

CONTROL BLOCK: _____ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

7/01/82 1 9 A R I A N 10 2 12 10 10 10 10 10 10 10 10 10 10 10 10 10 13 14 11 11 11 11 14 15 15
 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

7/01/82 16 10 15 10 10 10 3 6 8 17 11 11 11 11 8 12 18 10 15 12 15 18 4 19
 REPORT SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLY CONSEQUENCES 10

10 On 11/11/82 while in Mode 2 during low power physics testing (LPPT), emergency feedwater (EFW) control valve 2CV-1076-2 was found to not be wired according to installation drawings. A contact for the close circuit which bypasses the torque switch until the valve is approximately 99% closed was not wired into the circuit. This was discovered while troubleshooting control valve 2CV-1026-2. The occurrence involving 2CV-1026-2 was reported in LER-82-036 but was not related to the wiring discrepancy above. The only other occurrence reported on either 2CV-1076-2 or 2CV-1026-2 was LER-79-037 on 2CV-1076-2 but was not related to the circuit described in this report. The valves would still perform their function without this circuitry.

SYSTEM CODE		CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE			COMP SUBCODE	VALVE SUBCODE	
17	18	9	11	12	13	14	15	20	
17	18	9	11	12	13	14	15	20	
17	18	9	11	12	13	14	15	20	
LER/RO REPORT NUMBER		EVENT YEAR	CAUSE CODE	SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE	REVISION NO	
17	18	19	21	22	23	24	25	26	
17	18	19	21	22	23	24	25	26	
ACTION TAKEN		FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
17	18	19	21	22	23	24	25	26	27
17	18	19	21	22	23	24	25	26	27

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 The cause of the occurrence is believed to be an installation oversight. The circuitry for the operators for both 2CV-1076-2 and 2CV-1026-2 was corrected to conform to the electrical schematic for these valve operators. An inspection of similar safety related valve operators has been conducted. Three additional valve operators were found to have the same wiring discrepancy. These discrepancies have been resolved.

FACILITY STATUS

FACILITY STATUS		% POWER	OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
17	18	9	10	11	12	13	14	15
17	18	9	10	11	12	13	14	15
17	18	9	10	11	12	13	14	15
ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE		
17	18	19	20	21	22	23	24	
17	18	19	20	21	22	23	24	
PERSONNEL EXPOSURES NUMBER		TYPE	DESCRIPTION		PERSONNEL INJURIES NUMBER		DESCRIPTION	
17	18	19	20	21	22	23	24	
17	18	19	20	21	22	23	24	
LOSS OF OR DAMAGE TO FACILITY TYPE		DESCRIPTION		PUBLICITY ISSUED		DESCRIPTION		
17	18	19	20	21	22	23	24	
17	18	19	20	21	22	23	24	

PUBLICITY ISSUED DESCRIPTION

7/20/82 9 N 144 NA 10 145 146
 NAME OF PREPARER Pat Rogers PHONE: (501) 964-3100

8406040192 840525
 PDR ADOCK 05000368
 S PDR

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May 25, 1984

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Washington, D.C. 20555

Subject: Arkansas Nuclear One - Unit 2
Docket No. 50-368
License No. NPF-6
Licensee Event Report
No. 82-038/03X-1

Gentlemen:

In accordance with Arkansas Nuclear One - Unit 2 Technical Specification 6.9.1.9.b, attached is the subject report concerning incorrect wiring of Emergency Feedwater control valve 2CV-1076-2. This is a revision to a previous submittal dated December 6, 1982.

Very truly yours,

A handwritten signature in black ink that reads "John R. Marshall".

John R. Marshall
Manager, Licensing

JRM:RJS:ac

Attachment

cc: Mr. Richard P. Denise, Director
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and Engineering Programs
U. S. Nuclear Regulatory Commission
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