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J. D. Woodard Vice President-Nuclear Farley Project



May 24, 1989

Docket No. 50-364

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

Dear Sir:

Joseph M. Farley Nuclear Plant - Unit 2 Licensee Event Report No. LER 89-005-00

Joseph M. Farley Nuclear Plant, Unit 2, Licensee Event Report No. LER 89-005-00 is being submitted in accordance with 10CFR50.73.

If you have any questions, please advise.

Respectfully submitted,

D. Woodard

JDW/JAR:slc 8.20

Enclosure

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

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NRC Form 385

LICENSEE EVENT	REPORT	(LER) TEXT	CONTINUATION
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U.S. NUCLEAR REGULATORY COMMISSION

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NRC Form 366A

Farley Nuclear Plant Unit 2

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TEXT (If more space is required, use additional NRC Form .366A's) (17)

Plant and System Identification:

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

Summary of Event

At 1313 on 4-29-89, during a refueling outage with the reactor vessel at reduced reactor coolant system inventory, an actuation of Engineered Safety Feature (ESF) [JE] equipment occurred when a safety injection (SI) signal was generated. The SI signal was generated when the A train Solid State Protection System (SSPS) [JG] mode selector switch was placed in OPERATE. This switch was repositioned to set up for a surveillance test. However, the switch was not repositioned in accordance with the surveillance test procedure. This resulted in the A train SI signal being generated.

Description of Event

On 4-29-89, preparations were being made for the performance of FNP-O-STP-16.6 (Spray and Phase B Actuation Test). Two of the initial conditions of STP-16.6 are to place the input error inhibit switches to INHIBIT and then to place the mode selector switches for both trains of the SSPS to OPERATE. The mode selector switches were hold-tagged to the I&C foreman as part of FNP-2-IMP-0.7 (Modes 5 and 6 Surveillance Test Performance). Since these switches were hold-tagged in TEST, a release was being prepared so the hold tags could be removed and the switches changed to OPERATE.

The Shift Foreman - Operating (SFO) was not familiar with the initial conditions of the test procedure; however, he realized that the mode selector switch needed to be placed in OPERATE. Thus, the SFO indicated on the release to remove the tag and position the switch to OPERATE. The SFO had this sequence approved by the Shift Supervisor (SS). The SS believed that this sequence was going to be performed in accordance with the initial conditions of STP-16.6 and approved it. When the SS approved the sequence, the SFO believed that he was ready to have the switch placed in OPERATE.

Placing the selector switch to OPERATE prior to placing the inhibit switch to INHIBIT enables the unit's protective feature. Therefore, at 1313 on 4-29-89 when the SFO had the A train SSPS mode selector switch placed in OPERATE, an A train SI occurred. All A train ESF equipment operated properly.

Folloying the SI, the operators implemented FNP-2-EEP-0 (Reactor Trip or Safety Injection) and FNP-2-ESP-1.1 (SI Termination) to ensure that the plant was returned to a pre-SI alignment. The 2B charging pump, 2A RHR pump, and 2B service water pump were secured immediately. The diesel generators were then secured.

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Cause of Event

This event was caused by personnel error in that:

- There was inadequate ommunication between the personnel responsible for the test activities.
 - a. The SFO did not communicate with the SS to ensure that his understanding of the SSPS and the sequence of events was correct.
 - b. The SS did not specify what sequence of events was required when the release was approved and did not ensure that everyone involved was aware of what was planned.
- The SFO did not use the guidance of FNP-2-STP-16.6 for placing the mode selector switch to OPERATE.

Reportability Analysis and Safety Assessment

This event is reportable because of the actuation of Engineered Safety Feature equipment. The required equipment operated per design. The health and safety of the public were not affected by this event.

Corrective Action

Disciplinary action has been administered to the SS and SFO involved in this event. Also, this event will be discussed with on-shift licensed personnel emphasizing the need for clear communication and delineation of responsibility.

Additional Information

No similar LERs have been submitted by Farley Nuclear Plant.

No components failed during this event.

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