



Entergy  
Operations

Entergy Operations, Inc.  
Box 3 Box 1370  
Russellville, AR 72811  
Tel: 501-964-3100

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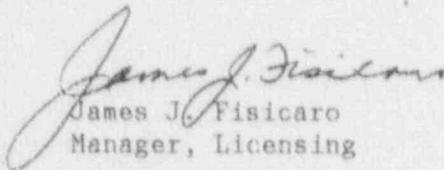
U. S. Nuclear Regulatory Commission  
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SUBJECT: Arkansas Nuclear One - Unit 2  
Docket No. 50-368  
License No. NPF-6  
Licensee Event Report 50-368/91-004-00

Gentlemen:

In accordance with 10CFR50.73(a)(2)(i)(B), attached is the subject report concerning a failure to maintain the control room ventilation system radiation monitor alarm/trip setpoint value within Technical Specifications due to a personnel error.

Very truly yours,

  
James J. Fisicaro  
Manager, Licensing

JJF/GRA/mmg  
Attachment

cc: Regional Administrator  
Region IV  
U. S. Nuclear Regulatory Commission  
611 Ryan Plaza Drive, Suite 1000  
Arlington, TX 76011

INPO Records Center  
Suite 1500  
1100 Circle, 75 Parkway  
Atlanta, GA 30339-3054

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Arkansas Nuclear One, Unit Two

DOCKET NUMBER (2)	PAGE (3)
050003681	OF 03

TITLE (4) Failure To Maintain Control Room Ventilation System Radiation Monitor Alarm/Trip Setpoint Value Within Technical Specifications Due To Personnel Error

EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)	
01	25	91	91	004	00	02	27	91	ANO-1	050003681	

OPERATING MODE (9) 1 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §:

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §:			
1		(Check one or more of the following) (11)			
POWER LEVEL (10)	088	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	Other (Specify in
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	Abstract below and
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	in Text, NRC Form
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	366A)

LICENSEE CONTACT FOR THIS LER (12)

Name	Telephone Number
Glenn A. Ashley, Nuclear Safety and Licensing Specialist	Area Code: 501964-1700

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

Cause	System	Component	Manufacturer	Reportable to NRCDS	Cause	System	Component	Manufacturer	Reportable to NRCDS

SUPPLEMENT REPORT EXPECTED (14)

Yes (If yes, complete Expected Submission Date)  No

EXPECTED SUBMISSION DATE (15)	Month	Day	Year

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On January 28, 1991 it was discovered that the Unit 2 control room radiation monitor had an alarm/trip setpoint greater than two times background and the control room emergency ventilation system had not been placed in the recirculation mode as required by Technical Specifications. On January 25, 1991 the average background was determined to be 83 counts per minute (CPM) and the alarm/trip setpoint at that time was set to 200 CPM. A job request was initiated to have the setpoint adjusted. It was not recognized until January 28, 1991 that Technical Specification 3.3.3.1 required the setpoint be adjusted within 4 hours. The control room ventilation system was placed in the recirculation mode, and subsequently, the setpoint was adjusted to 150 CPM. The event had no adverse impact on control room habitability; the capability of the monitor to perform its intended function was maintained. The root cause of this event was personnel error. The Operations Manager has issued a night order to remind operations personnel of the requirements of Technical Specification 3.3.3.1, and this event will be discussed during the training cycle following the 2R8 refueling outage.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	EVENT NUMBER (2)	LER NUMBER (6)						PAGE (3)
		Year	Sequential Number	Revision Number				
Arkansas Nuclear One, Unit Two	0150100368	91	004	00			02 OF 03	

TEXT (If more space is required, use additional NRC Form 366A's) (17)

A. Plant Status

At the time of discovery of this event, Arkansas Nuclear One, Unit Two (ANO-2) was operating in Mode 1 (Power Operation) at approximately 88 percent of rated thermal power. Reactor Coolant System (RCS) temperature was approximately 576 degrees Fahrenheit and RCS pressure was about 2250 psia.

B. Event Description

On January 28, 1991 it was discovered that the Unit 2 control room ventilation system radiation monitor (2RITS-8750-1) had an alarm/trip setpoint greater than two times background and the control room emergency ventilation system [VI] had not been placed in the recirculation mode of operation as required by Technical Specification 3.3.3.1.

On January 25, 1991 during the midnight shift, the average background count rate for the control room radiation monitor (2RITS-8750-1) was calculated using data from the Process Monitor Log. The average of the three readings from the previous day was determined to be 83 counts per minute (CPM). The alarm/trip setpoint at that time was set to 200 CPM. The Process Monitor Log specified that the setpoint be adjusted if the setpoint was greater than two times the average reading. Therefore, operations personnel initiated a job request to have the setpoint adjusted. It was not recognized that Technical Specification 3.3.3.1 required the setpoint be adjusted within 4 hours or the associated monitor be declared inoperable. If the radiation monitor is declared inoperable, initiation and maintenance of the control room emergency ventilation system in the recirculation mode of operation must be accomplished within one hour.

At approximately 0755 on January 28, 1991 operations personnel reviewing the Process Monitor Logs realized that the requirements of Technical Specification 3.3.3.1 had not been satisfied. At that time the radiation monitor was declared inoperable and the ventilation system was placed in the recirculation mode. The radiation monitor alarm/trip setpoint was adjusted to 150 CPM and at 1700 on January 28, 1991 the Technical Specification action statement was cleared.

C. Root Cause

The root cause of this event was personnel error. The Process Monitor Log that was used to record the radiation monitor readings and to calculate the average background reading referenced Technical Specification 3.3.3.1 and required the operations personnel to have the setpoint adjusted if the existing setpoint was greater than two times the average background reading. The Waste Control Operator (non licensed operator) completing the log and the Shift Supervisors reviewing the log did not refer to Technical Specification 3.3.3.1 to determine the required actions and did not recognize that the action required by the Process Monitor Log had time limits specified in the Technical Specifications.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Arkansas Nuclear One, Unit Two	DOCKET NUMBER (2) 05000368	LER NUMBER (6)			PAGE (3) 03 OF 03
		Year 91	Sequential Number 004	Revision Number 00	

TEXT (If more space is required, use additional NRC Form 366A's) (17)

D. Corrective Actions

The Operations Manager will counsel the Shift Supervisors involved in this event regarding the need to thoroughly investigate Technical Specification related conditions by March 15, 1991.

The Operations Manager has issued a night order to remind operations personnel of the requirements of Technical Specification 3.3.3.1.

The Operations Manager will discuss this event with all operating crews during the requalification training cycle following the upcoming 2R8 refueling outage. The discussion will emphasize that Technical Specification requirements must be properly identified and compliance must be ensured for sections of the operations logs that reference the Technical Specifications.

F. Safety Significance

With the alarm/trip setpoint remaining at 200 CPM, the control room ventilation system radiation monitor was still capable of performing its intended function to automatically initiate isolation of the control room from elevated airborne radioactivity to maintain control room habitability. Since the monitor background varies such that a setpoint greater than 200 CPM is not unusual, the monitor would continue to alarm/actuate on airborne radiation levels significantly below occupational exposure limits. Therefore, leaving the setpoint at a value greater than two times background for a time period greater than allowed by Technical Specifications has no actual safety significance.

F. Basis For Reportability

This event is reportable under the provisions of 10CFR50.73(a)(2)(i)(B), as operation prohibited by Technical Specifications. Specification 3.3.3.1 requires that the control room ventilation system radiation monitor be operable with the monitor setpoint at less than or equal to two times background. With the setpoint exceeding the specified value, four hours are allowed to adjust the setpoint to within the limits. Otherwise, within one hour the control room emergency ventilation system must be placed in the recirculation mode of operation. As a result of this event, the monitor was operated with the setpoint above the required limit beyond the allowable four hours and without placing the control room emergency ventilation system in the recirculation mode.

G. Additional Information

There have been no other similar events caused by personnel error reported at Arkansas Nuclear One.

Energy Industry Identification System (EIIS) codes are identified in the text as [X].