



Entergy
Operations

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September 14, 1992

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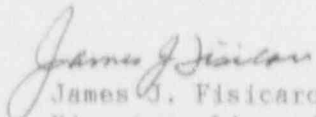
U. S. Nuclear Regulatory Commission
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SUBJECT: Arkansas Nuclear One - Unit 2
Docket No. 50-368
License No. NPF-6
Licensee Event Report 50-368/92-005-00

Gentlemen:

In accordance with 10CFR50.73(a)(2)(i)(B), enclosed is the subject report concerning fuel handling area ventilation monitoring.

Very truly yours,


James J. Fisicaro
Director, Licensing

JJF/TFS/mmg
Enclosure

cc: Regional Administrator
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Arkansas Nuclear One, Unit Two

DOCKET NUMBER (2)	PAGE (3)
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TITLE (4) Personnel Error Results In Failure To Monitor Fuel Handling Area
Ventilation Exhaust For Radioactivity As Required By Technical Specifications.

EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)	
08	11	92	92	005	-- 00	09	14	92		05000368	

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

POWER LEVEL (10)	100	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	Other (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name: Thomas F. Scott, Nuclear Safety and Licensing Specialist

Telephone Number: 501-964-5000

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

Cause	System	Component	Manufacturer	Reportable to NUREG	Cause	System	Component	Manufacturer	Reportable to NUREG

SUPPLEMENT REPORT EXPECTED (14)

EXPECTED SUBMISSION DATE (15)

Month	Day	Year

Yes (If yes, complete Expected Submission Date) No

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

On August 24, 1992, Arkansas Nuclear One Unit 2 discovered that a fuel handling area ventilation exhaust fan had been operated for two periods without the effluent having been monitored for radioactivity as required by Technical Specifications. The ventilation flow for both periods totaled approximately fifty four hours over August 11, 12, and 13, 1992. The root cause of not monitoring for radioactivity is attributed to personnel error on the part of the Chemist who obtained a weekly grab sample from that ventilation pathway on August 11, 1992 and did not realign the radiation monitor valves to their normal configuration as required by procedure. With the valves misaligned, the monitor obtained its sample from the room in which it is located. The individual involved has been counseled. The event has been reviewed with Chemists who routinely perform vent sampling. Based upon the results of the weekly samples and there having been no spent fuel movement during the period when ventilation flow was not being monitored, it was determined that no significant releases of radioactivity occurred.

LICENSE EVENT REPORT (LER) TEXT CONTINUATION

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

A. Plant Status

At the time this condition was discovered, Arkansas Nuclear One Unit 2 (ANO-2) was operating at 100 percent power (Mode 1) with Reactor Coolant System (RCS) [AB] temperature 580 degrees and pressure 2250 psia.

B. Event Description

At 0813 on August 11, 1992, the fuel handling area ventilation exhaust fan, 2VEF-14B, was started to provide a negative pressure in the Auxiliary Building [NF] while a hatch providing access from the Turbine Building [NM] was opened. At 0935 the radiation monitor for this flow path, Super Particulate Iodine and Noble Gas monitor (SPING-7), was removed from service to obtain a weekly grab sample. At 1000 Operations personnel in the Control Room were notified that the weekly sample had been completed. Ventilation from the fuel handling area was stopped at 1749.

At 1900 on August 11, 1992, fuel handling area ventilation was started to provide cooling for personnel working in the area. Ventilation flow was continuous via this pathway until 1632 on August 13, 1992.

The low range noble gas channel of SPING-7 was found to be inoperable at 1620 on August 14, 1992 by Operations personnel. Corrective actions to troubleshoot and repair the SPING were initiated. Since the fuel handling area exhaust fans were tagged out for maintenance when this problem was identified, there were no applicable Technical Specification action requirements. It was later determined that the problem with the low range noble gas channel was not related to the sampling evolution that occurred on August 11, 1992.

When Chemistry personnel performed the normal weekly grab sample on August 18, 1992, they discovered valves for SPING-7 already aligned in the positions for the grab sample. When the SPING is aligned for grab samples, the monitor receives its air supply from the room in which the monitor is located, not the ventilation pathway. It was assumed that the valve positions were the result of troubleshooting or maintenance for the problem discovered on August 14. During subsequent discussions, Chemistry personnel mentioned the valve misalignment. Based upon a review of logs and records and interviews with personnel who perform SPING maintenance, it was determined that this alignment was not the result of maintenance activities. On August 24, 1992, it was documented that there was no indication that valves for SPING-7 had been manipulated between the weekly samples. This resulted in releases between 0935 on August 11, and 1632 on August 13, a duration of approximately 54 hours, not having been monitored as required by Technical Specifications because the SPING valves had not been realigned after sampling on August 11, 1992. No other periods were identified where the fuel handling ventilation system was operated without the radiation monitor in service.

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

C. Root Cause

The procedure for sampling the ANO-2 vents requires that valves be returned to their normal alignment after obtaining the sample. Since a review of records and interviews with personnel involved in SPING-7 maintenance revealed no other indication of when the valves had been operated during the week of concern, the root cause of this event is attributed to personnel error due to failure to follow an approved procedure by the Chemist who performed the sample on August 11, 1992.

D. Corrective Actions

The Chemists who found the SPING-7 valves misaligned on August 18, 1992 immediately realigned the valves after they sampled the vent. They also verified that valves on the other SPINGs were aligned correctly.

The individual who performed the August 11 sample has been counseled concerning the importance of procedural compliance.

SPING-7 was repaired and restored to an operable status at 0011 on August 26, 1992.

This event has been reviewed with Chemists who perform vent sampling duties to take advantage of lessons learned.

E. Safety Significance

Weekly grab samples of the fuel handling area ventilation system routinely contain less than minimum detectable activity for particulates and iodines. Extremely low, insignificant levels of tritium are routinely detected. Grab samples on August 11 and 18 were typical. Irradiated fuel was not being moved in the spent fuel storage pool during the period when the ventilation system was in operation without SPING-7 in service. Since this is an isolated occurrence and there is no indication that any significant amount of radioactivity was released while the pathway was unmonitored, this event is considered to have minimal safety significance.

LICENSE EVENT REPORT (LER) TEXT CONTINUATION

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

F. Basis For Reportability

Failure to maintain SPING-7 operable during releases via the fuel handling area ventilation exhaust without taking compensatory actions as required by Technical Specification 3.3.3.9 (grab samples, estimates of ventilation path flowrate, and iodine/particulate samples) and failure to determine the dose rates due to gaseous effluents as required by Technical Specifications 4.11.2.1.1 and 4.11.2.1.2 represent operations prohibited by Technical Specifications reportable pursuant to 10CFR50.73(a)(2)(i)(B).

G. Additional Information

There have been no previous similar events reported by ANO.

Energy Industry Information System (EIIS) codes are identified in the text as [XX].