

Sequoyah 1

3Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Jun 30, 2005

Identified By: NRC

Item Type: FIN Finding

Gasket Failure on Turbine Trip Block Resulted in Reactor Trip

A finding was identified for a self-revealing failure to implement effective corrective actions for oil port misalignment between the main turbine front pedestal and the turbine protective trip block. Improper use of gasket material to correct a previous problem with oil seepage from the main turbine trip block resulted in the loss of auto stop oil pressure and a turbine and reactor trip.

This finding was more than minor because it affected the design control 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. Because the affected equipment was non-safety related, no violation of regulatory requirements was identified. The cause of this finding was associated with the cross-cutting area of Problem Identification and Resolution.

Inspection Report# : [2005003\(pdf\)](#)**G****Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Communications Problems Resulted in Failure to Meet TS LCO 3.9.1 for RCS Boron

The inspectors identified a non-cited violation of Technical Specification Limiting Condition for Operation 3.9.1 when communication failures between and within chemistry and operations resulted in Unit 1 reactor coolant system boron concentration dropping below the limit of 2000 ppm. Although chemistry analysis indicated the out-of-specification condition existed, the required actions of immediately borating to within specification were not taken for four hours.

This finding was more than minor because it affected the human performance attribute of the initiating event cornerstone with the potential to challenge reactivity control during shutdown operations. This finding is of very low safety significance because the core remained subcritical by a large margin and the duration of the out-of-specification was less than the boron analysis frequency required by the Technical Specifications

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

Mitigating Systems

G**Significance:** 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\(pdf\)](#)

Barrier Integrity

G**Significance:** 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

Significance: N/A Aug 12, 2005

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution (Pi&r) Inspection

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 lingering technical problems with the Electronic Corrective Action Program (eCAP) electronic document management program more than a year after it was placed in service. The team concluded, however, that the licensee was generally providing an effective corrective action program.

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.

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

Last modified : November 30, 2005