

## Sequoyah 2

# 4Q/2006 Plant Inspection Findings

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## Initiating Events

**Significance:**  Jun 30, 2006

Identified By: Self-Revealing

Item Type: FIN Finding

### **Loose Isolated Phase Bus Duct Gasket Actuated Main Generator Neutral Overvoltage Relay Causing Reactor Trip**

A self-revealing finding was identified for failure to implement effective preventive maintenance procedures to identify and correct a loose isolated phase bus duct gasket before its attachment degraded to the point of allowing the gasket to contact the bus duct conductor and cause a trip. The licensee entered the problem into their corrective action program and corrected the procedures.

This finding was more than minor because it was associated with the procedure quality attribute of the Initiating Events Cornerstone and resulted in an upset in plant stability by causing a reactor trip. While the finding resulted in an actual trip, the inspectors determined that it did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to a loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flood. Thus, the finding was considered to be of very low safety significance.

Inspection Report# : [2006003](#) (*pdf*)

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## Mitigating Systems

**Significance:**  Dec 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Certify Qualifications and Status of Licensed Operators Were Current and Valid**

The inspectors identified a Green, non-cited violation (NCV) of 10 CFR 55.53, "Conditions of Licenses" for failure to certify the qualifications and status of licensed operators were current and valid prior to their resumption of license duties. Specific aspects of the requalification program that were not valid included plant tours that were not completed with another licensed operator and not completing all shift functions in positions to which the individuals will be assigned. The licensee entered the finding into the corrective action program as PER No.112004.

The finding is greater than minor because it is associated with the human performance attribute of the Mitigating Systems Cornerstone that affects the cornerstone objective of ensuring the availability, reliability, and capability of operators to respond to initiating events to prevent undesirable consequences that could pose a potential risk to operations. The finding was evaluated using the Operator Requalification Human Performance Significance Determination Process. Under this SDP, record deficiencies can be either minor or of very low safety significance (Green). This finding was determined to be Green because it was related to the program for maintaining active licenses and more than 20% of the records reviewed had deficiencies.

Inspection Report# : [2006005](#) (*pdf*)

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**Significance:**  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Secure Crane Wall Doors in Mode 3**

The inspectors identified a non-cited violation of Technical Specification 6.8.1 for failure to follow procedure when entering containment at the beginning of the Unit 2 Cycle 13 outage. The doors between the raceway and the lower part of

the polar crane wall were left unsecured while in Mode 3. This would result in a lower containment sump level than was assumed in design basis calculations. The licensee immediately secured the doors and changed the procedure to emphasize the need to close and secure the doors.

This finding was more than minor because, although the licensee demonstrated that sufficient water was available for the containment sump to remain operable, the functional evaluation used assumptions substantially different from those in the design basis calculations with a significant reduction in margin in the calculation output. This finding was of very low safety significance because the degraded condition did not result in a loss of safety function of one or more trains and was not potentially risk-significant due to possible external events.

Inspection Report# : [2006003](#) (*pdf*)

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Procedure Results in Blocked Sprinkler Head Without Compensatory Actions**

The inspectors identified a non-cited violation of Sequoyah Operating Licenses DPR-077, Section 2.C.(16) and DPR-079, Section 2.C.(13) for failure to establish adequate compensatory actions for obstructed fire sprinklers in the cable spreading room. Due to an inadequate maintenance procedure, licensee personnel failed to evaluate scaffolding in the cable spreading room for the effect on fire protection and therefore did not implement a fire watch as required by the fire protection program. The licensee entered the problem into their corrective action program to correct the procedure and immediately implemented the fire watch.

This finding was more than minor because if left uncorrected, future scaffolding construction would result in similar unevaluated fire protection impairments and would become a more significant safety concern. In addition, the finding involved the Protection Against External Factors (fire) attribute of the Mitigating Systems cornerstone in that the licensee's ability to quickly extinguish a fire in the area was reduced due to the inoperable sprinkler head. This finding was of very low safety significance because the degradation rating was low due to the minimal impact of the limited number of sprinkler heads being partially obstructed.

Inspection Report# : [2006002](#) (*pdf*)

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Fully Implement Compensatory Measures Necessary for Air in the ERCW Discharge**

The inspectors identified a non-cited violation of Technical Specification 6.8.1 for failure to fully implement the compensatory measures needed to ensure the operability of the motor driven auxiliary feedwater pumps when using the essential raw cooling water system as the water source. The implementing procedure contained instructions to implement the compensatory measures on only one of two essential raw cooling water system discharge headers. The licensee entered the problem into their corrective action program and corrected the procedure.

This finding was more than minor because it affected the procedure quality attribute of the mitigating systems cornerstone by creating the situation that one essential raw cooling water discharge header would be in a flow condition that was conducive to air accumulation without monitoring as specified by the compensatory measures. This finding was of very low safety significance because the degraded condition did not result in an actual loss of safety function and was not potentially risk-significant due to possible external events

Inspection Report# : [2006002](#) (*pdf*)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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## **Public Radiation Safety**

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## **Physical Protection**

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

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## **Miscellaneous**

Last modified : March 01, 2007