

Sequoyah 1

4Q/2008 Plant Inspection Findings

Initiating Events

Significance: **G** Mar 31, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Calibration Procedure

Green. A self-revealing NCV was identified for failure to properly follow procedure when calibrating Loop 3 Steam Pressure Channel 1 on Unit 1. Because of failure to follow procedure, automatic steam generator level control rapidly reduced feedwater flow to the point where programmed level could not be maintained and caused the operators to manually trip the reactor. The licensee entered the problem into their corrective action program and initiated actions to prevent recurrence.

The finding was more than minor because it was associated with the human performance 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 finding was determined to be of very low safety significance, because it did not contribute to the likelihood of a loss of coolant accident, contribute to a loss of mitigation equipment functions, or increase the likelihood of a fire or flood. The cause of the finding was associated with the human error prevention techniques aspect of the human performance cross-cutting area, because the involved instrument technicians failed to follow proper placekeeping practices and failed to verify and validate the proper starting place in the procedure after taking a break. (Section 1R22).

Inspection Report# : [2008002](#) (*pdf*)

Mitigating Systems

Significance: SL-IV Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Notify the Commission Within 30 Days After a Licensed Operator Was Diagnosed With a Permanent Physical Medical Condition

The NRC identified a non-cited violation (NCV) of 10 CFR 55.25 and § 50.74 for failure to notify the Commission within 30 days after a licensed operator developed a permanent change in his physical condition. The licensee entered this finding into their corrective action program as problem evaluation report 158614.

This finding was evaluated using the traditional enforcement process because the licensee's failure to report the changes in medical condition impacted the Commission's ability to perform its regulatory function associated with operator licensing. Using Supplement I, "Reactor Operations," of the NRC Enforcement Policy, this finding was determined to be a Severity Level IV violation because the change in the operator's physical condition did not impact his ability to perform licensed duties.

The cause of the finding was the licensee failed to understand that all permanent conditions, disabilities, and incapacities must be reported to the NRC for evaluation, regardless of whether the operator had exceeded the specific minimum requirement or the related disqualifying condition threshold in ANSI/ANS-3.4, "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants."

Inspection Report# : [2008005](#) (*pdf*)

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Gland Seal Steam Header Isolation Valves Not Scoped In Maintenance Rule

The inspectors identified a Green, non-cited violation of 10 CFR 50.65(b)(2)(i) for the licensee's failure to include the gland seal steam supply and supply bypass isolation valves in the scope of their maintenance rule program. These valves are used in the emergency operating procedures to mitigate a steam generator tube rupture if a main steam isolation valve were to fail. The licensee entered the issue into their corrective action program.

The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. In accordance with Inspection Manual Chapter IMC 0609.04, Phase 1 - Initial Screening and Characterization of Findings, the finding was determined to be of very low safety significance (Green) because it did not represent an actual loss of a safety function of one or more non-Technical Specification trains of equipment designated as risk-significant per 10 CFR 50.65.

Inspection Report# : [2008003](#) (*pdf*)

Significance:  Jun 27, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Sprinklers too far below Ceiling in Cable Spreading Room

A green non-cited violation of Unit 1 License Condition 16 and Unit 2 License Condition 13, Fire Protection, was identified for failure to install the automatic suppression system (sprinkler system) in the cable spreading room according to the applicable National Fire Protection Association standard with regard to the ceiling to sprinkler head dimension. As a result, the fusible link type sprinkler heads may be significantly slower than originally intended after fire ignition. The licensee entered this problem into their corrective action program.

This finding is a performance deficiency because the licensee did not locate the sprinkler heads according to the applicable industry code of record for the facility. The finding is more than minor because it is associated with the reactor safety, mitigating systems, cornerstone attribute of protection against external factors, i.e. Enclosure fire, and it substantially affects the objective of ensuring reliability and capability of systems that respond to initiating events. The finding was determined to be of very low safety significance when the likelihood of fires, the transients that could be initiated by fires and the probability of failure of mitigating systems for those transients were evaluated.

Inspection Report# : [2008006](#) (*pdf*)

Significance:  Mar 31, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Tagging Procedure

Green. A self-revealing NCV was identified for an inadequate tagging procedure that resulted in a failure to properly isolate a fire hydrant before maintenance. Because of the failure, the hydrant was forced off the associated fire protection system header, depressurized the system, and rendered it inoperable. The licensee entered the problem into their corrective action program and initiated actions to prevent recurrence.

This finding was more than minor because it affected the mitigating system cornerstone objective of availability of systems, i.e. Fire Protection System, and was associated with the protection against fire, an external hazards attribute.

While the finding caused the fire protection system to be inoperable, the inspectors determined that the degradation rating used for the significance determination process was low. Therefore, the finding was considered to be of very low safety significance. The cause of the finding was associated with the accurate and up-to-date procedures and work packages aspect of the human performance cross-cutting area. The clearance procedure and Work Order (WO) were not sufficient to ensure continued fire protection system operability during hydrant maintenance.

Inspection Report# : [2008002](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : April 07, 2009