Sequoyah 2
2Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Identify Critical Steps in a Maintenance Procedure Resulted in a Reactor Trip
A non-cited violation of Technical Specification 6.8.1 was identified for a self-revealing failure to have adequate work procedures for testing molded case circuit breakers associated with 125-volt Vital Battery Board IV. The procedures included provisions for installing threaded rods in place of the panel mounting bolts to maintain positive positional control while removing and reinstalling panel covers, but these provisions applied only to 120-volt Vital Instrument Power Boards. While installing a breaker in Battery Board IV, the panel cover slipped, opened a control power breaker, and tripped the Unit 2 reactor.
This finding was more than minor because it affected the procedure quality attribute of the initiating event cornerstone and upset plant stability by causing a reactor trip. This finding was of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss-of-coolant initiator, did not contribute to a loss of mitigation equipment functions, and did not increase the likelihood of a fire or flood.
Inspection Report# : 2005003*(pdf)*

Mitigating Systems

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedure for Flood Mitigation
The inspectors identified a non-cited violation of Technical Specification 6.8.1 for an inadequate procedure to mitigate the probable maximum flood. Should the postulated flood event have occurred, conflicts between different sections of the procedure, conflicts between steps within one section of the procedure, and a missing step would have lead to a loss of decay heat removal or a loss of reactor coolant system inventory for a unit in a refueling outage.
This finding was more than minor because if the procedure problems were left uncorrected the result would be a more significant safety concern. This finding was of very low safety significance due to the low frequency of occurrence for the probable maximum flood and because the mitigating equipment for a loss of decay heat removal or reactor coolant inventory during a refueling outage would not be affected
Inspection Report# : 2005003*(pdf)*

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)*

Barrier Integrity

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Procedures Resulting in an Inadvertent Transfer of 10,000 Gallons of Spent Fuel Pool Inventory
The inspectors identified a non-cited violation of Technical Specification 6.8.1 for a self-revealing failure to follow plant procedures prior to and during draining of the fuel transfer canal. Leakage past the spent fuel pit gate seal resulted in inadvertently transferring approximately 10,000 gallons of spent fuel pit inventory to the refueling water storage tank.
This finding is more than minor because it affected the Barrier Integrity cornerstone, in that operators failed to adhere to procedures while changing plant configurations resulting in a loss of spent fuel pit inventory. Additionally, if left uncorrected, it would become a more significant safety concern. The cause of this finding is related to the cross-cutting area of human performance. This finding is of very low safety significance because it represented only a small degradation of the radiological barrier function provided by the spent fuel pit.
Inspection Report# : 2005003*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

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