



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064

DEC 10 1992

Docket Nos. 50-313  
50-368  
License Nos. DPR-51  
NPF-6

Entergy Operations, Inc.  
ATTN: J. W. Yelverton, Vice President  
Operations, Arkansas Nuclear One  
Route 3, Box 137G  
Russellville, Arkansas 72801

Gentlemen:

SUBJECT: NRC INSPECTION REPORT NO. 50-313/92-24; 50-368/92-24 (NOTICE OF VIOLATION)

Thank you for your letter of November 25, 1992, in response to our letter and Notice of Violation dated October 27, 1992. We have reviewed your reply and find it responsive to the concerns raised in our Notice of Violation. We will review the implementation of your corrective actions during a future inspection to determine that full compliance has been achieved and will be maintained.

Sincerely,

A handwritten signature in cursive script, appearing to read "A. Bill Beach".

A. Bill Beach, Director  
Division of Reactor Projects

cc:  
Entergy Operations, Inc.  
ATTN: Donald C. Hintz, President &  
Chief Operating Officer  
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PDR ADOCK 05000313  
Q PDR

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Entergy Operations, Inc.

-2-

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Entergy Operations, Inc.  
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Entergy Operations, Inc.  
ATTN: James J. Fisicaro  
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Honorable Joe W. Phillips  
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Entergy Operations, Inc.

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DEC 10 1992

bcc to DMB (IE01)

bcc distrib. by RIV:

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Section Chief (DRP/A)

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RSTS Operator

RIV File

Section Chief (DRP/TSS)

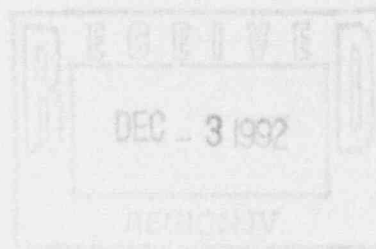
J. Lieberman, OE, MS: 7-H-5

RIV:DRP/A	C:DRP/A	D:DRP		
KMKennedy;df	WDJohnson	ABBeach		
12/9/92	12/9/92	12/10/92		



Entergy  
Operations

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Tel 501-964-3100



November 25, 1992

OCAN119207

U. S. Nuclear Regulatory Commission  
Document Control Desk  
Mail Station P1-137  
Washington, DC 20555


Subject: Arkansas Nuclear One - Units 1 and 2  
Docket Nos. 50-313 & 50-368  
License Nos. DPR-51 & NPF-6  
Response to Inspection Report  
50-313/92-24; 50-368/92-24

Gentlemen:

Pursuant to the provisions of 10CFR2.201, attached is the response to the violation identified during the inspection of activities associated with the maintenance activity which caused a bent valve stem and cracked disk on high pressure safety injection valve 2CV-5015-1.

Should you have questions or comments, please contact me at 501-964-8601.

Very truly yours,

*for*   
James J. Fisicaro  
Director, Licensing

JJF/DWE/mmg  
attachment

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U. S. NRC  
November 25, 1992  
Page 2

cc: Mr. James L. Milhoan  
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NOTICE OF VIOLATION

The NRC stated in inspection report 50-313/92-24;  
50-368/92-24 that:

"During an NRC inspection conducted on September 22 through October 6, 1992, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1992), the violation is listed below:

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

Appendix A of Regulatory Guide 1.33, Revision 2, February 1978 required, in part, "Maintenance that can affect performance of safety-related equipment should be properly pre-planned and performed in accordance with written procedures . . . appropriate to the circumstances."

Job Order 00880725 required "Craft to take precautions as necessary to keep the stem disk assembly from dropping back onto seat during removal of bonnet from valve body."

Contrary to the above, on September 27, 1992, during disassembly of high pressure safety injection Valve 2CV-5015-1, sufficient care was not taken to keep the stem disk assembly from dropping back onto the seat during removal of the bonnet from the valve body and, as a result, maintenance activity caused the valve stem to bend and the disk to crack all the way around the bottom of the disk.

This is a Severity Level IV violation (Supplement I) 368/9224-01).

RESPONSE TO VIOLATION 368/9224-01

(1) Reason for the violation:

Entergy Operations has reviewed the conditions and circumstances surrounding this event to determine the root cause and appropriate corrective actions. Our root cause determination identified the following facts:  
1) The performance of this task is considered to be within the skill of the craft, 2) during the shift turnover briefing the craft personnel were told that bonnet galling was experienced during the stem/disk disassembly completed during the previous shift;

therefore, when resistance was encountered they focused on galling and lost sight of the need for maintaining the stem in mid-position, 3) craft personnel have received training in valve fundamentals, and 4) a note prompting the craft to take precautions to keep the stem/disk assembly from dropping back onto the seat during disassembly was included in the work instructions for this job.

Based on the above, the root cause of this violation was determined to be personnel error. The craft involved with this maintenance activity failed to take adequate precautions to prevent the stem/disk assembly from dropping back onto the seat during valve disassembly, as stated in the job order.

(2) Corrective steps taken and results achieved:

The damaged stem/disk assembly was immediately replaced. The valve was verified to be operable prior to returning the valve to service.

The craft individuals involved in this incident received counselling regarding their failure to exercise appropriate precautions to prevent damage to the stem/disk assembly.

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

Mechanical maintenance craft personnel will receive a briefing during the weekly shop meetings regarding the details of this event, including a discussion of the proper procedure for disassembly of these valves. These briefings will be completed by December 31, 1992. Additionally, a similar discussion will be incorporated into the normal, craft continuing training program during the first cycle of 1993 continuing training which is scheduled to begin on February 10, 1993.

The increased awareness of craft personnel as a result of counselling and crew briefings, is designed to prevent recurrence of this condition.

Additionally, other corrective actions unrelated to the root cause of this condition are in progress in accordance with our corrective action program. These other corrective actions also address other instances of bent stems and cracked disks which have previously been identified. Examples of these corrective actions include: 1) development of a procedure which will provide an additional measure of control over the



maintenance activity for these valves, 2) a revision to the Station Information Management System (SIMS) Component Notes CRT screen which will prompt the job planners to include a caution statement, to maintain the stem in mid position during disassembly of the valve, when developing the instructions for a new job order, and 3) a component redesign which will strengthen the stem and disk assembly.

(4) Date when full compliance will be achieved:

ANO was in full compliance with its maintenance program upon completion of counselling the individuals involved on September 29, 1992, and the completion of post-maintenance testing on October 17, 1992, following final repairs to the valve.