

MAY - 5 1992

Docket Nos. 50-313
50-368
License Nos. DPR-51
NPF-6

Entergy Operations, Inc.
ATTN: Neil S. Carns, Vice President
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Route 3, Box 137G
Russellville, Arkansas 72801

Gentlemen:

SUBJECT: NPC INSPECTION REPORT NO. 50-313/92-05; 50-368/92-05

Thank you for your letter of April 22, 1992, in response to our letter and Notice of Violation dated March 23, 1992. 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,

Original Signed By:
Thomas P. Gwynn

A. Bill Beach, Director
Division of Reactor Projects

cc:
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Entergy Operations, Inc.

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**Entergy
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April 22, 1992

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

Subject: Arkansas Nuclear One - Unit 1
Docket No. 50-313
License No. DPR-51
Response to Inspection Report
50-313/92-05

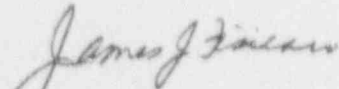


Gentlemen:

Pursuant to the provisions of 10CFR2.201, attached is the response to violation 50-313/9205-01.

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

Very truly yours,


James J. Fisicaro
Director, Licensing

JJF/G' /mmg

attachment

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92-0614

cc: Mr. Robert Martin
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Notice of Violation

During an NRC inspection conducted during the period January 26 through February 29, 1992, two examples of a violation of NRC requirements were 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:

Technical Specification 6.8.1 requires, in part, that written procedures shall be established, implemented, and maintained covering:

- (1) surveillance and test activities of safety-related equipment, and
- (2) activities referenced in Appendix A of Regulatory Guide 1.33, November 1972. Appendix A of Regulatory Guide 1.33, November 1972, recommends written administrative procedures regarding procedure adherence.

1. Step 7.2.2 of Procedure 1304.039, Revision 25, Temporary Change 1, "Unit 1 Reactor Protective System Channel C Test," instructed the instrument technician to place the RPS channel in manual bypass.

Contrary to the above, on February 17, 1992, the instrument technician placed the channel in shutdown bypass.

2. Procedure 1000.006, Revision 36, Plant Change 2, "Procedure Control," requires, in part, that any deviations to procedures shall be reported to the Shift Supervisor immediately after the situation is under control.

Contrary to the above, the instrument technician did not report the deviations to the Supervisor, Shift Operations immediately after the equipment was returned to normal.

These two examples constitute one Severity Level IV problem.
(Supplement 1) (313/9205-01)

Response to Violation 313/9205-01

- (1) Reason for the violation:

Arkansas Nuclear One (ANO) agrees that a violation occurred regarding the inadvertent placing of Channel C of the Unit 1 Reactor Protection System (RPS) in shutdown bypass rather than manual bypass, and that the deviation from procedures was not immediately reported to the Shift Supervisor.

On February 17, 1992 at approximately 1000 hours, two Unit 1 instrumentation and control (I&C) technicians commenced performance of Procedure 1304.039, "RPS Channel C Monthly Surveillance". The lead technician who was qualified on the RPS was reading the procedure steps and the other technician was performing the physical actions on the RPS as a trainee.

The first action step in the body of the procedure (step 7.2.2) states, "Place the channel in Manual Bypass and verify:..." This action is performed using the manual bypass keyswitch. Instead of turning the manual bypass keyswitch, the assisting technician turned the shutdown bypass keyswitch. The shutdown bypass keyswitch imposed the low power RPS trip functions (high pressure - 1720 psig and high power - 5% full power). With Unit 1 operating at 100% power, this caused a channel trip in the RPS channel C. The channel trip did not trip a control rod drive breaker but did put the RPS in a "one out of three" trip logic instead of the normal "two out of four" trip logic. At this point the technicians were not aware that they had done anything wrong; however, the requirements of the procedure made it apparent that there was a problem because step 7.2.2 required verification that "manual bypass lamps on the reactor trip module and indication panel go on bright." The lamps stayed dim. The lead technician notified his supervisor that there was a problem and asked for direction. The supervisor directed him to go to the applicable portion of the restoration section of the procedure and restore the channel to normal. During performance of restoration step 9.3.1, questions were asked by the observing NRC inspector that caused the technicians to realize that the wrong keyswitch had been operated. The channel was subsequently returned to normal, and the surveillance was completed correctly.

The control room operators had been informed by the I&C technicians to expect annunciators to be actuated during the testing; however, the operators were not told specifically which annunciators to expect or when to expect them. Also, it was not until the surveillance was completed at approximately 1300 that the technicians informed Operations of the error in performing the test.

The cause of the violation was determined to be personnel error:

- 1) The self-verification steps of STOP, LOCATE, TOUCH, AND VERIFY were not being performed in accordance with the Maintenance Management Principles handbook.
 - 2) The lead technician was not visually verifying the performance of the trainee.
 - 3) The lead technician did not recognize the error as significant, and therefore, did not inform Operations.
- (2) Corrective steps taken and results achieved:

As indicated above, the RPS Channel C was restored to normal and the surveillance was completed correctly. Operations was notified of the error and a condition report was initiated when the test was completed at approximately 1300.

The technicians involved with this event were counseled on the use of proper verification techniques and on proper communication with Operations.

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

A review of past condition reports was conducted. Although this is the first RPS incident of this type, other examples of inattention to detail were identified involving each of the maintenance disciplines on both units. Briefings were held with each maintenance discipline on both units and central maintenance to discuss this event and reinforce the management expectations on the use of self-verification, leader/trainee observation, and prompt Operations notification.

The briefings held with the Unit 1 I&C department also included specific emphasis on the RPS keyswitches and Operations notification of annunciator alarms.

To improve communications with Operations, an evaluation will be performed to identify any enhancements which can be made to the method for communicating which annunciators will be actuated as a result of testing. This evaluation will be completed by June 1, 1992.

To monitor the effectiveness of these actions, Quality Assurance personnel have been notified to include the following items in the surveillance checklists for outage and non-outage maintenance activities: 1) Use of self-verification by craftsmen, and 2) Exercising of control of test/activity by lead craftsman.

(4) Date of full compliance:

Full compliance was achieved on February 17, 1992 at approximately 1300 when the RPS channel C monthly surveillance test was completed and operations was notified of the error.

bcc to DMB (IE01)

bcc distrib. by RIV
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