VIRGINIA ELECTRIC AND POWER COMPANY
RICHMOND, VIRGINIA 23261

August 14, 1996

United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D. C. 20555

Serial No. 96-376
SPS/BCB/GDM R4
Docket No. 50-281
License No. DPR-37

Gentlemen:

VIRGINIA ELECTRIC AND POWER COMPANY
SURRY POWER STATION UNIT 2
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORT NOS. 50-280/96-05 AND 50-281/96-05

We have reviewed Inspection Report Nos. 50-280/96-05 and 50-281/96-05 dated July 15, 1996, and the enclosed Notice of Violation (NOV) for Surry Unit 2. The report identified one cited violation for the failure to ensure that plant systems were appropriately aligned to support a maintenance activity. As described in our attached reply to the NOV, we have concluded that this event was caused by personnel errors that resulted from a knowledge deficiency. This conclusion is based on the results of a Root Cause Evaluation of this event. We have initiated actions to correct the identified knowledge deficiency and are also evaluating additional enhancements to the tagging program.

We have no objection to this letter being made a part of the public record. Please contact us if you have any questions or require additional information.

Very truly yours,

James P. O'Hanlon

James P. O'Hanlon
Senior Vice President - Nuclear

Attachment

cc: U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, N.W.
Atlanta, Georgia 30323

Mr. M. W. Branch
NRC Senior Resident Inspector
Surry Power Station

REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION CONDUCTED JANUARY 7 - FEBRUARY 10, 1996
SURRY POWER STATION UNITS 1 AND 2
INSPECTION REPORT NOS. 50-280/96-01 AND 50-281/96-01

NRC COMMENT:

"During an NRC inspection conducted on May 5 through June 15, 1996, a violation of NRC requirements was identified. In accordance with the 'General Statement of Policy and Procedure for NRC Enforcement Actions,' NUREG 1600, the violation is listed below:

> Technical Specification 6.4 requires, in part, that detailed written procedures be provided for maintenance activities which would have an effect on nuclear safety and that they be followed.
>
> VPAP-2002, Work Request and Work Order Task, revision 5, partially implements these requirements for maintenance activities.
>
> VPAP-2002, Section 5.7.1, requires that the Shift Supervisor review and approve work orders on permanent plant structures, equipment, and components.
>
> VPAP-2002, Section 5.7.2, requires that the Shift Supervisor align plant systems, as required, to support work order task activities.
>
> VPAP-2002, Section 5.7.4, requires that equipment be prepared for maintenance prior to approval of a work order.
>
> Contrary to the above, on May 18, 1996, the Shift Supervisor who approved Work Order 00334395, Test Relief Valve 2-DG-RV-202, failed to ensure that the appropriate plant system was aligned to support the work order task requirements and failed to ensure that the appropriate equipment was prepared for maintenance prior to approval of the work order. Specifically, the Shift Supervisor failed to ensure that relief valve 2-DG-RV-202 was isolated from the overhead gas header.
>
> This is a Severity Level IV Violation (Supplement I)."

REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION CONDUCTED MAY 5 - JUNE 15, 1996
SURRY POWER STATION UNITS 1 AND 2
INSPECTION REPORT NOS. 50-280/96-05 AND 50-281/96-05

1. Reason for the Violation, or, if Contested, the Basis for Disputing the Violation

The violation is correct as stated and was caused by personnel errors that occurred during the preparation, review, and approval of the tagging record that was associated with the removal of relief valve 2-DG-RV-202. The Reactor Operator (RO) and Senior Reactor Operators (SRO) who processed the subject tagging record anticipated the potential for leakage from the upstream side of 2-DG-RV-202 and initiated the appropriate system configuration to address such leakage. However, the RO and SROs failed to consider conditions on the downstream side of the valve.

A Root Cause Evaluation (RCE) of this event concluded that the RO's and SROs' failure to account for the potential gas pathway through the discharge piping ("tailpipe") of 2-DG-RV-202 resulted from a knowledge deficiency relative to potential relief/safety valve tailpipe-system interactions.

2. Corrective Steps Which Have Been Taken and the Results Achieved

An RCE was conducted to determine the cause of this event and to recommend corrective actions. The management approved corrective actions are described below in Section 3.

The RCE was included in the required reading for Operations personnel.

3. Corrective Steps Which Will be Taken to Avoid Further Violations

Operator training is being revised to include a discussion of potential relief/safety valve tailpipe-system interactions. This training will correct the identified knowledge deficiency and will emphasize the need to consider such interactions when developing or reviewing a tagging record.

As an enhancement, the Outage Readiness Checklist is being revised to incorporate the lessons learned from this event and to specifically address relief/safety valve maintenance and testing.

4. The Date When Full Compliance Will be Achieved

Full compliance will be achieved when the revised operator training discussed in Section 3 above is conducted. This training will be completed by September 30, 1996.