



ENTERGY

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U. S. Nuclear Regulatory Commission
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Subject: Arkansas Nuclear One - Units 1 and 2
Docket Nos. 50-313 and 50-368
License Nos. DPR-51 and NPF-6
Response To Inspection Report
50-313/95-07; 50-368/95-07

Gentlemen:

Pursuant to the provisions of 10CFR 2.201, attached is the response to the notice of violation identified during the inspection activities associated with the inadvertent radiological contamination of the Unit 1 Service Air system.

Should you have any questions or comments, please call me at 501-858-4601.

Very truly yours,

Dwight C. Mims

Dwight C. Mims
Director, Nuclear Safety

DCM/bws

Attachments

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NOTICE OF VIOLATION

During an NRC inspection conducted on August 6 through September 16, 1995, one violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381; June 30, 1995) the violation is listed below:

Unit 2 Technical Specification 6.8.1.a requires, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978.

Regulatory Guide 1.33, Revision 2 Appendix A, February 1978, Section 7.b.(1), states, in part, that procedures should be written for the handling of spent resins.

Procedure 2104.017, Revision 7, "Spent Resin Transfer," provides instructions for the transfer of spent resin from a spent resin tank to a shipping cask and for the clearing of transfer lines which are clogged.

Contrary to the above, on September 11, 1995, a Unit 2 waste control operator failed to utilize the instructions provided in Procedure 2104.017 during an activity to clear an obstruction in the spent resin transfer line. The operator's actions resulted in extensive radiological contamination of the Unit 1 service air system.

This is a Severity Level IV violation (Supplement I) (368/9507-01).

Response to Notice Of Violation 368/9507-01

(1) Reason for the violation:

During the performance of Spent Resin Transfer procedure OP 2104.017, Supplement 11 *Resin Transfer From Spent Resin Tank 2T-13 To The Shipping Cask In The Train Bay*, the transfer line became clogged causing termination of the resin transfer. The Waste Control Operator (WCO) then implemented the requirements of 2104.017 Supplement 13 *Backflush Procedure*. The performance of this supplement as written was unsuccessful in clearing the clogged lines. With no other procedure guidance available for clearing the clogged lines, the WCO decided to continue without appropriate procedure guidance by alternately aligning Unit 1 Service Air and Unit 2 resin flush water. The difference in relative pressure between the Unit 2 resin flush water and the Unit 1 Service Air system resulted in the clogged transfer line being pressurized by the resin flush water which was subsequently depressurized into the Unit 1 Service Air system causing the contamination of the Unit 1 Service Air system.

The decision by the WCO to continue the operation without appropriate procedure guidance is considered a personnel error. Therefore, personnel error was the reason for the Unit One Service Air system becoming contaminated.

(2) Corrective steps that have been taken and the results achieved:

Disciplinary action was taken in accordance with Entergy policy C4.701.

Management expectations with regard to the details of this event as well as overall procedure compliance were communicated to the individual involved in the event and to the operating crews.

(3) Corrective steps that will be taken to avoid further violations:

Unit 1 and Unit 2 Resin Transfer procedures will be evaluated to determine if enhancements are needed. The evaluation will be completed by February 28, 1996.

(4) Date when full compliance will be achieved:

Full compliance was achieved on September 12, 1995 when the following actions were accomplished:

- The Unit 1 Service Air system was isolated, depressurized and hold carded to prevent the inadvertent use of the system,
- The contamination area that was created outside controlled access as a result of the event was properly posted, and
- It was verified that contamination was not spread to other clean systems.