



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION IV
612 EAST LAMAR BLVD, SUITE 400
ARLINGTON, TEXAS 76011-4125

April 3, 2009

Mr. Timothy G. Mitchell
Vice President Operations
Arkansas Nuclear One
Entergy Operations, Inc.
1448 S.R. 333
Russellville, AR 72802-0967

SUBJECT: ARKANSAS NUCLEAR ONE – NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000313/2009006 AND
05000368/2009006

Dear Mr. Mitchell:

On February 20, 2009, the U. S. Nuclear Regulatory Commission (NRC) completed a team inspection at Arkansas Nuclear One. The enclosed report documents the inspection findings, which were discussed on February 20, 2009, with Brad Berryman, General Manager Operations, Acting Site Vice President, and other members of your staff.

The inspection examined activities conducted under your license as they relate to identification and resolution of problems, safety and compliance with the Commission's rules and regulations and with the conditions of your operating license. The team reviewed selected procedures and records, observed activities, and interviewed personnel.

The International Atomic Energy Agency conducted an Operational Safety Review Team Evaluation at Arkansas Nuclear One from June 15 through July 2, 2008. The Operational Safety Review Team's review included an evaluation of your corrective action program which is documented in a report (ADAMS Accession Number ML083440148) which is accessible from the NRC Web-site at www.nrc.gov/reading-rm/adams.html. Nuclear Regulatory Commission personnel closely monitored the team's activities and deemed it appropriate to assess a 50 percent credit for the baseline problem identification and resolution inspection in accordance with the guidance provided in Inspection Manual Chapter 2515, "Light-Water Reactor Inspection Program-Operations Phase," Section 08.05.

Based on the samples selected for review, the team concluded that the implementation of the corrective action program at Arkansas Nuclear One, Units 1 and 2, was effective. The inspectors determined that Arkansas Nuclear One staff had a low threshold for identifying problems and issues were prioritized and evaluated commensurate with their safety significance. Corrective actions were typically implemented in a timely manner and addressed the identified causes of problems. Lessons learned from industry operating experience were reviewed and usually applied when appropriate. Audits and self-assessments were critical with

appropriate actions recommended; however, there were several examples where licensee management did not evaluate the validity of the recommendations and closed out the item without taking any actions.

Based on the results of this inspection, no findings of significance were identified. However, one licensee-identified violation, which was determined to be of very low safety significance, is listed in this report. This finding was determined to involve a violation of NRC requirements. However, because of the very low safety significance and because it has been entered into your corrective action program, the NRC is treating this finding as a noncited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy. If you contest this noncited violation, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001, with copies to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 612 East Lamar Blvd, Suite 400, Arlington, Texas, 76011-4125; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Arkansas Nuclear One , Units 1 and 2, facility.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web-site at www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/ Larry T. Ricketson for
Gregory E. Werner, Chief
Plant Support Branch 2
Division of Reactor Safety

Dockets: 50-313; 50-368
Licenses: DPR-51; NPF-6

Enclosure: Inspection Reports 05000313/2009006
and 05000368/2009006
w/Attachments:

1. Supplemental Information
2. Information Request

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ROPreports

File located:

SUNSI Rev Compl.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	ADAMS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Reviewer Initials	JFD
Publicly Avail	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Sens. Type Initials	JFD
RIV: RI:DRP/E	RI/DRP/E	SRI/DRS/PSB2	C:DRS/PSB2	C:DRP/E	
Z. Bailey	J. Josey	J. Drake	G. Werner	J. Clark	
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C:DRS/PSB2					
G. Werner					
/RA/					
4/3/09					

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U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket: 50-313 and 50-368
License: DPR 51 and NPF 6
Report: 05000313/2009006 and 05000368/2009006
Licensee: Entergy Operations, Inc.
Facility: Arkansas Nuclear One, Units 1 and 2
Location: Junction of Hwy. 64W and Hwy. 333 South
Russellville, Arkansas

Dates: January 19 to February 20, 2009
Team Leader: James F. Drake, Senior Reactor Inspector
Inspector: Jeffery Josey, Resident Inspector, Plant Support Branch E
Accompanied by: Zachary Bailey, Reactor Inspector, Plant Support Branch E

Approved By: Gregory E. Werner, Chief
Plant Support Branch 2
Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000313/2009006 and 05000368/2009006; 01/19/2009–02/20/2009; Arkansas Nuclear One, Units 1 and 2, "Biennial Baseline Inspection of the Identification and Resolution of Problems."

This inspection was performed by one regional inspector and one resident inspector. No findings of significance were identified during this inspection. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process". Findings for which the significance determination process does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG 1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

The inspectors reviewed approximately 300 condition reports, work orders, engineering evaluations, root and apparent cause evaluations, and other supporting documentation to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The inspectors reviewed a sample of system health reports, self-assessments, trending reports and metrics, and various other documents related to the corrective action program. The inspectors concluded that the licensee effectively identified, evaluated, and prioritized corrective actions for conditions adverse to quality. The inspectors concluded that the licensee implemented timely, effective corrective actions.

With minor exceptions, the licensee appropriately evaluated industry operating experience for relevance to the facility and had entered applicable items in the corrective action program. The licensee used industry operating experience when performing root cause and apparent cause evaluations. The licensee performed effective quality assurance audits and self-assessments, as demonstrated by self-identification of poor corrective action program performance and identification of ineffective corrective actions.

A. NRC-Identified and Self-Revealing Findings

No findings of significance were identified.

B. Licensee-Identified Violations

The inspectors evaluated one licensee-identified violation of very low safety significance. Corrective actions taken or planned by the licensee have been entered into the corrective action program. This violation and condition report numbers are listed in Section 4OA7 of this report.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (71152B)

a. Assessment of Corrective Action Program Effectiveness

(1) Inspection Scope

The inspectors reviewed the procedures describing Arkansas Nuclear One's corrective action program. The licensee identified problems for evaluation and resolution by initiating condition reports in their condition reporting system. The inspectors evaluated the methods for assigning and tracking issues to ensure that issues were screened for operability and reportability, prioritized for evaluation and resolution in a timely manner commensurate with their safety significance, and tracked to identify adverse trends and repetitive issues. In addition, the inspectors interviewed plant staff and management to determine their understanding of and involvement with the corrective action program.

The inspectors reviewed approximately 300 condition reports including associated root, apparent, and direct cause evaluations, from the approximately 14,000 condition reports that were issued between March 2007 and February 2009, to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The inspectors evaluated the licensee's efforts in identifying and establishing the scope of problems by reviewing selected logs, operability determinations, work requests, self-assessments results, audits, system health reports, action plans, and results from surveillance tests and preventive maintenance tasks. The inspectors attended the licensee's Condition Review Group screening committee meetings and Corrective Action Review Board meetings to assess the reporting threshold, prioritization efforts, and significance determination process, as well as observing the interfaces with the operability assessment and work control processes. The inspectors' review included verifying that the licensee considered the full extent of cause and extent of condition for problems, as well as how the licensee assessed generic implications and previous occurrences. The inspectors assessed the timeliness and effectiveness of corrective actions, completed or planned, and looked for additional examples of similar problems. The inspectors conducted interviews with plant personnel to identify other processes that may exist where problems may be identified and addressed outside the corrective action program.

The inspectors also reviewed condition reports that addressed past NRC-identified violations to ensure that the corrective actions addressed the issues as described in the inspection reports. The inspectors reviewed a sample of corrective actions closed to other corrective action documents to ensure that corrective actions were still appropriate and timely.

The inspectors considered risk insights from the NRC's and Arkansas Nuclear One's risk analyses to focus the sample selection and plant tours on risk significant systems and components. The corrective action review was expanded to five years for evaluation of the Unit 1 120 Vac vital power system and fire protection systems and administrative controls. The inspectors conducted a walkdown of these systems and the plant to assess whether problems were identified and entered into the corrective action program.

(2) Assessments

(a) Assessment - Effectiveness of Problem Identification

The inspectors determined that licensee personnel were effective at identifying conditions adverse to quality and entering them into the corrective action program in accordance with station procedures and NRC requirements. The inspectors determined that licensee personnel were usually identifying problems at a low threshold; although, there were nine examples identified where condition reports were not promptly initiated when warranted. For example, the inspectors identified that condition reports had not been initiated for the tripping of the primary pump or auto starting of the secondary pump during operations or maintenance for the component cooling water and the control rod drive cooling pumps on several occasions where plant operations had not been impacted. The inspectors also identified that contrary to licensee management's expectation, condition reports were not initiated on several occasions when multiple barriers in the tagout process failed.

(b) Assessment - Effectiveness of Prioritization and Evaluation of Issues

The inspectors determined that, in general, licensee personnel appropriately prioritized and evaluated issues commensurate with the safety significance of the issue. Condition reports were screened for operability and reportability, categorized by significance (A through D), and assigned to a department for evaluation and resolution. The Condition Review Group appropriately considered human performance issues, radiological safety concerns, repetitiveness, and adverse trends in their reviews.

During their review, the inspectors identified four condition reports where the licensee had failed to appropriately recognize and classify repetitive component performance issues as repeat conditions in a timely manner. These associated issues were not coded as repeat conditions in the corrective action program and as a result, this affected the station's ability to trend issues and raise station awareness. For example, the inspectors noted that the reactor building spray Pump B suction pressure transmitter (PT-2428) had a history of indicating lower than actual pressure. Specifically, this pressure transmitter had an 18-month calibration periodicity, and during every scheduled calibration from 2000 to 2007, the as-found reading had been out-of-tolerance low. Additionally, on two occasions during this time, Transmitter PT-2428 had required corrective maintenance between calibrations due to low readings. The inspectors determined that this transmitter was only used to perform in-service testing of the pump, and had been properly calibrated prior to use. Subsequently, the station identified this

issue as repetitive and the transmitter was replaced in November 2008 to correct the problem.

The inspectors found that the cause analyses reviewed were thorough and appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors determined that the reviews conducted by the Corrective Action Review Board were detailed and ensured that corrective actions addressed the identified causes. For significant conditions adverse to quality, the Corrective Action Review Board identified appropriate corrective actions to prevent recurrence.

(c) Assessment – Effectiveness of Corrective Action Program

The inspectors determined that the licensee usually developed appropriate corrective actions to address problems. However, the inspectors did identify several exceptions that included: one condition report where the corrective action was not implemented in a timely manner, one condition report had two corrective actions that lacked specific actions to address the contributing causes, and two condition reports where the causes were attributed to ineffective communications, for which the licensee has been taking extensive actions to correct. Specifically:

- The licensee failed to implement a corrective action to ensure that a solenoid valve design that had been determined to be inadequate in January 2006 was controlled and not issued for use or installation. The correct design solenoid valve was purchased and entered into the warehouse with the identical part number as the incorrect design. The incorrect valve design was not deleted from the stock, nor were any administrative holds placed on the parts to prevent issuance. As a result, the incorrect design solenoid valve was issued and installed in the plant. This issue is addressed in Section 4OA7 as a licensee identified violation.
- The licensee identified in Condition Report ANO-2-2007-313 that, "Policy guidance/management expectations were not well defined or understood as it relates to when a procedure would be required to perform a task or when skill-of-the-craft can be used." The licensee's corrective action added a step in Procedure COPD-001, "Operations, Expectations, and Standards", (Rev 030) referencing EN-WM-100, "Work Request Generation, Screening, and Classification", for the definition of "Skill of the Craft." The team considered this corrective action inadequate since the definition of skill of the craft in Procedure EN-WM-100, "Work Request Generation, Screening, and Classification", is the same now as it was when the incident occurred and there was no documentation of additional training regarding management expectations pertaining to the use of skill-of-the-craft. The only action was to reference Procedure EN-WM-100, "Work Request Generation, Screening, and Classification", in Procedure COPD-001, "Operations, Expectations, and Standards". Since Procedure COPD-001, "Operations, Expectations, and Standards", is an administrative procedure, it is not required to be reviewed or referenced prior to or during work.
- The licensee identified in Condition Report ANO-2-2007-313 (FIN 05000368/2007003-04, "Complete Loss of Component Cooling Water Flow During

Maintenance Operations,") that, "Written Communications PJB [pre-job brief] Form is too Generic." The corrective action was, "Establish guidance in COPD-001 for pre-job brief that will trigger additional rigor in evaluating high risk significant activities." The inspectors found that no additional guidance was inserted into the COPD-001, "Operations, Expectations, and Standards", pre-brief checklist. Only in the main body of COPD-001, "Operations, Expectations, and Standards", was additional guidance provided, but the procedure is marked as administrative, so it is not required to be reviewed prior to a pre-job brief.

- In Condition Report ANO-2-2007-0313, (FIN 05000368/2007003-04, "Complete Loss of Component Cooling Water Flow During Maintenance Operations"), the licensee identified that the system engineer had changed the scope of the job and not effectively communicated this information to the operations and maintenance personnel on the subsequent shifts. The licensee also identified that although the System Engineer was aware of increased leak rates from the heat exchanger due to the removal of the tube plugs, this information was not communicated to operations and maintenance personnel as a potential concern. This resulted in a loss of component cooling water and an unplanned manual trip of the reactor plant.
- In Condition Report ANO-2-2008-1634, which detailed a fuel oil day tank overflow, the licensee determined that there had been a missed opportunity to prevent this event, which dealt with inadequate communications. Specifically, the licensee determined that instrumentation and controls technicians attempted to communicate to the control room operators that the fuel oil day tank level transmitters were to be isolated. However, this communication was determined to be ineffective and, as a result, contributed to the event occurrence. This resulted in the fuel oil transfer pump auto starting and overflowing the fuel oil day tank and spilling fuel oil to the environment.

.3 Findings

No findings of significance were identified.

b. Assessment of the Use of Operating Experience

(1) Inspection Scope

The inspectors examined the licensee's program for reviewing industry operating experience, including reviewing the governing procedure and self-assessments. The inspectors reviewed 12 operating experience notifications to assess whether the licensee had appropriately evaluated the notifications for relevance to the facility. The inspectors then examined whether the licensee had entered these items into their corrective action program and assigned actions to address the issues. The inspectors reviewed a sample of root cause evaluations and corrective action documents to verify if the licensee had appropriately included industry-operating experience.

(2) Assessment

The inspectors found that operating experience information was appropriately considered for applicability, and corrective and preventive actions were taken as needed. Site operating experience coordinators screened issues from various sources for applicability and initiated condition reports for additional reviews and corrective actions as necessary. Operating experience information has been integrated into routine activities, such as pre-job briefs, procedures, and training material. The inspectors noted several positive examples in which plant personnel considered operating experience information in addition to material provided by the operating experience program. However, in a few cases the inspectors found that site-specific operating experience was not effectively utilized because operating experience reviews were not required to be completed for lower significance (Cat C and D) condition reports.

(3) Findings

No findings of significance were identified.

c. Assessment of Self-Assessments and Audits

(1) Inspection Scope

The inspectors reviewed a sample population of 20 out of 80 audits and self-assessments, including the most recent audit of the corrective action program, corrective action program trend reports, quality assurance audits, departmental self-assessments, and assessments conducted by independent organizations. A specific list of documents reviewed is included in the attachment to this report. These reviews were performed to determine if problems identified through these assessments were entered into the corrective action program, when appropriate, and whether corrective actions were initiated to address identified deficiencies. The effectiveness of the audits and assessments was evaluated by comparing audit and self-assessment results against self-revealing and NRC identified findings and observations made during the inspection.

(2) Assessment

The inspectors observed that, overall, audits and self-assessments were critical and, in most cases, appropriate actions were taken to address identified issues. However, in some cases, the inspectors found that management failed to evaluate the validity of the recommendations/observations made for issues identified during assessments. For example, the inspectors noted that in Condition Report ANO-C-2008-1311, quality assurance personnel indicated a concern with potential inadequate oversight of contractor personnel. After management review and evaluation, this condition report was closed based on the determination that the level and type of supervision being used for contract workers was sufficient and in line with standard industry practices. Subsequently, the inspectors noted that Condition Report ANO-C-2008-2565, written

several months later, identified inadequate oversight of contractor personnel as a contributing cause for continuing problems with fire watches and control of combustible materials. The inspectors noted that the basis for this determination was that contract supervisors were not as familiar with station procedures and processes as compared to licensee supervisors.

(3) Findings

No findings of significance were identified.

d. Assessment of Safety Conscious Work Environment

(1) Inspection Scope

A limited assessment of the licensee's safety culture was conducted during this inspection based on the significant assessment of the status of the safety-conscious work environment that was performed as part of the Operational Safety Review Team evaluation with no issues of significance being identified. The inspector did not conduct interviews

(2) Assessment

The inspectors noted from discussions with plant personnel, that the staff were aware of the importance of a strong safety conscious work environment and a willingness to raise safety issues. None of the plant employees had experienced retaliation for safety issues raised or knew of anyone who had been retaliated against for raising issues. All persons interviewed had an adequate knowledge of the corrective action program and engineering action request program. The threshold for entering concerns in the Employees' Concern Program was appropriate and the program administrator willing accepted not only safety concerns but also other work place concerns. Additionally, the resident inspectors had not identified any concerns of a safety conscious work environment. The licensee periodically monitored the safety conscious work environment and the results were consistent with the NRC observations. Based on these reviews and interviews, the inspectors concluded there was a safety conscious work environment.

(3) Findings

No findings of significance were identified.

40A6 Meetings, Including Exit

On February 20, 2009, the inspectors presented the inspection results to Mr. Brad Berryman, General Manager Operations, Acting Site Vice President, and other members of the staff, who acknowledged the findings. The inspectors confirmed that no

proprietary information reviewed during the inspection was retained by the inspectors nor was any included in this report.

40A7 Licensee Identified Violations

The following violation of very low safety significance (Green) was identified by the licensee and is a violation of NRC requirements which meets the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as a noncited violation.

Title 10 CFR Part 50, Appendix B, Criterion XV, "Nonconforming Materials, Parts, or components," requires, in part, that measures shall be established to control materials, parts, or components which do not conform to requirements in order to prevent their inadvertent use or installation. These measures shall include, as appropriate, procedures for identification, documentation, segregation, disposition, and notification to affected organizations. Contrary to the above requirement, the licensee failed to ensure that a solenoid valve design that had been determined to be inadequate in January 2006 was controlled and not issued for use or installation. This resulted in a subsequent failure of decay heat cooler 'A' bypass valve (CV-1433) because of the inadequate solenoid valve. This finding was determined to have very low safety significance because the condition did not result in the actual loss of any component, train, or system. This issue was entered into the licensee's corrective action program as condition reports ANO-1-2008-2525, ANO-1-2008-2578 and ANO-1-2008-2625.

ATTACHMENTS: SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

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R. Eichenberger, Manager, Corrective Actions and Assessments
M. Chisum, Manager, Planning, Scheduling, and Outages
R. Dodds, Manager, Maintenance
C. Reasoner, Director, Engineering
J. Smith, Manager, Quality Assurance
E. Blackano, Supervisor, Components
J. Sigle, Assistant Manager, Operations
P. Higgins, Supervisor, Training
F. Van Buskiak, Licensing Specialist
D. Moore, Manager, Radiation Protection
R. Schiede, Licensing Specialist
D. Bice, Acting Manager, Licensing

NRC personnel

T. Pruett, Deputy Director, Division of Reactor Safety
J. Clark, Branch Chief, E, Division of Reactor Projects
A. Sanchez, Senior Resident Inspector, Arkansas Nuclear One

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened

None

Opened and Closed

Closed

None

Discussed

None

LIST OF DOCUMENTS REVIEWED

Procedures

NUMBER	TITLE	REVISION
COPD-001	Operations Expectations and Standards	30 and 35
COPD-002	ANO Operations Concerns Program	9
EN-AD-102	Procedure Adherence and Level of Use	4
EN-AD-102	Procedure Adherence and Level of Use	4
EN-HU-101	Human Performance Program	6
EN-HU-102	Human Performance Tools	4
EN-HU-103	Human Performance Error Reviews	
EN-LI-102	Corrective Action Process	13
EN-LI-104	Self-Assessment and Benchmarking Process	4
EN-LI-118	Root Cause Analysis Process	9
EN-LI-119	Apparent Cause Evaluation Process	8
EN-LI-121	Entergy Trending Process	7
EN-LI-122	Common Cause Analysis Process	1
EN-OE-100	Operating Experience Program	5
EN-OP-104	Operability Determinations	3
EN-OP-115	Conduct of Operations	6
EN-WM-100	Work Request (WR) Generation, Screening and Classification	3
EN-WM-102	Work Implementation and Closeout	2
OM-123	Working Hour Limits	2
OP-1000.006	Procedure Control	58 and 61
OP-1000.024	Control of Maintenance	53
OP-1000.028	Control of Temporary Alterations	25
OP-1104.006	Spent Fuel Cooling System	43

OP-2104.006	Fuel Pool Systems	36
OP-2104.028	Component Cooling Water System Operation	24 and 37
OP-2306.005	Maintenance Surveillance on Unit 2 Emergency Diesel 2K-4	25
OP-6030.005	Control of Modification Work	7

Condition Reports

ANO-1-2004-00980
ANO-1-2004-01637
ANO-1-2005-02225
ANO-1-2005-03075
ANO-1-2006-0004
ANO-1-2006-1474
ANO-1-2006-00877
ANO-1-2006-01122
ANO-1-2006-01399
ANO-1-2007-00002
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ANO-C-2008-1973
ANO-C-2008-1977
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ANO-C-2009-0122
ANO-C-2009-0293
ANO-C-2009-0338
LO-ALO-2006-0001
LO-ALO-2006-0015
LO-ALO-2006-0077
LO-ALO-2007-0002
LO-ALO-2007-0183
HQN-2005-0240

Work Orders

00030725	0048034	0097729
0101553	0106687	00110914
0112657	00113452	0115323
0128155	0136344	00150346
0151157	00156003	0166086
00166576	50246939	51031145

Miscellaneous

Approved OM-123 Attachment 9.1, "Authorizations for exceeding working hour limits"

Licensee Event Report 50-368/2008-001-00, "Containment Isolation Valve Inoperable Longer Than Allowed by Technical Specifications"

Licensee Event Report 50-368/2008-002-00, "Manual Reactor trip"

Safeguards Event Report 50-313/2008-S0 1 -00, 50-368/2008-S0 1 -00, "Suspension of Safeguards Measures during a Non-Radiological Emergency"

Licensee Event Report 50-313/2008-SO2-00, 50-368/2008-SO2-00 " Electronic Files Containing Safeguards Information Not Properly Marked, Stored, or Controlled"

Quality Assurance Audit Report QA-10-2008-ANO-1, "Maintenance"

Quality Assurance Audit Report QA-03-2007-ANO-1, "ANO Corrective Actions"

Quality Assurance Audit Report QA-04-2008-ANO-1, "Engineering, Design Control"

Quality Assurance Audit Report QA-12-2007-ANO-1, "ANO Operations Focus Review"

Quality Assurance Audit Report QA-3-2007-ANO-1, ANO Corrective Actions

Quality Assurance Audit Report QA-1-2007-ANO-1 Quality Assurance Audit for the Fitness for Duty/PADS Program

Quality Assurance Audit Report QA-2-2008-ANO-1 Quality Assurance Audit of the Chemistry Program

Quality Assurance Audit Report QA-6-2007-ANO-1 ANO Environmental Monitoring

Quality Assurance Audit Report QA-11-2008-ANO-1 ANO Materials, Purchasing, and Contracts

Quality Assurance Audit Report QA-12-2007-ANO-1 Operations Focus Review

Quality Assurance Audit Report QA-14-2007-ANO-1 ANO Radiation Protection

Quality Assurance Audit Report QA-14-2007-ANO-2 ANO Radiation Protection

Quality Assurance Audit Report QA-15-2007-ANO-1 ANO Radioactive Waste

Quality Assurance Audit Report QA-16-2007-ANO-1 Security

Quality Assurance Audit Report QA-19-2008-ANO-1 Training

Surveillance Report, QS-2007-ANO-003 Engineering Audit (QA-4-2006-ANO-1) Follow-up

Surveillance Report, QS-2007-ANO-009 Engineering Audit (QA-8-2007-ANO-1) Follow-up

Surveillance Report, QS-2007-ANO-011 Follow-up of Performance Deficiency CR-ANO-2007-0549 on Records Vault Fire Suppression System

LO-ALO-2006-00104 CA 00035, ANO Fire Protection Program Assessment

LO-ALO-2007-0183 CA-71, Management of Training Processes and Resources in the Maintenance and Technical Training

**Information Request
November 05, 2008
Arkansas Nuclear One
Problem Identification and Resolution Inspection Document Request
(IP 71152; Inspection Report 05000313; 368/2009006)**

To the extent possible, please provide the information in electronic media. The agency's text editing software is MS Word, Excel, Power Point, and Adobe Acrobat (.pdf) text files. However, we have document viewing capability for Corel WordPerfect 10, Presentations, and Quattro Pro.

The inspectors will get updated lists et cetera during the first day onsite (January 26, 2009).

Please provide the following by December 21, 2008, to Jim Drake by posting to CERTREC, e-mail or to:

U.S. Nuclear Regulatory Commission
Attn: Jim Drake
Region IV
612 E. Lamar Blvd, Suite 400
Arlington, TX 76011

Note: For requested summary lists, please include a description of problem, significance level, status, initiation date, and owner organization.

1. A complete copy of all Condition Reports (CRs) related to significant conditions adverse to quality that were opened or closed during the period, including any evaluations.
2. Summary list of all CRs that were generated since January 1, 2007.
3. List of all CRs that subsume or "roll-up" one or more smaller issues for the period
4. Summary list of all CRs that were up-graded or down-graded during the period
5. List of root-cause analyses completed during the period
6. List of root-cause analyses planned, but not complete at end of the period
7. List of all apparent cause analysis completed during the period
8. List of plant safety issues raised or addressed by the employee concerns program during the period
9. List of action items generated or addressed by the plant safety review committees during the period

10. Copy of quality assurance audits and surveillances of corrective action activities completed during the period
11. Summary list of all quality assurance audits and surveillances scheduled for completion during the period but which were not completed
12. Copy of corrective action activity reports, functional area self-assessments, and non-NRC third party assessments completed during the period (Do not include INPO assessments)
13. Copy of corrective action performance trending/tracking information generated during the period and broken down by functional organization
14. Copy of current revisions of governing procedures/policies/guidelines for:
 - a. Condition reporting
 - b. Corrective Action Program
 - c. Root Cause Evaluation/Determination
 - d. Operator work arounds
 - e. Work requests
 - f. Temporary modifications
 - g. Procedure change requests
 - h. Deficiency reporting and resolution
 - i. Operating experience evaluation
 - j. Safety culture policy/procedures
 - k. Employee Concerns Program
15. List of external events and operating experience (OE) evaluated for applicability at Arkansas Nuclear One during the period
16. Copy of CRs or other actions generated for each of the items below during the period:
 - a. Part 21 Reports
 - b. NRC Information Notices and Bulletins
 - c. LERs issued by Arkansas Nuclear One (also include a copy of the LERs)
 - d. NCVs and Violations issued to Arkansas Nuclear One
17. Copy of security event logs during the period
18. Copy of radiation protection event logs during the period
19. Copy of current system health reports or similar information
20. Copy of current predictive maintenance summary reports or similar information
21. Copy of corrective action effectiveness review reports generated during the period

22. List of risk significant components and systems
23. List of corrective actions closed to other programs, such as maintenance action requests/work orders, engineering requests, etc.
24. List of degraded conditions and nonconformances under Generic Letter 91-18, which were not corrected in the last outage
25. Lists of operator work arounds, engineering review requests and/or operability evaluations, temporary modifications, and control room and safety system deficiencies opened or closed during the period
26. Copy of CRs associated with adverse trends in human performance, equipment, processes, procedures, or programs during the period