Sequoyah 2
4Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 25, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Comply with TS 3.3.1 to Trip RPS Bistables
The inspectors identified a non-cited violation (NCV) for a failure to comply with Technical Specification 3.3.1. when a Loop Control Processor (LCP) failed in Unit 2. The processor failure caused one channel of the reactor protection system to be inoperable and that required the channel to be placed in trip within 6 hours. Because of a licensee position that the processor failure placed all channel bistables in the correct position, operators took no action to trip the channel until approximately 9½ hours after the failure, when preparing to replace the failed processor.

This finding was more than minor because it affected the configuration control attribute of the mitigating systems cornerstone in that it reduced the reliability of the required number of operable channels required by the reactor protection system. Had actual plant conditions called for a trip, not taking deliberate operator action to place the inoperable channels in a tripped condition would reduce the likelihood of proper coincident protection system actuation. This finding is of very low safety significance because there was no loss of safety function and the bistables were actually in the tripped condition.
Inspection Report# : 2004004*(pdf)*

Significance: G Jun 26, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Comply with Configuration Control Procedures
The inspectors identified a non-cited violation of Technical Specification (TS) 6.8.1 for a self-revealing failure to comply with status control procedures. While attempting to get information to set a limit switch on Electric Board Room Chiller A, maintenance personnel removed the slide valve position indicator cover on Electric Board Room Chiller B. When replacing it, the cover contacted the control power circuits and caused a short circuit that tripped the B Chiller. In removing the cover, maintenance personnel had not obtained prior approval from operations, nor did they have work documents that authorized the actions.

This finding is more than minor because it affected the availability of both electric board room chillers, a mitigating system. Alteration of safety-related equipment configuration outside of approved processes would, if left uncorrected, result in a more significant safety concern. A protected train that is lost due to configuration control errors has an increased chance that it will not restart.

This finding is of very low safety significance because there was no loss of safety function, no loss of TS equipment for more than the allowed outage time, no loss of maintenance rule (MR) risk-significant system for more than 24 hours, and no increase in risk from external events. The cause of this finding is related to the cross-cutting area of human performance.

Inspection Report# : 2004003*(pdf)*

Significance: G Mar 27, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Comply with Procedure for Shutting Down Unit 2
The inspectors identified a non-cited violation of Technical Specification (TS) 6.8.1 for a self-revealing failure to comply with plant general operating procedures. While shutting down Unit 2 in November 2003, operators failed to close the motor-operated reheater steam supply valves to all six moisture-separator reheaters. This resulted in an open steam flow path through the reheaters to the main condenser and caused a Reactor Coolant System temperature decrease to the point where operators had to close the Main Steam Isolation Valves to maintain control.

This finding is more than minor because it affected the availability of the power conversion system to handle an anticipated transient. This

finding is of very low safety significance because there was no actual loss of a safety function, no loss of a TS-required system or loss of a risk-significant maintenance rule system for greater than 24 hours, and no increase in risk from external events. The cause of the finding is related to the cross-cutting element of human performance
Inspection Report# : 2004002*(pdf)*

Significance: G Mar 27, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Inappropriate Change to the Approved Fire Protection Program
A non-cited Severity Level IV violation of 10 CFR 50.48(a) and the Unit 1 and 2 Operating License Conditions was identified for the licensee making an inappropriate change to the approved fire protection program. This change removed the requirement to implement fire watches for impaired fire protection systems and features.

This finding is more than minor because the lack of a posted fire watch could adversely affect the ability to achieve and maintain safe shutdown in the event of a severe fire in the affected area. This was based on recognition that the ability of the fire watch was not limited to fire identification, but also included mitigating actions taken in the event of fires, such as the ability to close doors limiting fire exposure to adjacent areas and providing more timely fire detection capability in certain cases. This finding is of very low safety significance because, based on an assessment of the impacts of the identified fire protection features removed from service, the licensee's overall safe shutdown capabilities and related fire protection features remained adequate to achieve and maintain safe shutdown conditions. Therefore, this finding is characterized as Green. (Section 4OA5).
Inspection Report# : 2004002*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

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