

Surry 1

1Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Feb 14, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Test Diesel Driven Fire Pump Automatic Start Features

A failure to establish written operating test procedures to demonstrate the functional capability of the diesel-driven fire pump (DDFP) loss-of-power automatic start feature could have resulted in a loss of fire suppression water during a loss-of- offsite power condition. A non-cited violation of 10 CFR 50.48 was identified. This finding is greater than minor because it is associated with fire protection performance and degraded the ability to meet the mitigating systems cornerstone objective. The finding is considered to have very low safety significance because the DDFP successfully started when a loss-of-power test was performed.

Inspection Report# : [2003007\(pdf\)](#)

Significance:  Feb 14, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Control of Diesel Driven Fire Pump Fuel Oil Isolation Valve

A failure to properly implement and maintain an adequate fire protection program inspection and valve position control process could have resulted in isolation of the fuel oil supply to the diesel-driven fire pump (DDFP). The position of the DDFP fuel oil supply valve was not being controlled by the licensee. A non-cited violation of 10 CFR 50.48 was identified. This finding is greater than minor because it is associated with fire protection performance and degraded the ability to meet the mitigating systems cornerstone objective. The finding is considered to have very low safety significance because the fuel oil supply valve was in its proper position and it had not been mis-positioned in the past.

Inspection Report# : [2003007\(pdf\)](#)

Significance:  Sep 28, 2002

Identified By: NRC

Item Type: FIN Finding

Adequacy of emergency diesel generator contingency plans to meet intent of Nuclear Energy Institute (NEI) 99-02 guidance and report unavailability time accurately

A finding was identified when the Revised Oversight Process Working Group determined that the recovery actions in an emergency diesel generator (EDG) surveillance procedure did not meet the guidelines of NEI 99-02, and the corresponding unavailability hours should be counted towards the Safety System Unavailability - Emergency AC Power Performance Indicator (PI) during the testing of the EDG. When the licensee revised the PI data, the PI on Unit

1 changed from green to white for the fourth quarter of 2001 and the first and second quarters of 2002. The finding was of very low safety significance because the added unavailability hours reflect only a small portion of the time required for the PI to exceed the green/white threshold. The majority of the unavailability hours were the result of issues that were previously identified and inspected, and therefore, no additional regulatory response is required.

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

Significance:  Jun 29, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to provide appropriate instructions to ensure proper operation of the emergency switchgear room chillers following a loss of instrument air

A Non-Cited Violation of Technical Specification 6.4.A was identified due to an inadequate abnormal procedure. Abnormal procedure (AP) - 40, "Non-Recoverable Loss of Instrument Air," did not contain adequate guidance to ensure continued operation of the emergency switchgear room chillers following a loss of instrument air. The finding was of very low safety significance due to the combination of events that would have to occur for the emergency switchgear room components to be adversely affected by the loss of the chillers. The combination of events included a medium or large break loss of coolant accident coupled with a loss of offsite power during the winter months (cold service water temperatures).

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

Significance:  Jun 29, 2002

Identified By: NRC

Item Type: FIN Finding

Determine the risk significance of the failure to provide proper separation between the 125V DC busses

A finding was identified for not providing proper separation between the 125V DC busses. A single failure could affect both redundant DC busses on a unit and encumber normal decay heat removal systems. The finding was of very low safety significance due to plant design features which mitigate the consequences of a fault within the DC system. Specifically, there are numerous alternative methods of decay heat removal available with simple operator actions.

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

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

Significance: N/A Apr 12, 2002

Identified By: NRC

Item Type: FIN Finding

Supplemental Inspection Results For Unit 1 and 2 White Finding, Emergency Diesel Generator Bearing Failures, and Unit 2 White Performance Indicator, Safety System Unavailability - Emergency AC Power

This supplemental inspection was performed by the NRC to assess the licensee's evaluation and corrective actions associated with a low to moderate risk significance (White) finding applicable to Units 1 and 2 and a Unit 2 White performance indicator (PI). The White finding and PI are in the mitigating systems cornerstone in the reactor safety strategic performance area. The White finding is described in NRC Final Significance Determination letter dated December 21, 2001, and was associated with the Emergency Diesel Generator (EDG) 3 wrist pin failures. The PI, Safety System Unavailability - Emergency AC Power, crossed the White threshold in the third quarter of calendar year 2001 and remained there through the current quarter. The White PI resulted mainly from the EDG 3 piston wrist pin failures and from EDG 2 output breaker problems. During this supplemental inspection, which was performed in accordance with Inspection Procedure 95001, the inspector determined that the licensee performed an overall adequate evaluation of performance deficiencies related to the EDG 3 piston wrist pin failure and the EDG 2 output breaker problems. The depth of root cause evaluations was adequate. The corrective actions were appropriately prioritized and consistent with the identified root cause and contributing factors and provided reasonable assurance to prevent

recurrence.

Inspection Report# : [2002008\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : May 30, 2003