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Docket Nos.: 50-348

NL-15-0962

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

Joseph M. Farley Nuclear Plant – Unit 1
Licensee Event Report 2015-001-00
Automatic Actuation of the Auxiliary Feedwater System
When the 1B SGFP was Tripped

Ladies and Gentlemen:

This Licensee Event Report is being submitted pursuant to the requirements of the Code of Federal Regulations, 10 CFR 50.73(a)(2)(iv)(A) as a condition that resulted in automatic actuation of the Auxiliary Feedwater System.

This letter contains no NRC commitments. If you have any questions regarding the submittal, please contact Ms. Julie Collier at (334) 814-4639.

Sincerely,

A handwritten signature in black ink that reads "C. R. Pierce". The signature is written in a cursive, flowing style.

C. R. Pierce
Regulatory Affairs Director

CRP/jac/lac

Enclosure: Unit 1 Licensee Event Report 2015-001-00

cc: Southern Nuclear Operating Company

Mr. S. E. Kuczynski, Chairman, President & CEO

Mr. D. G. Bost, Executive Vice President & Chief Nuclear Officer

Mr. M. D. Meier, Vice President – Regulatory Affairs

Mr. D. R. Madison, Vice President – Fleet Operations

Mr. B. J. Adams, Vice President – Engineering

Ms. B. L. Taylor, Regulatory Affairs Manager - Farley

RTYPE: CFA04.054

U. S. Nuclear Regulatory Commission

Mr. V. M. McCree, Regional Administrator

Mr. S. A. Williams, NRR Project Manager - Farley

Mr. P. K. Niebaum, Senior Resident Inspector - Farley

Joseph M. Farley Nuclear Plant – Unit 1

Unit 1 Licensee Event Report 2015-001-00

Enclosure

**Automatic Actuation of the Auxiliary Feedwater System
When the 1B SGFP was Tripped**



LICENSEE EVENT REPORT (LER)

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollections.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME

Joseph M. Farley Nuclear Plant, Unit 1

2. DOCKET NUMBER

05000 348

3. PAGE

Page 1 of 3

4. TITLE

Automatic Actuation of the Auxiliary Feedwater System When the 1B SGFP was Tripped

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
05	05	2015	2015 - 001 - 00			7	2	2015	FACILITY NAME	DOCKET NUMBER
9. OPERATING MODE 2			11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)							
			<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)				
			<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)				
			<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)				
10. POWER LEVEL 1 %			<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)				
			<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)				
			<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)				
			<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)				
			<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER				
			<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A				

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME

Julie A. Collier - Licensing Engineer

TELEPHONE NUMBER (Include Area Code)

(334) 814-4639

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
N/A	N/A	N/A	N/A	N/A					

14. SUPPLEMENTAL REPORT EXPECTED

☐ YES (If yes, complete 15. EXPECTED SUBMISSION DATE) ☒ NO

15. EXPECTED SUBMISSION DATE

MONTH	DAY	YEAR

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

On May 5, 2015 at 04:22 CDT with Farley Nuclear Plant (FNP) Unit 1 in mode 2 and the 1A Steam Generator Feedwater Pump (SGFP) in the tripped condition, an Auxiliary Feedwater (AFW) autostart signal was received due to a manual trip of the 1B SGFP. The trip of the second SGFP initiated the auto start signal for the Motor Driven Auxiliary Feedwater (MDAFW) pumps due to the auto start signal not being defeated. When the actuation signal was received, both the A and B MDAFW pumps were already in service supplying AFW to the steam generators (SG). The effects of this actuation were that the AFW Flow Control Valves were fully opened and the SG blowdown and SG blowdown sample valves were isolated. These actions occurred successfully and the auto start signal was reset.

The human performance cause of this event was that the operating crew did not meet expectations for effective teamwork to ensure proper decision making. While responding to a degrading condenser vacuum, the operating crew made the decision to trip the 1B SGFP instead of securing it per the standard operating procedure, which would have been adequate for preventing the event. Corrective actions included individual remediation plans. Planned corrective actions include the installation of bump preventer covers with caution placards, and management intervention on teamwork and decision-making.

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

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
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NARRATIVE**PLANT AND SYSTEM IDENTIFICATION**

Westinghouse - Pressurized Water Reactor

Energy Industry Identification Codes are identified in the text as [XX].

DESCRIPTION OF EVENT

On May 5, 2015, at 04:22 CDT, Farley Nuclear Plant (FNP) Unit 1 was in mode 2 and reactor power was approximately 1 percent. With the 1A Steam Generator Feedwater Pump (SGFP) in the tripped condition, an Auxiliary Feedwater (AFW) autostart signal was received due to manually tripping of the 1B SGFP. The trip of the second SGFP initiated the auto start signal for the Motor Driven Auxiliary Feedwater (MDAFW) pumps due to the auto start signal not being defeated. When the actuation signal was received, both the A and B MDAFW pumps were already in service supplying AFW to the steam generators (SG). The effects of this actuation were that the AFW Flow Control Valves were fully opened and the SG blowdown and SG blowdown sample valves were closed. These actions occurred successfully and the auto start signal was reset.

Just prior to the event the 1B SGFP was rolling on boiler control and not providing feed flow. Due to a degrading condenser vacuum which had started at approximately the same time that the feed pump was started, the Shift Supervisor, after consultation with the Shift Manager and the Outage Control Center, gave specific direction to the Unit Operator to decrease the 1B SGFP speed to 2400 rpm and to then "trip" the SGFP, instead of securing it. A peer check was performed to "trip" the 1B SGFP; however the peer check operator had only overheard the reason for tripping the SGFP, assumed an abnormal operating mindset, and did not take the time to challenge the decision or method in which the pump was to be secured. The task performer did not challenge the directions from the Shift Supervisor because of familiarity with the task and because the terminology "trip the SGFP" was used in specific directions by the Shift Supervisor.

When the only running SGFP was secured all the automatic actuations occurred as expected. Steam generator blowdown was secured and the flow control valves went full open. Both motor driven auxiliary feed water pumps were already running. The operating crew reset the flow control valve main control board hand switches to gain control of AFW.

CAUSE OF EVENT

This was a human performance-related event. The cause was that the operating crew did not meet expectations for effective teamwork to ensure proper decision making. While responding to a degrading condenser vacuum, the operating crew made the decision to trip the 1B SGFP instead of securing it per the standard operating procedure, which would have been adequate for preventing the event.

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

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by Internet e-mail to Infocollects.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

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NARRATIVE**REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT**

This event is reportable in accordance with 10 CFR 50.73(a)(2)(iv)(A) as a condition that resulted in automatic actuation of the Auxiliary Feedwater System.

When the only running SGFP was secured all the automatic actuations occurred as expected. Steam generator blowdown was secured and the flow control valves went full open. Both motor driven auxiliary feed water pumps were already running. The operating crew reset the flow control valve main control board hand switches to gain control of AFW. There was no impact on Steam Generator water level.

CORRECTIVE ACTION

Corrective actions included individual remediation plans. Planned corrective actions include the installation of bump preventer covers with caution placards, and management intervention on teamwork and decision-making.

ADDITIONAL INFORMATION

Other system affected: No systems other than those mentioned in this report were affected by this event.

Commitment Information: This report does not create any licensing commitments

Previous Similar Events: No similar previously reported events were identified