UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30303

Report No.: 50-348/78-34

Docket No.: 50-348

License No.: NPF-2

Licensee: Alabama Power Company
Post Office Box 2641
Birmingham, Alabama 35291

Facility Name: Farley Unit 1

Inspection at: Farley Site, Ashford, Alabama

Inspection conducted: December 11-15, 1978

Inspectors: A. K. Hardin

Accompanying Personnel: None

Approved by: W T Cottle 12/8/78
for R. C. Lewis, Chief Date
Reactor Projects Section No. 2
Reactor Operations and Nuclear Support Branch

Inspection Summary

Inspection on December 11-15, 1978 (Report No. 50-348/78-34)
Areas Inspected: Routine unannounced inspection of licensee event reports, plant operations, plant cleanliness and open and unresolved items. The inspection involved 36 hours of on-site inspection by one NRC inspector. Results: Of the four areas inspected, no items of noncompliance or deviations were identified.

DETAILS I

Prepared by: W F Cotton 12/29/78
FOR A. K. Hardin, Reactor Inspector Date
Reactor Projects Section No. 2
Reactor Operations and Nuclear
Support Branch

Dates of Inspection: December 11-15, 1978

Reviewed by: W F Cotton 12/29/78
FOR R. C. Lewis, Chief Date
Reactor Projects Section No. 2
Reactor Operations and Nuclear
Support Branch

1. Persons Contacted

*J. D. Woodard, Assistant Plant Manager
*K. W. McCracken, Technical Superintendent
*J. E. Garlington, Operations Supervisor
*T. C. Grozan, Plant Engineer
R. Hill, Plant Quality Assurance Engineer
*J. W. Kale, Jr., Operations QA
*F. A. Wurster, Operations QA

Other licensee employees interviewed during the course of the inspection included Shift Supervisors, Shift Foremen and Reactor Operators.

*Denotes those present at the exit interview.

2. Licensee Action Previous Inspection Findings

a. (Closed) Unresolved Item 348/78-33-02. Potential failure to conduct a safety evaluation as required by 10 CFR 50.59 prior to the installation of plastic tubing on the diesel engine day tank drain valves (paragraph 6b).

3. Unresolved Items

None identified during this inspection.

4. Exit Interview

An exit interview was held, at the conclusion of the inspection on December 15, 1978, with J. D. Woodard and other members of Alabama Power Company as identified by an asterisk in paragraph one. The scope and findings of the inspection were discussed.

5. Licensee Event Reports (LERs)

Five licensee event reports were reviewed at the site. Interviews with various licensee personnel, review of records and inspection of equipment involved in selected events were conducted to ascertain that the licensee's response to the event was in accordance with regulatory requirements. No items of noncompliance or deviations were identified. The LERs reviewed are listed below with additional comments relative to inspection findings. The items are closed, unless otherwise stated.

a. LER No. 79 - "Low Level in Fire Protection System Water Storage Tanks"

On November 14, 1978 the licensee found both fire protection water storage tanks below Technical Specification (TS) limits. The cause was found to be that construction personnel at Unit 2 were using the water source for the Unit 2 condensor hydrostatic testing. The cause was defined as failure of Unit 2 construction personnel to coordinate construction activities with Operation's personnel. The stated corrective action, was to restrict use of fire protection system water to fire protection training and actual emergencies unless authorized by the Shift Supervisor. The corrective action taken, which was verified by the inspector, was for the Nuclear Project Director for Unit 2 construction to transmit a written directive to Daniels Construction Company Manager, stating that fire protection system water was not to be used unless authorized by the Shift Supervisor in advance of use.

b. LER No. 80 - "Power Supply Failure to Steam Pressure Transmitter PT484"

The event was caused by a printed circuit card failure. No special significance was attached to the failure by the licensee, i.e., the printed circuit card failure was not considered abnormal.

c. LER No. 81 - "Containment Air Lock Door Seal Failed Surveillance Test"

The door seals are to be tested at 20 plus or minus 5 psig with no detectable leakage. The exterior seal was found to leak on test at the rate of one-half psig in 15 minutes. Correction consisted of cleaning the seals and conducting a satisfactory retest.

d. LER No. 82 - "Failure of B Train Penetration Room Filter to Pass DOP Test"

The B train filter was found to have DOP penetration of 0.07 percent as compared to a limit of 0.05 percent. The licensee corrected the problem by adjusting the spring tension on the filter support

assembly and performing a satisfactory retest. The licensee has taken under consideration a proposal to change the TS limit from 0.05 percent penetration to less than one percent penetration. The site licensee personnel stated the proposed change had been sent to the corporate personnel for review (348/78-34-01).

e. LER No. 83 - Surveillance Test Procedure (STP) not Revised to Specify New IR Flux Monitor Set Points"

New intermediate range flux monitor (IRFM) trip set points were established per STP 228.3 and 228.4 on April 29, 1978. However, the set points were not transferred to STP 41.2, the STP for testing the IRFM set points. The licensee reviewed actual IRFM trip values obtained between 4/29/78 and detection of the omission on 9/14/78. Of the eight occasions on which the trip values were checked, none were found to exceed the TS limit. The licensees corrective action was to revise STP 228.3 and 228.4 to require I and C personnel to record set point values in a "Surveillance Test Data Book" in the control room and to revise STP 41.2 to require the operations personnel to obtain correct setpoint values from the "Surveillance Test Data Book" when the surveillance is performed. The revised surveillance tests and the Surveillance Test Data Book were examined by the inspector and the above described revisions verified.

6. Open and Unresolved Items

a. Open Item - LER No. 75 - "Excessive Delay for DG 1-2A to Close on Bus"

The subject LER discussed an event in which a failed fuse in the generator excitation circuit caused the generator to come up to voltage on residual magnetism only, which in turn, resulted in about a 10 second delay for the generator breaker to close on the bus. A question raised by the inspector was, why wasn't the delay in the DG closing on the bus observed during routine tests of the diesel generator sets. Discussion of DG surveillance testing with the licensee revealed the licensee does not measure the time interval required for the DG to reach 4160 volts. Thus whether a DG set is slow coming up to sufficiently high voltage to close on the bus may or may not be observed. The licensee did not include in the LER report a corrective action directed toward detecting excessive delay for the DG to reach 4160 volts. On the current inspection, the licensee committed to a supplemental report and two actions; one immediate and one longer range. The immediate action will be a procedural change which will require that when running the test to see that the diesel reaches the required RPM within the TS time limit, the voltage will also be observed to assure there is no delay in the voltage reaching the required level within the same time as the DG reaches rated speed.

The long term action consisted, according to the licensee, of submitting a production change request, i.e., a proposed design change, which would provide an interval timer, to time both voltage and frequency. This item will remain open pending disposition of the licensees' proposed design and procedure change (348/78-34-02).

b. Tubing on Diesel Generator Day Tank Drains

Unresolved item 348/78-33-02 discussed observation by the inspector of the addition of a length of plastic tubing to a drain valve on each of the day tanks. The item was left unresolved pending a determination of whether the addition of the tubing should have been reviewed as per 10 CFR 50.59 requirements. On the current inspection the inspector determined that a Standard Operating Procedure is in effect, SOP 38.0, which requires that diesel generator day tank drain valves be closed as a normal valve line up. Since the safety aspects of the installed tubing come into effect only if the valve is open and a standard operating procedure requires the valves to be closed, the addition of the tubing is not considered to be a 50.59 review situation. The inspector verified on the current inspection that the tubing had been removed from each of the tanks.

c. Open Item 78-22-01 "Tagging and Storage of Anchor Darling Tilt Disk Check Valves"

IE Circular 78-15 discussed a certain type of tilting disk check valve which failed to function correctly when installed in a vertical position. The licensee's search did not reveal any incorrectly installed check valve. However, two similar valves were found in storage. The licensee stated they had labeled the valves as spares and tagged them to prevent their installation in a safety related system. On the current inspection, the inspector verified the two valves were labeled as spares, but were not adequately tagged to prevent their being used in safety related systems. At the exit interview a licensee representative stated he had instituted that the values be tagged and had visited the warehouse following the inspection visit and had observed that the valves were now tagged to prohibit their use in safety related systems. The inspector stated he had no further questions.

7. Plant Operations

Several aspects of plant operations were reviewed by the inspector. These were:

a. Control room annunciators in alarm at the time of the inspection were reviewed.

b. The licensee's file of about 25 conditions in which action statements of the Technical Specification had been entered, was reviewed.

c. A tour of the auxiliary building corridors and some of the equipment rooms was made.

d. Reviewed several reactor trip reports.

No item of noncompliance or deviations were identified in these areas.