

Surry 2 3Q/2013 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedure Results in Inoperability of One Train of Charging Pump Service Water

A self-revealing NCV of Technical Specification 6.4.D was identified for the failure to follow procedure 2-MOP-SW-001, "Charging Pumps Service Water Pumps Removal from and/or Return to Service," Revision 3 . Specifically, the licensee incorrectly implemented procedure steps that directed the tagout of the Unit 2 'A' train charging pump service water pump, which resulted in the inoperability of the Unit 1 'A' train charging pump service water pump. The issue was documented in the licensee's corrective action program (CAP) as CR 501208.

The inspectors determined that the failure to follow procedure 2-MOP-SW-001 was a performance deficiency that was within the licensee's ability to foresee and correct and should have been prevented. The inspectors determined that the finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Equipment Performance and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the closure of the Unit 1 'A' train charging service water pump discharge isolation valve resulted in the inoperability of that train and entry into the associated TS LCO. The inspectors screened this finding in accordance with IMC 0609, "Significance Determination Process," Attachment 4, "Initial Characterization of Findings," and IMC 0609, Appendix A, "SDP for Findings At-Power", and determined the finding was of very low safety significance (Green), since it did not cause a loss of operability or functionality of a single train for greater than its TS allowed outage time. The finding had a cross-cutting aspect in human performance, work practices, H.4(a), because inadequacies were identified associated with the pre-job brief, self-check practices, and proceeding in the face of unexpected circumstances. (Section 4OA3.3)

Inspection Report# : [2013002](#) (*pdf*)

Significance: G Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Submerged Cables Identified in Safety-Related Manhole

The inspectors identified a Green noncited violation of Technical Specification 6.4.A.7, which requires appropriate corrective maintenance procedures which would have an effect on the safety of the reactor. Specifically, Dominion procedure 0-MCM-1207-01, "Pumping of Security and Electrical Cable Vaults," was inadequate to prevent or detect submerged cables in a safety-related manhole, which is a performance deficiency.

The inspectors determined that Dominion procedure 0-MCM-1207-01, "Pumping of Security and Electrical Cable Vaults" was inadequate to accomplish its intended purpose, which constitutes a performance deficiency in accordance

with Technical Specification 6.4.A.7, which requires appropriate corrective maintenance procedures which would have an effect on the safety of the reactor. The inspectors determined that the finding was more than minor because it was associated with the mitigating systems cornerstone attribute of equipment performance and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, this condition could lead to cable degradation, increased likelihood of cable failure, and subsequent risk associated with the failure of safety-related equipment.

The inspectors screened this finding in accordance with IMC 0609, “Significance Determination Process,” Attachment 4, “Initial Characterization of Findings,” dated 6/19/12 and IMC 0609, Appendix A, “SDP for Findings At-Power”, dated 6/19/2012 and determined the finding was of very low safety significance, Green, since it was a deficiency determined not to have resulted in the loss of operability or functionality of a single train for greater than its TS allowed outage time. The finding had a cross-cutting aspect in problem identification and resolution, corrective action program, P.1(c), because the corrective actions taken to address previous NRC identified concerns in the same manhole did not thoroughly evaluate the problem such that resolutions addressed the causes. (Section 1R06)

Inspection Report# : [2012005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Jul 26, 2013

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The inspection team concluded that, in general, problems were adequately identified, prioritized, and evaluated; and effective corrective actions were implemented. Site management was actively involved in the corrective action program (CAP) and focused appropriate attention on significant plant issues. The team found that employees were encouraged by management to initiate condition reports (CRs) as appropriate to address plant issues.

The licensee was effective at identifying problems and entering them into the CAP for resolution, as evidenced by the relatively few deficiencies identified by the NRC that had not been previously identified by the licensee during the review period. The threshold for initiating CRs was appropriately low, as evidenced by the type of problems identified and large number of CRs entered annually into the CAP. In addition, CRs normally provided complete and accurate characterization of the problem.

Generally, prioritization and evaluation of issues were adequate and consistent with the licensee's CAP guidance. Formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems did address the cause of the problems. The age and extensions for completing evaluations were closely monitored by plant management, both for high priority condition reports, as well as for adverse conditions of less significant priority. Also, the technical adequacy and depth of evaluations (e.g., root cause investigations) were typically adequate.

Corrective actions were generally effective, timely, and commensurate with the safety significance of the issues. The operating experience program was effective in screening operating experience for applicability to the plant, entering items determined to be applicable into the CAP, and taking adequate corrective actions to address the issues. External and internal operating experience was adequately utilized and considered as part of formal root cause evaluations for supporting the development of lessons learned and corrective actions for CAP issues. The licensee's audits and self-assessments were critical and effective in identifying issues and entering them into the corrective action program. These audits and assessments identified issues similar to those identified by the NRC with respect to the effectiveness of the CAP.

Based on general discussions with licensee employees during the inspection, targeted interviews with plant personnel, and reviews of selected employee concerns records, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP as well as the employee concerns program to resolve those concerns.

Inspection Report# : [2013007](#) (pdf)

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