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

DEC 11 1995

Entergy Operations, Inc.
ATTN: J. W. Yelverton, Vice President
Operations, Arkansas Nuclear One
1448 S.R. 333
Russellville, Arkansas 72801-0967

SUBJECT: NRC INSPECTION REPORT 50-313/95-07; 50-368/95-07

Thank you for your letter of December 5, 1995, in response to our letter and Notice of Violation dated October 30, 1995. We have reviewed your reply and find it responsive to the concerns raised in our 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.

Sincerely,

RDyer

J. E. Dyer, Director
Division of Reactor Projects

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

cc:
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E-Mail report to D. Nelson (DJN)
E-Mail report to NRR Event Tracking System (IPAS)

bcc to DMB (IE01)

bcc distrib. by RIV:
L. J. Callan
Branch Chief (DRP/C)
MIS System
RIV File
Project Engineer (DRP/C)
Resident Inspector
Leah Tremper (OC/LFDCB, MS: TWFN 9E10)
DRS-PSB
Branch Chief (DRP\TSS)

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E-Mail report to D. Nelson (DJN)
E-Mail report to NRR Event Tracking System (IPAS)

bcc to DMB (IE01)

bcc distrib. by RIV:
L. J. Callan
Branch Chief (DRP/C)
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ENTERGY

Entergy Operations, Inc.
1448 S.R. 333
Russellville, AR 72801
Tel 501 858-5000

November 29, 1995

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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
50-313/95-07; 50-368/95-07

Gentlemen:

Pursuant to the provisions of 10CFR 2.201, attached is the response to the notice of violation identified during the inspection activities associated with the inadvertent radiological contamination of the Unit 1 Service Air system.

Should you have any questions or comments, please call me at 501-858-4601.

Very truly yours,

Dwight C. Mims

Dwight C. Mims
Director, Nuclear Safety

DCM/bws

Attachments

96-0359

9512050158

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NOTICE OF VIOLATION

During an NRC inspection conducted on August 6 through September 16, 1995, one violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381; June 30, 1995) the violation is listed below:

> Unit 2 Technical Specification 6.8.1.a requires, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978.
>
> Regulatory Guide 1.33, Revision 2 Appendix A, February 1978, Section 7.b.(1), states, in part, that procedures should be written for the handling of spent resins.
>
> Procedure 2104.017, Revision 7, "Spent Resin Transfer," provides instructions for the transfer of spent resin from a spent resin tank to a shipping cask and for the clearing of transfer lines which are clogged.
>
> Contrary to the above, on September 11, 1995, a Unit 2 waste control operator failed to utilize the instructions provided in Procedure 2104.017 during an activity to clear an obstruction in the spent resin transfer line. The operator's actions resulted in extensive radiological contamination of the Unit 1 service air system.
>
> This is a Severity Level IV violation (Supplement I) (368/9507-01).

Response to Notice Of Violation 368/9507-01

(1) Reason for the violation:

During the performance of Spent Resin Transfer procedure OP 2104.017, Supplement 11 *Resin Transfer From Spent Resin Tank 2T-13 To The Shipping Cask In The Train Bay*, the transfer line became clogged causing termination of the resin transfer. The Waste Control Operator (WCO) then implemented the requirements of 2104.017 Supplement 13 *Backflush Procedure*. The performance of this supplement as written was unsuccessful in clearing the clogged lines. With no other procedure guidance available for clearing the clogged lines, the WCO decided to continue without appropriate procedure guidance by alternately aligning Unit 1 Service Air and Unit 2 resin flush water. The difference in relative pressure between the Unit 2 resin flush water and the Unit 1 Service Air system resulted in the clogged transfer line being pressurized by the resin flush water which was subsequently depressurized into the Unit 1 Service Air system causing the contamination of the Unit 1 Service Air system.

The decision by the WCO to continue the operation without appropriate procedure guidance is considered a personnel error. Therefore, personnel error was the reason for the Unit One Service Air system becoming contaminated.

(2) Corrective steps that have been taken and the results achieved:

Disciplinary action was taken in accordance with Entergy policy C4.701.

Management expectations with regard to the details of this event as well as overall procedure compliance were communicated to the individual involved in the event and to the operating crews.

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

Unit 1 and Unit 2 Resin Transfer procedures will be evaluated to determine if enhancements are needed. The evaluation will be completed by February 28, 1996.

(4) Date when full compliance will be achieved:

Full compliance was achieved on September 12, 1995 when the following actions were accomplished:

- The Unit 1 Service Air system was isolated, depressurized and hold carded to prevent the inadvertent use of the system,
- The contamination area that was created outside controlled access as a result of the event was properly posted, and
- It was verified that contamination was not spread to other clean systems.