



**Entergy  
Operations**

Entergy Operations

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September 23, 1992

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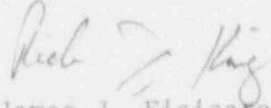
U. S. Nuclear Regulatory Commission  
Document Control Desk  
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Washington, D. C. 20555

SUBJECT: Arkansas Nuclear One - Unit 1  
Docket No. 50-313  
License No. DPR-51  
Licensee Event Report 50-313/92-006-00

Gentlemen:

In accordance with 10CFR50.73(a)(2)(iv), enclosed is the subject report concerning an inadvertent Control Room Emergency Ventilation System actuation.

Very truly yours,

*for*   
James J. Fisicaro  
Director, Licensing

JJF/EKH/mmg

Enclosure

cc: Regional Administrator  
Region IV  
U. S. Nuclear Regulatory Commission  
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1100 Circle, 75 Parkway  
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Arkansas Nuclear One, Unit One

DOCKET NUMBER (2) 05000313  
PAGE (3) 1 OF 3

TITLE (4) Inadvertent Actuation Of The Control Room Emergency Ventilation System Due To An Invalid Unit Two Radiation Monitor Trip Which Was Initiated By Electronic Component Failure

EVENT DATE (5)			LER NUMBER (6)		REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
Month	Day	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)
0	8	2	6	9	2	9	2	AND-2	05000313
0	8	2	6	9	2	9	2		05000313

OPERATING MODE (9) N THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

POWER LEVEL (10)	20.402(b)	20.405(a)(1)(i)	20.405(a)(1)(ii)	20.405(a)(1)(iii)	20.405(a)(1)(iv)	20.405(a)(1)(v)	20.405(c)	50.36(a)(1)	50.36(c)(2)	50.73(a)(2)(i)	50.73(a)(2)(ii)	50.73(a)(2)(iii)	50.73(a)(2)(iv)	50.73(a)(2)(v)	50.73(a)(2)(vi)	50.73(a)(2)(vii)	50.73(a)(2)(viii)(A)	50.73(a)(2)(viii)(B)	50.73(a)(2)(ix)	73.71(b)	73.71(c)	Other (Specify in Abstract below and in Text, NRC Form 366A)	
1	0	0											X										

LICENSEE CONTACT FOR THIS LER (12)

Name	Telephone Number
Elizabeth K. Kolbert, Nuclear Safety and Licensing Specialist	Area Code 501 964-5000

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

Cause	System	Component	Manufacturer	Reportable to NRC	Cause	System	Component	Manufacturer	Reportable to NRC
X	I	L	R	I	W	1	2	0	N

SUPPLEMENT REPORT EXPECTED (14)

EXPECTED SUBMISSION DATE (15)	Month	Day	Year

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On August 26, 1992, at 0640 hours, an inadvertent actuation of the Control Room Emergency Ventilation System (CREVS) occurred as a result of a spurious trip signal initiated by radiation monitor 2RE-8750-1. The Control Room was maintained in its isolated condition while troubleshooting the radiation monitor. On August 27, 1992, it was identified that an undesirable pulse was present on the output of the monitor's A2 level amplifier. The A2 circuit card was replaced and the radiation monitor was proven operable. The Control Room Ventilation System was returned to its normal configuration at 1600 on August 27, 1992. The root cause of this event was attributed to the random failure of electronic components of the radiation monitor. Therefore, no further corrective actions are considered necessary. During this event, the CREVS actuated as designed even though no actual high radiation condition existed.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						PAGE (3)
		Year	Sequential Number	Revision Number				
Arkansas Nuclear One, Unit One	05000313	92	--	006	--	00		02 OF 03

TEXT (If more space is required, use additional NRC Form 366A's) (17) A. Plant Status

A. Plant Status

At the time this event occurred, Arkansas Nuclear One Unit 1 (ANO-1) and Arkansas Nuclear One Unit 2 (ANO-2) were operating at approximately 100 percent power.

B. Event Description

On August 26, 1992, at 0640 hours, an inadvertent actuation of the Control Room Emergency Ventilation System (CREVS) [VI] occurred as a result of a spurious trip signal initiated by radiation monitor 2RE-8750-1.

The CREVS for the ANO-1 and ANO-2 combined Control Room consists of two redundant filter trains, both of which are located outside the ANO-1 section of the Control Room. Each filter train includes a centrifugal fan, roughing filter, absolute filter, and charcoal adsorbent. In addition to recirculation and filtration of Control Room air, filtered outside makeup air is also provided to pressurize the Control Room to minimize unfiltered air leakage into the Control Room under isolated conditions. The CREVS trains are normally isolated from the Control Room by isolation dampers. In the event of detection of high radiation or high chlorine concentration, the normal Control Room air ventilation systems of both Unit 1 and Unit 2 are automatically isolated and the CREVS is automatically started.

Two quick acting chlorine detectors (2CLS-8760-2 and 2CLS-8761-1) are provided at the normal ventilation system supply duct for ANO-1 and two detectors (2CLS-8762-2 and 2CLS-8763-1) are located in the ANO-2 supply air duct. Any one of these detector signals will initiate operation of the CREVS. Additionally, radiation monitors RE-8001 (an area radiation monitor located in the ANO-1 Control Room area) and 2RE-8750-1 (a process radiation monitor located in the ANO-2 normal ventilation system outside air intake ductwork) are provided to actuate the CREVS automatically upon detection of high radiation. If either one of these radiation monitors detects radiation levels above predetermined values the CREVS will be automatically actuated.

The Control Room was maintained in its isolated condition following the CREVS actuation to facilitate troubleshooting of the radiation monitor.

On August 27, 1992, it was identified that an undesirable pulse was present on the output of the A2 level amplifier of 2RE-8750-1. The A2 circuit card was replaced and the radiation monitor was proven operable. The Control Room Ventilation System was returned to its normal configuration at 1600 on August 27, 1992.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Arkansas Nuclear One, Unit One		Year	Sequential Number	Revision Number	
	05000313	92	006	00	03 OF 03

TEXT (If more space is required, use additional NRC Form 366A's) (17) D. Corrective Actions

C. Root Cause

The root cause of this event was attributed to the random failure of electronic components of the radiation monitor.

D. Corrective Actions

On August 27, 1992, the A2 circuit card of 2RE-8750-1 was replaced, the monitor was proven operable and the Control Room Ventilation System was returned to its normal configuration. Since the cause of this event was determined to be random electronic component failure, no further corrective actions are considered necessary.

E. Safety Significance

During this event, the CREVS actuated as designed even though no actual high radiation condition existed. Therefore, there was no safety significance related to this event.

F. Basis For Reportability

This event is reportable pursuant to 10CFR50.73(a)(2)(iv) as an automatic actuation of an Engineered Safety Features System [JE]. It was also reported pursuant 10CFR50.72(b)(2)(ii) to the Nuclear Regulatory Commission Operations Center on August 26, 1992 at 0936 hours.

G. Additional Information

Previous inadvertent CREVS actuations which were initiated by the radiation monitor due to electronic deficiencies were reported in Licensee Event Reports 50-313/89-014-00, 50-313/90-009-00 and 50-313/90-019-00.

Energy Industry Identification System (EIIIS) codes are identified in the text as [XX].