UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

JUN 17 1994

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

Entergy Operations, Inc.
ATTN: J. W. Yelverton, Vice President
Operations, Arkansas Nuclear One
Route 3, Box 137G
Russellville, Arkansas 72801

SUBJECT: NRC INSPECTION REPORT 50-313/93-11; 50-368/93-11

This refers to your letters dated April 29 and May 18, 1994, in response to our letter and Notice of Violation dated April 1, 1994. We have reviewed your April 29 letter and find it responsive to the concerns raised in Violation B of the Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

In the May 18 letter, you provided a response to Violation A of the Notice of Violation and requested that we reconsider the violation. Specifically, you requested that we reconsider our determination that written procedures were not properly implemented after a control rod drive mechanism (CRDM) temperature exceeded the vendor recommended limit and after the wrong chemicals were injected into the feedwater system. We have reviewed your response and have reconsidered the violation.

With respect to the high CRDM temperature, you indicated that Step 3.6 of Abnormal Operating Procedure 1203.003, "Control Rod Drive Malfunction Action," was not intended to be applicable for the situation which occurred on January 7, 1994, when all CRDM cooling was lost. You also indicated that operators made a decision not to follow procedure Step 3.6 when one CRDM temperature exceeded the limit but would have followed other procedure steps if two CRDM temperatures exceeded limits. Although we recognize that procedures cannot always provide direction for all conditions that may exist, we were concerned with this event because the operators made choices regarding the applicability of procedure steps when Step 3.6 provided specific direction for the temperature condition that was experienced. Your response indicated that the operators chose not to perform Step 3.6 because they did not believe it was applicable. However, we have reviewed the procedure and concluded that Step 3.6 did apply to the situation, which, we believe, could have led to a potential common mode failure for all of the CRDMs as a result of increasing temperatures. Furthermore, we believe that performance of the step would not have resulted in an unsafe condition. In this instance, we believe that the conservative response from the operators would have been to follow the

procedure even if it meant reducing power or, although less probable, circumstances resulting in the necessity to trip the reactor. Therefore, we have concluded that this part of the violation is appropriate. We note that you have taken action to revise the procedure, and we will review the implementation of your action during a future inspection.

With respect to the injection of the wrong chemicals into the feedwater system, we acknowledge that this event was self-identified after unexpected chemistry results were observed following the chemical injection. We noted that this event involved multiple errors by personnel in different organizations and that Condition Report CR-1-94-0015 indicated that this event had occurred in the past when the wrong chemical had been staged (though not injected). We further noted that no corrective actions were previously taken to prevent recurrence. Thus, this violation cannot be classified as a noncited violation. While we recognize that the safety significance of the event was low, these facts have led us to conclude that this part of the violation is appropriate. Your response indicated that you have taken corrective actions as a result of the event, and we will review the implementation of your actions during a future inspection.

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

Sincerely,

John M. Montgomery
Deputy Regional Administrator

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April 29, 1994

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U. S. Nuclear Regulatory Commission
Document Control Desk
Mail Station P1-137
Washington, DC 20555

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
50-313/93-11; 50-368/93-11

Gentlemen:

Pursuant to the provisions of 10CFR2.201, attached is the response to the violation (50-368/9311-02) identified during the inspection of activities associated with failure to update operating instructions for the Unit 2 emergency diesel generator following the implementation of a plant change.

Per discussions with Mr. Tom Stetka of NRC Region IV, Arkansas Nuclear One's (ANO's) response to the Notice of Violation concerning improper procedure adherence (50-313/9311-01) will be delayed until May 18, 1994. This delay will allow ANO adequate time to perform an independent assessment of the control rod drive cooling water failure event.

Should you have questions or comments, please call me at 501-964-8601.

Very truly yours,

Dwight C. Mims

Dwight C. Mims,
Director, Licensing

DCM/slp

Attachments

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NOTICE OF VIOLATION

During an NRC inspection conducted on December 26, 1993, through February 5, 1994, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10CFR Part 2, Appendix C, the violation is listed below:

> 10 CFR Part 50, Appendix B, Criterion V, requires that activities affecting quality be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and be accomplished in accordance with these instructions, procedures, or drawings.
>
> Procedure 6000.030, Revision 7, *Control of Installation*, Step 5.4.4, requires that operating procedures which are affected by modifications are identified and revised.
>
> Contrary to the above, on January 14, 1994, Procedure 2104.036, Revision 36, *Emergency Diesel Generator Operations*, had not been revised to include drain valves on three starting air compressors. The physical installation of these valves was accomplished under Plant Change 92-8024, which was implemented in March 1993.
>
> This is a Severity Level IV violation (Supplement I) (368/9311-02)

Response to violation 368/9311-02

(1) Reason for the violation

Due to moisture build-up in the Emergency Diesel Generator (EDG) starting air systems, three low point drain valves were installed on the EDG air compressors and are to be operated periodically to drain moisture accumulation in the low point of the compressors.

To limit the number of outages on the EDG air compressors, the installation of the drain valves was accomplished during the quarterly preventive maintenance activity of each compressor. As a result, these valves were installed during a four month period from November 1992 to March 1993. After the installation was completed, the responsible System Engineer did not verify the valves were added to the appropriate operating procedure. The System Engineer did initiate a Procedure Improvement Form (PIF) to revise the appropriate operating procedure after the final drain valve was installed; however, the PIF did not specify that these were new valves and the PIF was not properly prioritized to indicate it was needed to reflect current plant configuration.

The Modifications Department procedures were not clear regarding the actions required for the installation of the drain valves. The root cause of this event is inadequate procedures and controls as they relate to non-outage plant changes (PCs) initiated and implemented by System Engineering. The plant changes that

are affected are a small percentage of all PCs since most PCs are implemented during outages when adequate controls are in place.

Additionally, a contributing cause was that the responsible System Engineer was not cognizant of administrative requirements and follow-up actions required for new equipment installation.

(2) Corrective steps taken and results achieved:

Procedure 2104.036, *Emergency Diesel Generator Operations*, was revised to include the three drain valves in the valve lineup and to add operating instructions for the drain valves.

A review of Unit 1 and Unit 2 System Engineering generated PCs and LCPs known to be installed and not closed was performed to ensure that necessary drawing updates and Operations procedure revisions were completed.

Procedure 6010.003, *Limited Change Package and Plant Change Development*, was revised to more accurately and clearly describe the specific requirements for turnover of work performed by a PC to Operations and closing open PCs.

This event was discussed with Unit 2 Operations shift personnel. In addition, training was provided to them regarding the need to ensure that configuration control has been established after the installation of new components.

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

Open Unit 2 Operations Department PIFs were reviewed by Operations personnel to determine if there were any procedure revisions that had not been incorporated in a timely manner. An additional independent review of incorporation of PIFs in a timely manner will be conducted by Quality Assurance (QA). This independent review will be completed by June 15, 1994.

ANO will perform a review of the methods for identifying procedural changes and the effectiveness of the modification process for alerting Operations procedure writers regarding the scope of modifications. This evaluation will be completed by June 1, 1994. The results of this review will be used to determine whether a more in-depth evaluation of the modification related procedure change process is warranted.

Unit 1 and 2 System Engineering personnel will receive training on the changes made to Procedure 6010.003 to ensure that they are aware of the actions required before PC's and LCP's are released to Operations or other responsible organization. These actions will be completed by May 30, 1994.

Training on the need to maintain configuration control after the installation of new components will be provided to Unit 1 Operations shift personnel by June 30, 1994.

(4) Date when full compliance will be achieved

Full compliance for this event was achieved on January 25, 1994, when Procedure 2104.036, *Emergency Diesel Generator Operations*, was revised to include the three drain valves in the valve lineup and to add operating instructions for the drain valves. Full compliance to correct the overall condition will be accomplished on June 30, 1994, when training is complete.

ENTERGY

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Jerry W. Yelverton
Vice President
Operations ANO

May 18, 1994

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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
Follow-Up Response To Inspection Report
50-313/93-11; 50-368/93-11

Gentlemen:

Pursuant to the provisions of 10CFR2.201, attached is the response to the violation identified during the inspection of activities associated with procedure adherence.

An extension to the response for violation 313/9311-01 was granted by Mr. Tom Stetka of the NRC Region IV staff on April 28, 1994. The extension request, until May 18, 1994, was documented in the letter dated April 29, 1994 (0CAN049407). The April 29, 1994 correspondence contained the response to violation 368/9311-02 concerning failure to update operating instructions for the Unit 2 emergency diesel generator following implementation of a plant change.

Regarding violation 313/9311-01, we have reviewed in detail the ANO Unit 1 procedural adherence conditions, operator actions and management involvement concerning the subject Notice of Violation. After careful consideration and corrective action program reviews, we have concluded that clearer procedural guidance should be provided to our operations staff. In addition, we understand how a literal reading of the procedural requirements could have suggested that a power reduction be initiated for the control rod drive mechanism (CRDM) malfunction. However, ANO believes that the personnel involved acted conservatively within procedural guidance and management expectations. The operator actions taken to limit heat input to the CRDMs constituted a prudent and safe approach to plant operations.

The second example regarding the inadvertent injection of monoethanolamine (ETA) into the Unit 1 feedwater system consisted of a human error which indicates a weakness in our

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chemical addition program. This self-identified weakness in our chemical addition program may be more appropriately classified as a non-cited violation.

In response to the Notice of Violation, ANO is presenting the additional information surrounding the ANO operator procedural activities and we request a reconsideration of the NRC position as to whether a condition warranting a cited violation occurred. Should you have questions or comments, please call Mr. Dwight Mims at 501-964-8601.

Very truly yours,

Jerry W Yelverton

JWY/slp

Attachments

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NOTICE OF VIOLATION

During an NRC inspection conducted on December 26, 1993, through February 5, 1994, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violation is listed below:

Unit 1 Technical Specification 6.8.1.a requires, in part, that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, November 1972.

Regulatory Guide 1.33, Appendix A, Section E, designates abnormal, offnormal, or alarm conditions as safety-related activities that should be covered by written procedures. Section J similarly designates the maintenance of secondary water chemistry as a safety-related activity.

1. Abnormal Operating Procedure 1203.003, *Control Rod Drive Malfunction Action*, Step 3.6, required that, in the event a control rod drive mechanism attained a temperature in excess of 180°F, reactor power was to be reduced to 40 percent and the affected mechanism was to be deenergized.

   Contrary to the above, on January 7, 1994, Abnormal Operating Procedure 1203.003 was not properly implemented. Cooling water was temporarily lost to the control rod drive assemblies and one assembly reached a temperature of 185°F. Reactor power was not reduced and electrical power to the affected mechanism was not deenergized.

2. Operating Procedure 1106.028, *Secondary System Chemical Addition*, Section 10, provides instructions for the replacement of the morpholine injection tank.

   Contrary to the above, on January 19, 1994, Operating Procedure 1106.028 was not properly implemented in that the morpholine supply was replaced with monoethanolamine (ETA). The ETA solution was injected, resulting in a degradation of the secondary plant chemistry.

This is a Severity Level IV violation. (Supplement I) (313/9311-01)

A. Response to violation 313/9311-01

1. First Example

(1) Discussion:

On January 7, 1994, a back-flow prevention valve malfunctioned and allowed domestic water to begin filling the ammonia pump pit. This resulted in an increase in the water level up to the area of the Control Rod Drive Mechanism (CRDM) cooling pump motor vents which resulted in CRDM cooling flow oscillations.

Due to the oscillating flow conditions, the standby pump was started. The breaker for the operating pump subsequently tripped on thermal overloads. Oscillating flow conditions were observed on the standby pump and minutes later it tripped. After the standby pump tripped, the Control Board Operator Turbine began monitoring CRDM temperatures for any changes.

Abnormal Operating Procedure (AOP) 1203.003, *Control Rod Drive Malfunction*, was reviewed to determine what corrective actions were required. It was recognized and discussed between the Shift Superintendent and the Control Room Supervisor that this condition was a multiple rod concern. The control room personnel then decided to pursue restoration of cooling water in accordance with the AOP in an attempt correct the problem until such time that the CRDM temperatures reached the vendor recommended limit of 180°F. (The operational temperature limit of 180°F is based on the vendor technical manual which states that this limit is for the twenty year life of the CRDM. Catastrophic failure is not expected to occur at this temperature.) The water flow into the ammonia pump pit was stopped and submersible pumps were used to remove the water. The circuit breakers for the CRDM cooling pumps were reset several times in order to facilitate continued cooling.

As the CRDM temperatures continued to increase, the Shift Superintendent notified the Unit 1 Operations Manager at home regarding the event in progress. The Operations Manager's initial response was to reinforce the need to trip the reactor if CRDM temperatures could not be maintained within specified limits, and he suggested that the crew review the reactor trip emergency operating procedure. Recognizing that the condition was due to the loss of the CRDM cooling pumps which affected cooling to all CRDMs, the Shift Superintendent briefed the Operations Manager regarding his assessment of the problem. They concurred that the appropriate approach was to minimize heat input to the CRDMs by remaining at the existing power level and not initiating rod movement, attempting to restore the CRDM cooling water pumps, monitoring CRDM temperatures, and manually tripping the reactor if the specified limit of 180°F was exceeded on two CRDMs in accordance with the AOP.

At approximately 25 minutes into the event, one CRDM reached 180°F. At this time, the Shift Superintendent again reinforced to the operating crew the need to trip the reactor in the event that two CRDMs reached 180°F. The Shift Superintendent and the Control Room Supervisor agreed that step 3.6 (actions for de-energizing a single CRDM due to excessive stator temperature) of procedure 1203.003 did not apply to this situation since the pump failures affected all CRDMs. This was a multiple rod event caused by a loss of cooling water flow. The decision to maintain the existing power level was also considered to be a prudent action since control rod motion would result in increased CRDM temperatures. The actual time that one CRDM was greater than 180 degrees was less than 90 seconds.

Minutes later, the water level was reduced in the ammonia pump pit and CRDM cooling was restored resulting in reduced CRDM temperatures.

Procedure 1203.003, step 3.2 stated, "If more than one CRD stator exceeds 180°F, trip the reactor...." This step, for a multiple CRDM event, was deemed appropriate by operators and Operations management. Step 3.6, stated, "If only one CRD stator temperature exceeds 180°F, proceed as follows...." This step was written to define the actions necessary to combat a single CRDM failure due to excessive temperatures. This step, for a single CRDM overheating event, provides instructions for reducing power and de-energizing the affected rod. This step was not applicable in this situation since all CRDMs were being affected. In a loss of CRDM cooling event, reducing power by performance of step 3.6 will most likely cause additional heating of the CRDMs in the controlling group. Therefore, the actions taken by the operating crew were appropriate for the actual plant conditions.

(2) Actions:

Abnormal Operating Procedure 1203.003, *Control Rod Drive Malfunction Action*, was revised to clarify that step 3.6 pertains to an event confined to one CRDM stator.

The ANO Condition Reports for the previous two years were reviewed to determine if a procedure step not being performed due to nonapplicability was a recurring event. No events were found that were similar to this condition.

An ANO Quality Assurance (QA) review was conducted by a licensed Unit 2 Senior Reactor Operator to determine the philosophy of Unit 1 Operations personnel regarding procedure compliance. The specific areas QA focused on were:

- the general philosophy for procedure use and compliance
- actions to be taken if procedure compliance would jeopardize nuclear safety

- appropriate action if plant conditions are such that some steps in the procedure are not applicable
- appropriate sources of input if a decision to deviate from a procedure must be made (team versus individual decision)
- the affect of the emphasis on plant availability, production records, and performance-based incentives on decision making

This review concluded that the philosophy of procedural compliance is well understood and consistent through the Operations Department chain of supervision. Further, this review concluded that an attitude of conservatism in procedure compliance is evident, and Operations personnel would not hesitate to react conservatively and trip the reactor as necessary to assure nuclear safety.

The Plant Safety Committee (PSC) reviewed the root cause evaluation along with the actions taken to respond to the incident and concluded that appropriate actions were taken to mitigate the incident. The PSC concluded that, although a literal interpretation of procedure 1203.003 step 3.6 could have suggested a power reduction be initiated for this event, the operating crew acted conservatively within procedural guidance and management expectations.

This event was initially discussed with the Unit 1 operating crews. However, a more in-depth discussion with emphasis placed on the concerns associated with procedure compliance will be presented to Unit 1 and Unit 2 Operations personnel during the next operator requalification cycle.

A review of the Unit 1 and Unit 2 Abnormal Operating Procedures (not including Annunciator Corrective Actions) will be conducted for any additional concerns associated with actions that may need further clarification. These reviews will be completed by July 13, 1994.

(3) Safety Significance:

The decision to maintain power and avoid control rod movement during this event minimized the addition of heat to the CRDMs. The actions taken in response to the loss of cooling minimized the safety significance and allowed the plant to remain in a more stable condition.

(4) Conclusions:

Unit 1 Operations personnel were in technical compliance with existing procedural guidance during the loss of CRDM cooling. The operators complied with the intent of the procedure and were prepared to trip the reactor in the event a second CRDM exceeded the 180 °F limit as specified in the procedure. The operators and Operations management followed the appropriate steps, acted conservatively

within procedure requirements and management expectations for the unique circumstances that they faced.

Based on the information above, ANO requests reconsideration of the determination that a violation occurred. The operator actions taken to limit heat input to the CRDMs constituted a prudent and safe response to this event.

2. Second example

(1) Discussion:

On January 19, 1994, the incorrect pH control chemicals were injected into the Unit 1 feedwater system. The Unit 1 feedwater pH is controlled by the injection of morpholine, while Unit 2 feedwater pH is controlled by the injection of monoethanolamine (ETA).

When operation's personnel requested a replacement of a morpholine liquid bin, plant services personnel incorrectly retrieved and delivered an ETA liquid bin. Operations personnel made the connection of the ETA liquid bin to the Unit 1 feedwater system and placed it in service.

The condition was discovered approximately 24 hours later when the feedwater and condensate pH and conductivity readings increased. A system walkdown was performed. The incorrect chemical liquid bin was discovered and replaced.

The investigation of the condition revealed that both the ETA and morpholine liquid bins are stored in the same bay. The bay labeling addressed only morpholine. The liquid bins are identically shaped with only a difference in labeling of the individual liquid bins.

The root cause for the injection of ETA into the Unit 1 secondary side feedwater was lack of self-checking. This occurred during the retrieval, delivery, and connection of the liquid bins and continued during the operation of the system. A contributing cause was lack of adequate bay labeling.

(2) Actions:

The ETA liquid bin was isolated and the day tank drained. A bin of morpholine was subsequently placed in service on Unit 1.

The labeling of the outside bulk chemical storage building was upgraded to include ETA.

A Human Performance Enhancement System (HPES) review was conducted to evaluate the human error associated with this condition.

This incident was reviewed with plant services personnel with specific emphasis placed on self-checking and how self-checking could have prevented this event.

This incident and how self-checking could have prevented it was discussed with Unit 1 Operations personnel.

Unit 1 Operations procedures 1104.026, *Chilled Water System*, 1104.028, *ICW System Operating Procedure*, 1104.039, *Plant Heating and Cold Weather Operations*, 1106.022, *Startup Boiler Operation*, and 1106.028, *Secondary System Chemical Addition*, were all revised to provide guidance to verify that the correct chemicals are being added to the appropriate systems.

Unit 2 Operations procedure 2106.028, *Secondary System Chemical Addition*, was revised to provide guidance to verify that the correct chemicals are being added to the appropriate systems.

(3) Safety Significance:

The addition of ETA to the Unit 1 feedwater system had little affect on the chemistry of the system. Monitored chemistry parameters did not exceed specifications. This event was of minimal safety significance.

(4) Conclusion

ANO personnel discovered this condition by monitoring trended information and initiated a Condition Report which resulted in a corrective action plan. The condition was a human error which indicated a weakness in our chemical addition program. However, this condition was self-identified and corrected in a timely and efficient manner before any monitored chemistry parameters exceeded specifications. Entergy Operations requests reconsideration and recommends that this self-identified condition may be more appropriately categorized as a non-cited violation.