

Sequoyah 2

4Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Procedure for Loss of Power Diesel Generator Start Instrumentation Surveillance Testing

A self-revealing non-cited violation of Unit 2 Technical Specification (TS) 6.8.1.a was identified for the licensee's failure to follow station procedures during the performance of a surveillance testing activity. While performing degraded voltage/load shed relay testing associated with the 2B 6.9kV shutdown board, the use of improper test equipment and the incorrect connection of test equipment resulted in a control power circuit fuse being blown, which caused inoperability of an emergency diesel generator and a motor driven auxiliary feedwater train. This issue was entered into the licensee's corrective action program as Problem Evaluation

Report (PER) 415324.

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Nuclear Instrumentation System Channel Calibration Error

A self-revealing non-cited violation of Unit 2 TS 3.0.3 was identified for the licensee's failure to place the unit in Mode 3 within seven hours when a Limiting Condition for Operation (LCO) was not met in Modes 1 and 2. The requirements of LCO 3.3.1, "Reactor Trip System Instrumentation," associated with the power range neutron flux function in Modes 1 and 2 were not met for a period of approximately 24 hours. This was the result of an error made during the performance of a channel calibration activity, which caused one channel to be left in an inoperable condition. This issue was entered into the licensee's corrective action program as PER 397142.

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to perform instrumentation surveillance testing within required frequency

The inspectors identified a non-cited violation of Units 1 and 2 TS Surveillance Requirement (SR) 4.0.2 for the licensee's failure to perform SRs specified in Units 1 and 2 TS 3/4.3.1, "Reactor Trip System Instrumentation," and 3/4.3.2, "Engineered Safety Feature Actuation System (ESFAS) Instrumentation," within the required surveillance frequencies. The inspectors identified eight examples over the last three years (five examples on Unit 1 and three examples on Unit 2) where the interval between tests of the automatic actuation logic and reactor trip breaker functions required by SRs 4.3.1.1.1 and 4.3.2.1.1 exceeded the maximum surveillance interval allowed by TS. The licensee entered this issue into their corrective action program as PER 369938. Corrective actions included ensuring that work control processes correctly implement the required surveillance intervals.

The finding was determined to be greater than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

Specifically, extending beyond the required maximum interval between TS surveillance tests affects the ability to confirm continued availability of TS equipment, and the ability to detect potential latent operability concerns in a timely manner. Using Inspection IMC 0609, "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance (Green) since it did not represent an actual loss of safety function of a single train for greater than the associated TS allowed outage time. The inspectors did not identify that the cause of this finding was related to any of the cross-cutting aspects defined in IMC 0310, and therefore no cross-cutting aspect was assigned to this finding. (Section 1R22)
Inspection Report# : [2011003](#) (*pdf*)

Significance:  Jun 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish Compensatory Actions for Blocked Sprinklers

The inspectors identified a non-cited violation of Sequoyah Operating License Conditions 2.C.(16) and 2.C.(13) for Units 1 and 2, respectively, for failure to establish compensatory measures for an obstructed sprinkler system. Specifically, scaffolding installed in auxiliary building fire area FAA-054/Room A01 was in a configuration which obstructed sprinkler heads A198 and A208. The licensee entered this issue into the corrective action program as Problem Evaluation Report 321911 and implemented compensatory measures (fire watches) in accordance with the approved fire protection program.

Inspection Report# : [2011006](#) (*pdf*)

Significance:  Jun 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Sprinkler System in Room 690.0-A1 of the Auxiliary Building has NFPA Code Deviation

The inspectors identified a non-cited violation of Operating License Conditions 2.C.(16) and 2.C.(13), for Units 1 and 2 respectively, for failure to install the automatic suppression system (sprinkler system) in the auxiliary building corridor 690 foot elevation, in accordance with applicable National Fire Protection Association (NFPA) Standard No. 13, "Automatic Sprinkler Systems." Specifically, NFPA 13-1975 required sprinklers to be installed within 12-inches of the ceiling. Portions of the auxiliary building sprinkler system were installed greater than 12-inches below the ceiling. As a result, the actuation of the fusible link type sprinklers would have been slower than originally intended after fire ignition. The licensee entered this issue into the corrective action program as Problem Evaluation Report 147467 and implemented compensatory measures (fire watches) in accordance with the approved fire protection program. The inspectors determined that there was no cross-cutting aspect associated with this finding because the condition has existed since initial plant licensing and was not reflective of present performance.

Inspection Report# : [2011006](#) (*pdf*)

Significance:  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to adequately qualify molded-case circuit breakers to safety-related application through commercial grade dedication.

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control, for the licensee's failure to assure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, the licensee failed to ensure that the molded case circuit breakers utilized in the station 120VAC vital instrument power boards were properly seismically qualified for their application. The licensee entered this issue into their corrective action program as PERs 264271, 266599, 286156, and 319161. Corrective actions included revision of applicable procedures to perform re-alignment of breakers in the vital instrument power boards.

The finding was determined to be greater than minor because it was associated with the design control attribute of the mitigating systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to ensure that the 120VAC vital instrumentation board components had proper seismic qualification had the potential to

affect the ability of safety-related equipment to perform its required function under design basis conditions. Using Inspection IMC 0609, “Significance Determination Process,” Attachment 4, “Phase 1 - Initial Screening and Characterization of Findings,” the finding was determined to have very low safety significance (Green) because it did not represent an actual loss of safety function. No cross-cutting aspect was identified, since the issue was determined to not reflect current licensee performance. (Section 1R15.1)

Inspection Report# : [2011002](#) (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

Significance: SL-IV Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to report system actuation

The inspectors identified a non-cited violation of 10 CFR 50.73, “Licensee Event Report System,” for the licensee’s failure to report an invalid system actuation. On May 5, 2011, a containment ventilation isolation (CVI) signal was inadvertently generated on Unit 2 while performing surveillance testing. This system actuation was not reported to the NRC as required by 10 CFR 50.73(a)(2)(iv) within 60 days of discovery of the event. This issue was entered into the licensee’s corrective action program as PER 417453, and was reported to the NRC as EN #47249 on September 8, 2011.

This violation was determined to be applicable to traditional enforcement because of its potential to impact the ability of the NRC to perform its regulatory oversight function, and was therefore evaluated in accordance with the NRC Enforcement Policy. This issue was determined to be a Severity Level IV violation in accordance with Section 6.9.d.9 of the NRC Enforcement Policy. No cross-cutting aspect was assigned since traditional enforcement violations for which there are no associated ROP findings are not screened for cross-cutting aspects. (Section 1R15)

Inspection Report# : [2011004](#) (pdf)

Last modified : March 02, 2012