

## Arkansas Nuclear 2

### 3Q/2006 Plant Inspection Findings

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## Initiating Events

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## Mitigating Systems

**Significance:**  Mar 24, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO ENSURE FIRE DOORS WERE LATCHED**

Four examples of an NRC identified noncited violation of Unit 1 License Condition 2.C.(8), "Fire Protection," and ANO Unit 2 License Condition 2.C.(3)(b), "Fire Protection," were identified for the failure of licensee personnel to ensure fire doors were latched. On various days in January 2006, four fire doors were found unlatched. These four failures degraded the doors' fire confinement capability assumed in the fire hazards analyses. This issue was entered into the licensee's corrective action program as Condition Report ANO-C-2006-0067.

The finding is greater than minor because it is associated with the mitigating systems cornerstone attribute of protection against external factors and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the fire protection significance determination process, the finding was determined to have very low safety significance because the fire areas adjacent to the unlatched doors either were covered by an automatic suppression system, did not contain redundant equipment, or were only unlatched for a very short time. The cause of the finding is related to the crosscutting element of human performance in that licensee personnel did not ensure fire doors were being maintained shut and latched.

Inspection Report# : [2006002\(pdf\)](#)

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## Barrier Integrity

**Significance:**  Dec 31, 2005

Identified By: NRC

Item Type: FIN Finding

### **FOREIGN MATERIAL CAUSES LEAK IN A UNIT 2 SG**

The inspectors reviewed a self-revealing finding which occurred when a Unit 2 steam generator developed a tube leak (February 2005). A metallic piece of foreign material fretted a hole in one steam generator tube and wore away some thickness of two others. The licensee identified several more pieces of foreign material after conducting more thorough searches in both of the Unit 2 steam generators. The licensee performed a thorough review of the event to determine the short and long term corrective actions.

This issue is more than minor because it affected the reactor coolant system barrier performance attribute under the Barrier Integrity Cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance after management review, because the affected tubes could have withstood three times the differential pressure across them during normal full power, steady state operation.

Inspection Report# : [2005005\(pdf\)](#)

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## Emergency Preparedness

**Significance:**  Jun 23, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO MEET IMMEDIATE NOTIFICATION REQUIREMENTS DURING TRANSIENT EVENTS**

A noncited violation of 10 CFR 50.54(q), 10 CFR 50.47(b)(5), and 10 CFR 50, Appendix E.IV.D.3. was identified for programmatic and procedure inadequacies that allow the licensee to not make immediate offsite notifications for certain situations after a valid emergency classification was made. Specifically, following certain transient events, the licensee developed a practice of not completing immediate notifications to local authorities if the emergency action level conditions cleared before the notifications were completed. The licensee entered the deficiency into their corrective action program as condition report CR-ANO-C-2006-00665 for resolution.

The finding was assessed through the Emergency Preparedness Significance Determination Process. The finding is a performance deficiency in that the current interpretation and implementation of Emergency Plan Implementing Procedure 1903.010, "Emergency Action Level Classification," could result in failure to conduct a 15 minute notification following declaration of an emergency condition, potentially delaying offsite emergency response. Because the finding affected the reactor safety emergency preparedness cornerstone objective, the finding is greater than minor. The finding was determined to have very low safety significance because it represented a degradation and not a loss of the notification emergency planning standard function.

Inspection Report# : [2006003\(pdf\)](#)

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## Occupational Radiation Safety

**Significance:**  Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **FAILURE TO BARRICADE AND CONSPICUOUSLY POST AN HRA**

The inspector reviewed a self-revealing noncited violation of Technical Specification 6.7.1.a because the licensee failed to control a high radiation area by not barricading and conspicuously posting the area. Specifically, on March 15, 2005, the licensee removed a temporary barrier (scaffold boards) creating an entrance to a high radiation area without the proper radiological controls in place for a high radiation area. It was not until two radiation workers entered the area that a radiation protection technician identified the unposted entry and took appropriate actions to control the area. The finding was entered into the licensee's corrective action program as Condition Report ANO-2-2005-0574.

The failure to control a high radiation area as per Technical Specification requirements is a performance deficiency. The finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of program and process and affected the cornerstone objective, to ensure the adequate protection of the worker health and safety from exposure to radiation, in that not controlling high radiation areas could increase worker exposure. The finding was evaluated using the Occupational Radiation Safety Significance Determination Process and is of very low safety significance because it does not involve: (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. In addition, this finding has crosscutting aspects associated with human performance because poor coordination and communication between the scaffold crew and radiation protection personnel directly contributed to the finding.

Inspection Report# : [2005005\(pdf\)](#)

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## Public Radiation Safety

## **Physical Protection**

[Physical Protection](#) information not publicly available.

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## **Miscellaneous**

Last modified : December 21, 2006