



ARKANSAS POWER & LIGHT COMPANY

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May 17, 1985

2CAN058505

Director of Nuclear Reactor Regulation  
ATTN: Mr. James R. Miller, Chief  
Operating Reactors Branch #3  
Division of Licensing  
U. S. Nuclear Regulatory Commission  
Washington, DC 20555

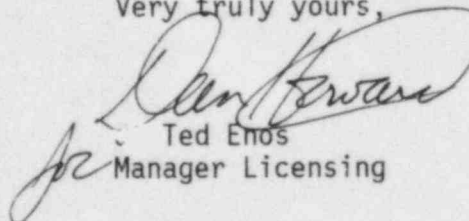
SUBJECT: Arkansas Nuclear One - Unit 2  
Docket No. 50-368  
License No. NPF-6  
ANO-2 Inservice Testing Program

Gentlemen:

During an April 8, 1985 conference call between NRC's Messrs. Bob Lee and Dale Powers and AP&L's Messrs. Dan Howard and Dale James, it was agreed that AP&L would provide NRC with written clarification of the circumstances surrounding several missed ANO-2 Inservice Testing (IST) Program check valve surveillances. Even though it was recognized that there was no requirement to report these missed surveillances per 10CFR50.72 or 73, NRC desired this information to supplement a current review of the ANO-2 IST Program Plan.

Our written description of these missed surveillances is enclosed for your information as requested. Our review of this matter indicates there was no reduction of safety during cycle four operation.

Very truly yours,

  
Ted Enos  
Manager Licensing

JTE:WC:DET:ds

Attachment

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ENCLOSURE TO 2CAN058505

AP&L's letter dated December 10, 1982 (2CAN128206) committed to opening and manually full-stroking the following sets of check valves:

2BS-1 (A and B)  
2BS-5 (A and B)  
2SI-16 (A, B, C and D)  
2EFW-2 (A or B)

Our plan was to visually inspect the valves indicated above during the ANO-2 refueling outage number 2R3, then alternately inspect half of each set during successive refueling outages to demonstrate continuing operability. Following transmittal of 2CAN128206 to NRC, the IST coordinator revised the IST procedure to reflect the long-term plan to inspect alternate sets of valves each refueling outage, but inadvertently failed to note that all the valves should be tested during 2R3. Additionally, the 2R3 visual inspections were physically performed by yet another IST coordinator. The following valves, described in our December 10, 1982 letter, were opened and stroked during 2R3:

2BS-1A  
2EFW-2A  
2SI-16A and B

The result of the above circumstances was our not inspecting all the valves described in our December 10, 1982 letter that should have been inspected during 2R3. The cause of this oversight was a lack of attention to detail on the part of the IST coordinators and their supervisor. Contributing to the oversight was the fact that the supervisor was new at his job, as were the IST coordinators who set up and performed the visual inspections.

After recognizing the error, the inspection plan for refueling outage 2R4 was set up to include the following valves: 2BS-1A & B; 2BS-5A & B; 2SI-16A, B, C & D; and 2EFW-2B. These inspections were performed and all the valves were successfully stroked with no apparent deficiencies. It is evident from the results of the 2R4 visual inspections that all the valves covered by the December 10, 1982 letter were functional during the ANO-2 fourth cycle operation, i.e., between refueling outages 2R3 and 2R4. As a result, we have concluded that there was no loss in safety margin as a result of the missed inspections.