UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET, SW, SUITE 23T85
ATLANTA, GEORGIA 30303-8931

October 3, 2006

Florida Power and Light Company
ATTN: Mr. J. A. Stall, Senior Vice President
Nuclear and Chief Nuclear Officer
P. O. Box 14000
Juno Beach, FL 33408-0420

SUBJECT: ST LUCIE NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 050000335/2006008 AND 05000389/2006008

Dear Mr. Stall:

On August 25, 2006, the U. S. Nuclear Regulatory Commission (NRC) completed a team inspection at your St. Lucie Nuclear Plant, Units 1 and 2. The enclosed inspection report documents the inspection findings, which were discussed on August 25, 2006, with Mr. Gordon Johnston and other members of your staff during an exit meeting.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, there were no findings of significance identified during this inspection. The inspectors concluded that problems were properly identified, evaluated, and resolved within the problem identification and resolution programs (PI&R).

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system

(ADAMS). ADAMS is accessible from the NRC Web-site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Joel T. Munday, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Docket Nos. 50-335 and 50-389
License Nos. DPR-67 and NPF-16

Enclosure: Inspection Report 05000335/2006008 and 05000389/2006008
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

(ADAMS). ADAMS is accessible from the NRC Web-site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Joel T. Munday, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Docket Nos. 50-335 and 50-389
License Nos. DPR-67 and NPF-16

Enclosure: Inspection Report 05000335/2006008 and 05000389/2006008
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

☐ PUBLICLY AVAILABLE ☐ NON-PUBLICLY AVAILABLE ☐ SENSITIVE ☐ NON-SENSITIVE

ADAMS: ☐ Yes ACCESSION NUMBER:_____

OFFICE	RII:DRS	RII:DRP	RII:DRP	RIII:DRP	RII:DRP	RII:DRP	
SIGNATURE	SJV	JSS1	SPS	DCE	JHW2	ODM	
NAME	SVias:rcm	SStewart	SSanchez	DEskins	JWallo	ODeMiranda	
DATE	09/26/2006	09/27/06	09/29/06	09/28/06	10/02/06	09/27/2006	10/ /2006
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: E:\Filenet\ML062770011.wpd

cc w/encl:
William E. Webster
Vice President, Nuclear Operations
Florida Power & Light Company
Electronic Mail Distribution

Gordon L. Johnston
Site Vice President
St. Lucie Nuclear Plant
Florida Power & Light Company
Electronic Mail Distribution

Christopher R. Costanzo
Plant General Manager
St. Lucie Nuclear Plant
Electronic Mail Distribution

Bill Parks
Operations Manager
St. Lucie Nuclear Plant
Electronic Mail Distribution

Terry L. Patterson
Licensing Manager
St. Lucie Nuclear Plant
Electronic Mail Distribution

Mark Warner, Vice President
Nuclear Operations Support
Florida Power & Light Company
Electronic Mail Distribution

Rajiv S. Kundalkar
Vice President - Nuclear Engineering
Florida Power & Light Company
Electronic Mail Distribution

Seth B. Duston
Training Manager
Florida Power & Light Company
Electronic Mail Distribution

M. S. Ross, Managing Attorney
Florida Power & Light Company
Electronic Mail Distribution

Marjan Mashhadi, Senior Attorney
Florida Power & Light Company
Electronic Mail Distribution

William A. Passetti
Bureau of Radiation Control
Department of Health
Electronic Mail Distribution

Craig Fugate, Director
Division of Emergency Preparedness
Department of Community Affairs
Electronic Mail Distribution

J. Kammel
Radiological Emergency
Planning Administrator
Department of Public Safety
Electronic Mail Distribution

Douglas Anderson
County Administrator
St. Lucie County
2300 Virginia Avenue
Ft. Pierce, FL 34982

Distribution (See page 4)

Report to J. A. Stall from Joel T. Munday dated October 3, 2006

Distribution w/encl:
B. Moroney, NRR
C. Evans (Part 72 Only)
L. Slack, RII EICS
OE Mail (email address if applicable)
RIDSNRRDIRS
PUBLIC

U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.:	05000335, 05000389
License Nos.:	DPR-67 and NPF-16
Report Nos.:	05000335/2006008 and 05000389/2006008
Licensee:	Florida Power & Light Company (FPL)
Facility:	St Lucie Nuclear Plant, Units 1 & 2
Dates:	August 7-25, 2006
Inspectors:	S. J. Vias, Senior Reactor Inspector, Lead Inspector S. Stewart, Senior Resident Inspector, Turkey Point S. Sanchez, Resident Inspector, St Lucie D. Eskins, Resident Inspector, LaSalle J. Wallo, Senior Security Inspector O. DeMiranda, Senior Allegation Coordinator
Approved by:	Joel Munday, Chief Reactor Projects Branch 3 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000335/2006008 and 05000389/2006008; on August 7-25, 2006; St. Lucie Nuclear Plant, Units 1 & 2; biennial baseline inspection of the identification and resolution of problems.

The inspection was conducted by two Senior Reactor Inspectors, one Senior Resident Inspector, two Resident Inspectors, and one Allegation Coordinator.

Identification and Resolution of Problems

The inspectors identified that the licensee was effective at identifying problems and entering them into the corrective action program. The licensee's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. The licensee effectively used risk in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementing corrective actions. Corrective actions, when specified, were generally implemented in a timely manner. Operating experience usage was also found to be effective. Self assessment results adequately identified problems. The inspectors identified a number of weaknesses that are detailed in the report in various aspects within the corrective action process.

On the basis of the samples selected for review, the inspectors concluded that, 1) in general problems were properly identified, evaluated, and corrected within your problem identification and resolution program, 2) the processes and procedures of your corrective action program were generally effective; thresholds for identifying issues were appropriately low, and in most cases, corrective actions were adequate to address conditions adverse to quality, and 3) on the basis of interviews conducted during this inspection, workers at the site felt free to input safety findings into the corrective action program.

A. Inspector Identified Findings

None

B. Licensee Identified Violations

None

REPORT DETAILS

4 OTHER ACTIVITIES (OA)

4OA2 Identification and Resolution of Problems

The inspectors based the following conclusions, in part, on issues that were identified in the assessment period, which ranged from March 1, 2004 (the last biennial problem identification and resolution inspection) to the end of the inspection on August 25, 2006. In addition, the inspectors reviewed problems for selected systems identified outside the planned assessment period whose significance might be age dependent.

a. Assessment of the Corrective Action Program Effectiveness

(1) Inspection Scope

The inspectors reviewed the licensee's corrective action program (CAP) procedures which described the administrative process for initiating and resolving problems through the use of condition reports (CRs). The inspectors reviewed selected CRs, and attended meetings where CRs were screened for significance, to determine if the licensee was identifying, accurately characterizing, and entering problems into the corrective action process at an appropriate threshold.

The inspectors reviewed condition reports of varying severity levels and from most site departments. The inspectors also conducted a detailed review of CRs for four risk significant systems. These systems were selected based on equipment performance history, Maintenance Rule (MR) considerations, and risk significance insights from the licensee's probabilistic safety assessment. The systems reviewed were Intake Cooling Water (ICW), Emergency Diesel Generators (EDG) including the starting air and fuel oil systems, Reactor Protection System (RPS), and Component Cooling Water (CCW). The inspectors reviewed the maintenance history and selected completed Work Orders (WOs) for the four systems and reviewed associated system health reports. Additional CRs were selected associated with MR evaluations and problems previously identified by the NRC. The inspectors also reviewed NRC inspection results of CRs documented in NRC reports over the previous two years. These reviews were performed to verify that problems were being properly identified, appropriately characterized, and entered into the CAP. In addition to the two year review, in accordance with the inspection procedure, a five year review was performed for the selected systems for issues the inspectors determined to be age dependant.

The inspectors reviewed licensee event reports, condition reports, selected licensee effectiveness reviews, work requests, and work orders tied to condition reports, along with the inspections discussed in this report, to verify that the licensee had implemented timely and appropriate corrective actions to address significant problems. The inspectors verified that the corrective actions were properly documented, assigned, and tracked to completion. The review was also to verify the adequacy of corrective actions to address equipment deficiencies and MR functional failures of risk significant plant safety systems.

The inspectors also conducted plant walkdowns of equipment associated with the four selected systems to assess the material condition and to look for any deficiencies that had not been previously entered into the CAP. Control Room walkdowns were performed by the inspectors to verify the main control room (MCR) deficiency list and to ascertain whether deficiencies were entered into the CAP.

The inspectors attended various plant meetings to observe management oversight functions of the corrective action process. These included morning meetings, Condition Report Oversight Group (CROG) meetings, Corrective Action Program Coordinator (CAPCO) meetings and Work Request Review meetings (per CR 2006-23991). The inspectors also held discussions with various personnel to evaluate their threshold for identifying issues and entering them into the CAP.

(2) Assessment

Effectiveness of Problem Identification

The inspectors determined that the licensee was generally effective at identifying problems and entering them into their CAP. The threshold for initiating CRs was low and employees were encouraged by management to initiate CRs. As a result, the inspectors observed that there was an increasing trend in the number of CRs generated over the last few years. However, this has placed an increased demand on the staff to provide timely and quality reviews and evaluations. This has also challenged the organization's ability to prioritize and evaluate CR issues in a timely manner, which oftentimes exceeded the evaluation completion time periods.

During the system walkdowns by the inspectors, very few conditions adverse to quality were identified by the inspectors not previously documented by the licensee. However, during a walkdown of the Unit 2 EDG rooms, inspectors identified ladders that had not been seismically evaluated as required by licensee procedures for safety related and seismic class 1 areas (CR 2006-23014). Though these areas were frequently walked down by operations staff, this issue was not identified by licensee personnel. This was considered a weakness in the area of problem identification relative to seismic storage requirements. The licensee initiated a CR documenting this concern.

During a review of a March 2005 maintenance event (CR 2005-07449), the inspectors noted that a related issue involving aspects of the security program, was not adequately identified in the licensee's corrective action program. Based on a subsequent review of this issue by the licensee, an additional condition report (CR 2006-22869) was issued which documents the issue and corrective actions taken to prevent recurrence. This inadequate review is considered a weakness in the area of problem identification, however, additional inspection is needed. Pending completion of additional inspection, this issue will be identified as URI 05000335, 389/2006008-01, Inadequate Review of Condition Report Concerning Security Issues.

Although the CAP program procedures suggested that senior management attend various CAP-related meetings, including the CAPCO and PWO screening meetings, the inspectors noted this to be rare. The licensee acknowledged this concern.

Effectiveness of Prioritization and Evaluation of Issues

The inspectors determined that the licensee was generally effective at problem prioritization and evaluation. Most evaluations were technically adequate and of appropriate depth. Among the documents reviewed, the inspectors identified no issues with the licensee's operability or reportability evaluations. In most cases, the licensee appropriately considered risk in prioritizing or evaluating issues. However, several weaknesses in this area were identified as discussed below.

The inspectors concluded that CAP-related meetings were well attended and participating members appeared to be prepared. Assignment of significance level and investigation types to CRs appeared to be in accordance with CAP procedures and guidance. In general, there was good discussion and interaction among the group members that the inspectors observed with the proper focus on reactor safety. In some cases the CR investigation type was changed from what was originally presented by the CAPCO screening meeting quorum to what was decided upon by the CROG.

The inspectors also observed several work request (WR) review meetings and determined that WR's were not receiving the same level of review as condition reports (CR 2006-23991). Specifically, all department representatives required per procedure MPG-001, Work Order Planning, to attend this meeting were not present and all WR's generated were not reviewed. Additionally, the WR review packages did not always establish a clear linkage to an associated CR, when written, and a formal review process was not always followed. Because the Plant Work Order (PWO) system was part of the CAP, this represented a weakness in problem identification in the area of WR review.

Inspectors identified several issues related to the licensee's evaluation of repetitive failures of emergency diesel generator (EDG) air start motors. In February of 2006, a Root Cause Evaluation (RCE) determined that the failure interval for these motors was between eighteen and twenty-four months. In June of 2006, an additional failure occurred after approximately five months and though a RCE was initially proposed to evaluate this failure, it was later downgraded to an Apparent Cause Evaluation (ACE). The underestimation of the air start failure rate in RCE 2006-2748 and the decision not to perform a new RCE when additional failures occurred demonstrated a weakness in the CAP's evaluation of the air start motors failure mechanism. However, because the issue did not impact EDG operability and the licensee has taken interim corrective action to detect additional failures, the licensee's overall corrective actions appeared adequate to prevent the failure of the EDG air start system function.

CR 2006-17321 documented an issue where a CR (2006-17271) was changed without the originator's consent or knowledge. The change involved the acting PID manager amending the brief description wording to augment future trending and/or searches, and

subsequently failed to inform the CR originator in a timely manner. Evaluation of CR 2006-17321 identified a programmatic deficiency whereby CR text could be changed without a documented record of the change. However, it was noted that the administrative rights to change the text of a CR exists only within the Performance Improvement Department (PID). The human performance evaluation performed as part of this CR determined that the issue involved a human error associated with communication. Additionally, the inspectors noted two separate issues during the review of CR 2006-17321. First, the human performance evaluation was conducted and approved by the same individual. Second, the issue was referred to Speakout for evaluation, however, it was two months before Speakout actually opened a case. Although these are not violations of the CAP procedures, the inspectors considered them to be weaknesses.

The team noted many instances in which work orders associated with corrective actions or deficiency tags had been deferred. However, no failures or issues associated with the deferment of corrective actions were identified.

The inspectors' review of CRs associated with the ICW and CCW Systems revealed a couple possible trends, not any of which resulted in a significant concern. However, after reviewing System Health Reports, interviewing the cognizant system engineer, and walking down the systems, the Unit 2 ICW system continues to display material condition degradation. This was evident in the System Health Report where the material condition attribute is coded "red" (unacceptable material condition), along with the system "Structures" also coded "red". Attachment 3 to the System Health Report for Unit 2 ICW indicates several SSCs within the ICW system continually being rescheduled and sometimes completely dropping out of the schedule. CR 2004-5294, dated July 7, 2004, documents an NRC concern regarding the material condition of the Unit 2 ICW pump enclosure. CR 2004-7280, dated August 27, 2004, identifies an ineffective corrective action from CR 2004-5294. The CAs did not address the housekeeping or the degraded material condition aspect of the CR, instead only stated that Engineering would monitor the degraded condition. This CR (2004-07280) was deleted for some unknown reason, thereby forgoing any corrective action(s) for addressing the Unit 2 ICW pump enclosure material condition. This is considered a weakness in the areas of prioritization and evaluation of issues and corrective action effectiveness.

Effectiveness of Corrective Action

The inspectors found that corrective actions developed and implemented for problems were timely and effective, and commensurate with the safety significance of the issues. Generally, the corrective actions directly addressed the cause and effectively prevented recurrence for significant conditions adverse to quality. However, the inspectors noted that the number of CRs being submitted had increased from previous years.

(3) Findings and Observations

The inspectors determined that overall, corrective actions were effective in correcting problems which resulted in generally good material condition and operating performance

of the systems reviewed. The inspectors noted that somewhat frequent problems with the reactor protection system were typically caused by age related degradation and were being adequately managed to prevent functional failures or more significant problems. The inspectors also observed a number of minor plant deficiencies on secondary systems where corrective action had been delayed, as indicated by numerous deficiency tags. Scaffolding that remained in the intake cooling water pump area had been left in place to deal with repeated problems with secondary systems in this area. Although a number of work orders had due date extensions, the inspectors found no problems of significance that had occurred due to incomplete or extended corrective actions.

b. Assessment of the Use of Operating Experience

(1) Inspection Scope

The inspectors conducted a review of the licensee's Operating Experience (OE) program to verify actions were completed in accordance with licensee procedure NAP-414, Operating Experience Program. The inspectors reviewed a sampling of the items the licensee had submitted for OE to verify the information accurately reflected the events, were appropriately evaluated, and documented in their CAP. The inspectors also focused on NRC generic communications and OE items associated with the four systems selected for a detailed review to verify issues were appropriately evaluated for applicability and whether issues identified through these reviews were entered into the CAP.

(2) Assessment

In general, OE items were adequately identified, evaluated, and utilized, however, several weaknesses were identified. During a review of OE screening, inspectors noted that the training organization conducted its own OE screening apart from the station OE coordinator. Also, no screening records were maintained for OE that was considered not applicable to the station and OE that was dispositioned as applicable prior to the year 2004 may not be contained within the licensee's current OE database system. This represented a weakness in problem identification in the area of OE review.

In the area of OE evaluation, inspectors noted that OE evaluations are normally screened as 4/D and non-CAQ. In some examples, this low priority has led to repeated delays in evaluating the applicability of OE. For example, NRC Information Notice 2005-23 which involved vibration induced failures of butterfly valves was entered into the CAP as CR 2005-22485 in August of 2005. The evaluation of this item was deferred multiple times due to resource limitations with the latest due date for completion being November 2006. The routine assignment of low priority to OE evaluations for which the potential plant implications are unknown is a weakness in the CAP's evaluation of issues.

(3) Findings and Observations

No findings of significance were identified. The station's OE program had several

identified weaknesses which the licensee plans to address with upgrades to the OE program. Improvements being considered include the creation of a corporate level OE screening program and the inclusion of an OE module in the SITRIS CAP tracking database.

c. Assessment of the Self-Assessment and Audits

(1) Inspection Scope

The inspectors reviewed licensee quality assurance audits, quality assurance quality reports, and department self-assessments including those which focused on problem identification and resolution to verify that findings were entered into the CAP and to verify that these findings were consistent with the NRC's assessment of the licensee's CAP.

(2) Assessment

The inspectors reviewed licensee event reports, condition reports, selected licensee effectiveness reviews, work requests, and work orders tied to condition reports, along with the inspections discussed in this report, to verify that the licensee had implemented timely and appropriate corrective actions to address significant problems. The inspectors verified that the corrective actions were properly documented, assigned, and tracked to completion. The review was also to verify the adequacy of corrective actions to address equipment deficiencies and MR functional failures of risk significant plant safety systems.

(3) Findings and Observations

Department self-assessments and QA audits were self-critical and effective in identifying areas for improvement that were entered into the CAP where appropriate.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

The inspectors randomly interviewed approximately 40 on-site workers, focusing on their knowledge of the problem identification process (corrective action program, Speakout) at St Lucie. Interviewees were questioned on their understanding and their willingness to initiate condition reports or raise safety concerns. Discussions with plant staff were conducted to develop a general sense of the safety-conscious work environment at the site. The inspectors looked for indications of conditions that would cause employees to be reluctant to raise safety concerns.

Additionally the inspectors reviewed thirty-one closed Speakout files for completeness, adequacy of the investigation conducted, file documentation, responsiveness to the concerned individuals and responses to "recommended corrective actions" by station management and for employees to raise concerns and remain anonymous. The

inspectors also interviewed the Speakout site representative, the Speakout supervisor and the Director Quality Assurance to glean their awareness of any areas needing additional attention in light of the increased NRC allegations at St Lucie. The inspection included verification that concerns were being properly reviewed and identified deficiencies were being resolved and entered into the CAP when appropriate.

(2) Assessment and Observations

In general, the inspectors determined that the Safety Conscious Work Environment appeared to be adequate where most people felt free to raise issues without fear of retaliation. The investigations conducted by Speakout were thorough, complete and the recommended corrective actions were appropriately focused to address the actions needed to resolve the individual concerns.

The inspectors noted that the number of NRC allegations received was high when compared to the number of Speakout concerns received. When coupled with information obtained during the site interviews the inspectors noted some reluctance by several organizations to bring issues to Speakout. Some interviewed commented that they did not feel issues got resolved in a timely manner, or in some cases at all, and therefore they were reluctant to use the Speakout program. Others commented that Speakout was not readily accessible and there was not enough management emphasis on the program. Others interviewed were unaware that the program existed. However, all interviewed indicated they would raise their concern through some process.

Inspectors noted several concerns with the implementation of the licensee's anonymous kiosk CR submission program. Many of the staff interviewed were unfamiliar with the existence or use of the kiosks and some were concerned that the location of the kiosks allowed observation by management. Additionally, the CROG's occasional practice of determining that a CR was not intended to be anonymous and attempting to identify the author for more information was determined to have a potential chilling effect on the use of this system. The inspectors also noted that the practice of publically posting the count of "Anonymous" CRs in an effort to drive down the number of such CR's may also discourage the use of this method of raising concerns. In response, the licensee agreed to stop posting anonymous CR charts and to stop pursuing anonymous kiosk CR identifications.

(3) Findings and Observations

There were two Speakout files that contained evidence that a condition report (CR) was not written as described in NSS-1, 6.1.1.1. In one case, Speakout recommended corrective actions that included the Security Force attend refresher training on changes that have occurred to the Security Force Instructions (SFIs) and the Plant Security Plan (PSP). A condition report should have been initiated to formalize that there existed a misunderstanding of the PSP. This matter being handled without a condition report circumvented the corrective action process. A second example involved a CR that was initiated but the scope of the CR only described identifying areas for improvement rather than the failure to follow security procedures. Because of the low significance of these

two issues, both were considered to be minor.

The inspectors conducted a review of Speakout files for any potential safeguards information (SGI) that may have been inadvertently included in the files. Even though no SGI was discovered, Speakout does not have a program or procedure in place to preclude SGI from inadvertently being included in Speakout files. The licensee acknowledged that a procedure should be in place that delineates the process for assuring that safeguards information does not inadvertently get added to Speakout files.

4OA6 Management Meetings

On August 25, 2004, the inspectors presented the inspection results to Mr. Gordon Johnston and other members of his staff who acknowledged the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTARY INFORMATION

KEY POINTS OF CONTACT

Licensee personnel

R. Acosta, Director Nuclear Assurance
R. Bailey, Security Analyst
D. Bonthron, FPL Corp. Access Authorization Manager
R. Boskey, STL Access Authorization Supervisor
M. Danford, Corrective Action Program Supervisor
B. Jacques, Security Manager
G. Johnston, Site Vice President
R. Lecky, Supervisor Speakout
A. Scales, Plant Engineering Manager
M. Seidler, STL Security Operations Supervisor

NRC personnel
D. Jones, Acting Senior Resident Inspector, St. Lucie

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

05000335, 389/2006008-01	URI	Inadequate Review of Condition Report Concerning Security Issues

Closed

None

Discussed

None

LIST OF DOCUMENTS REVIEWED

Procedures:

NAP-204, Condition Reporting, Rev. 8
NAP-414, Operating Experience Procedure, Rev. 1
ADM-0010432, Control of Plant Work Orders, Rev.44
ADM 08.04, Root Cause and Apparent Cause Evaluations, Rev. 14C
ADM-08.08, Identification and Tracking of Maintenance Rework, Rev. 3
ADM-10.01, Critical maintenance Management, Rev. 16B
ADM 10.02, Plant Work Order Request / Order Origination, Rev. 12B
ADM 10.03, Work Week Management, Rev. 19A
ADM-15.02, Access Authorization and Control, Rev. 19B
ADM-21.01,Nuclear Safety Speakout Program , Rev. 3B
2-OSP-68.04, Purge Valve Leak Rate Test, Rev. 1B
ADM 17.12, Duties and Responsibilities of System and Component Engineering, Rev. 3A
SCEG-018, System and Program Health Reports, Rev. 14
WCG-016, Online Work Management, Rev. 1
MPG-001, Plant Work Order Planning, Rev. 7
SFI-2100, PA Access Control, Rev. 3
SFI- 01, Access Control, Rev. 73
AI-001, Processing Applications for UAA, Rev. 8
AI-002, UAA Suitability Guidelines, Rev. 3
AI-006, Plant Access Data System (PADS), Rev. 6
CLOG Job Familiarization Guide
NSS-1, Nuclear Safety Speakout Program, Rev. 9
IP-1304, Safeguards Information Protection Program, Rev. 0
0006127, Safeguards Information Protection Program, Rev. 15A

Condition Reports (CR):

2001-03033	2004-04611	2004-07280	2004-14378	2004-16374	2004-17817
2004-05294	2004-07280	2004-02796	2004-13663	2004-13663	2004-18100
2004-15275	2004-18100	2004-15275	2004-02980	2005-01563	2005-02160
2005-03296	2005-08105	2005-04621	2005-28131	2005-07449	2005-26590
2005-07449	2005-09521	2005-12644	2005-15398	2005-18432	2005-18555
2005-15366	2005-16023	2005-15074	2005-16048	2005-16040	2005-15807
2005-15937	2005-22485	2005-24844	2005-27594	2005-25039	2005-33755
2005-32434	2005-32448	2005-35584	2005-30742	2005-10126	2005-20687
2005-06551	2005-01121	2005-01745	2005-03109	2005-30063	2005-04415
2005-07449	2005-24494	2005-35477	2005-27218	2005-33960	2006-23114
2006-22820	2006-20345	2006-14269	2006-20072	2006-01856	2006-07917
2006-01189	2006-09937	2006-23505	2006-01856	2006-01947	2006-04088
2006-23482	2006-04549	2006-21801	2006-10885	2006-22820	2006-22869
2006-17321	2006-06900	2006-22845	2006-22845	2006-15787	2006-20345
2006-20869	2006-21885	2006-22488	2006-22569	2006-22643	2006-22739
2006-22845	2006-22869	2006-23065	2006-24007	2006-08114	2006-06293
2006-20182	2006-17321	2006-21716	2006-16488	2006-16595	2006-17321
2006-06876	2006-10295	2006-10675	2006-14917	2006-06399	2006-06731

2006-07232 2006-07025 2006-06900 2006-17667 2006-20331 2006-14610
2006-23505 2006-22820

Condition Reports Initiated for NRC Identified Issues:

2006-23991 Work request Review Meeting inconsistency with attendees
2006-23982 Opportunity for improvement - screening incoming work orders for operability/reportability review
2006-23014 Ladders Installed on Unit 2 Diesel generators Without Proper Seismic Evaluation
2006-14269 (updated) NAP-204 Rev. 8 requirement for job familiarization guide for CROG members
2006-04549 Failed leak rate testing required emergent activity to install flange on FCV-25-36
2006-02748 Failure of 2B EDG air start motors
2005-09521 2A instrument air dryer when in service causes low instrument air pressure
2006-03353 2A EDG 2A2 south air start motors found locked up during 2-MMP-59.03 inspection
2006-19193 2 out of 8 EDG air start motors failed during a datasheet 4 surveillance
2006-06606 CR 2006-2748 SL 1A on the 2A and 2B EDG air start motor failures does not include deferral justification for corrective actions
2006-24268 Condition Report 2006-01856, closed prior to completion of actions

Work Orders:

35025803 35002501 35002502 36011261 34004621

LERs:

50-389/2005-001-00, Degradation of ASME Class 1 and 2 Safety Injection Instrument Lines
50-335/2005-001-00, Operation with Inoperable Steam Generator Level Channel
50-335/2005-006-00, Equipment Failure Led to Inadvertent Mode Change During Cooldown
50-335/2004-002-00, B Train Emergency Core Cooling System Room Ventilation System Inoperable
50-389/2004-002-00, Reactor Auxiliary Building Shield Doors Not Closed

Other Documents:

St. Lucie Station Top Ten Reliability Issues dated 7-13-2006
Abnormal Procedure AP005753, Severe Weather Preparations
St. Lucie Maintenance Rule (a)(1) Action Plan Timeline, dated August 1, 2006
Speakout Report # NSS-PSL-06-004

WR Screening packages:

Aug 11, 2006
Aug 10, 2006
Aug 22, 2006

Self Assessments:

SA-04-01, Problem Identification and Resolution
Focused Self-Assessment of the Corrective Action Program, February 2005
QSL-CA-04-04, Corrective Action Functional Area Audit, August 2004
QAS-CA-05-1, Corrective Action Program, November 2005

System Health Reports:
02 Chemical and Volume Control System, 2006-2, Unit 1
02 Chemical and Volume Control System, 2006-2, Unit 2
52 4.16 KV Switchgear Breakers, 2006-2, Unit 1
63 Reactor Protection System, 2006-2, Unit 1
63 Reactor Protection System, 2006-2, Unit 2

Operability Assessments:

CR 2006-23014	Ladders Installed on Unit 2 Diesel generators Without Proper Seismic Evaluation, Rev. 0
CR 2006-2748	2B EDG South Bank Air Motors Seized, Rev. 0

Root Cause Analysis:

2006-2748	2A and 2B Emergency Diesel Generator Air Start Motor Failures, 2/22/2006

LIST OF ACRONYMS

ACE	Apparent Cause Evaluation
CFR	Code of Federal Regulations
CR	Condition Report
EDG	Emergency Diesel Generator
FIN	Finding
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PI&R	Problem Identification and Resolution
RCE	Root Cause Evaluation
ROP	Reactor Oversight Process
SDP	Significance Determination Process
TS	Technical Specifications
WO	Work Order