

Surry 1

4Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Apr 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Evaluate and Approve the Storage of Flammable Materials in the Vicinity of Safety-related Equipment

The licensee failed to properly evaluate and approve the storage of flammable materials in the vicinity of safety-related equipment in the Auxiliary Building and the Unit 2 Safeguards area.

An NRC-identified non-cited violation of the Technical Specification 6.4.E was identified. This finding is more than minor because the amount of material improperly stored exceeded the quantity specified in the licensee's Combustible Loading Analysis. The finding is of very low safety significance because it did not cause the impairment or degradation of a fire protection feature or defense in depth.

Inspection Report# : [2003002\(pdf\)](#)

Mitigating Systems

Significance:  Dec 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Auxiliary Feedwater Pump Design Basis not Translated into Procedures

The inspectors identified a non-cited violation of 10 CFR 50 Appendix B, Criteria III (Design Control), in that, a design basis requirement for the Unit 1 auxiliary feedwater pump turbine governor oil viscosity was not correctly translated into a March 2001 procedure revision. The procedure revision failed to require the main steam valve house room temperature to be above that required for minimum vendor specified governor oil viscosity. This non-cited violation contributed to the pump's failure to continue to operate after starting in response to a reactor trip on January 25, 2003.

This finding is greater than minor because it affected the reliability of the Unit 1 turbine driven auxiliary feedwater pump. However, the finding was determined to be of very low safety significance since (1) except for January 25, 2003, conditions after the procedure change in March 2001 would not have been expected to lower main steam valve house room temperatures below acceptable temperatures, and (2) on January 25, 2003, the two motor driven auxiliary feedwater pumps were operable and performed as expected. Surry personnel tracked corrective actions for this issue under plant issue S-2003-5822.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Emergency Diesel Generator No. 3 Bus-Tie Breaker Control Circuit Design Deficiency

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control because emergency diesel generator (EDG) no. 3 could have been overloaded following a concurrent loss-of-offsite power on Units 1 and 2. The licensee has resolved the problem through a modification of the breaker control circuitry.

This finding is greater than minor because it is associated with EDG performance and affects the mitigating systems cornerstone objective. The finding is of very low safety significance because the inspectors determined that the automatically connected loads are less than the 168-hour rating of the EDG.

Inspection Report# : [2003004\(pdf\)](#)

Significance:  Apr 05, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Take Adequate Corrective Actions to Preclude Additional De-alloying Failures for Valves in the Charging Service Water System

The licensee failed to take adequate corrective actions to preclude additional de-alloying failures for valves in the charging service water system after a failure had occurred in August 2001.

A self-revealing non-cited violation of 10 CFR 50, Appendix B, Criterion XVI was identified. This finding is more than minor because of the potential impact on the reliability of the safety injection system. The finding is of very low safety significance because the failure did not actually cause the loss of cooling to the charging pumps.

Inspection Report# : [2003002\(pdf\)](#)

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\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Dec 05, 2003

Identified By: NRC

Item Type: FIN Finding

Biennial Problem Identification and Resolution Report

The team concluded that Surry personnel were properly identifying problems and entering them into the corrective action program at a threshold that supported safe plant operation. The team did not identify instances where conditions adverse to quality were handled outside the corrective action process. The team further concluded that evaluations were prioritized and completed in a timely fashion consistent with the safety significance of the issue. Cause evaluations generally were found to address technical issues to a depth necessary to identify likely causes. The team identified one finding regarding a less than adequate procedure change evaluation that impacted the reliability of the Unit 1 turbine driven auxiliary feedwater pump. The team found that corrective actions were adequately tracked and completed in a time frame commensurate with their safety significance.

Inspection Report# : [2003009\(pdf\)](#)

Last modified : March 02, 2004