

## Sequoyah 2

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### Initiating Events

G**Significance:** Sep 28, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

**Failure to demonstrate the remaining offsite A.C. circuit as operable when one offsite A.C. Circuit of the required electrical power sources became inoperable.**

Technical Specification 3.8.1.1.a Action a. requires that, with one offsite A.C. circuit of the required A.C. electrical power sources inoperable, the remaining offsite A.C. circuit be demonstrated OPERABLE by performing SR 4.8.1.1.1.a. within one hour and at least once per 8 hours thereafter. Contrary to this, from 10:23 PM until 11:55 PM on July 12, 2002, the licensee failed to perform SR 4.8.1.1.1.a. as required when one offsite A.C. Circuit of the required A.C. electrical power sources became inoperable. This NCV was identified in the licensee's corrective action program as PER 02-008493-000.

Inspection Report# : [2002004\(pdf\)](#)

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### Mitigating Systems

G**Significance:** Jun 29, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PERFORM AN ADEQUATE DESIGN MODIFICATION REVIEW PRIOR TO MODIFYING EMERGENCY DIESEL GENERATORS STARTING AIR SYSTEM**

The inspectors identified a non-cited violation of 10 CFR 50 Appendix B, Criterion III, Design Control, for failure to perform an adequate design modification review prior to modifying the starting air systems of the site's four EDGs. The inadequate design modification review had a credible effect on safety because it contributed to the installation of modified EDG air start system pressure control valves that failed to perform as required. The modification simultaneously degraded all four of the site EDGs, reducing their reliability and necessitating corrective actions that reduced EDG availability. The finding was of very low safety significance because it did not result in an actual loss of safety function.

Inspection Report# : [2002002\(pdf\)](#)G**Significance:** Mar 30, 2002

Identified By: NRC

Item Type: FIN Finding

**DEGRADATION OF EMERGENCY DIESEL GENERATOR (EDG) STARTING AIR PRESSURE CONTROL VALVES**

The inspectors identified deficiencies in identifying, communicating, and addressing a common cause degradation of the air starting systems (pressure control valves) of the site's four EDGs during the period from January 2001 through March 2002. The finding had very low safety significance because no actual loss of safety function was identified.

Inspection Report# : [2001005\(pdf\)](#)G**Significance:** Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO START REMAINING EDGs When 2A-A EDG FAILED TO START**

The inspectors identified a non-cited violation of Technical Specification 3.8.1.1, for failure, to demonstrate the operability of the remaining emergency diesel generators (EDGs) within one hour and at least once per 8 hours thereafter, following a start failure of a EDG. The finding had very low safety significance because the remaining EDGs were subsequently started during their routine surveillance intervals which demonstrated that their safety function had not been lost.

Inspection Report# : [2001005\(pdf\)](#)

**Significance:** Mar 30, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

**INADEQUATE PROCEDURE FOR FILLING EMERGENCY CORE COOLING SYSTEM (ECCS)**

The licensee identified a non-cited violation of Technical Specification 6.8.1.a, Procedures and Programs on January 9, 2002 for an inadequate procedure (Standard Operating Procedure 1-SO-62-1). The procedure did not provide adequate instructions to ensure ECCS suction piping was full following system draining for maintenance.

Inspection Report# : [2001005\(pdf\)](#)**Significance:** Mar 29, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**INADEQUATE PROCEDURE GUIDANCE FOR PLANT FIRES**

The inspectors identified a non-cited violation of Technical Specification 6.8.1.a, Procedures and Programs, for inadequate procedure guidance related to the transition from Abnormal Operating Procedure (AOP), Plant Fires, to AOP, Shutdown From Auxiliary Control Room (ACR), in the event of a severe fire. The delayed transition to the ACR could challenge the operators' ability to perform certain critical safe shutdown functions within the times specified in the licensee's safe shutdown calculation for Appendix R. This finding had very low safety significance because it did not affect fire detection, fire suppression, or fire barriers.

Inspection Report# : [2002003\(pdf\)](#)**Significance:** Mar 29, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

**INADEQUATE EMERGENCY LIGHTING FOR REFUELING WATER STORAGE TANK (RWST) SUCTION VALVES**

The licensee identified a non-cited violation of 10 CFR 50 Appendix R, III.J, Emergency Lighting, for failure to provide emergency lighting with at least an 8-hour battery power supply for Unit 1 and 2, RWST suction valves. Manual operation of these valves is required in the event of a severe fire in accordance with licensee's shutdown procedures.

Inspection Report# : [2002003\(pdf\)](#)**Significance:** Mar 29, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

**INADEQUATE PROTECTION FOR VOLUME CONTROL TANK (VCT) SUCTION VALVES**

The licensee identified a non-cited violation of 10 CFR 50 Appendix R, III. G.2, Fire Protection Safe Shutdown Capability, for failure to protect cables to the VCT suction valves to prevent maloperation of components necessary to achieve and maintain hot shutdown conditions.

Inspection Report# : [2002003\(pdf\)](#)

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## Barrier Integrity

**Significance:** Jun 29, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO COMPLETE CORRECTIVE ACTIONS TO REPAIR DEFICIENCIES IDENTIFIED DURING EXAMINATION OF UNIT 2 STEEL CONTAINMENT VESSEL**

The inspectors identified a non-cited violation of 10 CFR 50 Appendix B, Criterion XVI, Corrective Action, for failure to promptly correct Unit 2 steel containment vessel degraded coatings and remove the accumulated rust. This steel containment vessel condition remained uncorrected approximately nine years (1990 - 1999). The degraded condition had a credible impact on safety because: (1) the extent of condition and its effects on the structural integrity of the steel containment vessel were previously unknown; (2) corrective actions had not been scheduled; and (3) the degraded condition may not have been identified because the licensee's inspection procedures excluded re-examination of the areas where the degraded coatings and rust exist. The degraded condition was of very low safety significance because insufficient corrosion of the steel containment vessel had occurred to affect containment integrity.

Inspection Report# : [2002002\(pdf\)](#)

G**Significance:** Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO ENSURE AUX BLDG SECONDARY CONTAINMENT EXCLUSION/FIRE DOOR A55 WAS SHUT & LATCHED**

The inspectors identified a non-cited violation of License Condition 2.C.16, Fire Protection Program, for failure to maintain a door shut, which was required to be closed and latched to maintain the integrity of the auxiliary building secondary containment exclusion boundary and to prevent the spread of a fire. The finding had very low safety significance because fire detection and suppression were operable on both sides of the door and there were no plant activities in the affected area to substantially increase the severity of a postulated fire.

Inspection Report# : [2001005\(pdf\)](#)

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## Emergency Preparedness

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## Occupational Radiation Safety

G**Significance:** Mar 01, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

**FAILURE TO MAINTAIN COMPLETE AND ACCURATE PERSONNEL DOSE RECORDS**

The licensee identified a non-cited violation of 10 CFR 20.401, 10 CFR 20.2106 and 10 CFR 50.9 for failure to maintain accurate records of doses received by all individuals for whom monitoring was required. This finding was not processed under the Reactor Oversight Process and was characterized as a severity level IV violation consistent with Supplement VII of the Enforcement Policy because it involved the accuracy of required records.

Inspection Report# : [2002006\(pdf\)](#)

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## Public Radiation Safety

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## Physical Protection

G**Significance:** Nov 19, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Personnel Search Prior to Entry into Protected Area**

A non-cited violation was identified for the licensee's failure to comply with Section 5.3.1 of the Physical Security Plan and Section 3.3 B of Security Instruction No.1, in that on September 13, 2002, security officers failed to perform a physical search of an individual who had previously alarmed the explosives detector, prior to allowing the individual access to the protected area. The finding was of very low safety significance in that, using the Physical Protection Significance Determination Process, it was identified as a vulnerability in access control, without a malevolent act, and without two similar findings in four quarters.

Inspection Report# : [2002007\(pdf\)](#)**Significance:** SL-IV Dec 28, 2001

Identified By: NRC

Item Type: VIO Violation

**FAILURE TO ADHERE TO PHYSICAL SECURITY INSTRUCTION PERSONNEL SEARCH**

The NRC determined that a violation for a deliberate failure to implement the plant Physical Security Plan and Physical Security Instruction (PHYSI)-32, occurred on April 19, 2000 when an individual entering the protected area received an alarm from the metal detector. The security officer did not ensure that all metal, including his shoes, were removed, but conducted a physical search of the individual instead of requesting that the individual remove metal and shoes and process through the metal detector again. The violation had very low safety

significance because an adequate physical search had been conducted.  
Inspection Report# : [2001007\(pdf\)](#)

**Significance: SL-IV** Dec 28, 2001

Identified By: NRC

Item Type: VIO Violation

**EMPLOYEE PROTECTED ACTIVITY**

The NRC determined that a violation of 10 CFR 50.7, Employee Protection, occurred on April 19, 2000 when the licensee discriminated against a contract security officer as a result of engaging in protected activity. Specifically, the individual objection to being instructed not to follow Physical Security Instruction PHYSI-32, which was part of his assigned responsibilities. The violation had very low safety significance because the uncertainty of the intent of the verbal communications, and the low underlying safeguards significance of the procedural violation (i.e., the procedure was subsequently revised to allow security guards the discretion to conduct a physical search instead of requiring an individual to remove his or her shoes and process through the metal detector again).

Inspection Report# : [2001007\(pdf\)](#)

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## Miscellaneous



**Significance:** Jun 29, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

**FAILURE TO ENSURE CENTRIFUGAL CHARGING PUMP (CCP) SUCTION VALVE FROM VOLUME CONTROL TANK (VCT) WAS PROPERLY ISOLATED DURING MAINTENANCE**

The licensee identified a non-cited violation of Technical Specification 6.8.1.a, Procedures and Programs, for failure to follow procedure to ensure that the Unit 2 CCP suction valve from the VCT (2-FCV-62-132), was properly isolated for maintenance activities.

Inspection Report# : [2002002\(pdf\)](#)

**Significance: N/A** Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO FOLLOW ADMINISTRATIVE GUIDANCE FOR PROCEDURE CHANGES**

The inspectors identified a non-cited violation of Technical Specification 6.8.1.a, Procedures and Programs, for failure to follow administrative guidance for making an intent change to a procedure. A containment pressure control procedure, which temporarily resets the steam generator low-low water reactor trip setpoint during venting, was used to make a change to this setpoint for a purpose unrelated to venting. The finding was of very low safety significance because not performing a intent change review before procedure execution did not directly affect any initiating events or mitigation equipment.

Inspection Report# : [2001005\(pdf\)](#)

**Significance: SL-II** Jun 30, 2001

Identified By: NRC

Item Type: VIO Violation

**EMPLOYEE PROTECTED ACTIVITY**

On February 7, 2000, a Severity Level II violation with civil penalty was issued to the licensee. The violation was not site-specific and involved employment discrimination contrary to the requirements of 10 CFR 50.7, "Employee Protection," in that the licensee did not select a former employee to a competitive position in the corporate chemistry organization in 1996, due, at least in part, to his engagement in protected activities. On January 22, 2001, the licensee denied the violation and on May 4, an Order was issued sustaining the violation and imposing the civil penalty. On June 1, TVA requested an enforcement hearing on the Order.

Inspection Report# : [2001002\(pdf\)](#)

Last modified : March 25, 2003