

## Surry 2

### 2Q/2004 Plant Inspection Findings

#### Initiating Events

#### Mitigating Systems

**Significance:** **G** Jan 07, 2004  
Identified By: NRC

Item Type: NCV NonCited Violation  
**Alternate Shutdown Panel Ventilation System Not Independent From Impacts Of A Main Control Room Fire.**

A Green non-cited violation was identified for failure to comply with 10 CFR 50, Appendix R, Sections III.G.3.a and III.L.3. Specifically, the shared ventilation system between the main control room (MCR) and the Unit 1 and Unit 2 emergency switchgear and relay rooms (ESGRs), did not have adequate separation, isolation, or barriers to preclude smoke and toxic gases from being transported to the ESGRs during a fire in the MCR. The alternative shutdown capability for an MCR fire is located in each unit's ESGR, respectively. Consequently, operators may not have the environmental conditions or visibility to safely man and accomplish a successful shutdown of either Unit 1 or Unit 2 from the Auxiliary Shutdown Panels. The licensee has entered this finding into its corrective action program.

This finding is greater than minor because it was associated with the "protection against external factors" attribute and affected the objective of the Mitigating Systems cornerstone to ensure the availability, reliability, and capability of systems that respond to initiating events. This finding was determined to be of very low safety significance because heat from a fire, and the natural buoyancy of smoke, will cause the smoke gas layer to accumulate near the ceiling of the MCR (away from the ESGRs), the likelihood of a severe fire in the MCR is low, and the prompt response and actions of the MCR operators and the fire brigade would prevent any fires that start from becoming severe.

Inspection Report# : [2003008\(pdf\)](#)

**Significance:** **G** 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\(pdf\)](#)

#### Barrier Integrity

**Significance:** **G** Dec 27, 2003  
Identified By: NRC

Item Type: NCV NonCited Violation  
**Violation of 10 CFR 50.55a(b)(2)(ix) for Failure to Perform Examinations of the Unit 2 Containment Liner in Accordance with Requirements of Subsection IWE of ASME Section XI.**

The inspectors identified a non-cited violation of 10 CFR 50.55a(b)(2)(ix), for failure to examine the metal liner of the Unit 2 concrete containment in accordance with Subsection IWE of Section XI of the 1992 Edition with the 1992 Addenda of the ASME Code

Failure to perform inspections of containment moisture barriers, failure to identify defective areas in the moisture barrier, and failure to correct the defects were of greater than minor significance because they could lead to more significant degradation of the containment. The licensee's inspection procedures were not adequate to identify the degraded moisture barrier and the condition may not have been identified because the licensee's inspection program was pre-conditioned based on the details shown on drawings and not actual observations. Degradation of the moisture barrier had the potential to permit moisture intrusion into inaccessible areas of the pressure retaining surfaces of the containment liner. The performance deficiency was of very low safety significance because sufficient corrosion of the containment vessel had not occurred to cause an open pathway in the physical integrity of the containment.

Inspection Report# : [2003005\(pdf\)](#)

---

## Emergency Preparedness

---

## Occupational Radiation Safety

---

## Public Radiation Safety

---

## Physical Protection

[Physical Protection](#) information not publicly available.

---

## 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 : September 08, 2004