

## Arkansas Nuclear 2

### 1Q/2005 Plant Inspection Findings

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#### Initiating Events

**Significance:**  Sep 23, 2004  
Identified By: Self Disclosing  
Item Type: FIN Finding

##### **INADEQUATE MAINTENANCE PROCEDURE FOR THE MAIN GENERATOR REVERSE POWER RELAYS**

A self-revealing finding associated with an inadequate maintenance procedure occurred when the Unit 2 main generator reverse power relays contributed to a turbine trip and a reactor trip. The licensee had not incorporated vendor recommended maintenance on the reverse power relays, and as a result, one of the reverse power relays actuated with no reverse power condition present. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program as Condition Report ANO-2-2002-2173.

The finding is more than minor because it was analogous to Example 4.b. in Appendix E, "Examples of Minor Issues," of Manual Chapter 0612, "Power Reactor Inspection Reports," because a procedural error contributed to a reactor trip. This finding affected the initiating events cornerstone. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," the finding is of very low safety significance because, although it resulted in a reactor trip, all mitigating systems remained available.

Inspection Report# : [2004004\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Mar 24, 2005  
Identified By: Self Disclosing  
Item Type: NCV NonCited Violation

##### **FAILURE TO CONDUCT POSTMAINTENANCE TESTING FOR A CONTAINMENT COOLER FAN**

A self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," occurred when postmaintenance testing for Unit 2 Containment Cooler Fan 2VSF-1B was not performed after circuit breaker maintenance. This resulted in the failure to detect that the fan was inoperable. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program as Condition Report ANO-2-2004-1688.

This finding is more than minor because it affected the mitigating systems cornerstone objective of ensuring the availability and reliability of a system that responds to initiating events to prevent undesirable consequences. Based on the results of Phases 2 and 3 Significance Determination Process analyses, the finding was determined to be of very low safety significance because only Containment Cooling Fan 2VSF-1B was inoperable.

Inspection Report# : [2005002\(pdf\)](#)

**Significance:**  Mar 24, 2005  
Identified By: Self Disclosing  
Item Type: NCV NonCited Violation

##### **CONTAINMENT COOLER FAN INOPERABLE IN EXCESS OF TECHNICAL SPECIFICATION ALLOWED OUTAGE TIME**

A self-revealing noncited violation of Unit 2 Technical Specification 3.6.2.3, "Containment Cooling System," occurred since the Unit 2 Containment Cooler 2VSF-1B was inoperable in excess of its specified allowed outage time. The containment cooler was out of service for over 11 months before the licensee discovered that the fan motor had been improperly wired. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program as Condition Report ANO-2-2004-1688.

This finding is more than minor because it affected the mitigating systems cornerstone objective of ensuring the availability and reliability of a system that responds to initiating events to prevent undesirable consequences. Based on the results of Phases 2 and 3 Significance Determination Process analyses, the finding was determined to be of very low safety significance because only Containment Cooling Fan 2VSF-1B was inoperable.

Inspection Report# : [2005002\(pdf\)](#)

**Significance:**  Feb 11, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**9 examples of failure to follow boric acid control procedures**

Green. The team identified a noncited violation of 10 CFR 50, Appendix B, Criterion V (Procedures) for nine examples of the failure to follow plant procedures with respect to documenting, evaluating and correcting boric acid leaks. This issue has crosscutting aspects associated with problem identification and resolution, as the licensee was not effective at ensuring compliance with the boric acid corrosion program following three similar noncited violations (since 2001).

The failure to follow boric acid control procedures was a performance deficiency. This issue is greater than minor because it affected the mitigating systems cornerstone objective of ensuring availability, reliability, and capability of mitigating systems. The issue is similar to non-minor example 4.a. of Manual Chapter 0609 Appendix E, in that the licensee routinely failed to follow these plant procedures. The finding had very low safety significance (Green) because the affected equipment remained operable consistent with Generic Letter 91-18, "Information to Licensees Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions," Revision 1.

Inspection Report# : [2005009\(pdf\)](#)

**G**

**Significance:** Feb 11, 2005

Identified By: NRC

Item Type: FIN Finding

**Long-standing reactor coolant pump and molded case circuit breaker problems**

Green. The team identified a finding, with two examples, where the licensee did not take prompt actions to address longstanding equipment problems that could impact the initiating events and mitigating system cornerstones. Specifically: 1) reactor coolant pump vibrations on two reactor coolant pumps exceeded vendor recommended alert levels, for approximately 15 years in one case; and 2) the licensee has not promptly addressed the extent of condition for molded case circuit breaker problems. This issue involved crosscutting aspects associated with problem prioritization.

The failure to address these longstanding equipment problems is a performance deficiency. Each issue was more than minor because it either affected the Initiating Events or Mitigating System cornerstone objectives of limiting the likelihood of initiating events (reactor coolant pump vibrations) or ensuring the availability of systems that mitigate plant accidents (molded case circuit breakers). Both issues were of very low safety significance because the affected equipment remained operable consistent with Generic Letter 91-18, "Information to Licensees Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions," Revision 1.

Inspection Report# : [2005009\(pdf\)](#)

**G**

**Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO ESTABLISH ADEQUATE MEASURES TO DEMONSTRATE THE PERFORMANCE OR CONDITION OF THE UNIT 2 PRESSURIZER PROPORTIONAL HEATERS**

The inspectors identified a noncited violation of 10 CFR 50.65(a)(2) for failure to establish adequate measures to demonstrate that the performance of the Unit 2 pressurizer proportional heaters was effectively monitored in the maintenance rule program. Failures of the heater breakers were not being monitored as part of the reactor coolant system or the 480 volt electrical system in the licensee's maintenance rule program. The inspectors identified human performance cross-cutting aspects associated with engineers not identifying events that should have been entered in the maintenance rule database.

The inspectors determined that this finding is greater than minor because it is analogous to Example 1.i of Appendix E, "Examples of Minor Issues," of Manual Chapter 0612, "Power Reactor Inspection Reports," because the licensee's equipment performance problems were such that an (a)(2) demonstration could not be justified. Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the issue was determined to have very low safety significance because it did not screen as risk significant due to external initiating events and because the licensee always maintained the minimum required amount of heater input from both trains of pressurizer heaters.

Inspection Report# : [2004005\(pdf\)](#)

**G**

**Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**FAILURE TO IDENTIFY AND CORRECT A LOOSE CIRCUIT CONNECTION IN CONTAINMENT SPRAY PUMP CIRCUITRY**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XV, "Nonconforming Materials, Parts, or Components," for the failure to establish controls to prevent a circuit breaker with a loose connection from being installed in Unit 2. A loose connection in the Containment Spray Pump 2P-35A breaker was not identified prior to installation in the plant even though there were several undocumented instances where similar loose connections were discovered during receipt inspections of other breakers in its group. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program as CR ANO-2-2004-1712.

The finding is more than minor because it affected the mitigating systems cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. Using Appendix A, "Technical Basis For At Power Significance

Determination Process," of Manual Chapter 0609, "Significance Determination Process," and the Phase 2 worksheets from "Risk-informed Inspection Notebook for Arkansas Nuclear One - Unit 2," the finding was determined to potentially have greater than very low safety significance because the loose connection could have resulted in an actual loss of the safety function of the Unit 2 Train A containment spray pump during small break loss of coolant accident or stuck open relief valve events. Further examination in a Phase 3 analysis by regional senior risk analysts demonstrated that this finding is of very low safety significance because the fault was highly intermittent and, even if the pump would not have started, it could have been easily started locally.

Inspection Report# : [2004005\(pdf\)](#)

**G**

**Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**FAILURE TO INCLUDE NONSAFETY RELATED COMPONENTS THAT AFFECT SAFETY-RELATED FUNCTIONS INTO THE MAINTENANCE RULE PROGRAM**

A self-revealing noncited violation of 10 CFR 50.65(b)(2) was identified when the licensee failed to include the Unit 2 startup and blowdown demineralizer pressure relief valves in their maintenance rule program. These valves are nonsafety related however, their failure could prevent the safety-related emergency feedwater system from performing its function during accidents occurring during plant startups and shutdowns. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program as CR ANO-2-2004-1743.

The inspectors determined that the finding is more than minor because, if left uncorrected, the finding would become a more significant safety concern since failure of these valves could result in an over pressure condition on the emergency feedwater pumps common suction piping. Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the inspectors considered this finding to have very low safety significance because it did not screen as risk significant due to external initiating events and, even though periodic preventative maintenance has not been performed on the relief valves, they have prevented emergency feedwater pumps suction piping from exceeding design values

Inspection Report# : [2004005\(pdf\)](#)

**G**

**Significance:** Sep 23, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PERFORM REQUIRED HYDROSTATIC TESTING OF PRESSURIZED FIRE EXTINGUISHERS**

The inspectors identified a noncited violation of Unit 2 operating license Condition 2.C.(3)(b), "Fire Protection," for the failure to perform hydrostatic testing on approximately 80 to 90 percent of the carbon dioxide fire extinguishers. The licensee failed to implement a plan to ensure carbon dioxide fire extinguishers would not exceed their hydrostatic retest expiration dates in response to NRC Information Notice 2001-004, "Neglected Fire Extinguisher Maintenance Causes Fatality." This issue involved problem identification and resolution crosscutting aspects associated with fire protection technicians failing to correct adverse conditions in a timely manner. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program as Condition Report ANO-1-2004-1544.

This finding is more than minor because, if left uncorrected, it would become a more significant safety concern in that internal degradation of the fire extinguishers could continue without any means of detection until the extinguishers were unable to perform their intended functions. Using Appendix F, "Determining Potential Risk Significance of Fire Protection and Post-Fire Safe Shutdown Inspection Findings," of Manual Chapter 0609, "Significance Determination Process," the inspectors determined the issue is of very low safety significance because the fire protection element's performance and reliability was minimally impacted.

Inspection Report# : [2004004\(pdf\)](#)

**G**

**Significance:** Sep 23, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO ADEQUATELY ASSESS RISK DUE TO EXTERNAL CONDITIONS OR HELB DOORS REMOVED**

The inspectors identified two examples of a noncited violation of 10 CFR 50.65(a)(4) for the failure to consider the external risk from changing weather conditions (tornado warning) while a Unit 2 emergency diesel generator was out of service for maintenance and the failure to perform an adequate risk assessment of the removal of a high energy line break barrier between the turbine building and the Unit 1 South switchgear room. This finding involved problem identification and resolution crosscutting aspects associated with operations and engineering personnel not implementing corrective actions to address the extent of condition from a previous noncited violation documented in NRC Inspection Report 05000313/2004003. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program as Condition Reports ANO-C-2004-1279 and ANO-C-2004-1402.

The inspectors determined that these issues are more than minor because, if left uncorrected, they would become a more significant safety concern in that actions to manage increases in risk may not be implemented. This finding affected the mitigating systems cornerstone. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," the example involving changing weather conditions was determined to have very low safety significance because the finding did not result in a loss of function per Generic Letter 91-18, Revision 1,

"Information to Licensee's Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions." Next, using Appendix A, "Technical Basis For At Power Significance Determination Process," of Manual Chapter 0609, "Significance Determination Process," and the Phase 2 worksheets from "Risk-informed Inspection Notebook for Arkansas Nuclear One - Unit 1," the finding involving the high energy line break barrier was determined to be of very low safety significance because the only affected initiator was a main steam line break and a redundant train of safety related switchgear always remained available during the short exposure time for the condition.

Inspection Report# : [2004004\(pdf\)](#)

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**Significance:** Jun 23, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PROVIDE ADEQUATE COMPENSATORY MEASURES FOR A LOSS OF FIRE WATER TO THE INTAKE STRUCTURE**

The inspectors identified a noncited violation of Unit 1 Technical Specification 5.4.1.c and Unit 2 Technical Specification 6.8.1.f when the licensee provided inadequate manual suppression firefighting equipment upon a loss of automatic and manual suppression to the intake structures and service water pump areas. The equipment staged by the licensee would have required numerous actions by the fire brigade to ready a fire hose for manual fire suppression. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. This issue involved human performance cross-cutting aspects associated with operations personnel not implementing appropriate compensatory measures.

The finding is greater than minor because it affected the mitigating systems cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. Using Appendix F, "Determining Potential Risk Significance of Fire Protection and Post-Fire Safe Shutdown Inspection Findings," of Manual Chapter 0609, "Significance Determination Process," the finding was determined to have very low safety significance because all remaining mitigating systems needed to respond to a loss of service water on either unit were available.

Inspection Report# : [2004003\(pdf\)](#)

G

**Significance:** Jun 23, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO ADEQUATELY ASSESS RISK DUE TO EXTERNAL CONDITIONS**

The inspectors identified a noncited violation of 10 CFR 50.65(a)(4) for the failure to perform adequate risk assessments on Units 1 and 2. The licensee failed to update a prior risk assessment due to changing external events (declaration of a tornado watch) that could have had an impact on the existing assessment (increased likelihood of grid instability). In addition, the licensee did not include the added external risk from fire and its impact on safe shutdown equipment in aggregate risk assessments for the plant. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program.

The inspectors determined that these issues are more than minor because, if left uncorrected, they would become a more significant safety concern in that future risk assessments could result in failures to properly manage increases in risk. Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the finding was determined to have very low safety significance because mitigating systems were available and it did not affect the likelihood of external initiating events.

Inspection Report# : [2004003\(pdf\)](#)

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**Significance:** Jun 23, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**UNTIMELY CORRECTIVE ACTIONS TO CLEAN DISCOLORED BORIC ACID DEPOSITS**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the failure to take timely corrective action to correct indications of material wastage on Unit 2 Containment Spray Pump B. Specifically, the licensee did not implement actions to remove discolored boric acid deposits from the containment spray pump for approximately 9 months. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. This issue involved problem identification and resolution cross-cutting aspects associated with the timely implementation of corrective actions for conditions adverse to quality.

The inspectors determined that this issue is more than minor because if left uncorrected it could become a more significant safety concern in that continued wastage of the pump could impact operability. Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the finding was determined to have very low safety significance because the actual wastage of the pump studs, nuts, and washers did not affect the safety function of the containment spray pump.

Inspection Report# : [2004003\(pdf\)](#)

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**Significance:** Jun 23, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO CORRECT INACCURATE HPSI AND LPSI VALVE POSITION INDICATIONS**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the failure to correct inaccurate main control room valve position indicators on the Unit 2 high and low pressure safety injection system motor-operated valves. The valve position indicators were not calibrated for approximately 8 years yet were relied upon for indication in station procedures, including the loss of shutdown cooling procedure. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. This issue involved problem identification and resolution cross-cutting aspects associated with operations personnel not identifying conditions adverse to quality.

The finding is greater than minor because it affected the mitigating systems cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. Using the Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," the finding was determined to have very low safety significance because the safety function of the valves was not affected and other indications were available to monitor system performance.

Inspection Report# : [2004003\(pdf\)](#)

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## **Barrier Integrity**

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Significance: Feb 11, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to promptly correct degraded containment isolation valves**

Green. The team identified a violation of 10 CFR 50, Appendix B, Criterion XVI (Corrective Actions) for the failure to take prompt corrective actions to address an inadequate containment isolation valve design. In 2000, the licensee identified that the containment isolation valves were not properly designed for their design basis application, in that the valves were designed for a maximum temperature of 200 F but could be exposed to a temperature of 300 F during a design basis accident. The valves were still in service at the time of the inspection. This issue had crosscutting aspects associated with problem prioritization.

The failure to take prompt corrective measures to address a condition adverse to quality was a performance deficiency. The inspectors determined that the issue had more than minor safety significance because it impacted the Barriers cornerstone objective and could have affected the ability of safety-related containment isolation valves to perform their design basis function. The finding was of very low risk significance because it was a design/qualification deficiency that did not result in a loss of function per Generic Letter 91-18, "Information to Licensees Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions," Revision 1.

Inspection Report# : [2005009\(pdf\)](#)

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## **Emergency Preparedness**

## **Occupational Radiation Safety**

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Significance: Mar 24, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO POST A RADIATION AREA**

On March 14, 2005, the inspectors identified a noncited violation of 10 CFR 20.1902 (a) because the licensee failed to post a radiation area. When downposting the Unit 2 Train B high pressure safety injection room, a licensee radiation protection technician removed the high radiation area posting and did not replace it with a radiation area posting. The licensee subsequently properly posted the room as a radiation area. This finding had human performance crosscutting aspects in the area of personnel that involved a radiological protection technician's inattention to detail.

The finding was greater than minor because it is associated with the occupational radiation safety cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material and affected the cornerstone attribute of program and process because the room was not posted as required due to personnel error. When processed through Appendix C, "Occupational Radiation Safety Significance Determination Process," of Manual Chapter 0609, "Significance Determination Process," the finding was determined to be of very low safety significance because it was not associated with as low as is reasonably achievable planning or work controls, there was no overexposure or a substantial potential for overexposure, and the ability to assess dose was not compromised

Inspection Report# : [2005002\(pdf\)](#)

**G****Significance:** Jun 23, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO CONTROL A HIGH RADIATION AREA**

The inspector identified an event in which the licensee failed to control a high radiation area in violation of Unit 2 Technical Specification 6.13.1 after workers received abnormal dosimeter readings on October 14, 2003. The licensee performed dose measurements and found an uncontrolled high radiation area in the Unit 2 sample cooler room. The licensee should have been alerted to the potential for a high radiation area in this room when reactor coolant system radioactivity levels increased and high radiation areas were identified in adjoining areas on October 12, 2003. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. The issue involved human performance cross-cutting aspects associated with the thoroughness of radiation surveys by radiation protection personnel.

The failure to control a high radiation area is a performance deficiency. This finding is greater than minor because it was associated with one of the cornerstone attributes and affected the cornerstone objective, in that, inadequate exposure controls of a high radiation area affected the licensee's ability to ensure adequate protection of worker health and safety from exposure to radiation. Because the finding involved the potential for workers to receive significant, unplanned, unintended dose as a result of conditions contrary to Technical Specification requirements, the inspector used the occupational radiation safety significance determination process described in Manual Chapter 0609, "Significance Determination Process," Appendix C, "Occupational Radiation Safety Significance Determination Process," to analyze the significance of the finding. The inspector determined that the finding was of very low safety significance because it did not involve (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose.

Inspection Report# : [2004003\(pdf\)](#)

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## Public Radiation Safety

**G****Significance:** Jun 23, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**IMPROPERLY INSTALLED REACTOR COOLANT SAMPLE SINK MODIFICATION**

A self revealing noncited violation of Unit 2 Technical Specification 6.8.1.a was reviewed for the failure to follow written procedures associated with the modification of the reactor coolant sample sink. Specifically, the licensee improperly connected the discharge of the reactor coolant sample sink into a secondary drain header which ultimately drained into the main condenser. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program.

This finding is more than minor because it was analogous to Example 3.a in Appendix E, "Examples of Minor Issues," of Manual Chapter 0612, "Power Reactor Inspection Reports," because the modification required rework to correctly address design concerns. Using Appendix D, "Public Radiation Safety Significance Determination Process," of Manual Chapter 0609, "Significance Determination Process," the finding was determined to have very low safety significance because the licensee was able to assess the amount and curie content of the reactor coolant introduced into the secondary plant and there was no dose impact to the public.

Inspection Report# : [2004003\(pdf\)](#)**G****Significance:** Jun 18, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**RADIOACTIVE SHIPMENT PACKAGE EXCEEDED 10 CFR 71.47 RADIATION LIMITS**

The team reviewed a self-revealing, non-cited violation of 10 CFR 71.47 resulting from the licensee's failure to correctly prepare a radioactive shipment so that dose rates did not exceed regulatory limits. Specifically, on March 24, 2003, the licensee was notified by a shipment recipient that the contact radiation dose rate of a package exceeded 200 millirem per hour. A contact radiation dose rate of 380 millirem per hour was identified on the bottom of the package. However, the accessible radiation levels to the public from underneath the flatbed trailer were only 70 millirem per hour. The finding was placed into the licensee's corrective action program.

The finding was greater than minor because it is associated with the Public Radiation Safety Cornerstone attribute of Program and Process and affected the associated cornerstone objective (to ensure adequate protection of public health and safety from exposure to radioactive materials). The finding had very low safety significance because: (1) it involved radioactive material control, (2) it was a transportation issue, (3) external radiation levels were exceeded, (4) dose rates in excess of regulatory limits were not accessible to the public, and (5) the radiation levels did not exceed two times the federal limits. This finding also had crosscutting aspects associated with human performance

Inspection Report# : [2004009\(pdf\)](#)

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## Physical Protection

[Physical Protection](#) information not publicly available.

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## Miscellaneous

**Significance:** N/A Feb 11, 2005

Identified By: NRC

Item Type: FIN Finding

### PIR Inspection

The team reviewed approximately 260 condition reports, apparent and root cause analyses, as well as supporting documents, to assess problem identification and resolution activities. In general, performance in most areas had improved when compared to the prior problem identification and resolution assessment. Notwithstanding the improvements, poor problem evaluations and untimely resolution of some issues continued to result in self-disclosing and NRC identified violations and findings. The licensee has specified remedies to curb these performance problems. Overall, the procedures and processes were generally effective; thresholds for identifying issues were low and, in most cases, corrective actions were adequate to address conditions adverse to quality.

Based on the interviews conducted, the team concluded that a positive safety conscience work environment exists at Arkansas Nuclear One, Units 1 and 2. The team determined that employees felt free to raise safety concerns to their supervision, the employee concerns program, and the NRC. The team received a few isolated comments regarding trust of site management, an increased work load caused by the corrective action process, and the perception for negative consequences for going to the NRC with safety issues. However, the interviewees all believed that potential safety issues were being addressed and there were no instances identified where individuals had experienced consequences for bringing safety issues to the NRC. The team determined that licensee management was aware of the perceptions and was taking action to address them.

Inspection Report# : [2005009\(pdf\)](#)

Last modified : June 17, 2005