

# Arkansas Nuclear 2

## 3Q/2010 Plant Inspection Findings

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### Initiating Events

**Significance:**  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Follow Natural Emergencies Procedure to Control Site Missile Hazards During Severe Weather Warnings and Watches**

The inspectors identified a noncited violation of Technical Specification of 5.4.1.a for failure to follow Procedure OP-1203.025, "Natural Emergencies," Revision 30. Specifically, on April 23, 2010, the licensee entered the before mentioned procedure due to a tornado watch/warning and failed to identify and control potential missile hazards in and around the Unit 1 transformer yard. The licensee entered this issue into the corrective action program as Condition Report CR-ANO-C-2010-1003.

Failure of the licensee to assess and control potential missile hazards on site, in and around transformer yards was a performance deficiency. Specifically, the licensee failed to follow Procedure OP 1203.025, "Natural Emergencies," Revision 30 and adequately secure missile hazards on site. The performance deficiency was determined to be more than minor because it was associated with the external hazards attribute and directly affected the Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability while in shutdown or at power conditions, and is therefore a finding. Specifically, the failure of the licensee to secure missile hazards on site, especially around the safety related transformers increased the likelihood of a loss of power event that could result in upsetting plant stability. The inspectors evaluated the significance of the finding using Manual Chapter 0609, "Significance Determination Process," Appendix G, Checklist 3, and determined the finding to be of a very low safety significance, Green, because the finding did not cause the loss of mitigating capability of core heat removal, inventory control, power availability, containment control, or reactivity control. The finding was determined to have a crosscutting aspect in the area of problem identification and resolution, associated with the corrective action program, P.1(d), in that the licensee failed to take appropriate corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance and complexity. Specifically, the licensee failed to take effective corrective action from a previous NRC-identified issue, in that the corrective actions did not ensure that the control room operators had adequate guidance to assess and control potential missile hazards on site prior to the onset of severe weather.

Inspection Report# : [2010003](#) (*pdf*)

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: FIN Finding

#### **Troubleshooting in Switchyard Causes Loss of Power to Unit 1 and Unit 2 Startup Transformers**

The inspectors documented a self-revealing finding for failure to implement Procedure OP-1015.033, "ANO Switchyard Controls," Revision 12. Specifically, On March 26, 2010, while performing 161 kV Breaker B1205 post-installation testing, several issues developed and testing activities morphed into troubleshooting activities. Per the above mentioned procedure, a new component and plant impact statement should have been performed. The impact statement should have described the new work activities, objectives and potential for plant impacts so that a proper assessment could be made by operations as to allow the work or not. These troubleshooting activities ultimately resulted in a lockout of the auto-transformer, which resulted in the lockout of startup Transformers 1 and 3 (offsite power source) for Units 1 and 2, respectively. The licensee entered the issue into the corrective action program as Condition Report CR-ANO-C-2010-0726.

The failure to properly implement Procedure OP-1015.033, ANO Switchyard Controls," Revision 12, was a performance deficiency. Specifically, the licensee did not stop and obtain a component and plant impact statement when test activities transitioned into troubleshooting activities in the Arkansas Nuclear One switchyard. The

troubleshooting activities led an auto lockout of the auto transformer and resulted in the loss of offsite power to startup transformers 1 and 3. The performance deficiency was determined to be more than minor because it is associated with the human performance attribute and directly affected the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown conditions, and is therefore a finding. The significance of the finding was determined using Manual Chapter 0609, "Significance Determination Process," Appendix G, Checklist 4, and determined to be of very low safety significance, because it did not cause the loss of mitigating capability of core heat removal, inventory control, power availability, containment control, or reactivity control. The finding was determined to have a crosscutting aspect in the area of human performance associated with work practices, H.4(c), in that the licensee failed to ensure supervisory and management oversight of work activities in the switchyard such that nuclear safety is support. Specifically, the licensee became too involved helping solve the issue discovered in the switchyard and failed to recognize that Procedure OP-1015.033 need to be implemented.

Inspection Report# : [2010003](#) (pdf)

**Significance:**  Mar 31, 2010

Identified By: NRC

Item Type: FIN Finding

### **INADEQUATE ROOT CAUSE EVALUATION FAILED TO PREVENT MAIN FEEDWATER PUMP THRUST BEARING FAILURE**

Green. The inspectors identified a Green finding for the licensee's failure to develop an adequate root cause evaluation and subsequent corrective actions to prevent reoccurrence of main feedwater pump 2P-1A thrust bearing failure. Specifically, the licensee's root cause evaluation for a thrust bearing failure on March 13, 2009, failed to identify that the main feedwater pump performance had been degrading and did not implement corrective actions to repair the pump during the Unit 2 refueling outage in September 2009. The pump thrust bearing failed again on December 8, 2009, which led to an unplanned manual reactor trip. The licensee entered the issue into their corrective action program as Condition Report CR ANO 2 2009 3744.

The failure to perform an adequate root cause evaluation to prevent the reoccurrence of the main feedwater pump 2P-1A thrust bearing failure was a performance deficiency. The performance deficiency was determined to be more than minor because if left uncorrected could become a more significant safety concern and is therefore a finding. Specifically, the failure to perform thorough and adequate root cause evaluations could lead to a more significant safety concern. Using Manual Chapter 0609, Attachment 4, Phase I worksheet, the finding was determined to be of very low safety significance, Green, because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. The finding was determined to have a crosscutting aspect in the area of problem identification and resolution associated with corrective action program P.1 (c), in that the licensee failed to adequately evaluate the problem with main feedwater pump 2P 1A thrust bearing failure and did not prevent reoccurrence following implementation of corrective action.

Inspection Report# : [2010002](#) (pdf)

**Significance:**  Aug 14, 2009

Identified By: NRC

Item Type: FIN Finding

### **Failure to Follow Procedure to Obtain OSRC Review Prior to Restart**

A Green NRC identified finding was identified for failure of operations personnel to follow procedures to obtain an Operational Safety Review Committee review and approval prior to restart of the unit where the cause of the trip had not been positively identified. Specifically, on December 13, 2008, and again on December 23, 2008, Unit 1 was restarted without an Operational Safety Review Committee review and approval as required by the Post Transient Review procedure (OP-1015.037), Attachment B. In both cases, the cause of the trip was identified as probable. The issue was not a violation of NRC requirements because the affected activities were not safety related. The licensee entered this issue into their corrective action program as condition report CR-ANO-C-2009-01217.

The performance deficiency was greater than minor because it could be reasonably viewed as a precursor to a significant event, as evidenced by the December 20, 2008 manual reactor trip. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," this finding affects the initiating events cornerstone and is

determined to have very low safety significance by NRC management review because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. The finding was determined to have a crosscutting aspect in the area of Human Performance associated with Decision-Making [H.1(b)], in that the licensee made non-conservative assumptions in the decisions to restart the unit after each trip. The licensee failed to conduct sufficient effectiveness reviews to verify the validity of the underlying assumptions.

Inspection Report# : [2009008](#) (*pdf*)

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## Mitigating Systems

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### Barrier Integrity

**Significance:**  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Adequately Implement Foreign Material Exclusion Controls**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” associated with the licensee’s failure to adequately implement Procedure EN-MA-118, “Foreign Material Exclusion,” Revision 5. Specifically, between March 21, 2010, and April 22, 2010, multiple occasions were identified where licensee personnel failed to implement appropriate foreign material exclusion controls in areas designated as Zone 1 foreign material exclusion areas. This issue was entered into the licensee's corrective action program as Condition Reports ANO-2-2010-0262, ANO-2-2010-269, ANO-1-2010-0469, ANO-1-2010-0564, ANO-1-2010-0874, ANO-1-2010-0903, ANO-1-2010-0750, ANO-1-2010-1338, ANO-1-2010-1526, ANO-1-2010-1958, and ANO-C-2010-688.

The performance deficiency was more than minor because it affected the human performance attribute of the barrier integrity cornerstone and directly affected the cornerstone objective of providing reasonable assurance that physical barriers protect the public from radionuclide releases caused by accidents or events, and is therefore a finding. Specifically, station personnel’s continued failure to implement appropriate foreign material exclusion controls would result in the introduction of foreign material into critical areas, such as the spent fuel pool or the reactor cavity, which in turn would result in degradation and adverse impacts on materials and systems associated with these areas. Using the Manual Chapter 0609, Appendix G, “Shutdown Operations Significance Determination Process,” Phase 1 guidance, the finding is determined to have very low safety significance because the finding did not result in an increase in the likelihood of a loss of reactor coolant system inventory, degrade the ability to add reactor coolant system inventory, or degrade the ability to recover decay heat removal. This finding had a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program, P.1(d), in that the licensee takes appropriate corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance and complexity.

Inspection Report# : [2010003](#) (*pdf*)

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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### 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.

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### Miscellaneous

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