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November 16, 1999

Docket Nos.: 50-348
50-364

NEL-99-0408

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555-0001

Joseph M. Farley Nuclear Plant
Licensee Event Report 99-003-00
Control Room Ventilation Radiation Monitors Inoperable

Ladies and Gentlemen:

Joseph M. Farley Nuclear Plant Licensee Event Report No. 99-003-00 (Shared) is being submitted in accordance with 10 CFR 50.73(a)(2)(i). There are no NRC commitments in the Licensee Event Report.

If you have any questions, please advise.

Respectfully submitted,

A handwritten signature in cursive script that reads "Dave Morey".

Dave Morey

BLG/clt:LER99_03(0).doc

Enclosure

IE22

PDL ADDL C.500348

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U. S. Nuclear Regulatory Commission

cc: Southern Nuclear Operating Company
Mr. L. M. Stinson, General Manager – Farley

U. S. Nuclear Regulatory Commission, Washington, D. C.
Mr. L. M. Padovan, Licensing Project Manager – Farley

U. S. Nuclear Regulatory Commission, Region II
Mr. L. A. Reyes, Regional Administrator
Mr. T. P. Johnson, Senior Resident Inspector – Farley

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

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 4

TITLE (4)

Control Room Ventilation Radiation Monitors Inoperable

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER	
1	0	27	1999	1999	003	0	11	16	99	Joseph M. Farley Unit 2	0 5 0 0 0 3 6 4
											0 5 0 0 0

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
1	1 0 0	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(1)	<input checked="" type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)
		<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 20.2033(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)
		<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 20.2033(a)(4)	<input type="checkbox"/> 50.73(a)(2)(iii)
		<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(iv)
		<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> 50.73(a)(2)(viii)
					<input type="checkbox"/> 50.73(a)(2)(ix)
					73.71
					OTHER
					Specify in Abstract below or in NRC Form 366A

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (include area code)
L. M. Stinson, General Manager Nuclear Plant	3 3 4 - 8 9 9 - 5 1 5 6

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

At 1008 on October 27, 1999, it was determined that Units 1 and 2 had been operated contrary to the requirements of Technical Specifications (TS). Actions of TS 3.3.3.1 require in part, with less than the minimum Control Room ventilation (CRV) radiation monitor channels OPERABLE, that compensatory actions be taken. The sampling points for the control room ventilation radiation monitors are located downstream of the computer room ventilation system inlet isolation damper, which is a source of outside air to the CRV system. Therefore, when the computer room ventilation system is secured, the control room ventilation radiation monitors are inoperable. The actual sampling location does not agree with the drawing that was used to prepare the CRV operating procedures. Since it was not recognized that the computer room dampers being closed prevented outside air from reaching the radiation monitors, the CRV system operating procedure did not direct that actions required by TS be taken. This condition has existed since initial plant startup. The cause of this event was personnel error in that the discrepancy between design drawings was not identified, resulting in inadequate procedural guidance that has been incorrect since initial plant startup. However, the computer room HVAC has been normally maintained in continuous operation and CRV radiation monitor channels operable as required. The control room HVAC operating procedure has been revised to address the issue of radiation monitor inoperability when the computer room HVAC is shut down. Action has been initiated to correct the piping and instrument drawing and other related design document discrepancies. This action will be completed by March 1, 2000.

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

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

Description of Event

The control room ventilation [VI] radiation monitors (R 35 A & B) draw a sample from the inlet air duct to the computer room HVAC. In the event high radiation is detected, the computer room HVAC supply to the control room is automatically isolated and the operator is alerted to start the safety related control room emergency filtration system (CREFS) to provide filtered air to the control room. These actions are needed to maintain operator radiation dose within limits in the event of certain postulated accidents.

Repair of the auxiliary building roof during the summer of 1999 periodically resulted in fumes from heated tar. To reduce the level of fumes in the control room, the computer room ventilation was intermittently shut down. This practice was questioned, and at 1008 on October 27, 1999, it was determined that the R 35 A & B sample points are downstream of the computer room HVAC inlet isolation damper. Investigation revealed that the as-built location of the radiation monitors is contrary to that shown on the piping and instrument drawings (P&ID). Further, shutting the computer room inlet isolation damper prevents R 35 A & B from receiving adequate sample flow. Therefore, the air sampled would not be representative of outside air, and thus the monitors may not detect a radiological problem. Upon discovery, the computer room HVAC system was immediately restarted.

Actions of TS 3.3.3.1 require that with less than one control room ventilation radiation monitor operable, then within one hour initiate and maintain operation of the control room emergency ventilation system in the recirculation mode of operation. This requirement has not been met in the past when the computer room HVAC system has been shut down with the inlet damper closed.

Additional investigation revealed that the sample points were installed in accordance with installation drawings, but that these drawings did not agree with the P&ID. Plant personnel writing procedures used P&IDs and therefore did not recognize that the R 35 A & B sample points are isolated with the computer room ventilation system secured. Since it was not recognized that the computer room inlet damper being closed prevented outside air from reaching the radiation monitors, the CRV system operating procedure did not direct that actions required by TS be taken.

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

Cause of Event

The cause of this event is personnel error in that the discrepancy between design drawings was not identified, resulting in inadequate procedural guidance, which has been incorrect since initial plant startup.

Safety Assessment

Significance Determination Process results: The function of the control room HVAC radiation monitors is to isolate the normal makeup to the control room in the event of high airborne radiation. This action is necessary to protect operators for a Waste Gas Decay Tank rupture, or a fuel handling accident. For other design basis accidents that result in Engineered Safety Features (ESF) actuations, the isolation of normal control room makeup and startup of the CREFS are automatic and do not depend on response of R 35 A & B. Other plant radiation monitors and communications channels are available to alert the operator to a fuel handling accident or Waste Gas Decay Tank rupture.

The procedural steps required to start the CREFS are performed from the control room; therefore, the probability of successful operator action to mitigate these postulated events is high. In addition, the control room is isolated by shutdown of the computer room HVAC, resulting in some degree of operator protection had a radiological release actually occurred. The computer room HVAC system has been normally maintained in continuous operation, and R 35 A & B have been operable as required. In addition, neither a waste gas decay tank rupture nor a spent fuel handling accident has occurred at FNP. Therefore, this event is of low safety significance.

The discrepancy between design drawings has existed since initial plant startup. Throughout the life of the plant, numerous programs have been developed and strengthened to address Configuration Management issues. These programs have been effective in identifying and resolving discrepancies as they are discovered. Identification of discrepancies such as this are infrequent. Because of the demonstrated effectiveness of existing programs to address such issues, this occurrence is being treated as an isolated event.

SNC has reviewed this condition from a PRA perspective and has concluded that there is no change in core damage frequency (CDF) or large early release fraction (LERF) as a result of this condition.

The health and safety of the public were unaffected by this event.

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

Corrective Action

The control room HVAC operating procedure has been revised to address the issue of radiation monitor inoperability when the computer room HVAC is shut down.

Action has been initiated to correct the P&ID and other related design document discrepancies. This action will be completed by March 1, 2000.

Additional Information

The Control Room HVAC radiation monitors also have a non-Technical Specification function of placing the Technical Support Center HVAC in recirculation mode. This function is routinely performed from the TSC and is verified in the TSC. Therefore, this event is also of low safety significance.

The following LER's have been submitted in the past two years on the subject of failure to meet technical specification action requirements due to configuration control:

1. LER 97-014-00 Unit 1, RCS Leak Detection System Inoperable Due to Defective Procedure Results in Operating in Condition Prohibited by TS
2. LER 97-013-00 Unit 1, Operating Outside Design Basis Due to Control Room Exhaust Isolation Dampers Not Closed
3. LER 97-004-00 Unit 2, Operating Outside of Technical Specifications Due to Required Containment Atmospheric Grab Samples Not Being Taken
4. LER 97-003-04, Shared, Failure to Comply with Technical Specifications 4.5.3.2 and 3.5.2
5. LER 98-006-00 Unit 1 Penetration Room Filtration System Suction Damper Outside Design and Licensing Basis