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Southern Nuclear Operating Company

*the southern electric system*

J. D. Woodard  
Vice President  
Farley Project

November 19, 1992

Docket No. 50-348

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

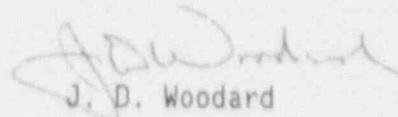
Joseph M. Farley Nuclear Plant - Unit 1  
Licensee Event Report No. LER 92-006-00

Gentlemen:

Joseph M. Farley Nuclear Plant, Unit 1, Licensee Event Report No. 92-006-00  
is being submitted in accordance with 10 CFR 50.73.

If you have any questions, please advise.

Respectfully submitted,



J. D. Woodard

EFB:cht

Enclosure

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

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## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Joseph M. Farley Nuclear Plant - Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 3 4 8				PAGE (3) 1 of 3		
TITLE (4) LOSP Actuation Due To Inadvertent Contact While Installing Jumper																
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)			
1 0	2 8	9 2	9 2	0 0 6	0 0	1 1	1 9	9 2					0 5 0 0 0			
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)													
N			20.402(b)			20.405(c)			X			50.73(a)(2)(iv)			73.71(b)	
POWER LEVEL			0 0 0			20.405(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v)			73.71(c)	
			20.405(a)(1)(ii)			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						
R. D. Hill, General Manager - Nuclear Plant										AREA CODE		205 899-5156				
COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRC						
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO				
ABSTRACT (16)																

On 10-28-92 at 2220, an inadvertent actuation of an engineered safety feature (ESF) occurred when an electrician performing a surveillance test procedure allowed a jumper he was installing in the BlG sequencer to make contact with an adjacent terminal inside the sequencer. The inadvertent contact resulted in generation of a load shed signal which caused the normal power supply breaker to 'B' train 4160 volt bus 1G to open. This caused the 'B' train loss of site power (LOSP) sequencer to operate.

All equipment functioned properly in response to the 'B' train LOSP signal.

This event was discussed with personnel in plant safety meetings the next day as part of FNP's ongoing self-verification program. The electrician involved has been coached on the proper techniques for landing jumpers in congested spaces. Procedural enhancements have been made to aid in the prevention of recurrence of this incident. Plant personnel whose job requirements include installing jumpers were trained on the procedural enhancements prior to performing any further work involving installation of jumpers. Annual Maintenance retraining will include instruction on the procedure for jumper installation.

Also, the BlG sequencer was inspected for evidence of arcing or other damage and none was found.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)		
		YEAR	SEQ NUM	REV			
Joseph M. Farley Nuclear Plant - Unit 1	05000348	92	006	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

During the performance of FNP-1-STP 40.2, "B Train Sequencer SI With Off-site Power Available and Load Shedding Circuit Test", an electrician, while working inside the BlG sequencer [JE], made contact with a terminal adjacent to the one on which he was attempting to install a jumper. This inadvertent contact resulted in the generation of a load shed signal (LOSP) on the 'B' train safety related electrical busses.

Description of Event

On 10-28-92 at 2220, FNP-1-STP-40.2, "B Train Sequencer SI with Off-Site Power Available and Load Shedding Circuit Test" was in progress.

An electrician, attempting to install a jumper in accordance with the test procedure, made inadvertent contact with an adjacent terminal inside the BlG sequencer. The electrician did not use an adequately insulated jumper nor did he apply appropriate insulating material to prevent inadvertent contact with adjacent terminals. This inadvertent contact resulted in the generation of a load shed signal which caused the normal power supply breaker to 'B' train 4160 volt bus 1G to open and the 'B' train LOSP sequencer to operate.

The 1B and 2C diesel generators started as required and the 1B diesel generator energized the 1G 4160 volt bus. All equipment functioned properly in response to the 'B' train loss of site power.

The control room operators performed the actions of FNP-1-AOP-5.0, "Loss of A or B Train Electrical Power". Off-site power was restored to the 'B' train electrical busses and the 1B and 2C diesel generators were secured.

Cause of Event

This ESF actuation was caused by personnel error. An electrician made inadvertent contact with an adjacent terminal inside the BlG sequencer while attempting to install a jumper per STP-40.2. This inadvertent contact resulted in the generation of a load shed signal, which caused the normal power supply breaker to 'B' train 4160 volt bus 1G to open.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)		
		YEAR	SEQ NUM	REV			
Joseph M. Farley Nuclear Plant - Unit 1	05000348	92	006	00	3	OF	3

TEXT

Reportability Analysis and Safety Assessment

This event is reportable due to the actuation of an Engineered Safety Feature, namely the loss of power to 'B' train 4160 volt safety related electrical bus 1G.

All equipment functioned properly in response to this event.

The health and safety of the public was not affected.

Corrective Action

A team of FNP personnel held a critique and preliminary investigation meeting immediately following the event. A root cause investigation was then initiated.

This event was discussed with personnel in plant safety meetings as part of FNP's ongoing self-verification program. The electrician involved has been coached on the proper techniques for landing jumpers in congested spaces. Procedural enhancements have been made to aid in the prevention of recurrence of this incident. Plant personnel, whose job requirements include installing jumpers, were trained on the procedural enhancements prior to performing further work involving installation of jumpers. Annual Maintenance retraining will include instruction on the procedure for jumper installation.

Also, the B1G sequencer was inspected for evidence of arcing or other damage and none was found.

Additional Information

The following LERs have been submitted by FNP for an inadvertent load shed on a safety related bus due to accidental contact while connecting jumpers or using tools: LER 85-003-00 (Unit 1), 87-005-00 (Unit 2), 87-006-00 (Unit 2) and 88-024-00 (Unit 1)

The appropriate nonemergency 4 hour report was made to the NRC at 2231 on 10-28-92.

The unit was defueled at the time of the activation.

This event would not have been more severe during power operations because this surveillance test procedure is only performed in Modes 5, 6 or defueled.