

Surry 2

4Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: SL-IV Dec 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Proceduralized Departures from TS

The inspectors identified a Severity Level IV non-cited violation of 10 CFR 50.59, "Changes, Tests, and Experiments." Specifically, the licensee implemented proceduralized departures from the approved station technical specifications (TS) without the required NRC approval in procedures AP-13.0, Turbine Building Flooding, revision 13, and FCA 6.01, Uncontrollable Turbine Building Flooding, revision 2.

This finding was evaluated using traditional enforcement since it impacted or impeded the regulatory process in that the licensee improperly used the 10 CFR 50.59, "Changes, Tests, and Experiments," process to incorporate operator actions inconsistent with the TS. This finding was of more than minor safety significance because the procedure changes improperly bypassed the required NRC review and approval prior to implementation. The unapproved procedural actions would only be involved at the end of a very rare accident sequence. Given the time during the accident sequence in which these actions were to be accomplished, the actions were not a deterrent to core damage. Therefore, the violation was of very low safety significance. The finding is identified as Severity Level IV because the noncompliance is not considered to be of more than very low significance based on risk.

Inspection Report# : [2006005](#) (*pdf*)

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Removal of Damper Motor Operators From CO2 System in Normal Switchgear Rooms

The team identified a non-cited violation of Operating License Condition 3.I for removing the automatic feature of ventilation dampers which degraded the fixed gaseous suppression system in the normal switchgear room at both units by allowing carbon dioxide to flow out should the manual operated dampers be in the open position.

The finding is more than minor because it was associated with the reactor safety, mitigating systems cornerstone attribute of protection against external factors, i.e. fire, and it affected the objective of ensuring reliability and capability of systems that respond to initiating events. The finding is of very low safety significance because the frequency of fires potentially challenging mitigating systems was relatively low and multiple trains of shutdown equipment would be available.

Inspection Report# : [2006009](#) (*pdf*)

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure for Post-Fire Safe Shutdown During a Fire in Mechanical Equipment Room 3

The team identified a non-cited violation of Technical Specification 6.4.E for failure to provide an adequate post-fire safe shutdown procedure. Procedure 0-FCA-7.00, Rev. 10, failed to ensure that a source of water would be aligned to the suction of the charging pump service water pumps during a severe fire in Mechanical Equipment Room 3. Consequently, all charging pumps of both units could have no service water cooling resulting in pump overheating and failure.

The finding is greater than minor because it affected the objective of the mitigating system cornerstone to ensure the availability, reliability, and capability of systems that respond to initiating events. Since the procedure had been in place for less than one month and during that time a source of water could have been aligned, this finding is of very low safety significance.

Inspection Report# : [2006009](#) (*pdf*)

Significance:  Feb 10, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Non-Conservative ECA Procedure Setpoint for Operator Action to Secure LHSI and HHSI Pumps on Low RWST Level

The team identified a Green, non-cited violation (NCV) of Technical Specification 6.4.A.3, Unit Operating Procedures and Programs, for a non-conservative emergency contingency action (ECA) procedure setpoint regarding low Refueling Water Storage Tank (RWST) level. Specifically, the licensee failed to adequately address the potential for vortexing at low RWST levels into the determination of the RWST level for operator action to secure low head safety injection and high head safety injection pumps drawing suction from the RWST, in Procedures 1,2-ECA-1.1, Loss of Emergency Coolant Recirculation, Rev. 23. When the NRC notified the licensee of this condition, the licensee entered it into the corrective action program, and proceeded to revise the ECA setpoint in the affected procedures.

This finding is greater than minor because it is associated with the procedure quality attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring reliable, available, and capable systems that respond to initiating events to prevent undesirable consequences. This finding is of very low safety significance because no loss of safety function occurred and operators have been trained to identify loss of pump suction. This finding has been entered into the licensee's corrective action program as PIIant Issue S-2006-0334.

Inspection Report# : [2006006](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Significance:  Oct 27, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Activate ERDS Within One Hour of an Alert Declaration

A green self-revealing non-cited violation of 10 CFR 50.72(a)(4) was identified. During the October 7, 2006, partial loss of offsite power event, the licensee failed to activate the Emergency Response Data System (ERDS) within one hour of an Alert declaration. The ERDS was not made operable until approximately five and one-half hours after the Alert declaration due to an upgrade to the telephone exchange that had been done seven days prior to the event.

The finding is more than minor due to its impact on the Emergency Preparedness cornerstone objective to ensure that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency and the related attribute of Emergency Response Organization response. The finding is of very low safety significance (Green) because it involved a "failure to implement" (in distinction to a "failure to meet") an NRC emergency planning standard. The cause of the finding is related to the cross-cutting area of human performance, in that, the licensee failed to reprogram the telephone exchange following a telephone system change which occurred prior to the event. Upon discovery, the licensee immediately reprogrammed the telephone exchange and entered the problem into their corrective action program as condition report CR 002183.

Inspection Report# : [2006011](#) (*pdf*)

Significance: **W** Mar 29, 2006

Identified By: NRC

Item Type: VIO Violation

Failure of Exercise Critique to identify a RSPS weakness as a DEP PI opportunity Failure

The NRC identified an apparent violation (AV) for failure of the licensee's exercise critique process to properly identify a weakness associated with a risk-significant planning standard (RSPS) that was determined to be a Drill/Exercise Performance (DEP) Performance Indicator (PI) opportunity failure during a full-scale exercise. The AV is associated with emergency preparedness planning standards 10 CFR 50.47(b)(14) and 10 CFR 50.47(b)(4), and the requirements of 10 CFR 50, Appendix E, IV.F.2.g. This finding was not entered into the licensee's corrective action program.

The failure of the licensee's exercise critique process was a performance deficiency. This finding was greater than minor because it was associated with the Emergency Preparedness Cornerstone. The finding affects the associated cornerstone objective to ensure that the licensee was capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The finding was an identified weakness that demonstrated a level of performance that could preclude effective implementation of the Emergency Plan in an actual emergency. This finding was also determined to potentially have greater significance because the licensee's exercise critique process failed to properly identify a weakness associated with a RSPS that was determined to be a DEP PI opportunity failure during a full-scale exercise.

NRC inspection report 05000280, 281/2006010, issued July 25, 2006, closed the apparent violation to a violation with a final significance of White for both Units 1 and 2. The violation, designated as 05000280, 281/2006010-01, is listed below.

10 CFR 50.47(b)(4) requires, in part, that a standard emergency classification and action level scheme, the bases of which include facility system and effluent parameters, is in use by the nuclear facility licensee, and State and local response plans call for reliance on information provided by facility licensees for determinations of minimum initial offsite response measures.

10 CFR 50.47(b)(14) requires, in part, that periodic exercises be conducted to evaluate major portions of emergency response capabilities and deficiencies identified as a result of exercises be corrected.

10 CFR Part 50, Appendix E, Section IV.F.2.g, requires that all training, including exercises, shall provide for formal critiques in order to identify weak or deficient areas that need correction. Any weaknesses or deficiencies that are identified shall be corrected.

Contrary to the above, the licensee's formal critique of an emergency preparedness exercise conducted on February 7, 2006, failed to identify weak or deficient areas. Specifically, the exercise critique failed to identify that the Station Emergency Manager's Site Area Emergency event classification was an inaccurate classification.

Inspection Report# : [2006008](#) (*pdf*)

Inspection Report# : [2006010](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Last modified : March 01, 2007