OFFical

SEP 23 1991

Docket Nos. 50-348, 50-364
License Nos. NPF-2, NPF-8
EA 91-102

Alabama Power Company
ATTN: Mr. W. G. Hairston, III
Senior Vice President
Nuclear Operations
40 Inverness Center Parkway
P. O. Box 1295
Birmingham, AL 35201

Gentlemen:

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY - $25,000 (NRC INSPECTION REPORT NOS. 50-348/91-17 AND 50-364/91-17)

This refers to the Nuclear Regulatory Commission (NRC) inspection conducted by Mr. M. Hunt on July 23 - 24, 1991, at the Farley Nuclear Plant. The inspection included a review of the facts and circumstances related to a recent valve misalignment which resulted in Unit 1 changing modes while the turbine driven auxiliary feedwater pump (TDAFWP) flowpath was inoperable during the period May 17-22, 1991. The problem was identified by the plant staff and subsequently reported in Licensee Event Report No. 1-91-005 dated June 14, 1991. The report documenting this inspection was sent to you by letter dated August 7, 1991. As a result of this inspection, significant violations of NRC requirements were identified. An enforcement conference was held on August 22, 1991, in the NRC Region II office to discuss the violations, their cause, and your corrective actions to preclude recurrence. A summary of this conference was sent to you by letter dated August 29, 1991.

On May 17, 1991, at approximately 1:30 a.m., with Unit 1 in Mode 3 (Hot Standby), auxiliary feedwater recirculation valve Q1N23V008, which is normally locked closed, was unlocked and opened to allow for a time response test to be performed on the TDAFWP following a refueling outage. The valve was not closed when the test was completed. Violation A, described in Part I of the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice), occurred when Unit 1 changed operational modes from Mode 3 to Mode 1 on May 18-19, 1991, with auxiliary feedwater recirculation valve Q1N23V008 misaligned to the open position in the TDAFWP recirculation line which caused the system flowpath to be inoperable.

Violation A was caused by ineffective procedural controls and communications. The procedure step for closing the valve did not provide assurance of valve closure because it did not explicitly direct operations personnel to close the valve and did not require a verification signature by operations. Instead, the procedure directed maintenance personnel to request operations to close the valve with a maintenance sign-off. Following completion of the test, maintenance personnel informed a plant operator that the test had been completed and that the valve could be closed and locked. However, because of ineffective

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communication between the personnel involved, the valve was not returned to the closed and locked position. It was not until May 22, 1991, at approximately 4:15 a.m., with Unit 1 at 41 percent power, that the improperly positioned valve was discovered by the licensee and immediately corrected.

Violation B in Part 1 of the Notice addresses the failure of the operations staff to follow administrative procedures which required the initiation of a Limiting Condition of Operation (LCO) Status Sheet for the LCO created when AFW valve Q1N23V008 was unlocked and placed in the open position for the time response test. This failure to initiate the LCO Status Sheet contributed to the mispositioned valve remaining undetected for an extended period because the LCO Status Binder containing the LCO Status Sheet would have been reviewed and the TDAFWP flowpath restored to operable condition prior to any mode change. This apparent lack of attention to detail, which is evidenced by other missed opportunities to identify and correct the problem, impacts your operations staff's ability to control plant evolutions. One opportunity to correct and identify the problem was the review of the key checkout book performed on May 20 and 21, 1991, which would have identified that the valve was in the wrong position. A second opportunity was missed when shift operators standing the rover position failed to identify the mispositioned valve.

The staff recognizes that immediate corrective action was taken when the violation was identified and that action was taken to return the valve to its proper alignment. In addition, we understand that you plan to review procedures to determine if similar verification errors exist.

The violations in Part I of the Notice have been considered together to be a Severity Level III problem in accordance with the NRC Enforcement Policy. To emphasize the importance of ensuring operability of equipment important to safety, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty in the amount of $25,000 for the Severity Level III problem because of the safety importance of the affected components and the clear operability requirements provided for in your Technical Specifications.

The base value of a civil penalty for a Severity Level III problem is $50,000. The escalation and mitigation factors in the Enforcement Policy were considered. Neither escalation nor mitigation was warranted for identification and reporting. The fact that your staff identified the violation and submitted an LER was offset by several missed opportunities to detect the violation earlier; those included the numerous system operator tours conducted in the vicinity of TDAFWP that failed to detect the unlocked open valve, where the locking chain was hanging from the valve. Neither escalation nor mitigation was warranted for corrective action to prevent recurrence. Your immediate corrective actions to properly align the valve and return the system to operable status, modify the procedure to ensure that operations verifies the valve closed and locked, and counsel the individuals involved addressed those important immediate concerns. However, prior to the enforcement conference, your long-term corrective actions did not include plans to revise the procedure writer's guide to ensure that future procedure revisions would require an operations verification sign-off for similar valve manipulations.

Additionally, actions focused on one individual were not viewed as sufficient to prevent the potential recurrence of the failure of operations to prepare an LCO Status Sheet when the valve was unlocked and opened. Mitigation of 50 percent was warranted for the SALP 1 rating in Plant Operations over previous SALP periods and your good prior enforcement history. Additional mitigation was not warranted for this factor because of a number of problems identified in the past nine months that involve plant configuration control. Examples included the loss of control room HVAC caused by operation of the wrong valve (Inspection Report 50-348/91-10), startup with the reactor vessel flange leakoff valve closed (Inspection Report Nos. 50-348, 364/90-36 and 50-364/90-36), dumping approximately 4500 gallons of water to the containment sump when maintenance personnel were allowed to reposition five valves without any restrictions (Inspection Report Nos. 50-348, 364/91-10), and the potential loss of the reactor coolant system vent path as a result of overtightening the reactor head stud nuts (Inspection Report No. 50-364/90-33). The other adjustment factors in the Policy were considered and no further adjustment to the base civil penalty is considered appropriate. Therefore, based on the above, the base civil penalty has been decreased by 50 percent.

Part II of the Notice contains a violation that addresses a failure to follow procedure, which, had it been followed, may have provided for earlier detection of the misaligned valve. In this particular case, administrative procedures required that the operations shift supervisor periodically audit the locked valve and key checkout sheets. Operations Memorandum 82-05 defines the periodic interval as each Monday night shift. However, no audit was conducted from May 2, until May 21, 1991, a period of 19 days. Had the audit been performed weekly, the misaligned valve may have been discovered sooner.

Inspection Report Nos. 50-348/91-17 and 50-364/91-17 identified an apparent violation involving reporting requirements associated with 10 CFR 50.72. After further review and consultation with the Office for Analysis and Evaluation of Operational Data, the staff has determined that no violation of the reporting requirements of 10 CFR 50.72 occurred in this case.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room. The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96.511.

Should you have any questions concerning this letter, please contact us.

Sincerely,

Original Signed By
J. L. Milhoan

Stewart D. Ebneter
Regional Administrator

Enclosure:
Notice of Violation and Proposed
Imposition of Civil Penalty

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JPartlow, NRR
Enforcement Coordinators
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FIngram, PA
BHayes, OI
EJordan, AEOD
DWilliams, OIG
EA File
Day File
DCS

*******See previous page for HQ's concurrence*******

OE	RII	OE:D	DEDR	
WTroskoski	SEbneter	JLieberman	JSniezek	
9/ /91	9/ /91	9/ /91	9/ /91	
RII	RII	RII	RII	RII
AFGibson/	LAReyes	GRJenkins	CEvans	JLMilhoan
9/19/91	9/19/91	9/20/91	9/20/91	9/23/91

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OK per J. Wachselberger

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9/13/91	9/16/91	9/16/91	9/16/91
	per telecon w/ B. Urye		