SALP NOTES

Arkansas Nuclear One Units 1 & 2 Evaluation Period: 1/1/79 - 8/19/80

I. General

The Arkansas Nuclear One facility was determined to be weak in the areas of training (Contention A), security (Contention B), reporting (Contention C), and quality control (Contention D).

The licensee has developed and implemented an improved, formal training program that meets regulatory requirements, including (1) a schedule of training lectures and requalification programs, (2) a method for performing performance evaluations, (3) a system to identify weak areas in the annual examination, then retrain and reexamine individuals, and (4) a better system of record keeping to provide confirmation that required training is being performed.

The quality control area has received increased management attention resulting in (1) increased review and followup of procedures, design changes and maintenance activities, (2) reinstruction of personnel on the requirements for adherance to procedures, and (3) increased control of equipment and verification of work performed.

The licensee has provided additional security training and increased area surveillance, resulting in a reduced number of violations during the last four months of the evaluation period.

In the matter of reporting, the licensee has provided more complete LER's in recent months, and shown increased willingness to keep the NRC notified of problem areas and corrective actions taken.

In all areas of concern to the NRC, AP&L management has demonstrated increased interest and direct involvement in the implementation of corporate policies.

II. Specific

Contentions A through D below are examples of the more general contention, "The Arkansas Nuclear One facility displayed evidence of weaknesses in the areas of training (See Contention A), security, (See Contention B), reporting (See Contention C), and quality control (See Contention D).

A. Contention

"Portions of the licensee's training plan were not implemented and portions of the requalification training program were not accomplished. Several items of noncompliance were identified a civil penalty was subsequently devised, and licensee management meetings were held to correct training weaknesses."

1. Basis

	References
There were several instances of failure to properly train personnel at the Arkansas Nuclear one facility. Examples include: a schedule was not provide for training lectures and requalification	IE Rpt. 50-313/79-15 IE Rpt. 50-313/79-16

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programs; their licensed operators were not given lectures in areas where weaknesses were noted in the annual requalification examinations; their operators did not receive performance evaluations; the licensee did not maintain a retraining and replacement training program for the facility staff as required by the Technical Specifications; the licensee did not provide means for evaluating the effectiveness of the training program; and the licensee had not instructed its emmployees as required by 10 CFR 19.12 to promptly report any condition which may result in a violation of regulatory requirements or unnecessary exposure to radiation or radioactive material.	IE Rpt. 50-368/ 79-14 IE Rpt. 50-368/ 79-13
The several training problems were not in the training program itself, but in the implementation of the training program and the lack of a management overview of training activities.	IE Rpt. 50-31[illegible] 79-1[illegible] IE Rpt. 50-368/ 79-14
Failure of licensee to conduct requalification lectures and to perform performance evaluations. The licensee's Training System had not been revised and significant portions of the training referred to by the licensee had not been conducted, as of July 1980, when this training was committed to begin by the first quarter of 1980. Written examinations were not administered to several individuals who, due to weaknesses identified during the annual examination, participated in the requalification lecture series.	IE Rpt. 50-313/ 80-12 50-568/ 80-12
Annual operator and SRO written examinations administered during May-June 1979, identified specific weaknesses in the area of instrumentation and control systems and lectures were not conducted to correct these specific weaknesses.	
Fire brigade training was not conducted six times per year as required.	
Records were not maintained, as required, to furnish evidence of activities affecting quality.	

2. NRC Actions

An inspector attended a classroom lecture and interviewed two SRO's and two RO's related to small break loss of coolant accident analysis and procedure guidelines. He also reviewed training records. No violations or deviations were identified.

IE Rpt. 50-313/80-03 50-368/80-03

An interview of a health physicist indicated that hands-on training had been incorporated into the training program and would be part of the routine program in future training.

IE Rpt. 50-313/80-04 50-368/80-04

Following the inspections on June 17-20, 1980, and July 14-18, 1980, a management meeting was held in the Region IV office on August 11, 1980, to discuss the licensee's nuclear training program. This discussion included actions completed, projects underway, and long-term projects and goals. As a result of this meeting, the licensee made firm commitments to having a nuclear training program which meets or exceeds regulatory requirements.

Letter from licensee to RIV, dated 8/13/80.

On October 20, 1980, the licensee was issued a Civil Penalty related to the June 17-20, 1980, and July 14-18, 1980, inspections. The licensee's November 12, 1980 response to the October 20, 1980 escalated enforcement action was reviewed and the licensee's actions and proposed actions to correct the problems in the area of training have been found acceptable. Subsequent inspections have monitored licensee progress in implementation of the corrective actions related to the licensee's November 12, 1980 response. No violations or deviations have been identifeid in the area of training.

A special inspection was conducted on March 2-13, 1981, regarding the status of the training program.

IE Rpt. 50-313/81-06 50-368/81-05

NRC inspector attended a requalification lecture for licensed personnel and a portion of the licensee's health physics training program for new employees. Lesson plan objectives were met and training in accordance with requalification program.

IE Rpt. 50-313/81-18 50-368/81-16

3. Licensee's Corrective Actions

The licensee has taken specific corrective actions in response to identified items (violations and

deviations) and to events described in LER's. In addition, the licensee had submitted progress reports on May 8, 1981 and April 14, 1981 to up-date Region IV on the status of the licensee's training progress and status of commitments.

The licensee has met his commitments.

IE Rpt. 50-313/81-06 50-368/81-05

Licensee letters to RIV, dated 8/13/80, 4/14/81, 5/8/81.

IE Rpt. 50-313/81-06 50-368/81-05

IE Rpt. 50-313/81-18 50-368/81-16

B. Contention

"Numerous noncompliances were identified in the security area. There were weaknesses in the training of security personnel and other members of the plant staff regarding security requirements. Instances were identified in which licensee audits of security programs were not sufficient to identify discrepancies."

1. Basis

References

The following are examples of weaknesses in the training of security personnel and other members of the plant staff regarding security requirements and instances where the licensee audits of security programs were inadequate.

. A door in the protected area perimeter at the egress from the administration building did not always close locked and could be opened from outside the protected area.

IE Rpt. 50-313/79-05 50-368/79-05

. A gap existed under a fence of a vital area for Unit 2. This gap was about 18 inches from the ground to the fence.

- A purse carried by an NRC inspector was not searched prior to her entry into the protected area.

- Access to vital areas is afforded by keys issued by the shift supervisor. This person did not have a list indicating which individuals should be granted vital area access.

- Vital area door was unlocked and the door latch taped such that the lock was inoperable. — IE Rpt. 50-368/79-21, para. 10

- One of the licensee designated vehicles was unlocked with the keys in the ignition. — IE Rpt. 50-313/79-27, 50-368/79-26

- Unlocked door on roof outside a certain Unit 1 area and it was possible to enter a vital area through this door. — IE Rpt. 50-313/80-10

2. NRC Actions

Following the NRC inspections that identified the above items, Notices of Violation were issued to the licensee. In addition, the NRC increased their inspection efforts in the area of egress into vital or protected areas. — IE Rpt. 50-313/80-19, 50-368/80-19; IE Rpt. 50-313/81-09, 50-368/81-08

The licensee's responses were carefully evaluated and corrective actions completed by the licensee were verified. Subsequent inspections monitoring the licensee's progress in the security area indicated improvement in this area.

3. Licensee's Correct ve Actions

The licensee has taken specific corrective actions in response to the above identified violations in the security area. — Licensee letters to NRC dated 3/16/79, 7/29/80, 8/27/80.

During the period of April 22 and May 21, 1980, an inspector verified that the security plan was being implemented by observing selected areas for observation. No deviations or violations were identified. — IE Rpt. 50-313/80-07, 50-368/80-07

An inspection was conducted on June 15-19, 1981. No deviations or violations were identified. — IE Rpt. 50-313/81-19

C. Contention

"The reporting was characterized by several licensee event reports that were late or incomplete."

1. Basis	References
The licensee's reporting of abnormal and unusual operating conditions and/or problem area were weak, in that the LER's were too brief, did not contain information necessary to evaluate the LER, and at times omitted the actual conditions or results and necessary data or information to determine if appropriate corrective action or preventative measures had been completed or planned.	IE Rpt. 50-313/ 80-12 50-368/ 80-12
Unit 1 was operating at a steady power level of 86% when a reactor coolant pump seal partially failed and a large leak developed. This LER was so devoid of information that the leakage (60,000 gallons into the Reactor Building) was not included in the LER. The significance of the seal failure was also omitted in this LER. Region IV personnel learned of this significant seal failure through - and only through - the resident inspectors. Subsequently, Region IV required a revised LER to be submitted. This revised LER reported the necessary elements of the seal failure.	LER 80-015 IE Rpt. 50-313/80-17 LER 80-015-01X-2
The significance of failures of the emergency steam driven feedwater pump (2P7A) was partially masked by the lack of information in the LER's. The necessary information was supplied through the resident inspectors. Again it was required that the licensee submit revised LER's that were informative and technically correct.	IE Rpt. 50-368/ 80-17 50-368/ 79-08 50-368/ 79-24 50-368/ 80-05 50-368/ 80-21 50-368/ 80-25

2. NRC Actions	References
Region IV met with the licensee in the Region IV Offices on August 11, 1981. The licensee committed to improving his overall communications.	IE Rpt. 50-313/80-17 50-368/80-17 Letter from licensee to Region IV, dated 8/13/81.

3. Licensee's Actions — References

The licensee's overall LER system has improved. The LER information is generally discussed with the resident inspectors prior to completion of the LER. The information contained in LER's generally meets the criteria to assure that informed readers can readily understand the information and determine the significance of the event.

References: Letter from licensee to Region IV, dated 8/13/81.

D. Contention

"Quality control weaknesses precluded the licensee from identifying and correcting some discrepancies that were subsequently identified by the NRC."

1. Basis

There were several instances where the licensee's quality control system failed to identify or correct quality control discrepancies at the Arkansas Nuclear One facility. Some of the more significant quality control items not identified by the licensee, but subsequently identified by the NRC include:

An inspector observed welding and grinding being performed without appropriate authorization.	IE Rpt. 50-313/ 79-07
An NRC inspector observed that Unit 1 emergency feedwater system was not capable of being started automatically.	IE Rpt. 50-313/ 79-11
Trending of noncompliance, licensee events, or component failures, was not being accomplished beyond the coginzant supervisor's daily awareness of plant activities.	IE Rpt. 50-313/ 79-16 50-368/ 79-14

2. NRC Actions

NRC inspectors followed up on previously identified unresolved items, open items, licensee SRC reviews and other quality control items.	IE Rpt. 50-313/ 79-02 50-368/79-02
An NRC inspector observed the licensee performing a proper valve line-up in accordance with the established procedures.	IE Rpt. 50-313/ 79-11
The inspector verified that appropriate had been prepared and issued	IE Rpt. 50-313/ 80-05 50-368/ 80-05

The inspector verified that the licensee had issued the proper "Q" List	IE Rpt.	50-313/ 80-03 50-368/ 80-03
An inspector verified that the licensee had added a provision for a review of test results to Procedure 1401.03.	IE Rpt.	50-313/ 80-05
Failure of licensee to properly review a safety question was forwarded to NRC management for resolution. The item had been determined to be an item of noncompliance with 10 CFR 5^ 59.	IE Rpt.	313/ 80-05

3. Licensee Actions

The licensee's design, design changes and modifications were accomplished in accordance with licensee procedures and 10 CFR 50.59 requirements..		50-313/ 80-01 50-368/ 80-01
An NRC inspection determined that the licensee was performing the required activities in the areas of: performing the required activities in the areas of: Plant Operations Review, Test and Measuring Equipment Program, and Maintenance as required.		50-368/ 80-03 50-313/ 80-03
The licensee revised Procedures 1401.03 by adding a provision for the review of test results (related to the Pressurizer Code Safety Valve testing).	IE Rpt.	50-313/ 80-05
The licensee improved his independent Safety Review Committee (SRC) reviews of safety evaluations for design changes.	IE Rpt.	50-313/ 80-05
Licensee corrective actions and improvements were inspected and considerable improvement over previous inspections in this area were noted.		50-313/ 81-06 50-368/ 81-05

E. Contention

"The licensee had weaknesses in the staff support of licensing activities." (See Contention A and D, which represent weaknesses in staff support with regard to: training and quality control)