Mailing Address
Alabama Power Company
600 North 18th Street
Post Office Box 2641
Telephone 205 783-6090

R. P. McDonald
Senior Vice President-
Nuclear Generation
Flintridge Building

Alabama Power
the southern electric system

July 3, 1984

Docket No. 50-348
Docket No. 50-364

Mr. R. C. Lewis
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, N.W.
Suite 3100
Atlanta, GA 30303

SUBJECT: J. M. Farley Nuclear Plant NRC Inspection of April 11 - May 10, 1984

RE: Report Numbers 50-348/84-15
50-364/84-15

Dear Mr. Lewis:

This letter refers to the two violations cited in the subject inspection reports.

1. The first violation states:

"The following violations were identified during an inspection conducted on April 11 - May 10, 1984. The Severity Levels were assigned in accordance with the NRC Enforcement Policy (10 CFR Part 2, Appendix C).

1. 10 CFR 50.59 allows the licensee to make changes to the facility as described in the FSAR without prior Commission approval provided that the change does not involve a change to the Technical Specifications or constitute an unreviewed safety question. The licensee is required to maintain records which include a written safety evaluation which provides the bases for determining that the change does not constitute an unreviewed safety question. The operation of the service water system and the diesel generator loading during an accident are both described in the FSAR.

Contrary to the above, the licensee did not perform a written safety evaluation prior to:

a. Removing a bolt from a service water vacuum breaker weight arm, and adding a flexible hose to the vacuum breaker's vent line. Both changes could have prevented the vacuum breaker from performing its design function.

b. Adding an electric dewatering pump to motor control center 1X which is powered by a diesel generator during a loss of off site power.

This is a Severity Level IV violation (Supplement I)."

Admission or Denial

The above violation occurred as described in the subject reports.

Reason for Violation

The first part of this violation was caused by personnel error. The service water breaker has had a history of leaking and the hose had been installed to route this leakage to a drain without a 10CFR50.59 evaluation being performed.

The second part of this violation was also caused by personnel error. Due to problems with the river water sump pumps, a temporary pump was installed to protect the switchgear. This pump was connected to a spare power supply cable in Motor Control Center 1X without a 10CFR50.59 evaluation being performed.

Although this violation resulted from personnel error, Alabama Power Company has identified the root cause of the violation and corrective action is being taken in a manner to minimize recurrence. The root cause of the violation has been identified as an insufficient level of awareness by the plant staff for performing safety evaluations of changes made to the plant.

Corrective Action Taken and Results Achieved

The hose was removed from the service water vacuum breaker on April 21, 1984. An evaluation of this event determined that even a total failure of the vacuum breaker would have had no effect on the service water system over a short period of time.

The temporary pump was removed on April 21, 1984. An investigation of this event indicated that although the pump was installed, it was never operated. Even if the pump had been in operation and the diesel generators had been required to start, plant procedures would have required operator action to prevent excessive diesel generator loading, thus eliminating the possibility of diesel generator damage.

Corrective Steps Taken to Avoid Further Violations

Based on initial evaluation of these incidents, Alabama Power Company management required supervisory personnel to survey the accessible plant areas under their direct supervision to determine if unauthorized modifications existed. The results of these surveys, which identified a number of minor descrepancies, indicated that no additional plant modifications have been implemented without completion of proper written safety evaluations. In addition, all operations, maintenance and chemistry personnel are being trained on the requirements related to 10CFR50.59. It is the judgement of Alabama Power Company that the supervisory personnel surveys and the personnel training will increase awareness of plant personnel and thereby minimize recurrence. All associated corrective action items are scheduled to be completed by October 26, 1984.

Date of Full Compliance

April 21, 1984.

2. The second violation states:

"2. Technical Specification 6.8.1 requires that written procedures be established, implemented and maintained.

Contrary to the above;

a. The thermostat control switch for 2B battery changer (SIC) room cooler, a Safety Related System, was not included in FNP-2-SOP-58.0 "Auxiliary Building HVAC" system check list.

b. A temporary change notice (TCN) to SOP-38.0 "Diesel Generator" had expired which covered operation of the diesel generator while the fuel oil day tank level indicator in the control room was out of service.

This is a Severity Level V Violation (Supplement I)."

Admission or Denial

The above violation occurred as described in the subject reports.

Reason for Violation

The first part of this violation was caused by a procedural deficiency in that the referenced control switch was not included in the system checklist.

The second part of this violation was caused by personnel error in that the temporary procedure change was allowed to expire before the level indicator was repaired.

Corrective Action Taken and Results Achieved

For the first part, the control switch was placed in the AUTO position and a procedure change was implemented to include this switch in the system checklist. An analysis was performed to determine what the maximum potential room temperature would have been with the thermostat control switch in the "off" position, concurrent with a design basis accident. The potential impact on the operability of safety related equipment located in the subject area was also evaluated. It was determined that the maximum room temperature that would be experienced in a 24 hour period would be less than that temperature for which the safety related equipment located in the room would successfully operate. This temperature increase would have been mitigated by the system operator through manual initiation of the room cooler since the operator is required, by technical specifications, to monitor the room temperature every 24 hours. It is the judgement of Alabama Power Company that the equipment located in the 2B battery charger room necessary for plant shutdown would have operated for this required period of time.

For the second part, procedural changes were implemented to allow use of interim measures to allow surveillance of the diesel generator day tank level and the appropriate personnel involved were counseled concerning the use of TCNs. Subsequently, the level indicator has been returned to service.

Corrective Steps Taken to Avoid Further Violations

A comprehensive review of all safety related ventilation system operating procedures is in progress to identify and correct any further deficiencies. This review is scheduled to be completed by September 14, 1984.

A permanent procedure change was implemented to provide an alternate means of monitoring the day tank level should the control room indication become inoperable.

Date of Full Compliance

April 23, 1984.

Affirmation

I affirm that this response is true and complete to the best of my knowledge, information and belief.

The information contained in this letter is not considered to be of a proprietary nature.

Yours very truly,

R. P. McDonald

RPM/RLG:sam

cc: File