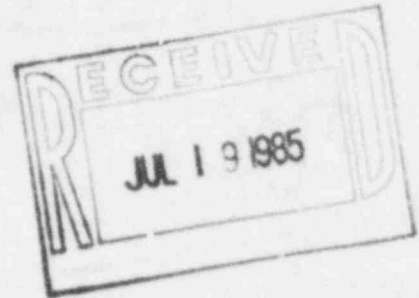




ARKANSAS POWER & LIGHT COMPANY

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July 10, 1985



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Mr. Richard P. Denise, Director
Division of Reactor Safety and Projects
U. S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, TX 76011

SUBJECT: Arkansas Nuclear One - Units 1 & 2
Docket Nos. 50-313 and 50-368
License Nos. DPR-51 and NPF-6
Response to Inspection Reports
50-313/85-07 and 50-368/85-07

Gentlemen:

The subject inspection reports have been reviewed. A response to the Notice of Violation is attached.

Very truly yours,

J. Ted Enos
Manager, Licensing

JTE/RJS/sg

Attachment

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

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

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IC-092/85

NOTICE OF VIOLATION

Based on the results of an NRC inspection during the period of April 1-30, 1985, and in accordance with the NRC Enforcement Policy (10 CFR Part 2, Appendix C), 49 FR 8583, dated March 8, 1984, the following violations were identified:

1. Failure to Follow Procedural Requirements for Design Change Control (Unit 2)

10 CFR Part 50, Appendix B, Criterion V and Section 5.1.1 of the AP&L Quality Assurance Manual-Operations (APL-TOP-1A) require that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances, and shall be accomplished in accordance with these procedures, instructions, and drawings.

Overall Plant Administrative Procedure 1000.13, "Control of Station Modifications," has been established in accordance with Criterion V and APL-TOP-1A.

Section 6.4.11 of Procedure 1000.13 requires that all design changes be installed as described in the design change package (DCP).

Contrary to the above, fire door 210 was installed and the DCP closed out; but the type of latching mechanism specified in the DCP was not installed.

This is a Severity Level IV Violation. (Supplement I.D) (368/8507-01)

Response

The ANO fire hazards analysis performed for compliance to 10 CFR 50, Appendix R determined that door 210, entry in the ANO-2 lower south piping room, was in a fire area boundary that was required to meet the 3-hour fire rating criteria. The existing hollow metal door was replaced with a door meeting the 3-hour criteria on December 16, 1983. The design change package (DCP) for door replacement indicated that the latching mechanism was to be adjusted to allow door opening at an internal room pressure of 0.25 psig. Contrary to the DCP instructions, no special adjustment was made during the replacement of the door. Subsequent modifications to fire doors/high energy line break doors resulted in the installation of a blank plate over the strike opening in the door frame. It is believed that during the performance of the DCP for door 210, the contractors did not understand the adjustments required. The field inspection report indicated satisfactory results for the door installation and while it did specifically address door hardware, it did not require an inspection for opening at 0.25 psig.

At the time the DCP was installed, an AP&L Field Construction Management program at ANO was being implemented. Since then, Field Construction Management has developed into a fully functional department with improved control over work performed by contractors. AP&L considers that present practices better ensure that when problems are encountered in the performance of contractor work, such as confusion over how to adjust a door latching mechanism, such problems will be resolved. This was in fact the case for a later DCP for modifications of other fire door/high energy line break doors.

The high energy line break analyses for room 2055 were reviewed. This review included recent analysis conducted during equipment qualification efforts and original FSAR analysis. The review determined that no modification to the latch was required as the conditions postulated in the analysis for purposes of equipment qualification assumed no special design features for equipment to remain fully qualified due to resultant conditions of a high energy break in this room. Neither were any special design features for this door required by original FSAR analysis for equipment qualification or structure integrity. Therefore, full compliance has been achieved.

2. Failure to Follow Procedural Requirements for Radiation Protection (Unit 2)

10 CFR Part 50, Appendix B, Criterion V and Section 5.1.1 of the AP&L Quality Assurance Manual-Operations (APL-TOP-1A) require that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances, and shall be accomplished in accordance with procedures, instructions, and drawings.

Overall Plant Administrative Procedure 1000.31, "Radiation Protection Manual," has been established in accordance with Criterion V and APL-TOP-1A.

Section 9.3.8.C of Procedure 1000.31 requires that personnel comply with the posted area entrance requirements.

Contrary to the above, on or about April 7, 1985, the NRC inspector observed an individual working in an area posted as beta protection required, without the proper beta protection equipment.

This is a Severity Level V Violation. (Supplement I.D) (368/8507-02)

Response

As discussed in the violation, an NRC Inspector observed a contractor technician performing control element assembly (CEA) transfers without wearing beta goggles as was required by the area posting.

Just prior to the event the person involved was outside the beta area observing another contractor technician operate the CEA handling tool. Because the technician operating the tool (who was wearing beta

goggles) was experiencing difficulties and the observer was more experienced in the operation, he stepped in to help and forgot to put on his beta goggles. This person had recently completed AP&L health physics training and should have been well aware that area postings must be obeyed.

It should also be noted that the CEA handling tool had recently been installed on the spent fuel bridge (<24 hours before). A fuel handling tool had previously been in use and was replaced by the CEA handling tool. Because of the fuel handling tool's long term use in spent fuel pool water and the tool's close proximity to the bridge operator, the area was posted as requiring beta protection. The CEA handling tool is not believed to have been contaminated to such an extent that beta protection was required. However, the posting remained in place after the tool changeout was performed.

This event has been discussed with the appropriate contractor personnel who subsequently implemented a program to ensure that personnel working at plant sites are aware of the necessity to follow and abide by plant procedures. The program consists of a classroom-type training session just prior to departure which outlines basic procedural requirements, plus specific requirements for the job they will perform. This program, along with AP&L contractor training, will emphasize to the contractor personnel the necessity of following plant procedures.

Because this is an isolated error made by an experienced person who had just completed AP&L's health physics training program, AP&L has concluded the actions taken by the contractor are adequate to prevent recurrence.