

LICENSEE EVENT REPORT

EXHIBIT A

NRC Form 366  
(9-83)

U.S. Nuclear Regulatory Commission  
Approved OMB No. 3150-0104  
Expires: 8/31/85

L I C E N S E E   E V E N T   R E P O R T   ( L E R )

FACILITY NAME (1) Arkansas Nuclear One, Unit Two DOCKET NUMBER (2) | PAGE (3)  
| 0 | 5 | 0 | 0 | 0 | 3 | 6 | 8 | 1 | 0 | 1 | 0 | 2

TITLE (4) Category "E" Valve Improperly Aligned

EVENT DATE (5)			LER NUMBER (6)		REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)														
Month	Day	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names		Docket Number(s)												
0	6	1	8	1	8	0	8	2	0	8	4	0	5	0	0	1	0	1	0	1	0	2

OPERATING MODE (9) | 1 | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)

POWER LEVEL (10)	20.402(b)	20.405(a)(1)(i)	20.405(a)(1)(ii)	20.405(a)(1)(iii)	20.405(a)(1)(iv)	20.405(a)(1)(v)	20.405(c)	50.36(c)(1)	50.36(c)(2)	50.73(a)(2)(i)	50.73(a)(2)(ii)	50.73(a)(2)(iii)	50.73(a)(2)(iv)	50.73(a)(2)(v)	50.73(a)(2)(vii)	50.73(a)(2)(viii)(A)	50.73(a)(2)(viii)(B)	50.73(a)(2)(x)	73.71(b)	73.71(c)	Other (Specify in Abstract below and in Text, NRC Form 366A)	
1   1   0   0																						

Name Donald B. Lomax, Plant Licensing Supervisor Telephone Number 5101191614-1311010  
Area | Code |

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

Cause	System	Component	Manufacturer	Reportable to NPRDS	Cause	System	Component	Manufacturer	Reportable to NPRDS

SUPPLEMENT REPORT EXPECTED (14) | EXPECTED SUBMISSION DATE (15) | 1 | 1 | 1 | 5 | 8 | 4

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

At approximately 0225 hours on 7/18/84, with the unit at 100% full power (FP), an operator discovered the "B" train sodium hydroxide pump (2P136B) manual discharge isolation valve (2BS-11B) in the locked closed position rather than the required locked open position for unit operation as stipulated by Technical Specification 3.6.2.2. The operator was performing system alignment for monthly surveillance testing of 2P136B at the time of discovery. Operations completed testing of 2P136B and returned 2BS-11B to the locked open position at approximately 0240. Investigation determined the most probable cause of the misalignment was failure to properly reposition 2BS-11B following the previous 2P136B monthly surveillance performed 6/18/84. The following actions to prevent recurrence have been implemented:

- Administrative procedures have been revised to provide clarification of "independent verification",
- Administrative controls over safety related components were reiterated via memorandum to all operators, and
- Sign-off sheets for category "E" valves are being developed to segregate valves for which visual inspection is adequate to determine correct position and valves for which physical manipulation is appropriate to determine correct position.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						PAGE (3)
		Sequential		Revision		Year	Number	
		Year	Number	Number	Number			
Arkansas Nuclear One, Unit Two	0151010101 31 61 81 81 41 --	0	1	8	--	0	0	01210F1012

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

At approximately 0225 hours on 7/18/84, with the unit at 100% FP, an operator discovered the "B" train sodium hydroxide pump (2P136B) manual discharge isolation valve (2B5-11B) in the locked closed position rather than the required locked open position for unit operation as stipulated by Technical Specification 3.6.2.2. The operator was performing system alignment for monthly surveillance testing of 2P136B at the time of discovery. Operations completed testing of 2P136B and returned 2B5-11B to the locked open position at approximately 0240. A verification check of accessible category "E" valves was begun and resulted in no additional valves found to be misaligned as required for operation.

Investigation to determine the cause for misalignment of 2B5-11B was promptly initiated. This investigation resulted in the determination that the most probable cause for the misalignment was failure to properly reposition 2B5-11B following the previous 2P136B monthly surveillance performed 6/18/84. During the 6/18/84, surveillance, the operator realigning the system following testing completion paused during the valve repositioning evolution to exchange restraining chains between 2B5-11B and another valve. The distraction of switching chains apparently resulted in the error of locking 2B5-11B in the closed, test position. Valve position is not readily detectable by observation of the threaded stem due to the short distance of stem movement from full open to full close positions. Additionally, the operator providing independent verification of valve positioning for the surveillance of 6/18/84, did not do so in the manner procedurally required, but rather relied on assurance from the operator performing the valve manipulations to expedite plant startup restraints.

This event resulted from a degree of inattentiveness on the part of the operator performing the system manipulations and from failure of the operator providing independent verification to act responsibly in signing off the procedural step indicating such verification. Disciplinary action has been taken in the case of the operators involved. The following actions to prevent recurrence have been implemented:

- Administrative procedures have been revised to provide clarification of "independent verification",
- Administrative controls over safety related components were reiterated via memorandum to all operators, and
- Sign-off sheets for category "E" valves are being developed to segregate valves for which visual inspection is adequate to determine correct position and valve for which physical manipulation is appropriate to determine correct position.

The redundant train for sodium hydroxide addition, its associated containment spray system, and their emergency power supplies were operable during the event period.

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August 20, 1984

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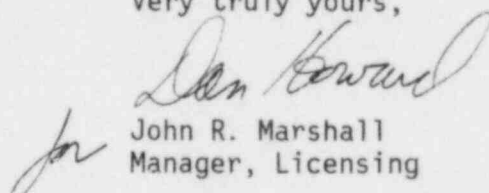
U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, D.C. 20555

Subject: Arkansas Nuclear One - Unit 2  
Docket No. 50-368  
License No. NPF-6  
Licensee Event Report  
No. 84-018-00

Gentlemen:

In accordance with 10CFR50.73(a)(2)(i), attached is the subject report concerning the discovery of the "B" train sodium hydroxide pump (2P136B) manual discharge isolation valve (2BS-11B) in the locked closed position rather than the required locked open position for unit operation as stipulated by Technical Specification 3.6.2.2.

Very truly yours,

  
John R. Marshall  
Manager, Licensing

JRM:RJS:ac

Attachment

cc: Mr. Richard C. DeYoung  
Office of Inspection and Enforcement  
U. S. Nuclear Regulatory Commission  
Washington, DC 20555

Mr. Norman M. Haller, Director  
Office of Management & Program Analysis  
U. S. Nuclear Regulatory Commission  
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