

Sequoyah 1 2Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Follow Procedure Results in an Inadvertent Sprinkler Deluge in the Cable Spreading Room

Green. A self-revealing Green non-cited violation (NCV) of Technical Specification (TS) 6.8.1.f, “Fire Protection Program Implementation,” was identified for the licensee’s failure to follow a fire protection procedure. Specifically, the licensee failed to isolate the fire main from the cable spreading room (CSR) header during testing as required by procedure. This resulted in pressurization of the fire header to the cable spreading room which then caused a rupture of one of the sprinkler heads in the room. The licensee entered this issue into their corrective action program (CAP) as problem evaluation report (PER) 1001695. As immediate corrective actions, the licensee replaced the failed sprinkler head and conducted a formal review of the incident.

The finding was determined to be more than minor because it was associated with the human performance attribute of the initiating events cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the excessive amount of water sprayed in the CSR increased the likelihood of a plant transient due to the potential impact on non-waterproof junction boxes located in the CSR as well as safety-related instrument racks located in the auxiliary instrument room (AIR) directly below the CSR. Using Appendix A, Exhibit 1, “Initiating Events Screening Questions,” the finding was determined to be of very low safety significance because the deficiency did not cause a reactor trip nor a loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding was determined to have a cross-cutting aspect in the avoid complacency component of the human performance area [H.12], because the technicians failed to properly implement appropriate error education techniques while performing a fire protection procedure. (Section 1R05)

Inspection Report# : [2015001](#) (*pdf*)

Mitigating Systems

Barrier Integrity

Significance: G Sep 30, 2014

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Perform Adequate Maintenance on Containment Vacuum Relief Valve (Section 1R12)

A Self-revealing Green Non-Cited Violation (NCV) of Technical Specification (TS) 6.8.1.a. was identified for the licensee’s failure to adequately implement a maintenance procedure associated with a vacuum relief containment

isolation valve. Specifically, during a refueling outage on May 24, 2014, the licensee failed to properly install a locking wire associated with the spring tension bolts on the Unit 2 containment vacuum relief valve. This error ultimately led to a failure of the valve on June 24 at 1600 and entry into TS 3.6.3, "Containment Isolation Valves." The valve was ultimately repaired and the valve was declared operable on June 26 at 0026. The inspectors determined that the licensee's failure to adequately develop and implement a procedure governing the maintenance of a containment isolation valve was a performance deficiency.

This finding was determined to be greater than minor because it was associated with the Configuration Control attribute of Barrier Integrity cornerstone and adversely affected the cornerstone's objective to ensure the structural integrity of the containment boundary. Specifically, the finding challenged containment integrity. A screening analysis was conducted using the assumption that all core damage sequences would lead to a Large Early Release. This was an overestimation of risk, since actions to mitigate a release were possible. The short exposure time multiplied by the Core Damage Frequency for the plant resulted in less than a 1E-7 increase in Large Early Release Probability, and the finding is Green. The cause of this finding was determined to have a cross-cutting aspect in the Human Performance component, relating to the assurance by supervision that procedures are adequate to ensure nuclear safety. [H.1]. (Section 1R12)

Inspection Report# : [2014004](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : August 07, 2015