 had drifted out of tolerance and become inoperable.

The Plant Operators and the Shift Supervisor involved were coached on the expectations for performance and review of surveillance. Shift personnel have been made aware of this event and this event will be covered during the next cycle of requalification training.

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

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Joseph M. Farley Nuclear Plant - Unit 2	05000364	92	004	00	2	OF 3

TEXT

Plant and System Identification

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

Summary of Event

At 1145 on 5-9-92, it was recognized that an inoperable pressurizer pressure channel [JG], PT-455, had not been placed in the tripped condition as required by Technical Specifications 3.3.1 and 3.3.2. When a pressurizer pressure channel is inoperable, Technical Specifications 3.3.1 and 3.3.2 allow startup and/or power operation to proceed until performance of the next required channel functional test, provided the inoperable channel is placed in the tripped condition within one hour.

At 0308 on 5-9-92, PT-455 was channel checked and found to be reading low and outside the maximum channel deviation of 48 psig, rendering it inoperable. The channel was placed in trip at 1243 on 5-9-92. Investigation determined the transmitter to be out of tolerance low. The transmitter was returned to service following calibration and declared operable at 2018 on 5-9-92.

Description of Event

On 5-8-92 at 0740, PT-455 was reading 45 psi below PT-456 and a Maintenance Work Request (MWR) was written. This 45 psi difference was within channel check allowable tolerance for operability. The channel reading difference held constant on day and evening shift. During turnover at the end of evening shift, the night shift Plant Operator was informed that PT-455 had drifted low and that an MWR had been submitted to repair the channel. The night shift Plant Operator assumed that the channel was out of Technical Specification tolerance and that appropriate actions had been taken. On 5-9-92 at 0308, the night shift Plant Operator, performing a channel check on PT-455 per FNP-2-STP-1.0, "Operation Daily And Shift Surveillance Requirements," recorded that PT-455 was reading 60 psi lower than PT-456 which was outside of the maximum allowed deviation of 48 psi. He assumed, based on miscommunications during his shift turnover, that the Technical Specification actions for an inoperable pressurizer pressure channel had been met and noted the previously written MWR number on FNP-2-STP-1.0. The Plant Operator did not verify that the Technical Specification action statements for an inoperable pressure channel had been met. In addition, a subsequent review of the completed surveillance by the Shift Supervisor did not identify that PT-455 had drifted out of tolerance and had thus become inoperable.

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TEXT

On day shift 5-9-92, a second Plant Operator made the same assumption based on his shift turnover. The Shift Supervisor on day shift, in his review of the FNP-2-STP-1.0, identified at 1145, that PT-455 had previously become inoperable at 0308 and placed PT-455 in the tripped condition at 1243 on 5-9-92. Since the inoperable channel was not placed in tripped condition within one hour of the channel check that recorded the channel being outside the maximum channel deviation, Technical Specifications 3.3.1 and 3.3.2 actions were not met. The inoperable channel was returned to service at 2018 on 5-9-92.

Cause of Event

The failure to meet the action statements of Technical Specifications 3.3.1 and 3.3.2 was caused by personnel error. The night shift and day shift Plant Operators performing the surveillance failed to inform the Shift Supervisor that PT-455 was inoperable. Through miscommunications during their shift turnovers, the Plant Operators assumed that the transmitter had been declared inoperable and that the required actions had been met for an inoperable pressurizer pressure transmitter. The night shift Shift Supervisor reviewing the completed surveillance did not recognize that PT-455 had become inoperable.

Reportability Analysis and Safety Assessment

This event is reportable because Technical Specifications 3.3.1 and 3.3.2 actions were not met.

The inoperable channel was returned to service at 2018 on 5-9-92.

This event had no effect on plant operation. The health and safety of the public was not affected by this event.

Corrective Action

The Plant Operators were coached on their inadequate communication during turnover and their failure to verify that the bistable indication on the Main Control Board was consistent with the Limited Condition for Operation (LCO) which they believed to be in effect. The Shift Supervisor was coached on the necessity of a thorough review of completed surveillance. In addition, shift personnel have been made aware of this event and this event will be covered with licensed personnel during the next cycle of requalification training.

Additional Information

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

LER 84-010-00, Unit 2, involved steam flow channel FT-475 not being placed in the tripped condition within one hour of the channel's inoperable condition.