UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
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ATLANTA, GEORGIA 30303-1257

August 4, 2011

Mr. Mano Nazar
Executive Vice President and Chief Nuclear Officer
Florida Power and Light Company
P.O. Box 14000
Juno Beach, FL 33408-0420

SUBJECT: TURKEY POINT UNIT 4 NUCLEAR PLANT– NRC SUPPLEMENTAL INSPECTION REPORT 05000251/2011012 AND ASSESSMENT FOLLOW-UP LETTER

Dear Mr. Nazar:

On July 14, 2011, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection pursuant to Inspection Procedure 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," at your Turkey Point Nuclear Plant. The enclosed inspection report documents the inspection results which were discussed at an exit meeting on July 14 with Mr. Kiley and other members of your staff. Additionally, implementation of corrective actions was discussed during a regulatory performance meeting with Mr. Kiley and your staff on the same date.

As required by the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed to examine the causes for and actions taken related to the Unplanned Scrams per 7000 Critical Hours performance indicator crossing the threshold from Green (very-low risk significance) to White (low-to-moderate risk significance) in the fourth quarter of 2010. The NRC was informed on February 3, 2011, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root and contributing causes were understood, (2) the extent of condition and extent of cause were identified, and (3) corrective actions were sufficient to address the root and contributing causes and to preclude repetition. The inspection consisted of examination of activities conducted under your license as they related to safety, compliance with the commission's rules and regulations, and the conditions of your operating license. The inspector revised selected procedures and records, observed activities and interviewed personnel.

Based on the results of this inspection, no findings of significance were identified. The inspectors determined that, in general: (1) the root and contributing causes were understood, (2) the extent of condition and extent of cause were identified, and (3) corrective actions were sufficient to address the root and contributing causes and to preclude repetition. As a result, the NRC determined the performance of Turkey Point Unit 4 to be in the Licensee Response Column of the Reactor Oversight Process Action Matrix as of the date of this letter.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Daniel W. Rich, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Docket Nos.: 50-251
License Nos.: DPR-41

Enclosure: Inspection Report 05000251/2011012
w/ Attachment: Supplemental Information

cc w/ encl. (See page 3)

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No.:	50-251
License No.:	DPR-41
Report No:	05000251/2011012
Licensee:	Florida Power & Light (FP&L)
Facility:	Turkey Point Nuclear Plant, Unit 4
Location:	9760 S. W. 344th Street Homestead, FL 33035
Dates:	July 11 to July 14, 2011
Inspectors:	R. Cureton, Resident Inspector, Catawba Nuclear Plant A. Alen, Reactor Engineer
Approved by:	Daniel W. Rich, Chief Reactor Projects Branch 3 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

Inspection Report (IR) 05000251/2011012; 7/11/2011 – 7/14/2011; Turkey Point Nuclear Plant, Unit 4; Supplemental Inspection for a White Performance Indicator (PI)

This inspection was conducted by a resident inspector and a reactor engineer. No findings were identified.

Cornerstone: Initiating Events

This supplemental inspection was performed in accordance with Inspection Procedure (IP) 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with a White Performance Indicator (PI) in the Initiating Events cornerstone associated with greater than four reactor trips in 7000 critical hours.

The Unplanned Scrams (Reactor Trips) per 7000 Critical Hours performance indicator crossed the threshold from Green (very-low risk significance) to White (low-to-moderate risk significance) in the fourth quarter of 2010. Specifically, the licensee experienced unplanned reactor trips on the following dates: January 11, 2010, September 8, 2010, September 21, 2010, and December 9, 2010.

The inspectors determined that the licensee's problem identification, root cause, extent of condition evaluation, extent of cause evaluation, and the corrective actions for the four unplanned reactor trips were generally adequate and properly prioritized.

Given the licensee's adequate evaluation addressing the White PI, it will no longer be considered an input in assessing plant performance since the PI for trips in 7000 critical hours has reverted to Green and the 95001 Inspection has been completed successfully in accordance with the guidance in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program." The implementation and effectiveness of the licensee's corrective actions will be reviewed during future inspections.

A. NRC-Identified and Self-Revealing Findings

None.

B. Licensee-Identified Violations

None.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 Supplemental Inspection (95001)

.1 Inspection Scope

The supplemental inspection was performed in accordance with IP 95001 to assess the licensee's evaluation of a White PI which affected the Initiating Events Cornerstone objective in the Reactor Safety strategic performance area. The White PI is associated with having greater than three reactor trips in 7000 critical hours. The inspection objectives were to:

- Provide assurance that the root and contributing causes were understood;
- Provide assurance that the extent of condition and extent of cause were identified; and
- Provide assurance that the licensee's corrective actions were sufficient to address the root and contributing causes and to preclude repetition.

The licensee entered the Regulatory Response Column of the NRC's Action Matrix based on the Unplanned Scrams per 7000 Critical Hours PI crossing the threshold from Green to White in the fourth quarter of 2010. The licensee notified the NRC on February 3, 2011, that they were ready for this supplemental inspection. The four unplanned reactor trips reviewed were:

- January 11, 2010 – A manual reactor trip was initiated by the operators due to steam generator (SG) level rising greater than 75% as the operators attempted to recover from a manual trip of the 4A steam generator feedwater pump (SGFP) (AR 403651)
- September 8, 2010 – An automatic reactor trip occurred during completion of a replacement of the 4B Reactor Protection System (RPS) Left Turbine Stop Valve Relay (AR 578473)
- September 21, 2010 – An automatic reactor trip occurred due to a spurious High Pressurizer Pressure signal on Channel I loop while the Channel II loop bistables were tripped for a surveillance (AR 581322)
- December 9, 2010 – A rapid downpower and subsequent manual reactor trip was initiated by the operators due to an increasing sodium level concentration in the condensate and feedwater system from a condenser tube leak in the 4BN main condenser tube bundle. (AR 01600528)

In addition to the root cause evaluations for each reactor trip, the inspectors reviewed root cause evaluation AR01612329. This investigation evaluated all four reactor trips to identify any similarities with the reactor trips, and identify additional actions needed to reduce reactor trips. The inspectors reviewed the root and contributing causes as well as the corrective actions taken or planned for all four reactor trips. The inspectors also held discussions with licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood and corrective actions taken or planned were appropriate to address the causes and preclude repetition.

.2 Evaluation of the Inspection Requirements

2.01 Problem Identification

a. Determine that the evaluation identifies who (i.e. licensee, self revealing, or NRC), and under what conditions the issue was identified

The inspectors determined that the licensee's evaluation of these unplanned reactor trips appropriately determined who and under what conditions the issue was identified.

All four reactor trips were classified as self revealing events.

b. Determine that the evaluation documents how long the issue existed, and prior opportunities for identification

The January 11, 2010 reactor trip was a manual reactor trip due to high steam generator water level. The SG water level transient began when a fast power reduction was initiated to support removing the 4P1A SGFP from service due to leaking oil and water from the pump outboard end. Due to the degrading lube oil inventory the pump was tripped from the control room at 90% power. The feedwater pump trip resulted in a turbine runback and subsequent steam generator level decrease. Steam generator levels recovered and continued to increase until operators manually tripped the Unit 4 reactor at SGs level greater than 75%. The oil level loss was caused by water intrusion into the outboard bearing housing labyrinth seal which became hydraulically locked, creating a siphoning (pumping) effect that drained oil from the bearing housing and main oil reservoir. The water intrusion was caused by flooding of the seal leak-off drain cavity (located next to the bearing housing) when seal water injection controls failed to control an increase in seal injection flow. Additionally, further investigation identified the seal leak-off cavity drain was partially clogged with foreign material. The licensee determined that there were no prior opportunities for identification because for this trip to occur the issues with the seal water controls and pump bearing cavity drain blockage would have to happen concurrently. The licensee did, however, identify previous individual missed opportunities for identification and correction of pump/motor water intrusion mechanisms and seal water injection equipment obsolescence issues.

The September 8, 2010, reactor trip was an automatic reactor trip which resulted from lifting the leads on RPS relay 4-SL-X-B for the Left Turbine Stop Valve while the reactor trip bypass breaker was open. The operators performed 4-OSP-049.1 "Reactor Protection System Logic Test" in which the licensee closed reactor trip bypass breaker 4B and entered Technical Specification (TS) 3.3.1 and the associated 2-hour action

statement. During performance of the procedure, relay 4-SL-X was identified as degraded. As a result the licensee entered TS 3.3.1 and the associated 6-hour action statement. In order to exit the 2-hour action statement, the licensee opened the reactor trip bypass breaker 4B and entered off-normal operating procedure 4-ONOP-049.1 "Deviation or Failure of Safety Related Reactor Protection Channels." After exiting the ONOP the licensee proceeded to replace the degraded relay in accordance with plant procedures; however, when the licensee lifted the leads to the relay, a reactor trip occurred due to the bypass breaker still being open. The licensee determined that the event was caused by process deficiencies in verifying required plant conditions for an evolution, as well as meeting plant expectations associated with communication, accountability, ownership, formality and rigor. The issue was determined to be a self-revealing violation and was documented in NRC inspection report 05000251/2010004. The licensee determined that there were no prior opportunities for identification.

The September 21, 2010, reactor trip was an automatic reactor trip due to a spurious High Pressurizer Pressure signal caused by spread pin defects in ELCO connectors for a comparator module in the Channel I Pressurizer Pressure Loop. The licensee determined this condition had existed before and previous corrective actions included development of visual inspection criteria in all replacement module work orders. However, the inspection criteria proved to be ineffective in detecting spread pin defects. This issue was determined to be a licensee identified violation and was documented in NRC inspection report 05000251/2011002.

The December 9, 2010, reactor trip involved a rapid power reduction and subsequent manual trip when a main condenser high conductivity/sodium alarm was received in the control room. The operators commenced a rapid power reduction and manually tripped the reactor at approximately 20-percent power, in accordance with plant procedures. Further investigation identified that tube R411/T5 of the 4BN main condenser was leaking and the condition revealed itself with the high conductivity/sodium alarm. The licensee determined that there were no prior opportunities for identification.

The inspectors determined that the licensee appropriately identified how long the above discussed conditions existed and any prior opportunities for identification.

c. Determine that the evaluation documents the plant risk specific consequences (as applicable) and compliance concerns associated with the issue

The licensee evaluated the risk significance impact (core damage frequency) of having four unplanned reactor trips as 7.9 E-07 per year, which is less than the Green threshold of 1.0 E-06 per year.

The inspectors reviewed the licensee's assessment of the plant-specific risk consequences of the unplanned reactor trips with a senior risk analyst in the region and determined it to be adequate.

d. Findings

No findings were identified.

2.02 Root Cause, Extent of Condition, and Extent of Cause Evaluation

a. Determine that the problem was evaluated using a systematic method(s) to identify root cause(s) and contributing cause(s)

The inspectors noted that the licensee used combinations of different systematic methods to identify root and contributing causes for the four unplanned reactor trips; equipment performance analysis, support/refute methodology, cause and effect analysis, barrier analysis, and human performance analysis. Additionally, the inspectors determined that the methods used were appropriate to the technical complexity of the issues evaluated.

For the January 11, 2010 reactor trip, the licensee utilized support/refute methodology, fishbone analysis and effect and causal analysis to identify the root and contributing causes for the unresponsive seal water injection flow and feed water pump bearing cavity drain blockage.

For the September 8, 2010, reactor trip, the licensee utilized event and causal analysis and barrier analysis to identify the root and contributing causes for the failure to verify plant conditions prior to lifting leads on the 4-SL-X-B relay.

For the September 21, 2010, reactor trip, the licensee utilized support/refute methodology and event and causal analysis to identify the cause for the spurious Loop I Pressurizer Pressure signal.

For the December 9, 2010, reactor trip, the licensee utilized support/refute methodology, event and causal analysis, and fishbone analysis to identify the root and contributing causes for the 4BN main condenser tube failure.

b. Determine that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem

For the four reactor trips, the inspectors determined that the root cause evaluations were of sufficient detail to support the identified root and contributing causes and were commensurate with the significance of the problem.

For the January 11, 2010, reactor trip, the licensee determined that the root cause of the event was due to unresponsive seal water injection control which resulted in excessive seal water injection flow to the 4P1A SGFP outboard seal coincident with a blockage of the seal water leak-off cavity drain.

For the September 8, 2010, reactor trip, the licensee determined that there were two root causes. The first root cause was deficiencies in the work order package and guiding procedure failed to establish and/or verify plant status control required to complete the evolution and relied on operations staff to provide validation that the evolution could be performed. The second root cause was a failure to meet the licensee's standard of excellence expected for communication, accountability, ownership, formality, and rigor resulting in no one group having the full picture required to successfully complete the evolution. The licensee also identified contributing causes in the areas of process and human performance.

For the September 21, 2010, reactor trip, the licensee determined that the root cause to be component failures due to inadequate installation instruction and inspection criteria for the ELCO connectors.

For the December 9, 2010, reactor trip, the licensee attributed the 4BN main condenser tube failure to axial cracking. The licensee determined that there were two root causes for the tube axial cracking failure. The first root cause was high cycle fatigue, which was caused by steam flow induced vibrations in the condenser. The second root cause was improper initial tube installation techniques that caused a latent metallurgical defect, which when combined with high cyclic loading, supported fatigue crack initiation. The licensee submitted the failed tube to metallurgical laboratory analysis and confirmed the root causes identified above.

c. Determine that the root cause evaluation included a consideration of prior occurrences of the problem and knowledge of prior operating experience

The inspectors determined that each of the root cause evaluations for the four unplanned reactor trips had adequately considered prior occurrences of the problem and knowledge of prior operating experience.

d. Determine that the root cause evaluation addressed the extent of condition and the extent of cause of the problem

The inspectors determined that the evaluations for each unplanned reactor trip adequately addressed extent of condition and extent of cause. The inspectors also noted that the licensee implemented corrective actions to address issues identified by the extent of condition or extent of cause analyses.

In addition, the inspectors reviewed the licensee's root cause evaluation which was performed to evaluate commonalities between the four unplanned reactor trips. Within this evaluation, the licensee conducted another extent of condition and extent of cause evaluation that considered all four events in aggregate. The licensee developed additional corrective actions for the root cause identified by this evaluation and for the contributing causes the licensee initiated separate apparent causes that were reviewed for adequacy.

e. Determine that the root cause evaluation, extent of condition, and extent of cause appropriately considered the safety culture components as described in IMC 0305

The inspectors determined that the safety culture components were appropriately considered and reviewed for all four unplanned reactor trips.

f. Findings

No findings were identified.

2.03 Corrective Actions

a. Determine that appropriate corrective actions are specified for each root/contributing cause or that there is an evaluation that no actions are necessary

The inspectors determined that appropriate corrective actions were established to address each of the root and contributing causes for all four unplanned reactor trips evaluations.

For the January 11, 2010, reactor trip, the licensee implemented corrective actions to replace the obsolete Unit 3 and 4 SGFP seal water controllers with a more responsive controller. Corrective actions also included implementation of preventative maintenance to verify the pump's cavity drains are clear of debris, periodically during operation, after completion of maintenance, and prior to SGFP starts.

For the September 8, 2010, reactor trip, the licensee implemented various corrective actions by communicating to the staff expectations for accountability, ownership, formality, and communication. These communications were accomplished by an all hands meeting to stress station expectations, development of a case study using lessons learned from the event, and by publishing guidance on decision making expectations for short duration TS and Limiting Conditions of Operation statements. The licensee also added requirements to the work order preparation checklist to ensure plant conditions are verified before proceeding with work.

For the September 21, 2010, reactor trip, the licensee developed detailed installation instructions and inspection criteria for the ELCO connectors. The instructions addressed the potential to cause spread pin damage while mating the connectors. The instructions also addressed using a spare pin to insert into each connector pin as a means of physical detection rather than just visual. The licensee also provided formal training to technicians on the new installation instructions and inspection criteria.

For the December 9, 2010, reactor trip, the licensee took interim corrective actions to perform eddy current testing (ECT) in the area of the leaking tube and subsequently plugged the affected and surrounding tubes before returning the unit to operation. During the next refueling outage, the licensee removed the failed tube and submitted it to metallurgical analysis to validate the root causes described in section 02.02(b) of this report. Additionally, the licensee performed 100% ECT of the 4BN condenser tubes and 50% ECT on the rest of the Unit 4 condenser tube bundles. Long term corrective actions include replacement of the Unit 3 and 4 condenser tube bundles as a part of the extended power uprate project (Spring 2012 and Winter 2013, respectively) followed by 100% ECT of all newly installed tube bundles.

The inspectors also reviewed the licensee's root cause evaluation which was performed to evaluate the four reactor trips for any commonalities. The licensee identified the root cause to be inadequate recognition of risk with the corrective action to prevent recurrence being to improve site wide risk awareness by developing four case studies related to risk recognition. The licensee also identified several broad contributing causes with apparent cause evaluations for each area.

b. Determine that the corrective actions have been prioritized with consideration of the risk significance and regulatory compliance

The inspectors determined that the corrective actions for the events were appropriately prioritized relative to their risk significance and regulatory compliance.

c. Determine that a schedule has been established for implementing and completing the corrective actions

The inspectors determined that the corrective actions for the events have been completed or reasonably scheduled.

d. Determine that quantitative or qualitative measures of success have been developed for determining the effectiveness of the corrective actions to prevent recurrence

The inspectors determined that effectiveness reviews had been completed or were scheduled for the causes of the four unplanned reactor trips. Additionally, the inspectors determined that each effectiveness review had quantitative or qualitative criteria established to measure success.

e. Determine that the corrective actions planned or taken adequately address a Notice of Violation (NOV) that was the basis for the supplemental inspection, if applicable

The NRC did not issue an NOV to the licensee: therefore this inspection requirement is not applicable.

f. Findings

No findings were identified.

4OA6 Meetings, Including Exit

.1 Exit Meeting Summary

On July 14, 2011, the inspectors presented the inspection results to Mr. Kiley and other members of the FPL staff. The inspectors confirmed that no proprietary information was obtained during the course of the inspection.

Additionally, on July 14, 2011, a regulatory performance meeting was held with Mr. Kiley and the FPL staff to review the results of the root cause analyses and proposed corrective actions.

ATTACHMENT: SUPPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee personnel:

V. Barry, Operations, Senior Reactor Operator
P. Czaya, Licensing Engineer
M. Kiley, Site Vice President
L. Nicholson, Florida Power & Light, Licensing Director
R. Wright, Operations Manager

NRC personnel:

S. Stewart, Senior Resident Inspector – Turkey Point
D. Rich, Chief, Reactor Projects Branch 3, Division of Reactor Projects Region II

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

None

LIST OF DOCUMENTS REVIEWED

Procedures
0-ADM-070 Change Authorization Request (CAR), 2/28/2010
3-NOP-074, Steam Generator Feedwater Pump, Rev 5
4-NOP-074, Steam Generator Feedwater Pump, Rev 0
3-NOP-081, Heater Drain Pumps, Rev 4
0-CMM-074.3, Feedwater Pump Repair, 0A
PI-AA-205, Condition Evaluation and Corrective Action, Rev 12
PI-AA-100-1005, Root Cause Analysis, Rev 4
PI-AA-100-1006, Common Cause Analysis, Rev 3
PI-AA-100-1007, Apparent Cause Analysis, Rev 4
0-ADM-059, Root Cause Analysis, 7/23/2008
WM-AA-1000, Work Activity Risk Management, Rev 8
WM-AA-1000-F01, Work Activity Risk Evaluation Form, Rev 4
WM-AA-1000-F02, Risk Management Plan, Rev 1
0-GMI-102.48, ELCO Connector; Inspection and Replacement, Rev 0
0-ADM-701.1, Desktop Instructions for PWO Planning and Assembly of Work Packages, Rev 6 & Rev 9
0-CMI-049.1, Testing and Replacement of BFD/NBFD Relays in Reactor Protection and Safeguards System, Rev 0 & Rev 0A
0-ADM-068, Work Week Management, Rev 6
F-503, Work approval after scope freeze, Rev 8

ARs
0160519, U4 Manual reactor trip due to condenser tube leak
01641525, As-found condition of the 4BS condenser based on 50% ECT
01636528, Root Cause Evaluation Report for U4 Manual reactor trip due to condenser tube leak
01657993, Quick hit self assessment for ARs 1600519 and 1636528
2007-39254, Water intrusion into various pump/motors
00403651, CR 2010-679-Forced Outage – PTN4 Manual reactor trip on steam generator high level
01665609, Unit 3/4 SGFPs seal water temperature control system replacements will not control in AUTO (Interim Disposition)
01612329, RCE for NRC Performance Indicator – U4 unplanned scrams per 7000 hrs
00451158, CR 2008-9909-FI-3-436 - Channel III Loop C RCS flow, failed low
00406450, CR 2009-33562 – Spurious HI Pressurizer pressure trip
2005-20853, Collective evaluation for unplanned scrams NRC performance indicator
00581322, Spurious automatic reactor trip on Unit 4
00578473, Unit 4 Auto Tripped from 100% power

Miscellaneous
LER 2010-008-00, Manual Rx trip due to condenser tube leak
LER 2010-002-00, Reactor trip resulting from steam generator feedwater pump trip
LER 2010-006-00, Automatic Reactor Trip due to spurious high pressurizer trip signal
FPL Turkey Point 3 & 4 Condenser Component Specific Technique Sheets, Rev 2 Turkey Point 95001 Inspection July 11-14, 2011 (Power Point Presentation provided toinspectors upon beginning of inspection)
WO #18000114-01, 3P1A pump quarterly oil sample
WO #18000115-01, 3P1B pump quarterly oil sample
WO #18000213-01, 4P1A pump quarterly oil sample
WO #18000214-01, 4P1B pump quarterly oil sample
PTN Nuclear Training Department Attendance Roster, CR-210-679 – Obsolesence Issues, 6/25/2010
Functional Failure Determination Checklist for CR 2010-679, 3/5/2010
Quick Hit Self-Assessment Report for AR 00403651
Quick Hit Self-Assessment Report on RCE for AR 00581322
Quick Hit Self-Assessment Report on RCE for AR 00578473
NRC 95001 Readiness Review Checklist for AR#00403651
NRC 95001 Readiness Review Checklist for AR#01600519 and 1636528
NRC 95001 Readiness Review Checklist for AR#00581322
NRC 95001 Readiness Review Checklist for AR#00578473
Risk Assessment Checklist
FPL Turkey Point Nuclear Plant Root Cause Evaluation Handbook, Rev 0
FPL Turkey Point Nuclear Plant Apparent Cause Evaluation Handbook, Rev 0
FPL PTN Nuclear Training Department, Dynamic Learning Activity N. 02, ELCO Connectors 8016 Series, (Reviewed 5/11/2011)
PTN Nuclear Training Department Attendance Roster on: I900911 and DLA 02, 6/3/2011
PTN Nuclear Training Department Attendance Roster on: I900911 and DLA 02, 6/9/2011
PTN Nuclear Training Training Schedule for I%C Continuing Training Cycle I 2011, (Trng Period 5/31/11 – 8/05/11)

Apparent Cause Evaluation for CR2010-154444 / AR 406646
Apparent Cause Evaluation for CR 2008-32083
Desktop Instructions for PWO planning and assembly of work packages, Rev 24
Human Performance Observation and Coaching, NUC HUP102 – FPL Common HU Training for Managers and Supervisors
Turkey Point Plant High/Medium Risk Program Flow Chart

Action Requests generated as a result of this inspection
01669192 – Inspection of pump drains for proper drainage
01669200 - Engineering training issue in AR 403651 missed the intent of the action request.
01669387 – 95001 Inspection observation of CAPR implementation of AR403651