NRC FORM 366								U.S.NUCLEAR REGULATORY COMMISSION								APPROVED BY OMB NO. 3150-0104 EXPIRES 04/30/98																
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At 2102 on May 16, 1998 with Unit 2 in Mode 3, it was determined that Farley Nuclear Plant (FNP) had operated in a condition prohibited by Technical Specifications (TS). TS 3.7.1.2 requires that the Turbine Driven Auxiliary Feedwater Pump (TDAFWP) be operable in Modes 1, 2 and 3. At approximately 2050 on May 16, 1998, while conducting a routine key checkout audit, the Unit 1 Shift Supervisor discovered that the TDAFWP to 2C Steam Generator Flow Control Valve (2C S/G FCV) inlet isolation valve was closed rendering the TDAFWP inoperable. The valve had been closed in accordance with the TDAFWP Quarterly Inservice Test surveillance procedure which had been performed to verify the operability of the TDAFWP following the Unit 2 twelfth refueling outage. The valve was not reopened as required by the surveillance procedure. Therefore, the provisions of TS 3.0.4 were not satisfied when Mode 2 was entered at 1519 on May 15, 1998. The 2C S/G FCV inlet isolation valve was locked open and the TDAFWP was restored to operable status at approximately 2102 on May 16, 1998. The cause of the event has been determined to be personnel error. The individual responsible for restoration of the 2C S/G FCV inlet isolation valve to the locked open position failed to recognize the valve had been closed in a previous step in the surveillance procedure and consequently did not open the valve. Operations supervision has discussed this event with the individuals involved. Appropriate personnel have been notified of this event emphasizing the need for attention to detail and self verification during procedural performance.

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(4-95) LICENSEE EVENT REPO TEXT CONTINUAT	APPROVED BY CMB NO. 3150-0104 EXPIRES 04/30/90 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REGUEST 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (7-8 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 2055-0007, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE DE MANAGEMENT AND BUDGET WASHINGTON, DC 2053.											
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Plant and System Identification

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

Description of Event

During night shift on May 15, 1998, the Turbine Driven Auxiliary Feedwater Pump (TDAFWP) Quarterly Inservice Test surveillance procedure was begun to verify the operability of the pump in preparation for entry into Mode 2 following the Unit 2 twelfth refueling outage. During the performance of this test the 2C Steam Generator Flow Control Valve (2C S/G FCV) inlet isolation valve was unlocked and closed in accordance with guidance provided in the procedure due to leak-by of the 2C S/G FCV. The unlocking and closing of the inlet isolation valve was properly documented in the procedure. Procedural guidance was provided that directed the initiation of a Limiting Condition for Operations (LCO) tracking sheet to document the valve closure. The Shift Foreman responsible for writing the required LCO incorrectly concluded that an LCO existed, which documented the inoperability of the TDAFWP and that it was not necessary to document the valve closure on an LCO tracking sheet. Day shift personnel were instructed to complete the surveillance procedure and the operator responsible for restoring the inlet isolation valve to the locked open position failed to recognize that the valve had been closed and did not open the valve. The surveillance procedure was completed and the TDAFWP was determined to be operable. After verification of the applicable requirements, Mode 2 was entered during reactor startup at 1519 on May 15, 1998.

At approximately 2050 on May 16, 1998, during a routine key checkout audit, it was observed that the 2C S/G FCV inlet isolation was documented as being closed. Personnel were dispatched to locally determine its position and confirmed at approximately 2102 that it was closed and subsequently locked it open. With this valve closed, the TDAFWP flow path to the 2C S/G was not operable. The requirements of Technical Specification 3.0.4 were not met during the Mode 2 entry due to the TDAFWP not being operable per TS 3.7.1.2. Unit 2 was in Mode 3 at the time of discovery. Mode 3 had been reentered at 2159 on May 15, 1998 when the reactor was manually tripped due to a dropped control rod.

NRC FORM 366A	U.S.NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB	NO. 3150-0104 /30/98
LICENSEE EVENT REPOR TEXT CONTINUATIO	T (LER) N	ESTIMATED BURDEN PER RESPONSE T MANDATORY FORMATION COLLECTION REPORTED LESSONS LEARNED ARE INC LICENSING PROCESS AND FED BACK TO COMMENTS REGARDING BURDEN ESTIMAT AND RECORDS MANAGEMENT BRANCH (REGULATORY COMMISSION, WASHINGTO TO THE PAPERWORK REDUCTION PROJE OF MANAGEMENT AND BUGGT, WASHING	O COMPLY WITH THIS REQUEST: 50.0 HRS. CORPORATED INTO THE INDUSTRY. FORWARD TE TO THE INFORMATION N. DC 20555-0001, AND CC 20555-0001, AND CC 3150-0104), OFFICE TON. DC 20503.
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Cause of Event			
The cause of the event has been deter for restoration of the 2C S/G FCV recognize the valve had been closed i surveillance procedure and consequent	mined to be personnel err inlet isolation valve to t in a previous step in the ly did not open the valve.	for in that the individual res the locked open position f TDAFWP Quarterly Inserv	ponsible ailed to ice Test
Contributing to this event was person LCO tracking sheet to document the v was not necessary.	anel error in that the Shift valve closure incorrectly co	Foreman responsible for woncluded that a new or revis	vriting a ed LCO
Safety Assessment			
Based upon engineering judgement as rates observed following the manual re- to provide sufficient feedwater flow to or other accident conditions considerin (low decay heat due to low power oper	actor trip on May 15, 199 satisfy heat sink requirem ing the plant conditions wh ration at the beginning of a	dwater System (AFWS) [B 98, the AFWS would have be ents during normal, station be nich existed at the time of the an operating cycle).	A] flow een able blackout he event
During the event, both Motor Driven available for use in feeding all three S/C	Auxiliary Feedwater Pum Gs during normal or accide	ps (MDAFWPs) were operated operated by the ope	able and
In the as-found condition, the TDAFW and 2B S/Gs during normal, station bla the effects of the accident on the TDAF	P was operational and ava ackout or other applicable FWP and its flow paths to	ilable to supply feedwater to accident conditions depende the 2A and 2B S/Gs.	o the 2A ent upon
During the time that the TDAFWP feet that required the use of the TDAFWP.	dwater supply was isolate	d to the 2C S/G, no event of	occurred
Based on the above the health and safet	ty of the public were not a	ffected.	

NRC FORM 366A	U.8	NUCLEAR REGULATORY COMMISS	ON	N APPROVED BY OMB NO. 3150-0104											
	REPORT	(LER)	ESTIM MAN(REPC LICE) COMI AND REGU TO TI OF M	MATED DATOR DATOR DATOR DATOR MENTS RECOUNTS REC	BURCEN PE INFORMATI LESSONS LE PROCESS AN SREGARDING RDS MANAGE RY COMMISSI PERWORK RI EMENT AND BI	R REON CON CON CON CON CON CON CON CON CON C	SPONSE TO SOLLECTION D ARE INCO D BACK TO EN ESTIMATI BRANCH (T VASHINGTON TION PROJE T, WASHINGT	COMPL REQUES ORPORAT INDUSTRY E TO THE 6 F33), L 1, DC 205 CT (3150- TON, DC 2	Y WIT T: 50. ED IN FOR I.S. N(55-000 0104), 0503.	H THIS 0 HRS. TO THE RWARD MATION JCLEAR J1, AND OFFICE					
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Corrective Action															
The isolation valve was opene immediately upon discovery th	d to restor at it was c	e the TDAFWP flow plosed.	path to	the	2C S/G	to	operabl	e statu	IS						
Operations supervision has dis isolation valve and the failure procedure.	cussed this e to initiat	event with the person e an LCO tracking s	nel inv heet a	olve s re	ed in the equired b	fail y t	ure to o he surv	pen the	ne ce						
Appropriate personnel have b verification during the perform LCO tracking sheets.	been notificance and r	ed of this event to er eview of surveillance t	nphasi est pro	ze a oced	attention lures and	to the	detail a prepar	and se ation (elf of						
Additional Information															
The following LERs have be mispositioning caused by perso	een submit	ted in the last two	years	on	the subj	ect	of con	npone	nt						
LER 97-003-03 (Shared)	Failure to	Comply with Technica	l Spec	ifica	tions 4.5	.3.2	2 and 3.	5.2							
LER 96-005-00 (Unit 1)	Valve Mi Surveillan	salignment Due to l ce	Person	nel	Error F	lesu	ilts in	Misse	d						