



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

Report No.: 50-348/79-03

Licensee: Alabama Power Company  
600 North 18th Street  
Birmingham, Alabama 35291

Facility Name: Farley Unit 1

Docket No.: 50-348

License No.: NPF-2

Inspection at Farley Site, Ashford, Alabama

Inspectors:	<u>A. K. Hardin</u>	<u>2/21/79</u>
	A. K. Hardin	Date Signed
	<u>D. G. Hinckley</u>	<u>2/21/79</u>
	D. G. Hinckley	Date Signed
Approved by:	<u>F. S. Cantrell</u>	<u>2/21/79</u>
	F. S. Cantrell, Acting Section Chief, RONS	Date Signed

Summary

Inspection on January 23-26, 1979

Areas Inspected

This routine, unannounced inspection involved 48 inspector-hours onsite in the areas of safety limits, limiting safety system settings, and limiting conditions for operation; licensee event followup; followup items of non-compliance; inspector identified items; and independent inspection effort.

Results

Of the five areas inspected, no apparent items of noncompliance or deviations were identified.

## DETAILS

### 1. Persons Contacted

#### Licensee Employees

- \*W. G. Hairston, Plant Manager
- \*J. D. Woodard, Assistant Plant Manager
- \*K. W. McCracken, Technical Superintendent
- \*D. C. Poole, Operations Superintendent
- \*R. D. Hill, Plant Quality Assurance Engineer
- \*D. L. Cox, Operations Quality Assurance
- \*F. A. Wurster, Operations Quality Assurance
- \*J. W. Kale, Operations Quality Assurance

Other licensee employees contacted included technicians and operators.

\*Attended exit interview.

### 2. Exit Interview

The inspection scope and findings were summarized on January 26, 1979, with those persons indicated in Paragraph 1 above. The licensee did not raise any questions regarding the findings.

### 3. Licensee Action on Previous Inspection Findings

- a. Open (noncompliance) 348/78-27-02; this noncompliance identified a failure to take timely corrective actions on nonconformances reported in an internal audit report. The licensee's response stated that OQA Administrative Procedures would be revised to provide for a tickler system to track the response to noncompliances and also to provide for action to be taken in the event of an untimely response. These procedure revisions were verified at the site. The licensee also stated the tickler system was in use and further that the noncompliance had been discussed with appropriate supervisors in the Production Nuclear Section. These items will require verification at the Corporate Office in Birmingham. The item remains open pending review at the Corporate Office.
- b. Closed (noncompliance) 348/78-27-12; this noncompliance identified that neither an agreement nor a specific submittal plan had been established for transfer of design documents from Bechtel Corporation to Alabama Power Company (APCO). The licensee responded to the noncompliance stating that APCO had transmitted to Bechtel a letter authorizing Bechtel to proceed with microfilming. According to the

licensee's response the turnover is in process and a goal of 1979 is set for completion. The authorizing letter discussed above was reviewed by the inspector.

- c. Closed (unresolved) 348/78-27-05; resolution of this item, which related to inventory control, required that Procedure FNP-0-AP21 be revised, implemented and reviewed to ensure inventory level is controlled. A temporary change to AP-21 was approved on January 17, 1979, which the licensee feels will solve the problem pointed out by this unresolved item. The procedure change was reviewed by the inspector and no further questions were raised.
- d. Closed (unresolved) 348/78-27-07; resolution of this item required a revised, updated issue of Administrative Procedure AP-8 be reviewed, approved and implemented. Revision 4 of AP-8 was issued on January 12, 1979, and met the regulatory requirements committed to by the licensee.
- e. Closed (unresolved) 348/78-27-09; Section 6.8 of the licensee's AP-8 required a log of design change titles, numbers, approvals and other significant information be maintained. No such log was maintained by the licensee. On the current inspection, the inspector verified that the log had been established and contained the required information.
- f. Closed (unresolved) 348/78-27-10; the licensee has issued Revision 4 to AP-8 which requires that all proposed changes received a nuclear safety evaluation review. All proposed design changes are also reviewed by the onsite safety committee. Thus all changes receive a safety evaluation, but unless the change has 10 CFR 50.59 applicability a written basis justifying the conclusion that an unreviewed safety question will not be created may not be prepared. AP-8, Revision 4 was reviewed by the inspector. At the exit interview the inspector stated there were no further questions at this time.
- g. Closed (unresolved) 348/78-27-14; this unresolved item required a procedure change to improve the control and consistency of entering revision status in vendor instruction manuals. On December 22, 1978, the licensee revised Procedure FNP-0-AP-4 to add instructions for processing revisions to vendor manuals. These instructions were reviewed by the inspector and no further questions were raised regarding this item.

#### 4. Unresolved Items

Unresolved items were not identified during this inspection.

5. Review of Safety Limits (SL), Limiting Safety System Settings (LSSS) and Limiting Conditions for Operation (LCO)

An inspector reviewed selected logs, LCO status sheets and instrument trip setpoints to determine if reactor operations are being performed in conformance with established procedures and Technical Specifications. A general review was performed of the scaling documents used to establish instrument setpoints and reactor protective system trip settings; calculations used to establish setpoint criteria in several selected system test procedures were reviewed in more detail. The status of control room instrumentation was observed during reactor operation at approximately 80 percent power. The following records and setpoints of the listed procedures were reviewed:

- Reactor Operators Log for the period December 10, 1978, thru January 24, 1979
- LCO status sheets generated during the period December 1, 1978, thru December 31, 1978
- STP-201.5, Pressurizer Pressure PT-456 loop calibration and functional test
- STP-201.9, Reactor Coolant System FT-416 loop calibration and functional test
- STP-201.19, RCS TE-422B and TE-422D calibration and functional test
- STP-213.1, Steam Generator 1A LT-475 loop calibration and functional test
- STP-201.21, Pressurizer Pressure Control

No noncompliances or deviations were identified.

6. Licensee Event Reports (LERS)

Three 30-day LERS were reviewed at the site. These were:

- LER No. 89 - "LOSP Sequencer Failure on Step 6 of DG-1B"
- LER No. 90 - "Charging Pump Discharge Header Isolation Valves Not Locked Open"
- LER No. 91 - "River Water Pumps in Tripped Condition and Not Operable From the Control Room"

For the above reports, the inspector determined that the licensee had met reporting requirements, that corrective action had been taken or planned and that the actions taken were commensurate with the significance of the event. No items of noncompliance or deviations were identified.

7. Plant Tour

A tour of selected portions of the plant was made. The licensee is remodeling the plant in the areas of fire protection and security such that significant portions of the plant are in disorder. The inspector commented at the exit interview that cigarette butts had been observed in no smoking areas of the diesel building. The licensee stated they would review the areas involved.

8. LER No. 55

In IE Report 50-348/78-29 an open item was established (348-78-29-01) dealing with a potential discrepancy related to the cause of failure of a diesel to close on the 4160 bus. In one view the cause was believed to be a misaligned auxiliary contact on the breaker operating mechanism. In another view, the cause was believed to be a faulty contact in a relay. The licensee has reviewed the LER and has concluded the LER is correct as written, i.e., a misaligned contact caused the failure. Open Item 348/78-29-01 is closed.