

Arkansas Nuclear 2

3Q/2008 Plant Inspection Findings

Initiating Events

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Significance: Jun 23, 2008

Identified By: NRC

Item Type: FIN Finding

Loss of 500 kV power line due to switchyard maintenance

The inspectors documented a self-revealing finding for emergent work performed outside of the original work scope that led to the loss of the Pleasant Hills 500 kV power line. Entergy switchyard technicians, while working on a switchyard breaker, stepped outside the bounds of the Arkansas Nuclear One work order and caused another breaker to trip. Consequently, the load dispatcher requested that the plant reduce the output power level and the licensee down-powered both units. The licensee entered the issue into the corrective action program as CR ANO-C-2008-1053, immediately stopped work in the switchyard, performed a stand down to reemphasize work procedures and expectations, and instituted supervisory tours of the work in the switchyard until the work was complete.

The finding was more than minor because it was associated with the human error attribute and affected the Initiating Event Cornerstone objective to limit the likelihood of those events that upset plant stability during power operations. The significance of the finding was assessed using Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet. The finding was of very low safety significance (Green) because it did not contribute to the likelihood that mitigation equipment or functions would not be available. The finding had a cross-cutting aspect in the area of Human Performance associated with work practices because the licensee did not ensure supervisory and management oversight of work activities, including Entergy transmission network technicians, in the switchyard such that nuclear safety was supported [H.4.(c)].

Inspection Report# : [2008003](#) (*pdf*)

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Significance: Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Fire Barrier for Emergency Feedwater Pump A

Green. The inspectors identified a Green noncited violation of Technical Specification 6.4.1.c, "Procedures," associated with the licensee's failure to adequately implement the fire protection program. Specifically, station personnel breached the fire barrier door for emergency feedwater (EFW) Pump 2P-7A and failed to implement compensatory measures as required by the station Fire Protection Program. This issue was entered into the licensee's corrective action program as Condition Report ANO-2-2007-1729.

The finding was determined to be more than minor because it affected the protection against external factors attribute of the mitigating systems cornerstone, and it directly affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because: (1) the duration factor was assumed to be 6E-5; and (2) the fire frequency was assumed to be 4E-4, which resulted in a change in CDF of less than 1E-6. The finding had crosscutting aspects in the area of problem identification and resolution associated with the corrective action program [P.1(c)] in that the licensee failed to thoroughly evaluate a previous occurrence of leaving fire doors open such that the resolution appropriately addressed the cause.

Inspection Report# : [2007005](#) (*pdf*)

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Significance: Nov 09, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

INADEQUATE MAINTENANCE PROCEDURE FOR MOTOR CONTROL CENTER BREAKERS

A self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," was identified associated with the licensee's failure to implement adequate corrective actions to prevent recurrence of a significant condition adverse to quality. Specifically, during the Root Cause Evaluation performed for the fire in Motor Control Center 2B-22 in October 2000, the licensee failed to recognize and evaluate previously documented instances where other breakers exhibited degraded connections that were similar, and as such precursors to the failure of the breaker in Motor Control Center 2B-22. Also, the licensee failed to recognize and evaluate these same degraded breaker connection conditions that were discovered during extent of condition inspections and subsequent motor control center maintenance inspections. The licensee's failure to identify and evaluate all instances of degraded breaker connections contributed to their failure to adequately identify the cause and implement corrective actions to prevent recurrence of this significant condition adverse to quality. This resulted in a fire in Motor Control Center 2B-52 on October 23, 2007. This issue was entered into the licensee's corrective action program as Condition Report ANO-2-2008-0060.

The finding was determined to be more than minor because it affected the protection against external factors attribute of both the Initiating Events and Mitigating Systems cornerstone. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheets, the inspectors concluded that a phase 2 evaluation was required.

The inspectors performed a Phase 2 analysis using Appendix A, "Technical Basis For At Power Significance Determination Process," of Manual Chapter 0609, "Significance Determination Process," and the Phase 2 worksheets for Arkansas Nuclear One. The inspectors determined that the Phase 2 presolved table and worksheets did not contain appropriate target sets to estimate accurately the risk impact of the finding therefore a phase 3 analysis was performed. The senior reactor analyst performed a Phase 3 analysis. The estimated change in core damage frequency was 8.463E-7/yr. The estimated change in large early release frequency was 4.842E-8/yr. Therefore, the significance of the finding was determined to be Green. The cause of this finding was determined to have a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program [P.1(c)] in that the licensee failed to thoroughly evaluate the fire in Motor Control Center 2B-22 such that the resolution addressed the cause and extent of condition. This also includes conducting effectiveness reviews of corrective actions to ensure that the issue was resolved after more indications were discovered

Inspection Report# : [2007009](#) (pdf)

Significance:  Nov 09, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY, CORRECT AND PREVENT RECURRENCE OF A SIGNIFICANT CONDITION ADVERSE TO QUALITY

A self-revealing noncited violation was identified associated with the licensee's failure to comply with Unit 2 Technical Specifications, Section 6.4.1, "Procedures," for the failure to ensure adequate procedures were available for maintenance that was conducted on the Unit 2 AC motor control centers. Specifically, the maintenance procedure used by the licensee did not require visual inspections, nor cleaning, and lubrication of the bus to stab contact surface which facilitated degradation of the motor control center bus bars and also allowed this degradation to continue unrecognized. This issue was entered into the licensee's corrective action program as Condition Report ANO-2-2007-1512.

The finding was determined to be more than minor because it affected the protection against external factors attribute of both the Initiating Events and Mitigating Systems cornerstone. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheets, the inspectors concluded that a phase 2 evaluation was required.

The inspectors performed a Phase 2 analysis using Appendix A, "Technical Basis For At Power Significance Determination Process," of Manual Chapter 0609, "Significance Determination Process," and the Phase 2 worksheets for Arkansas Nuclear One. The inspectors determined that the Phase 2 presolved table and worksheets did not contain appropriate target sets to estimate accurately the risk impact of the finding therefore a phase 3 analysis was performed. The senior reactor analyst performed a Phase 3 analysis. The estimated change in core damage frequency was 8.463E-7/yr. The estimated change in large early release frequency was 4.842E-8/yr. Therefore, the significance of the finding was determined to be Green.

Inspection Report# : [2007009](#) (pdf)

Significance:  Nov 09, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMPLEMENTATION OF CORRECTIVE ACTIONS FAIL TO CORRECT A CONDITION ADVERSE TO QUALITY

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to take adequate corrective actions in response to a Motor Control Center fire that occurred on October 24, 2000. Specifically, the licensee had identified dust and dirt in the MCC as a condition adverse to quality, assigned a corrective action for the condition and subsequently closed their corrective action without actions being taken to correct the condition. This issue was entered into the licensee's corrective action program as Condition Reports ANO-2-2007-1566, ANO-2-2008-0050 and ANO-2-2008-0071.

The finding was determined to be more than minor because it affected the protection against external factors attribute of the initiating events cornerstone, and it directly affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using the Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because the condition represented a low degradation of a fire prevention and administrative controls feature. The finding had crosscutting aspects in the area of problem identification and resolution associated with the corrective action program (P.1(d)) because the licensee failed to take appropriate corrective actions to address safety issues in a timely matter.

Inspection Report# : [2007009](#) (pdf)

Mitigating Systems

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Significance: Jun 23, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to adequately monitor the performance of the alternate AC diesel generator

The inspectors identified a noncited violation of 10 CFR 50.65 (a)(2) for the licensee's failure to demonstrate that alternate AC diesel generator performance was being effectively controlled through preventative maintenance. The licensee maintained the diesel generator in a Maintenance Rule a(2) status but the diesel had suffered ten functional failures (for Maintenance Rule scoped functions) between April 2006 through March 2008. Functional failures included 8 failures of the starting air compressor and 2 failures of building ventilation. The licensee maintained separate performance criteria for these components but had failed to properly characterize the malfunctions as Maintenance Rule functional failures. The licensee entered this issue in their corrective action program as CR ANO-2-2008-1265.

The finding was more than minor because it was similar to non-minor Maintenance Rule Example 7.b in NRC Manual Chapter 0612, Appendix E, "Examples of Minor Issues," in that the problem involved degraded equipment performance. This finding had very low safety significance because the finding did not lead to an actual loss of safety function or cause the diesel to be inoperable, nor did it screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Human Performance associated with decision making [H.1(b)], in that engineers failed to verify the validity of the underlying assumptions for compressor and building ventilation functional failures when evaluating preventative maintenance effectiveness.

Inspection Report# : [2008003](#) (*pdf*)

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Significance: Jun 23, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to adequately monitor the performance of the Unit 2 service water intake structure roof drains

The inspectors identified a noncited violation of 10 CFR 50.65 (a)(2) for the licensee's failure to demonstrate that Unit 2 service water intake structure roof drains performance was being effectively controlled through preventive maintenance. Specifically, the licensee has never tested or checked the drains for blockages. The failure (or blockage) of the drains could result in channeling water to the service water pump motors during design basis rain events. The licensee entered this issue in their corrective action program as Condition Report ANO-2 2008 1302.

The finding was more than minor because it was similar to nonminor Maintenance Rule Example 7.b in NRC Manual Chapter 0612, Appendix E, "Examples of Minor Issues," in that the problem could involve degraded equipment performance. This finding had very low safety significance because the failure to properly categorize failures in accordance with the Maintenance Rule Program did not create, in itself, additional operability or functionality concerns. The inspectors determined that the finding did not have a crosscutting aspect because the opportunity to identify that performance monitoring was inadequate had not occurred recently and therefore was not indicative of current licensee performance.

Inspection Report# : [2008003](#) (*pdf*)

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Significance: Jun 23, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Low pressure safety injection check valve failure due to inadequate maintenance procedures

The inspectors documented a self-revealing noncited violation of Technical Specification 6.4.1.a, "Procedures," for an inadequate Unit 2 low pressure safety injection discharge check valve assembly procedure. Specifically, during Refueling Outage 2R18 (Fall 2006) the Train A pump discharge check valve was incorrectly assembled such that it would not fully close. Subsequently, during Refueling Outage 2R19 (Spring 2008), operations swapped decay heat removal from Train A to Train B and noticed reverse flow through the Train A pump, indicating that the discharge check valve was not fully closed. The licensee determined that the safety function of the valve was maintained because the valve still limited sufficient reverse flow through the Train A pump such that Train B pump remained operable. Operability of the Train A pump was not affected. A contributor to the violation included inadequate postmaintenance testing following refueling outage 2R18 work. The licensee entered the issue into the corrective action program as CR ANO-2-2008-0422 and implemented compensatory measures as appropriate. The licensee performed corrective maintenance, successfully completed post maintenance testing, and returned the system to service.

The finding was more than minor because it was similar to nonminor Example 5.b in NRC Manual Chapter 0612, Appendix E, "Examples of Minor Issues," in that the valve was installed incorrectly during Unit 2 Refueling Outage 2R18 and then the system was subsequently returned to service with the faulty component. The finding was of very low safety significance because the Train B LPSI pump remained operable. The inspectors determined that this particular finding did not have a cross-cutting aspect because the inadequate procedure was in place for eight years, which is not indicative of current plant performance.

Inspection Report# : [2008003](#) (*pdf*)

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Significance: Jun 23, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate preventive maintenance activities result in emergency light failures

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix R, Section III.J, with two examples for inadequate preventive maintenance activities that resulted in 90 emergency light failures between January 2005 and December 2007. The first example related to inadequate preventive maintenance activities that resulted in the failure of 15 emergency light batteries. The second example related to inadequate preventive maintenance activities that resulted in the failure of 75 emergency light lamps. The licensee has entered these conditions in their corrective action program as CR ANO-C-2007-1646.

The finding was more than minor since it was associated with the Mitigating Systems Cornerstone attribute of protection from external factors and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, this finding adversely affected the ability of operators to access and align equipment necessary for safe shutdown in the event of a fire requiring evacuation of the control room. The significance of this finding was assessed using Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process." The finding was determined to be of very low safety significance (Green) because it was determined to be a low degradation of the post-fire safe shutdown category. In addition, operators were procedurally required to carry flashlights. This finding was determined to have a crosscutting aspect of Human Performance in that the licensee failed to appropriately plan work activities to support long-term equipment reliability. Specifically, the maintenance scheduling was more reactive than preventive [H.3(b)].

Inspection Report# : [2008003](#) (*pdf*)

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Significance: Oct 19, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN ADEQUATE FIRE BRIGADE STAFFING DURING ALTERNATE SHUTDOWN

The team identified a noncited violation of License Conditions 2.C.(8) for Unit 1 and 2.C.(3)(b) for Unit 2 for failure to implement and maintain in effect all provisions of the approved fire protection program. Specifically, the licensee failed to maintain adequate fire brigade staffing during fire scenarios requiring an alternative shutdown of Unit 2 coincident with a remote shutdown of Unit 1. The licensee entered the failure to maintain adequate fire brigade staffing under all circumstances into their corrective action process for resolution.

The failure to implement and maintain in effect all provisions of the approved fire protection program by failing to maintain adequate fire brigade staffing was a performance deficiency. The finding was more than minor since it was associated with the Mitigating Systems Cornerstone attribute of protection from external factors and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The significance of the finding was assessed using Appendix M of Manual Chapter 0609, "Significance Determination Process Using Qualitative Criteria." This finding was determined to be of very low safety significance (Green) by management review due to the short duration of the violation. The finding has a cross-cutting aspect in the area of human performance associated with resources because the licensee did not adequately ensure the procedures governing the procedure change process were complete and accurate (H.2.(c)).

Inspection Report# : [2007006](#) (*pdf*)

Barrier Integrity

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Significance: Sep 11, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

B.5.b. Phase 2 and 3 Mitigating Strategy

This finding, affecting the Barrier Integrity Cornerstone, is related to mitigative measures developed to cope with losses of large areas of the plant; in response to Section B.5.b. of the February 25, 2002, Interim Compensatory Measures (ICM) Order (EA-02-026) and related NRC guidance. This finding has been designated as "Official Use Only - Security-Related Information;" therefore, the details of this finding are being withheld from public disclosure. This finding has no cross-cutting aspect. See inspection report 2008-006 for more details.

Inspection Report# : [2008006](#) (*pdf*)

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Significance: Jun 23, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to maintain containment closure capability

The inspectors identified a Green noncited violation of Unit-2 Technical Specification 6.4.1.a, "Procedures," associated with the licensee's

failure to maintain containment closure capability as required by Station Procedure OP 1015.008, "Unit 2 SDC Control," Revision 23. The licensee was installing a "Hawke seal" at Containment Penetration 2P-53 to support outage work. However, seal installation would take approximately 1 hour and none of the workers had been designated as the responsible individual nor had the required materials been staged to ensure that they could accomplish containment closure in no more than 30 minutes. At the time, the estimated time to reactor coolant system boiling (assuming a loss of mitigating equipment) was 18 minutes. The licensee entered this issue in their corrective action program as Condition Report CR ANO-2-2008-0461.

The finding was greater than minor because it affected the configuration control attribute of the barrier integrity cornerstone, and it directly affected the cornerstone objective to provide reasonable assurance that the physical design barriers protect the public from radionuclide releases caused by accidents or events. Using Manual Chapter 0609, Appendix H, "Containment Integrity Significance Determination Process," the inspectors determined that a Phase 2 evaluation was required. The inspectors performed a Phase 2 analysis using Appendix H, Table 6.4, "Phase 2 Risk Significance-Type B Findings at Shutdown," and determined the finding was of very low safety significance (Green) because there was no mitigating equipment out of service and the finding existed for less than 8 hours. The finding had a crosscutting aspect in the area of Human Performance associated with the resources component [H.2(c)], because the licensee failed to provide complete, accurate and up-to-date procedures and work packages for the installation of the Hawke seal which ensured that the ability to maintain containment closure was directed.

Inspection Report# : [2008003](#) (*pdf*)

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Significance: Apr 04, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

SCAFFOLDING RENDERED CONTAINMENT ISOLATION VALVE INOPERABLE

Green. The inspectors documented a self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to follow a site scaffolding procedure, in that operators and the scaffolding certifying official failed to identify that scaffolding impeded the operation of the outboard chill water return containment isolation valve. The valve could not close to perform its safety function. This issue was entered into the licensee's corrective action program as Condition Report CR ANO 2 2008 0473.

The finding was more than minor because it was similar to nonminor Example 4.a in NRC Inspection Manual Chapter 0612, Appendix E, "Examples of Minor Issues." Specifically, the scaffolding had an adverse impact on a safety related containment isolation valve. In addition, this finding was associated with the configuration control attribute of the Barrier Integrity Cornerstone and affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radio nuclide releases caused by accidents or events. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding had very low safety significance because the condition did not represent a degradation of the barrier functions of the control room or auxiliary building; did not represent an actual open pathway in the physical integrity of reactor containment; and did not involve an actual reduction in the function of hydrogen igniters in the reactor containment. The finding had a crosscutting aspect in the human performance area, work practices component [H.4(c)], because the licensee failed to ensure supervisory and management oversight of work activities such that nuclear safety was supported.

Inspection Report# : [2008002](#) (*pdf*)

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Significance: Apr 04, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CONTAINMENT AIR LOCK LEAKAGE TESTING

Green. The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," involving unacceptable preconditioning during Unit 2 containment escape hatch outer door local leakage rate testing. Specifically, the test procedure as written failed to identify leakage through the air lock outer door seals in excess of that allowed by the Containment Leakage Rate Testing Program. The licensee entered this issue in their corrective action program as condition report CR ANO 2007 1687.

This finding was more than minor because it was associated with the procedure quality attribute of the Barrier Integrity Cornerstone and affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was of very low safety significance because it did not represent an actual open pathway in the physical integrity of reactor containment or involve an actual reduction in defense-in-depth for the atmospheric pressure control or hydrogen control functions of the containment. This finding has a crosscutting aspect in the area of human performance area associated with resources in that the licensee did not ensure that procedures were available and adequate to assure nuclear safety. Specifically, the licensee failed to provide complete and accurate procedures to allow detection of a degradation of the containment air lock door seals [H 2(c)].

Inspection Report# : [2008002](#) (*pdf*)

Occupational Radiation Safety

Significance:  Mar 28, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to follow procedure when exiting the RCA

The inspectors identified a noncited violation of Technical Specification 6.4.1 which resulted from workers failing to follow procedural requirements. On March 25, 2008, two workers entered the radiologically controlled area, dressed in protective clothing, then exited through a door marked "No Exit." There was a previous, similar occurrence on March 23, 2008. The licensee counseled the workers and documented the occurrences in the corrective action program as CR ANO-2-2008-00789.

The finding is greater than minor because it was associated with an Occupational Radiation Safety Cornerstone attribute (exposure control) and it affected the associated cornerstone objective because the failure to use the personnel contamination monitors could result in increased personnel dose and the release of radioactive material. Using the Occupational Radiation Safety Significance Determination Process, the inspectors determined the finding had very low significance because: (1) it was not an ALARA finding, (2) there was no overexposure, (3) there was no substantial potential for an overexposure, and (4) the ability to assess dose was not compromised. Additionally, the finding had a crosscutting aspect in the area of Human Performance, Work Practice Component, because the workers did not use self- or peer-checking as a human error prevention technique [H.4(a)].

Inspection Report# : [2008003](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-IV Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Communication of an NRC Inspector's Presence by Security Personnel

SL IV. The inspectors identified a Severity Level IV NCV of 10 CFR 50.70, "Inspections," for the licensee's failure to ensure that the arrival and presence of an NRC inspector is not communicated to persons at the facility. A security officer informed other security officers at the facility of the presence and expected arrival of an NRC resident inspector at their duty location. This issue was entered into the licensee's corrective action program as Condition Report ANO-2007-1508.

The finding was determined to be applicable to traditional enforcement because the NRC's ability to perform its regulatory function was potentially impacted by the licensee's notification of personnel whose activities are subject to unannounced inspection by NRC inspectors. The finding was not suitable for evaluation using the significance determination process, and was therefore evaluated in accordance with the Enforcement Policy. The finding was reviewed by NRC management and was determined to be of very low safety significance.

Inspection Report# : [2007005](#) (*pdf*)

Last modified : November 26, 2008