



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
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April 9, 2007

Timothy G. Mitchell
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SUBJECT: ERRATA FOR ARKANSAS NUCLEAR ONE NRC INTEGRATED INSPECTION
REPORT 05000313/2006005 AND 05000368/2006005

Dear Mr. Mitchell:

Please replace page 9 of NRC Integrated Inspection Report 05000313/2006005 and 05000368/2006005, dated February 14, 2007, with the attached revised page. The purpose of this change is to reconcile the crosscutting element of the finding with that described in the Report Details.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

Jeff Clark, PE, Chief
Project Branch E
Division of Reactor Projects

Dockets: 50-313
50-368
Licenses: DPR-51
NPF-6

Enclosure:
Page 9 from NRC Inspection
Report 05000313/2006005 and 05000368/2006005

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DRS STA (**DAP**)
D. Cullison, OEDO RIV Coordinator (**DGC**)
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ANO Site Secretary (**VLH**)

SUNSI Review Completed: __JAC__ ADAMS: ☒ Yes ☐ No Initials: __JAC__
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RIV:PE/DRP/E	C:DRP/E			
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/RA/	/RA/			
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Corrective actions that were taken by the licensee in response to this event to prevent recurrence included: moving the step-off pad farther away from the work area, clearing the area near the door of unnecessary equipment and materials, coaching the firewatch and his supervisor concerning the responsibility of the firewatch and how to deal with distractions, discussing alternatives to more effectively contain sparks from the cutting operation, discussing the event with craft personnel, and conducting more frequent area inspections.

A number of additional deficiencies were identified through a review of recent licensee performance in the conduct of related hot work activities. Section 4OA2 of this enclosure contains some details of other instances that occurred during the Unit 2 Refueling Outage 2R18. Also, three examples involving circumstances similar to the subject of this finding occurred during the prior refueling outages for each of the two units. On March 25, 2005, fallen welding slag caused the smoldering of debris below Containment Cooler D inside the Unit 2 containment building. On September 29 torch cutting resulted in falling hot metal and slag that caused combustible materials in the work area to catch on fire. On October 14 three small fires of trash bags containing combustible materials in the Unit 1 turbine building basement were caused by hot work activities that were being performed on the levels above. There was no firewatch posted on the basement level.

Each of these instances was entered into the licensee's CAP. These occurrences represent instances of inadequate implementation of applicable hot work control procedures. The inspectors concluded that the recent increase in the number of related findings when compared to past occurrences represented a trend which, if left uncorrected, could become a more significant safety concern in that it could result in a fire in or near risk important equipment.

Analysis. The performance deficiency associated with this finding involved the failure of maintenance personnel to adequately implement the licensee's procedure for control of hot work and ignition sources. The finding is greater than minor because it is associated with the protection against external factors attribute of the initiating events cornerstone, and affects the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Additionally, if left uncorrected, the practice of conducting hot work in a manner that results in unintended combustion of nearby materials would become a more significant safety concern in that it could result in a fire in or near risk important equipment. Manual Chapter (MC) 0609, "Significance Determination Process," Appendix F, "Fire Protection Significance Determination Process," does not address the potential risk significance of shutdown fire protection findings. Additionally, MC 0609, Appendix G, "Shutdown Operations Significance Determination Process," does not address fire protection findings. Thus, the finding is not suitable for significance determination process evaluation, but has been reviewed by NRC management and is determined to be of very low safety significance because the finding occurred while the unit was already in a cold shutdown condition; and the operability of equipment necessary to maintain safe shutdown was not challenged. The cause of the finding is related to the crosscutting element of human performance associated with work practices because the fire watch failed to use error prevention techniques like self checking and peer checking which would have prevented the event.