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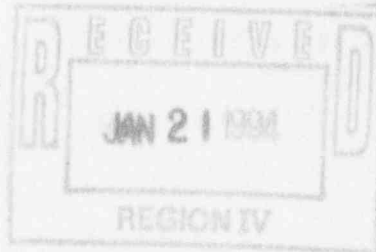
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Subject: Arkansas Nuclear One - Units 1 and 2
Docket Nos. 50-313 and 50-368
License Nos. DPR-51 and NPF-6
Response to Inspection Report
50/313/93-09; 50/368/93-09



Gentlemen:

Pursuant to the provisions of 10CFR2.201, attached is the response to the violations identified during the inspection of activities associated with the failure to replace an Emergency Diesel Generator Speed Sensing Switch and the mispositioning of Post Accident Sampling System solenoid valves.

Should you have questions or comments, please call Mr. Rick King at 501-964-8612.

Very truly yours,

Jerry W. Yelverton

JWY/rmc

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NOTICE OF VIOLATION

During an NRC inspection conducted on October 3 through November 13, 1993, two violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violations are listed below:

- A. 10 CFR Part 50, Appendix B, Criterion XVI, required that measures shall be established to assure that conditions adverse to Quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.

Procedure 1000.104, "Condition Reporting and Corrective Actions" required that "Each manager ensures that assigned action items are completed as scheduled."

Contrary to the above, on October 7, 1993, the licensee failed to replace emergency diesel generator speed sensing relays prior to the end of their apparent qualified life and thus failed to complete the corrective action required by Condition Report 1-89-0501, Item 4, which was closed on May 14, 1990.

This is a Severity Level IV violation. (Supplement I) (313/9309-01)

Response to violation 313/9309-01

(1) Reason for the violation

ANO Condition Report 1-89-0501 required that the qualified life for emergency diesel generator (EDG) speed sensing relays be determined and controls be implemented to ensure that the relays are periodically replaced. In response to the condition report, a Preventive Maintenance Engineering Evaluation (PMEE) was revised to establish a requirement for periodic replacement of these switches at 4.5 year intervals. A procedure was developed in April 1990 to provide instructions for replacement of these switches. A repetitive PM task, however, was not in place to utilize the procedure to satisfy the periodic replacement requirement. After there was a failure of an EDG to start, it was determined that the speed sensing relays had not been replaced at the required periodicity.

NRC violation 50-313/9309-01 identified this condition as a failure to complete the appropriate corrective actions under the ANO Condition Reporting Program. However, in review of the conditions it was concluded by ANO that the response and actions on the condition were adequate as discussed in ANO CR 1-93-0457.

ANO's evaluation of the condition concluded that the breakdown occurred in the Preventive Maintenance (PM) controls in place to ensure the new procedures were performed as required. The tasks that were developed to ensure the relays were replaced were not tracked to ensure completion.

The root cause of this event was determined to be a failure to adequately track and control the progress of PM task planning.

Additionally, the PMEE task for replacement of relays on oscillation, synch, and status switch board for inverters was not implemented and the Senior Resident Inspector stated that this issue will be addressed in Inspection Report 93-10. ANO identified other condition reports written on the ANO PM program which indicate that additional program tracking and process improvements are necessary to ensure that PM tasks are identified, scheduled, and performed in a timely manner.

ANO personnel recently evaluated the broader concerns associated with the PM processes. Enhancements were identified for managing the PM Program which would result in improvements in efficiency and tracking. Direct ownership of the PM basis documents along with the PM tasks would consolidate program changes in the responsible departments and simplify tracking. As a follow-up to this evaluation, ANO is in the process of implementing enhancements to management and tracking of PM tasks, building upon the initial program.

(2) Corrective steps taken and results achieved:

In response to the issue concerning the EDG speed sensing switch, a review of Preventive Maintenance (PM), Mandatory Preventive Maintenance (MPM), and Environmental Qualification (EQ) tasks for safety-related (Q) components was performed to identify any tasks that may have not been approved and have no past accomplished dates and those tasks which may have been approved, but have no assigned due dates. These tasks were reviewed to verify that component replacement tasks have been completed. Some schedule deviations were identified, but no component operability concerns existed.

A Human Performance Enhancement System evaluation was performed and outlined the chronology of the events leading from the initiation of the original condition report in 1989 to the failure of the EDG to start.

Procedure 1000.115, *Preventive Maintenance Program*, was revised to define responsibilities and requirements for tracking all unapproved PM/MPM/EQ tasks on ANO-1 and ANO-2. An implementation schedule was established.

(3) Corrective steps that will be taken to prevent further violations:

ANO will implement an improved PM Program process to ensure better tracking and management of PM tasks. A project plan for the improved PM Program will be finalized by February 15, 1994. The implementation schedule for this program will be identified at that time.

(4) Date when full compliance will be achieved

ANO was in full compliance for this event when the speed sensing relays for the EDG were replaced; however, full compliance for the PM program will be achieved when the revised program for managing and tracking PMs is implemented.

NOTICE OF VIOLATION

- B. Unit 2 Technical Specification 6.8.1.j required that written procedures shall be established, implemented, and maintained covering post accident sampling.

Procedure 1617.009, Revision 11, Permanent Change 3, "Panel 2C357 Valve Alignment," required that Chloride Analyzer Isolation Solenoid Valve 2SV-5998 be left in the open position and Chemical Analyzer Drain Valve 2SV-5945 be left in the closed position following the completion of post accident sampling system liquid sampling.

Contrary to the above, on November 3, 1993, Valve 2SV-5998 was found to be in the closed position and Valve 2SV-5945 was found to be in the open position following completion of post accident sampling system liquid sampling activities.

This is a Severity Level IV violation (Supplement I) (368/9309-02).

Response to violation 368/9309-02

(1) Reason for the violation

Guidance is provided in Procedure 1052.023 "Conduct of Chemistry", regarding procedure use and adherence. This guidance directs, in part, that if a procedure is found to be written such that it could cause equipment damage, then the user is to discontinue the use of the procedure until it is corrected. During a chemistry training session utilizing Procedure 1617.009, "Panel 2C357 Valve Alignment", it was noted that the Chloride Analyzer Isolation Solenoid Valve 2SV-5998, was required to be in the open position; however, the correct position should have been closed. The Chemist conducting the training felt he could prohibit the use of the procedure until the required procedure changes were made, and left 2SV-5998 in the closed position. However, Procedure 1052.023 contains additional guidance requiring the implementation of appropriate procedure changes necessary to correct the solenoid valve position in Procedure 1617.009 before the solenoid valve was re-positioned. The Chemist initially believed that his actions were correct in identifying the solenoid valve mispositioning and placing the solenoid valve in a position that would best provide for system reliability. Additionally, the requirements for procedure use and adherence direct the user to notify the responsible supervisor upon identifying deficiencies. For this event the supervisor was not notified of the problem.

A Human Performance Enhancement System evaluation was performed and determined that the Chemist failed to self check to ensure that the intended actions were taken to resolve the deficiency.

The reason 2SV-5998 was mispositioned was the failure to resolve the identified procedural deficiencies before placing the solenoid valve in the correct position.

The reason the Chemical Analyzer Drain Valve 2SV-5945 was mispositioned could not be determined. The sampling systems are unique to other ANO plant systems in that both Operations and Chemistry departments may have procedures for shared operation of certain sampling systems.

(2) Corrective steps taken and results achieved:

The mispositioned solenoid valves were restored to their proper positions and Procedure 1617.009 was revised to provide the correct position for 2SV-5998.

The details of this event were discussed with Chemistry Department personnel during the remaining 1993 Chemistry training cycles.

Appropriate Chemistry personnel were instructed on the proper protocol for performing procedure changes following identification of discrepancies.

The Chemist involved was held accountable for his failure to take appropriate action to resolve the discrepancy and was disciplined per Entergy company policies. Chemistry personnel will continue to be held accountable for their actions and disciplined as required.

(3) Corrective steps that will be taken to prevent further violations:

The Units 1 and 2 sampling systems will be evaluated and the responsibility for alignment of select portions of these systems will be transferred to the Chemistry department to prevent potential operational valve lineup inconsistencies in ANO sampling systems. This is scheduled to be completed by April 15, 1994.

Discussions of this event and management expectations concerning the requirements for procedure use and adherence will be included in the First Quarter 1994 Chemistry Training cycles.

(4) Date when full compliance will be achieved:

Full compliance was achieved when Procedure 1617.009 was revised and solenoid valves 2SV-5998 and 2SV-5945 were placed in their proper positions.