

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: 1 2 3 4 5 6

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

LICENSEE CODE 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

REPORT SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

On 9/26/83, with the unit at 100% power, it was determined that Battery 2D11 had failed its quarterly surveillance test, rendering it technically inoperable. The quarterly test was started on 9/23/83. Initial battery readings had indicated that 5 cells were out of specification in that they deviated by more than 0.05 volts from initial acceptance test data, the worst being 0.08 volts. The as found voltage deviation was not recognized as a limit specified in Technical Specification (T.S.) 4.8.2.3.2.b.1; thus, the action requirements of Specification 3.8.2.3 (b) were not taken within the time allowed by the Limiting Condition for Operation (LCO); therefore, General Specification 3.0.3 became applicable. The reactor was shut down and the unit was brought

SYSTEM CODE 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

CAUSE CODE 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

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ATTACHMENT SUBMITTED 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

NPRD-4 FORM SUB 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

PRIME COMP. SUPPLIER 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

COMPONENT MANUFACTURER 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

The cause of the battery degradation was determined to be normal aging coupled with the fact that previous equalizing charges were not sufficient in duration. An investigation was conducted with the Maintenance and Operations personnel involved to determine why the voltage deviation was not recognized as a Technical Specification (T.S.) limit, thereby causing the LCO to be exceeded. It was determined that the basic cause was an inadequate exchange of information between the shift supervisor and the maintenance technician. Contributing

FACILITY STATUS 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

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METHOD OF DISCOVERY 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

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NAME OF PREPARER: Dan Moeggenberg

PHONE: (501) 964-3100

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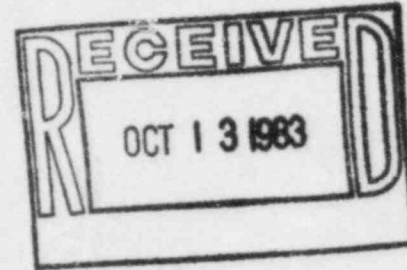
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October 10, 1983

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Mr. W. C. Seidle, Chief
Reactor Project Branch #2
U. S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76011



Subject: Arkansas Nuclear One - Unit 2
Docket No. 50-368
License No. NPF-6
Licensee Event Report
No. 83-044/01T-0

Gentlemen:

In accordance with Arkansas Nuclear One - Unit 2 Technical Specification 6.9.1.8.b, attached is the subject report concerning degradation of Battery 2D11.

Very truly yours,

John R. Marshall
Manager, Licensing

JRM:RJS:s1

Attachment

cc: Mr. Richard C. DeYoung
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. Norman M. Haller, Director
Office of Management & Program Analysis
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

LICENSEE EVENT REPORT

EXHIBIT A

LER No. 50-368/83-044/01T-0

Occurrence Date: 09/26/83

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (Continued)

to cold shutdown within the time requirements of General Specification 3.0.3, and subsequently entered the refueling outage. Upon evaluation of the significance of the battery cell voltage deviation, it was determined that the battery would have performed its safety function. In addition, redundant Battery 2D12 was available for service. This event is reportable per T.S. 6.9.1.8.b. Other LER's regarding battery cells were (50-368) 82-013, 82-016 and 82-020.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (Continued)

factors include:

- 1) The maintenance technicians did not recognize the deviation as a T.S. limit.
- 2) The surveillance procedure did not identify the limit as a T.S. limit.
- 3) The procedure did not specify the information to be conveyed to the shift supervisor.
- 4) Prior T.S. training given to the maintenance technicians regarding battery surveillance was not effective.
- 5) The electrical maintenance supervisor, who was first notified of the deviation by the maintenance technicians, was unfamiliar with the surveillance procedure. (Note: The regular electrical maintenance supervisor was not on site.)

After it was recognized that the T.S. limit and LCO were exceeded, the unit was brought to cold shutdown as required by General Specification 3.0.3. The battery was placed on equalizing charge for an extended time. Subsequent battery readings indicated certain cells were varying in and out of specification. As a result of an engineering evaluation of battery performance, 4 cells were replaced to provide additional assurance that the specification limit of 0.05 voltage deviation from initial acceptance data would not be exceeded. At the time of this report, the battery has not been declared operable pending further required testing. Regarding the failure to comply with T.S. 3.8.2.3 (b), the following corrective actions were taken:

- 1) As of 10/1/83, all limits in surveillance procedures in the plant's Master Test Control List are being treated as though they are T.S. limits. If a limit is exceeded, it is to be formally reported via a Report of Abnormal Condition to allow prompt operability assessment. This will remain in effect until such time as the surveillance procedures are reviewed and determined not to contain T.S. limits, or the procedures are revised to adequately inform the user of T.S. limits and instruct the user of his immediate responsibilities. The review of procedures will be documented and subsequently reviewed by the Plant Safety Committee. Revised procedures will be reviewed by the Plant Safety Committee. Management and supervision were required to review the above requirements for reporting out of specification conditions as well as individual responsibilities with their workers before they have performed a surveillance after 9/30/83.
- 2) Long term corrective actions will contain the following elements:
 - a) Surveillance procedures will be reviewed and revised to assure that the method of collecting data and comparing it to limits is standardized, that the procedure steps flow in a logical manner, and that adequate QC requirements are built into the procedure.
 - b) Training for all departments on technical specifications which apply to their discipline will be conducted. The SRO training program will be reviewed in the area of technical specifications to ensure it is thorough enough in light of this problem.
 - c) An investigation is being conducted of the apparent breakdown in administrative controls which resulted in the occurrence of this event. After the investigation is concluded, additional corrective actions will be taken in this area.