

UNITED STATES NUCLEAR REGULATORY COMMISSION

REGION II SAM NUNN ATLANTA FEDERAL CENTER 61 FORSYTH STREET, SW, SUITE 23T85 ATLANTA, GEORGIA 30303-8931

September 7, 2007

Tennessee Valley Authority
ATTN: Mr. William R. Campbell
Chief Nuclear Officer and
Senior Vice President
6A Lookout Place
1101 Market Street
Chattanooga, TN 37402-2801

SUBJECT: SEQUOYAH NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION AND

RESOLUTION (PI&R) INSPECTION REPORT 05000327/2007008 AND

05000328/2007008

Dear Mr. Campbell:

On August 10, 2007, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Sequoyah Nuclear Plant, Units 1 and 2. The enclosed inspection report documents the inspection findings, which were discussed on August 10, 2007, with Mr. R. Douet and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, overall the team concluded that problems were being properly identified, documented, evaluated, and corrected. However the team identified several isolated examples where corrective actions did not appear appropriate, were not accurately documented, or were not completely carried out. The team observed that the quality of Problem Evaluation Report documentation has improved since the last NRC biennial PI&R inspection. The team did observe that there continues to be some lingering issues regarding extension of corrective actions due to resource limitations.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure 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 http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Tilda Y. Liu, Acting Chief Reactor Projects Branch 6 Division of Reactor Projects

Docket No.: 50-327, 50-328 License No.: DPR-77, DPR-79

Enclosure: Inspection Report 05000327/2007008 and 05000328/2007008

w/Attachment: Supplemental Information

cc w/encl: (See page 3)

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U. S. NUCLEAR REGULATORY COMMISSION REGION II

Docket Nos: 50-327, 50-328

License Nos: DPR-77, DPR-79

Report No: 05000327/2007008 and 05000328/2007008

Licensee: Tennessee Valley Authority (TVA)

Facility: Sequoyah Nuclear Plant

Location: Sequoyah Access Road

Soddy-Daisy, TN 37379

Dates: July 23, 2007 - August 10, 2007

Inspectors: J. Baptist, Team Leader

S. Freeman, Senior Resident Inspector

W. Fowler, Reactor Inspector

A. Richardson, Physical Security Inspector

Approved by: T. Liu, Acting Chief

Reactor Projects Branch 6 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000327/2007008, IR 05000328/2007008; 07/23/2007 - 08/10/2007; Sequoyah Nuclear Plant, Units 1 & 2; Problem Identification and Resolution.

The inspection was conducted by one Region II senior project engineer, a senior resident inspector, one Region II reactor inspector, and a Region II physical security inspector. No findings were identified during this inspection.

Identification and Resolution of Problems

The team determined that the licensee was identifying plant deficiencies at an appropriately low level and effectively entering them into their corrective action program. The team also determined that the licensee was prioritizing and evaluating issues properly. The team identified several isolated examples where corrective actions did not appear appropriate, were not accurately documented, or were not completely carried out. Overall, the team found the effectiveness of corrective actions to be acceptable. The team observed that the quality of Problem Evaluation Report (PER) documentation has improved since the last NRC biennial PI&R inspection, but further improvements could be made. There continue to be multiple extensions for corrective actions with resources identified as the most significant contributing cause. The team concluded, however, that the licensee was generally providing an effective corrective action program.

The inspection team identified that the last NRC Sequoyah PI&R inspection report 50-327,328/2005009, issued 09/09/05 identified lingering technical problems with the Electronic Corrective Action Program (eCAP) electronic document management program. A review of the technical interface between personnel and the eCAP program identified that personnel were comfortable with the software and it's functionality in creating and processing PERs.

On the basis of interviews conducted during this inspection, the inspectors determined that workers at the site felt free to put safety concerns into the corrective action program. The inspectors concluded that the Employee Concerns Resolution program was functioning acceptably but the inspectors observed that there was a work backlog.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

a. Assessment of the Corrective Action Program

(1) Inspection Scope

The inspectors reviewed items selected across the seven NRC cornerstones of safety to determine if problems were being properly identified, characterized, and entered into the corrective action program (CAP) for timely and complete evaluation and resolution. The inspectors reviewed in detail the licensee's CAP procedure, SPP-3.1, "Corrective Action Program," Revision (Rev.) 12, which described the process for documenting and resolving issues via problem evaluation reports (PERs). The licensee's CAP procedure defined four priority action categories for significance screening of their PERs. These categories include Level A for significant adverse conditions, Level B for adverse conditions of substantial severity potentially warranting corrective action, Level C for conditions adverse to quality where documentation of corrective actions is required, and Level D for conditions that are not adverse to quality and do not warrant correcting, but rather, can be enhanced, improved, or made more efficient. The team reviewed items selected across the span of plant activities to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. Specifically, the inspectors selected and reviewed approximately 340 PERs initiated by the licensee from July 2005, to July 2007. When necessary, the inspectors' reviews included PERs older than July 2005 that were referenced by the original PER sample set. The team examined PERs and work orders (WOs) associated with the Auxiliary Feedwater System, Emergency Raw Cooling Water System, and the Component Cooling Water System. The team reviewed PERs associated with Operations, Maintenance, Engineering, Radiological Protection, Chemistry, Security and Emergency Preparedness events, problems, and deficiencies. The team reviewed operating experience resolution documents, and Employee Concerns Resolution activities. The team also reviewed licensee corrective action trend reports, PER effectiveness reviews, as well as Nuclear Assurance department audits and surveillances from the review period. The team evaluated these items to determine the licensee's threshold for identifying problems.

The inspectors conducted walkdowns of components associated with the Auxiliary Feedwater System, Emergency Raw Cooling Water System, and the Component Cooling Water System to verify that problems had been properly identified and characterized in the CAP. System performance was reviewed by discussion with system engineers and by review of work requests (WRs) and completed maintenance work orders (WOs), maintenance rule data, and system health reports to verify that equipment deficiencies were being appropriately entered into the CAP. Control room operator logs were reviewed to verify that PERs were initiated for deficiencies described in the logs when appropriate. In addition, the inspectors attended plant morning status meetings and CAP initial review meetings to observe management oversight in the corrective action process. The inspectors reviewed licensee audits and self-assessments (focusing primarily on problem identification and resolution) to verify that findings were

entered into the CAP and to verify that these findings were consistent with the NRC's assessment of the licensee's CAP.

Documents reviewed are listed in the Attachment.

(2) Assessment

Identification of Issues.

The team determined that the licensee was effective at identifying problems at an appropriately low threshold and entering them into the corrective action program. Only in review of PER 94993, written January 7, 2006 to document repetitive High Pressure Steam Supply controller component failure, was there evidence that a PER was never initiated to examine the cause of the repeat event. At the time of the close of the inspection, the licensee had already addressed this issue and entered the issue into the corrective action program as PER 128545.

The inspectors observed that the licensee had implemented a process for initiating an anonymous PER. Paper copies of PERs are available throughout the plant and have various drop-boxes for depositing the concerns. This is referenced in the last NRC Sequoyah PI&R inspection report 50-327,328/2005009, issued 09/09/05 and was verified to be functional through inspection of the anonymous PER database and interviews with site personnel.

Prioritization and Evaluation of Issues.

The team determined that PER level classifications were consistent with established procedures and that licensee audits and self-assessments generally confirmed that conclusion. The team further determined that operability, reportability, degraded or non-conforming condition determinations and cause evaluations were also consistent with SPP-3.1. However, the team did identify one evaluation and two classification deficiencies that were entered into the corrective action program by the licensee at the close of the inspection.

On November 27, 2004, operations identified elevated RHR discharge pressures during an RCS leak search. Subsequently, PER 72764 was then generated to address the cause and affects on operability. The Functional Evaluation (FE) to determine RHR operability did not address potential affects on elevated RHR system suction side pressures in the event the RHR pumps are started and maintained on min-flow. After operating on min-flow the RHR discharge piping pressures will then equalize with pressures in the suction piping. Equalizing pressure in the suction piping could then impact the ability of the containment sump valves to open in order to enter recirculation. During the inspection further evaluations were performed and verified the suction piping would have equalized at 275 psi, which is below the 305 psid maximum opening pressure that the double-disk containment sump gate valves can operate under. At the time of the completion of this inspection, the licensee had entered the issue into the corrective action program as PER 128560.

• PERs 88634, "Fitting Omitted from Design Documentation for EDG Pressure Control Valve Modification" and 88773, "Expert Panel not Properly Notified When 480V Auxiliary Board Room A/C Train B Exceeded Maintenance Rule Functional Failure Criteria" were identified to have been improperly classified as "D" level PERs when they met the licensee's criteria for issue classification of "C" level PERs. At the time of the completion of this inspection, the licensee had entered the issue into the corrective action program as PER 128216.

The inspectors observed that there had been many time extensions granted on PER actions in the past. The licensee has recently recognized this data, as well, and plans to revise procedures to require an escalating level of approval for successive corrective action extensions.

Effectiveness of Corrective Actions.

Based on a review of numerous corrective action plans and their implementation, the team found, for the most part, that the licensee's corrective actions were effective. Effectiveness reviews and audits were generally of good depth and correctly identified issues similar to those raised during previous NRC inspections. However, the team did identify several corrective action deficiencies.

- During a review of a May 2007 security event identified in PER 124559, the inspectors noted that an issue related to Safeguards Information, was not effectively dispositioned. The license identified Safeguards Information in a non-Safeguards document and performed actions to remove the Safeguards Information but did not ensure all actions were taken to expunge the information from other potential sources. Based on a subsequent review of this issue by the licensee, PER 128744 was issued to document the issue and corrective actions were taken. This ineffective review is considered a weakness in the area of problem resolution, however, additional inspection is needed. Pending completion of additional inspection, this issue will be identified as URI 05000327, 328/2007008-01, Safeguards Information.
- On July 13, 2006, PER 104944 was created to address testing of eight GL 89-10 MOVs prior to the 120 day deadline requirement for issuance of the trend report after the U1C13 outage. Subsequently, not all MOVs were tested prior to the 120 day deadline. However, procedural guidance has been revised by requiring testing of all valves prior to issuance of the trend report rather than being an expectation.
- On April 26, 2007, the Main Control Room (MCR) weather radio did not perform its function of informing the MCR staff of a tornado watch in the local area. This failure prevented the MCR staff from initiating actions to mitigate the potential damage should a tornado strike the site. This issue was previously identified in PER 99140 on March, 14, 2006 which was closed to Work Order (WO) 06-773314 without any further actions taken. At the time of the completion of this inspection, the licensee had purchased a new MCR radio and entered the issue into the corrective action program as PER 128060.

- On April 23, 2006, PER 101573 was written identifying the 1B-B Emergency Diesel Generator (EDG) 1B2 engine Woodward governor speed droop setting found out of position. The governor speed droop setting stayed in such a configuration for approximately three months without correction. A functional evaluation was performed verifying that the 1B-B EDG remained operable but numerous monthly maintenance test procedures were performed with the setting in a position contrary to that identified in the surveillance procedure. The team determined that actions to immediately disposition the PER were not adequate addressed in a timely manner.
- On July 17, 2006, PER 106937 was written to evaluate measures that would prevent the potential for releasing Tritium from the Reactor Water Storage Tank (RWST) moat in times of heavy rainfall. Actions were taken, however, on July 11, 2007 and July 28, 2007 the RWST moat was allowed to overflow. The team concluded that the corrective actions to prevent such occurrences were inadequate even though radiological limits were not exceeded. At the time of the completion of this inspection, the licensee had devised a new process to attempt to prevent such occurrences.
- On February 23, 2006 PER 97828 was written to identify Abnormal Operating Problems in Radiological Emergency Preparedness Drill. The problem description section of the PER asked for a training needs evaluation after changes were made to the procedure, however, there were no actions specified in the PER to accomplish this activity. The team concluded that the licensee did not comply with prescribed closeout provisions of licensee procedure SPP-3.1, Corrective Action Program. At the time of the completion of this inspection, the licensee had entered the issue into the corrective action program as PER 127938 with plans to complete the training needs analysis as previously mentioned.
- On August 25, 2005, PER 88252 was written to document the storage of items in front of an Emergency Operating Instruction (EOI)/ Abnormal Operating Procedure (AOP) gang box. The items maintained in the gang box provide a means to mitigate a loss of the safety related service water to the plants coolant charging pumps. This was a repeat occurrence from July 9, 2005 when PER 85589 was written for a similar occurrence. The actions taken to disposition PER 88252 were adequate in preventing future occurrences of the same event, however a PER was never written questioning why the adequacy of PER 85589 was not successful in preventing recurrence. At the time of the completion of this inspection, the licensee had entered the issue into the corrective action program as PER 128058.

The inspectors did not identify any more than minor equipment performance issues from the above described deficiencies.

b. Assessment of the Use of Operating Experience

(1) Inspection Scope

The inspectors examined licensee programs for reviewing industry operating experience, reviewed the licensee's operating experience database, and interviewed personnel, to assess the effectiveness of how external and internal operating experience data was handled at the plant. In addition, the inspectors selected thirteen operating experience notification documents (NRC generic communications, 10 CFR Part 21 reports, licensee event reports, vendor notifications, and TVA plant internal operating experience items, etc.), which had been issued since April 2005, to verify whether the licensee had appropriately evaluated each notification for applicability to the Sequoyah plant. Documents reviewed are listed in the Attachment.

(2) Assessment

The team determined that the licensee was effective in screening operating experience for applicability to the plant. The inspectors verified that the licensee had entered those items determined to be applicable into the CAP and taken adequate corrective actions to address the issues. External and Internal operating experience was adequately utilized and considered as part of formal root cause evaluations for supporting the development of lessons learned and corrective actions for CAP issues.

c. Assessment of Self-Assessments and Audits

(1) <u>Inspection Scope</u>

The inspectors reviewed CAP trend reports, CAP backlogs, PER trend reports, department self-assessments, and Nuclear Assessment Section audits to verify that the licensee appropriately prioritized and evaluated problems with the CAP in accordance with their risk significance. The inspectors compared the NRC's CAP assessment results against the licensee's assessment of the CAP effectiveness.

(2) Assessment

The team determined that the scope of self-assessments and audits were adequate. Department self-assessments and Nuclear Assessment Section audits were generally self-critical and effective in identifying issues that were entered in the CAP for resolution. Corrective actions developed as a result of these assessments and audits were generally effective. The team noted that these audits and assessments identified issues similar to those identified by the NRC.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

The team reviewed numerous audits, assessments, PERs, WOs, and other corrective action documents and held discussions with numerous personnel at various levels in the organization to assess if a work environment existed that was conducive to the

identification of nuclear safety issues. Inspectors also examined the licensee's employee Concerns Resolution Program records and discussed the program with the implementer to determine if issues affecting nuclear safety were being appropriately addressed.

(2) Assessment

The team determined that workers at the site felt free to raise safety concerns. Personnel stated that they do not hesitate to raise nuclear safety issues to their management without fear of retaliation by their management. The wide spectrum of PER documented issues supported this conclusion. The team had no indication during this inspection of individuals being inhibited from identifying problems using the corrective action process.

Inspectors concluded that the Concerns Resolution Program was functioning acceptably, but that there was a backlog of work to be done in the program. There were no technical safety issues identified that were lingering without attention in the program.

The inspectors reviewed the last three Nuclear Assurance (NA) assessments of the CAP program performance. The management organization is appropriately responding to NA by initiating PERs and taking corrective actions.

4OA6 Meetings

Exit Meeting Summary

On August 10, 2007, the inspectors presented the inspection results to Mr. R. Douet and other members of his staff, who acknowledged the findings. The inspectors asked the licensee whether any of the material examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

PARTIAL LIST OF PERSONS CONTACTED

Licensee personnel:

- P. Asendorf, Manager, Nuclear Security
- R. Reynolds, Security Manager
- J. Wilcox, Vice President Pinkerton Government Services
- C. Sneed, Security Coordinator
- K. Rao, AFW System Engineer
- T. Noe, NSSS Engineering Supervisor
- F. Little, Support Supervisor
- M. Williams, Facilities Manager
- S. Fraiser, System Engineer
- D. Clift, Site Support Manager
- D. Dotson, CCS System Engineer
- J. Walker, Chiller System Engineer
- R. Callergari, Mechanical Design Engineer
- K. Wilkes, Emergency Preparedness Manager
- K. Perkins, Operations Support Superintendent
- B. McCreary, Employee Concerns Specialist
- K. Jones, Engineering Manager
- B. Knitter, EDG System Engineer

NRC personnel:

None.

- S. Freeman, Sequoyah Senior Resident Inspector
- M. Speck, Sequoyah Resident Inspector
- S. Vias, Branch Chief, PI&R

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED						
<u>Opened</u>						
05000327, 328/2007008-01	URI	Safeguards Information				
Opened and Closed						
None.						
Closed						
None.						
Discussed						

LIST OF DOCUMENTS REVIEWED

PERs Initiated as a Result of this Inspection

- 126565, Corrective Action Program Improvement Opportunities
- 127938, Corrective Action Program failed to address training aspects of PER
- 128055, Inadequate PER corrective action
- 128058, Inadequate PER corrective action plan
- 128062, NRC questions on PER 99140
- 128216, Improperly classified Engineering PERs
- 128235, PER classification guidance
- 128545, NRC PI&R item 11
- 128560, Inadequate Functional Evaluation
- 128673, Safeguards Information
- 128675, Procedure deficiency in OPS PI
- 128683, ERCW Strainers
- 128773, Evaluation of performance deficiencies
- 128774, Closing PER actions to work orders

Selected Problem Evaluation Reports (PERs)

- 78364, Manual operations for App B fire
- 82765, 125v VBB ground
- 85589, EOI/AOP Equipment
- 87768, Analysis of repeat LCO entries due to weather related MET Tower failures
- 87777, Improve PORC
- 87796, Cooling Tower Blowdown
- 87899, Loss of accident monitoring system
- 87934, SPP 10.0 Site specific revision
- 87970, Repeat Maintenance
- 87987, Unplanned LCO action entry 2-FI-3-147
- 88070, Repeat unplanned LCO action entry
- 88252, EOI/AOP Gang box
- 88320, Appendix R AOP-N.08 times not met during drill
- 88323, Different Cold Shutdown Requirements
- 88457, Containment Spray
- 88538, Missed compensatory fire watches
- 88546, Containment Spray Heat Exchanger ERCW Valve Cycling
- 88546, CS Htx ERCW vlv cycling
- 88624, SAFETY HAZARD in the U-2 Lower Containment ACC. #4
- 88634, Fitting Omitted from Design Documentation for EDG Pressure Control Valve Modification
- 88728, During the initial startup on 1A Diesel generator
- 88760, Work hour tracking system violation
- 88773, Expert Panel not Properly Notified When 480V Auxiliary Board Room A/C Train B

Exceeded Maintenance Rule Functional Failure Criteria

- 88818, Lighting WOs affecting safety
- 88839, Woodward governor settings
- 88845, This PER is initiated to address generic review of Browns Ferry
- 88981, Procedure performance errors
- 89082, Cross-reference of PERs and Wos
- 89312, 1C CCW Strainer Bypass Valve
- 89315, Eagle rack card failure and LCO action entry
- 89434, Bowled Fuel Equipment RCFA
- 89508, RPI deviation
- 89667, Tracking of control room deficiencies
- 89727, RPIs nearing TS deviation limits during power reduction
- 89746. Late corrective action
- 90200, Fire pump operability miscommunication
- 90264, Procedure performance error
- 90289, Installation of improper gauge for troubleshooting
- 90293, Procedure compliance
- 90562, ERCW B-B Forebay Inspection
- 90565, Aux. FWP Motor 2AA outboard oil viscosity
- 90604, D/G 1B-B Woodward governor dial speed settings do not match procedure
- 90889, Human performance issues
- 91096, 0-PI-OPS-027-431.0
- 91236, Annual Force of Force drills
- 91275, RCP seal integrity Appendix R requirements
- 91295, Improper Procedure Compliance Results in Inoperable ECCS Equipment
- 91295, Improper procedure compliance results in unplanned inoperable ECCS equipment
- 91382, Lower Compartment Cooler Temperature Controller Locked Up
- 91383, Validation of AOP-N.08 Appendix R fire safe shutdown
- 91429, Throttle valve misposition
- 91473, Rad Monitor 0-90-134 Declared Inoperable on Low Flow
- 91491, 171-MAI-B.2 NRSB item
- 91899, NRC Identified Lighting Issue
- 92021, Manhole #33
- 92056, Oil Containment Project
- 92192, RHR 1A sample lines
- 92217, Channeling barrier issue
- 92359, NPDES self-assessment SQN-ENV-06-001
- 92361, O-ring sealing
- 92433, COG report identified issue- Admin processes
- 92485, "A" HUT collapsed due to apparent lack of adequate vent path.
- 92538, A small tear was noted in the Containment Recirc Sump Screen
- 92581. Severe weather warning radio inoperable
- 92643, During the 11/14/05 performance of 0-SI-EBT-250-100.1
- 92664, NRC identified deficiencies in AOP-C.04
- 92767, Appendix R scenario control building fire resulting in spurious SI
- 92781, During certain milling operation
- 92930. Unacceptable linear indications were found
- 93072, S/A SQN-OPS-05-006 Reactivity events

- 93120, LEFM
- 93201, Late corrective action plans
- 93347, CCP casing vents
- 93354, CTLP bearing lube water valve misposition
- 93408, Increasing tend of unplanned LCOs
- 93483, There has been an increasing trend of sodium in the 1A2 DG Engine
- 93598. Clearance hold order lifted improperly
- 93648, During the root cause investigation of HUT tank 'A'
- 94038, ERCW Header valves on elevation 669
- 94116, Flood mode discrepancies
- 94166, Aux Charging pump test deficiencies not adequately addressed
- 94381, During the post maintenance testing of the A Shutdown Board
- 94422, Chiller Oil Cooler TCV
- 94479, Preventative maintenance procedure
- 94714, No clearance on AHU with belts removed
- 94874, During a QC inspection of support 1-PSP-63-5416
- 94933, Failure of 2-PCV-47-183
- 94948, PER 27268 was initiated to address degradation
- 95000, Unplanned Entry into LCO Lower Compartment Cooler Temperature Control Valve Position Indication
- 95007, Component mispositioning
- 95086, On 07/17/2005 MSB initiated a potential trend PER 86076
- 95088, After the necessary repairs were made
- 95320, During the performance of 2-SI-IFT-099-90.8B
- 95328, SPP 10.3 CV
- 95391, Unit 2 forced shutdown due to 2B Main Bank Transformer gassing
- 95421, At the entrance of the CCW Pumping station
- 95459, Clearance 2-57-333-F/O error
- 95529, Equipment deficiency was not indicated on MCR panel
- 95589, AUO round quality
- 95595, Ability to terminate ECCS prior to pressurizer solid
- 95602, Beaver Valley identified a potential Appendix R fire scenario
- 95624, Dry cask storage multi-purpose canister lid for MPC-0011
- 95629, Inadequate clearance
- 95632, Reactivity Mgmt. review board minutes
- 95809, A gas analysis taken from the Main Bank Transformer 2A
- 95830, ILT suspension not documented in the CAP
- 96027, Conflicting requirements on number of SCBA-qualified AUOs
- 96470, Clearance Trend PER
- 96707, Need to evaluate level of use of FHIs
- 96885, Quarterly review identified adverse trend in admin process compliance
- 96893, Admin process weakness
- 96987, 1A Thermal Barrier Booster Pump degradation
- 96987, The AB AUO identified that there has been a recurring condition
- 96994, During the preventative maintenance calibration
- 97047. U1 RCS Nickel concentration exceeded action limit
- 97293. The INPO assist visit on rigging identified many examples

- 97397, During performance of WO 05-781372-002
- 97415, NSRB Management attention item
- 97417, NSRB Management attention item MAI #2
- 97472, Twenty-Five PERs or WOs have been written on delay gates
- 97488, UT of weld removal areas
- 97642. 2-VLV-84-504 failed one of two acceptance criteria
- 97837, Security Problems in Red Team REP Drill
- 97995, During review of level C apparent cause PERs
- 98061, Entry into AOP M.03
- 98110, Change out of lock cores
- 98212, Inconsistency Between FE and Associated Procedure Revision
- 98399, During a review of critical crack exclusion documentation
- 98572, In the past two years, at least a dozen closed work orders
- 99057, On 3/11/06 the U1 RCS nickel concentration increased
- 99087, During shop fabrication activities for DCN D21955
- 99140. Weather radio
- 99184, Elevated dose rates were identified in the Unit 1 Raceway
- 99396, Contamination of Explosive Detectors
- 99451, Benchmarking trips (Self assessment SQN-OPS-06-001)
- 99453, Self assessments frequently canceled (Self assessment SQN-OPS-06-001)
- 99455, Self assessment improvement awareness
- 99755, Unit 2 Generator Trip
- 99821, Unit 1 VCT divert valve
- 99878, Inappropriate PER action closure
- 100314, Unplanned LCO entry
- 100377, During QC inspection of pipe supports installed for TACF
- 100476, Midcycle findings on ODMI
- 100700, IM, TLD 1565, exited U-1 Annulus elevation 721'
- 100770, Individual (Inst. Maint., TLD #281890) received a Dose Rate alarm
- 100856, During removal of the CRDM platform seismic ties
- 100965, INPO SER 4-04 Not Fully Reviewed
- 100997, A spare 15 HK breaker was receipt inspection
- 101021, Just prior to head removal the cavity ladder extension is removed
- 101219. Valve stem for reactor head vent valve 1-FSV-068-0396
- 101294, Debris was identified
- 101556. During sleeve sealing activities in Accumulator Room #4
- 101573, Speed droop setting 1B-B D/G
- 101627, Breaker 204 and 205 on Vital Battery Board II
- 101657, Multiple remote shutdown transfer switch failures in 1-PI-OPS-000-010.D
- 101657. There have been multiple failures
- 101742, Failure to stroke of 1-FCV-63-72
- 101917, Minor maintenance work PMT
- 102424, During removal of the sump cover in the Terry Turbine Pump
- 102513, During the performance of WO # 05-778412-002
- 102591, RVLIS spoolpiece installed during draindown
- 102845, During initial pressurization of the Reactor Cooling System
- 102930, Steam header pressurization from steam seal header

- 103178, Rod speed indicator malfunction
- 103226, NRC Questions for PER 81622
- 103342, Motor Driven Auxiliary Feedwater Pump 1B-B
- 103342, PMT non-performance of 1-PI-EFT-003-128.1
- 103437, Control rod withdrawal without rod speed indicating 48 steps/min
- 103616, Reactivity management concern
- 103709, RPI F-2 failure
- 104029, Clearance backlog
- 104032, CCP and RHR room cooler TCV strokes
- 104344, Unplanned LCO entry
- 104392, Unplanned LCO entry
- 104669, The tritium concentration in Well-31
- 104933, Currently three through wall fire protection piping leaks exist
- 104944, Historically non-outage testing of GL 89-10 MOVs
- 104953, XE-133 result from U1 RCS sample collected
- 105035, For the past several months there has been an increasing dissolved
- 105267, This PER is to document the PM backlog of PMs in grace
- 105356, Generic review of BFN audit issue insufficient questioning by senior licensed operators
- 105611, PER 68218 effectiveness review
- 105764, During operator rounds no level indication could be determined
- 105801, On 6/23/06 U2 RCS lithium
- 105818, OPS coach of the day manipulated valve
- 106197, During recent MIG surveillance activities of 0-RM-90-101
- 106218, Reactivity management evaluations
- 106220, Missle cover holddown bolts
- 106366, Software used for calculating off-site dose in plant effluents
- 106419. The fan bearing for 6.9 kV AHU 1A
- 106473, 1-FCV-63-71 unplanned LCO entry
- 106582, D/G Engine 1B2 Woodward Governor dial setting
- 106677, During performance of PM #018160000
- 106739, Procedure adherence 1BB DG SI-7 B
- 106874, Adverse effects of Electrical Test Bench on 125V vital battery board II
- 106937, Tritium in unit 1 and 3 RWST moat
- 107427, Monthly report indicates weakness in intolerance of degraded equipment
- 107493, Non-functional aux. air hdr isol vlv
- 107611, Pressurizer heater capacity test/reactivity management
- 107646, Failure to log and generate PER
- 107698, Operator compensatory actions
- 108239, Conduct of Ops assessment identified for schedule preparation and adherence
- 108309, Valve Misalignment
- 108768, Reactivity control
- 109457, During maintenance to remove suspected blockage
- 109541, Breaker program inadequacy
- 109847, During the performance of WO 06-776146-000
- 110046, 0-PI-SXV-082-202.B procedure errors
- 110109, 2B Containment Spray Pump Blocking Device
- 110109, 2B CSP Room Cooler blocking device

- 110145, CCS Availability for Appendix R Fires
- 110493, Hexavalent Chromium issues not addressed in Safety Procedure 915
- 110567, Old tagging requests
- 110653, Inadequate clearance boundary
- 111770, Barton Transmitter NRC IN 2006-14 SI
- 112711, A calibration was not attempted on Unit-2 containment sump level
- 112989. The breaker supplying power to the ERCW chemical
- 113796, RHR Procedure
- 114018, Preferred inverter 2
- 114160, TRB overturns OPS crew failure to meet a WOG critical task
- 114455, Untimely corrective action for PER 91383
- 115490, Inability to comply with App. R operator action time limit
- 115534, RCS Leak
- 115651, Safety Issues
- 115880, U2 upper cavity drain down started prior to completion
- 115927, While leveling the top surface of the exiting concrete curb
- 116116, Time critical manually operated valves PMT
- 116195, The breaker feeding the centrifugal charging pump
- 116231, On 12/02/06, reactor cavity leakage from the vortex top hat
- 116421, Anonymous-Card-reader and Balance Magnetic Switch
- 116426, Anonymous-P3 Door
- 116535, Scaffolding erected as interim action with no permanent fix
- 116536, During the performance of 2-PI-ICC-085-050.0
- 116537, eWorkplace failure
- 116720, During sense line slope inspection
- 116822, Improper monitoring of confined space entry
- 116874, Damaged threads on Unit 2 RPV stud number 30 were discovered
- 117590, Intolerance for Eqpt. Deficiencies indicators not meeting goals
- 117738, Medical examiners guide revisions
- 118060, Concerned employee comments on U2C14 fuel movement
- 118229, FME controls
- 118278, Appendix R problem with AOP-C.04
- 118286, Concerned individual exit interview
- 118339, U2 RWST sample 1/18/07 had a boron concentration of 2541
- 118464, Reactor trip resulting from failed air supply line
- 118475, Manual reactor trip expectations
- 118699, 2A bus duct cooler
- 118792, Testing on reach rod valves used during SBO event
- 118895, Anonymous-Comfortable uniforms
- 118998, Anonymous-Security dress
- 119026, PMT not formally documented on App R valve
- 119351, Anonymous-Suggestion process
- 119353, Anonymous-Pinkerton training
- 119354, Anonymous-Response gear
- 119663, The processing and implementation of Technical Specification
- 120294. An oil sample taken February 8, 2007
- 120654, Inadequate screening review on AOP revision

- 120946, HUT transfer to Fuel Transfer Canal
- 121173, Manhole 33 bolt requirements
- 121255, Anonymous-Security misconduct
- 121390, Anonymous-Motor patrols schedules
- 121391, Anonymous-Access portal issues
- 121395, Anonymous-Labor issues
- 121514, WOs 06-773656-000 and 06-773659-000 to clean and lube 1A-A
- 121526, Unit 2 manual reactor trip
- 121540, 91-18 PER was closed
- 121687, PMs are being deferred without being escalated
- 121872, Inadequate documentation of existing LCO action
- 121902, Anonymous-Anonymous PER's
- 122104, D-4 RPI fluctuating
- 122519, On 3/29/07 it was noted by an NRC inspector
- 122680, Anonymous-Searches at vehicle gate
- 122681, Anonymous-Weapons accountability
- 122683, Anonymous-Public address system
- 122818, The 1A-A Thermal Barrier Booster Pump discharge check valve
- 122849, Crane inspection
- 122893, Unapproved chemical stored on site
- 123080, Security escort
- 123349, WO 07-771087-000 identified a leaking unloader valve
- 123363, Anonymous-Service contract act in security
- 123372, 0-TC-313-364's mounting bolts are loose
- 123583, Evaluate need for strainer to protect TDAFW bearing cooling water orifice
- 123730, Anonymous-Feedback on anonymous PERs
- 124102, R-A ERCW Pump relief valve
- 124507, LEFM MWT change
- 124559, Safeguards Information
- 124581, The American Nuclear Insurers (ANI) inspection report
- 124666, Anonymous-Training for security officers
- 124686, Sequoyah: Contrary to the requirements of BP-250
- 125022, Adverse trend noted in the clearance program
- 125023, Operations fundamentals performance and effective use of indicators
- 125025, Evaluate the accuracy of the Operations dept indicators
- 125150, Anonymous-Security training schedule time frame
- 125151, Anonymous-Motor Patrols
- 125152, Anonymous-Security qualification training
- 125205, SQN has had seven non-outage recordable injuries
- 125301, Anonymous-100-yard run in security
- 125304, Anonymous-Shift briefings/turnover PGS policy 04-302
- 125451, Anonymous-:Line of sight at post 18
- 125492, Generic review of BFN PER 122729
- 125572, Anonymous-Unauthorized personnel on post
- 125573, Anonymous-Safety hazards at security post
- 125641. Extent Evaluation for Degraded Conditions
- 125642, Risk Management Comments by NSRB

- 125643, NSRB Recommendation Number 3
- 125644, Pre-Job Briefs, NSRB Recommendation 4
- 125645, On Line Tubing Repair
- 125776, Temporary gages for TDAFW not in calibration program
- 125999, PER is to document a performance gap for Chemistry
- 126035, U-2 demand step counter failure
- 126086, Garbage bins at loading dock
- 126146, 1-FSV-43-55 will not open
- 126313, S3/S4 examination
- 126401, In-complete paperwork
- 126423, This PER is to address the Generic Review request of BFN
- 126515, Failure of LEFM transducers
- 126523, Unit 1 B train annunciator not resetting
- 126543, 2-FM-3-147D-B failed
- 126553, Ion Track Model 85 Explosive Detector
- 126734. TDAFW Exhaust fan
- 126785, SQN's chemistry and corrosion control program
- 126821, Anonymous-Supervisor conduct allegation
- 126853, Crew SRO staffing not consistent with FPDP-4
- 126928, Erroneous temperature utilized in TDAFW pump room HVAC calculations
- 127048, Search procedures
- 127101, Security UPS battery procedures problems
- 127126, Anonymous-Pinkerton compensation
- 127353, Annual report entry
- 127610, EPIP data without MET available
- 127639, Anonymous-Security towers
- 127658, Incorrect paperwork
- 127659, Officers carrying hammocks/cots/mats
- 127842, Security officers discipline for incorrect paperwork
- 127843, Anonymous-Smoking in TVA vehicles
- 127979, Anonymous-Pinkerton issue of discipline
- 127991, Anonymous-Pinkerton management
- 127992, Anonymous-Flag etiquette
- 128123, RWST moat spill
- 128345, SQN063 Safety Injection

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- Nuclear Assurance Engineering Functional Area Audit NO. SQA0603
- Nuclear Assurance TVAN-Wide-Audit Report NO. SSA0304
- Nuclear Assurance TVAN-Wide-Audit Report NO. SSA0407
- Nuclear Assurance TVAN-Wide-Audit Report NO. SSA0503
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PER 111740, Changes in diesel fuel oil to meet EPA requirements, 9/28/2006

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NEDP-22, "Functional Evaluations", Rev. 4

MMDP-1, Maintenance Management System, Rev. 10

NADP-1, Conduct of Quality Assessment and Inspection, Rev. 13

NADP-2, Audits, Rev.20

NADP-3, Managing the Operating Experience Program, Rev. 7

NEDP-12, System Component Health, Equipment failure Trending, Rev. 8

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SPP-1.6, TVAN Self-Assessment Program, Rev. 13

SPP-3.1, Corrective Action Program, Rev. 12

SPP-6.1 Work Order Process Initiation, Rev. 4

SPP-6.6 Maintenance Rule Performance Indicator Monitoring, Trending, and

Reporting - 10 CFR 50.65, Rev. 9

SPP-7.0 Work Management, Rev. 1

SPP-7.1, On Line Work Management, Rev. 9

SPP-9.7, Corrosion Control Program, Rev. 14

BP 250 Corrective Action Program Handbook, Rev. 12

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0-PI-OPS-000-027.0, Shift Manager Clerk Duty Station Shift Relief and Office Round Sheets, Revision 26

Walkdown Sheet – System 030/Chillers, "Auxiliary Building: 6.9 kV Shutdown Board Room and 480 V Board Room Chillers (Both Trains) – Frequency: Bi Monthly

TACF 1-05-002-063, RHR Continuous Vent, Rev. 1

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EPRI Report 1013420, Pressurized Water Reactor Primary Water Zinc Application Guidelines, Dec. 2006

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