

## Sequoyah 2

# 1Q/2005 Plant Inspection Findings

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## Initiating Events

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## Mitigating Systems

**Significance:**  Sep 25, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Comply with TS 3.3.1 to Trip RPS Bistables**

The inspectors identified a non-cited violation (NCV) for a failure to comply with Technical Specification 3.3.1. when a Loop Control Processor (LCP) failed in Unit 2. The processor failure caused one channel of the reactor protection system to be inoperable and that required the channel to be placed in trip within 6 hours. Because of a licensee position that the processor failure placed all channel bistables in the correct position, operators took no action to trip the channel until approximately 9½ hours after the failure, when preparing to replace the failed processor.

This finding was more than minor because it affected the configuration control attribute of the mitigating systems cornerstone in that it reduced the reliability of the required number of operable channels required by the reactor protection system. Had actual plant conditions called for a trip, not taking deliberate operator action to place the inoperable channels in a tripped condition would reduce the likelihood of proper coincident protection system actuation. This finding is of very low safety significance because there was no loss of safety function and the bistables were actually in the tripped condition.

Inspection Report# : [2004004\(pdf\)](#)

**Significance:**  Jun 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Comply with Configuration Control Procedures**

The inspectors identified a non-cited violation of Technical Specification (TS) 6.8.1 for a self-revealing failure to comply with status control procedures. While attempting to get information to set a limit switch on Electric Board Room Chiller A, maintenance personnel removed the slide valve position indicator cover on Electric Board Room Chiller B. When replacing it, the cover contacted the control power circuits and caused a short circuit that tripped the B Chiller. In removing the cover, maintenance personnel had not obtained prior approval from operations, nor did they have work documents that authorized the actions.

This finding is more than minor because it affected the availability of both electric board room chillers, a mitigating system. Alteration of safety-related equipment configuration outside of approved processes would, if left uncorrected, result in a more significant safety concern. A protected train that is lost due to configuration control errors has an increased chance that it will not restart.

This finding is of very low safety significance because there was no loss of safety function, no loss of TS equipment for more than the allowed outage time, no loss of maintenance rule (MR) risk-significant system for more than 24 hours, and no increase in risk from external events. The cause of this finding is related to the cross-cutting area of human performance.

Inspection Report# : [2004003\(pdf\)](#)

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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**

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