UNITED STATES



NUCLEAR REGULATORY COMMISSION

REGION II SAM NUNN ATLANTA FEDERAL CENTER 61 FORSYTH STREET, SW, SUITE 23T85 ATLANTA, GEORGIA 30303-8931

July 6, 2007

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: TURKEY POINT NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000250/2007008 AND 05000251/2007008

Dear Mr. Stall:

On June 8, 2007, the U. S. Nuclear Regulatory Commission (NRC) completed a team inspection at your Turkey Point Nuclear Plant, Units 3 and 4. The enclosed inspection report documents the inspection findings, which were discussed on June 8, 2007 with Mr. W. Jefferson and other members of your staff.

The 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 with 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, the team concluded that in general, problems were properly identified, evaluated, and corrected. However a weakness was identified for not adequately screening work orders and initiating condition reports as required by station procedures. In addition, the team identified several evaluations that did not assign appropriate corrective actions. For the corrective actions, the inspectors identified instances where corrective actions were not performed in a timely manner due to the station's backlog. Based on interviews conducted during the inspection and the results of the site's safety conscious work environment surveys, the inspectors determined that there is a reluctance by site personnel to identify low level issues that may result in further increases to an already large backlog. It was recognized that management is aware of these issues and has placed additional attention on the corrective action program and has initiated actions to improve performance in this area. There were three green findings identified during this inspection. These findings were determined to be violations of NRC requirements. However, because of the very low safety significance and because they are entered into your corrective action program, the NRC is treating these findings as non-cited violations (NCV), in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you contest any NCVs in this report, you should provide a response with the basis of your denial, within 30 days of the date of this inspection report, to the United States Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator,

Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001, and NRC Resident Inspector at the Turkey Point facility.

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 the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web-site at <u>http://www.nrc.gov/reading-rm/adams.html</u> (the Public Electronic Reading Room).

Sincerely,

/**RA**/

Michael Ernstes, Chief Reactor Projects Branch 3 Division of Reactor Projects

Docket Nos. 50-250 and 50-251 License Nos. DPR-31 and DPR-41

Enclosure: Inspection Report 05000250/2007008 and 05000251/2007008 w/Attachment: Supplemental Information

cc w/encl: (See page 3)

Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001, and NRC Resident Inspector at the Turkey Point facility.

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 the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web-site at <u>http://www.nrc.gov/reading-rm/adams.html</u> (the Public Electronic Reading Room).

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Michael Ernstes, Chief Reactor Projects Branch 3 Division of Reactor Projects

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Distribution w/encl: (See page 4)

Report to J. A. Stall from Michael E. Ernstes dated July 6, 2007.

SUBJECT: TURKEY POINT NUCLEAR PLANT - INTEGRATED INSPECTION REPORT 05000250/2007008 AND 05000251/2007008

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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

| Docket Nos.: | 05000250, 05000251 |
|---------------|---|
| License Nos.: | DPR-31, DPR-41 |
| Report Nos.: | 05000250/2007008 and 05000251/2007008 |
| Licensee: | Florida Power & Light Company (FPL) |
| Facility: | Turkey Point Nuclear Plant, Units 3 & 4 |
| Location: | 9760 S. W. 344 th Street Florida City, FL 33035 |
| Dates: | May 21 - June 8, 2007 |
| Inspectors: | D. Jones, Senior Reactor Inspector, Lead Inspector S. Vias, Senior Reactor Inspector N. Merriweather, Senior Reactor Inspector J. Polickoski, Resident Inspector (VC Summer) M. Pribish, Resident Inspector (Watts Bar) |
| Approved by: | Michael Ernstes, Chief Reactor Projects Branch 3 Division of Reactor Projects |

SUMMARY OF FINDINGS

IR 05000250/2007-008, 05000251/2007-008; 05/21/2007 - 06/08/2007; Turkey Point Nuclear Plant, Units 3 & 4; Identification and Resolution of Problems.

The inspection was conducted by three senior reactor inspectors, and two resident inspectors. Three findings of very low significance were identified during this inspection and were classified as non-cited violations. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems Summary

Three findings of significance were identified. The licensee was generally effective at identifying problems, however a weakness was identified for not adequately reviewing work orders for condition report (CR) applicability and initiating CRs as required by station procedures. The inspectors determined that the failure to initiate CRs for work orders adversely affects the ability of the licensee to fully utilize the corrective action program to evaluate, assign corrective actions, and identify potential or adverse trends for low level issues. The licensee properly prioritized and evaluated issues, however for several CRs appropriate corrective actions were not assigned by the evaluations. Overall, corrective actions were effective, but the team identified examples where corrective actions were not performed in a timely manner due to the station's backlog. Station management has recently implemented process changes, and action plans to address evaluation quality and CAP timeliness. Due to the recent implementation of the changes, the inspectors were not able to determine their effectiveness.

Generally, use of operating experience (OE) use was found to be effective. Self-Assessments and audits were self-critical and generally effective in identifying problems. On the basis of interviews conducted during the inspection, and the results of the licensee's safety conscious work environment (SCWE) surveys the inspectors determined that there is a reluctance by site personnel to identify low level issues that may result in further increases to an already large corrective action and work order backlog. The licensee is currently developing actions to address the SCWE survey.

A. <u>NRC-Identified and Self-Revealing Findings</u>

Cornerstone: Mitigating Systems

• <u>Green</u>. The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedure, and Drawings. Specifically, the inspectors identified several conditions adverse to quality where the licensee failed to initiate condition reports as required by procedure. The licensee entered this issue into the corrective action program.

This finding is greater than minor because, if left uncorrected, the issue would become a more significant safety concern involving programmatic and equipment issues. In addition, the inspectors determined that the Mitigating

Systems Cornerstone attribute of equipment performance to ensure the availability and reliability systems that respond to initiating events to prevent undesirable consequences was adversely affected. The inspectors determined that the finding was not suitable for SDP evaluation because the failure to initiate the condition reports did not directly result in degraded or inoperable equipment. Therefore, this finding was reviewed by Regional Management, in accordance with IMC 0612 Section 05.04c, and determined to be of very low safety significance. The cause of the finding is related to the cross-cutting element of problem identification and resolution. [Section 40A2.a(3)(I)]

<u>Green</u>. The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action. Specifically, the licensee failed to promptly correct a previously identified water intrusion trend which resulted in the failure of a safety-related component. The licensee entered this issue into the corrective action program.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance because the finding was not a design or qualification deficiency, and did not represent a loss of safety function because the redundant train was available. The cause of the finding is related to the cross-cutting element of problem identification and resolution. [Section 4OA2.a(3)(ii)]

<u>Green</u>. The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action. Specifically, the licensee failed to implement effective corrective actions to prevent recurring deficiencies associated with the erection of scaffolding near safety-related equipment. The licensee entered this issue into the corrective action program.

This finding is more than minor because it is associated with the mitigating system cornerstone attributes of protection against external factors such as a seismic events, and equipment performance such as availability and reliability. The finding is of very low safety significance because the finding was not a design or qualification deficiency, did not represent a loss of safety function, and did not render equipment inoperable due to a seismic event. The cause of the finding is related to the cross-cutting element of problem identification and resolution. [Section 4OA2.a(3)(iii)]

B. <u>Licensee-Identified Violations</u>.

None

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REPORT DETAILS

4 OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

The team based the following conclusions, in part, on issues identified / evaluated during the period, February 17, 2006 (the last biennial problem identification and resolution inspection) to the end of the inspection on June 8, 2007. In addition, for selected systems, the team reviewed problems which were identified outside this assessment period whose significance might be age dependent.

a. Assessment of the Corrective Action Program

Effectiveness of Problem Identification

(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 work orders (WO) and condition reports (CRs). The inspectors attended meetings where WOs and CRs were screened for significance, interviewed personnel, reviewed system health reports, and reviewed maintenance rule reports to determine whether the licensee was identifying, accurately characterizing, and entering problems into the corrective action process at an appropriate threshold. The inspectors also conducted plant walkdowns of safety-related equipment to assess the material condition and to look for any deficiencies that had not been previously entered into the CAP. Control Room walkdowns were also performed to assess the main control room (MCR) deficiency list and to ascertain if deficiencies were entered into the CAP.

The inspectors selected CRs for review covering the seven cornerstones of safety identified in the NRC's Reactor Oversight Process (ROP). The inspectors also conducted a 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 selected were the Intake Cooling Water (ICW) system, the Emergency Diesel Generator (EDG) system, the Auxiliary Feedwater (AFW) system, and the 480-volt load center system. The team reviewed the maintenance history and selected Work Orders (WOs) for the four systems as well as the associated system health reports. Additional CRs were selected for problems previously identified by the NRC. The inspectors also reviewed issues documented in NRC inspection reports and licensee event reports. In addition, in accordance with the inspection procedure a five-year review was performed for the fire protection system for age dependant issues.

To verify that the licensee appropriately prioritized and evaluated problems in accordance with their risk significance, the inspectors reviewed condition reports, including root and apparent cause evaluations, trend reports, and self-assessments. The inspection was to verify that the licensee adequately determined the cause of the

problems, including root cause analysis where appropriate, and adequately addressed operability, reportability, common cause, generic concerns, extent of condition, and extent of cause. The review included the appropriateness of the assigned significance, the timeliness of resolutions, level of effort in the investigation, and the scope and depth of the causal analysis. The review was also performed to verify that the licensee appropriately identified corrective actions to prevent recurrence and that these actions had been appropriately prioritized.

From the sample of CRs, the inspectors selected effectiveness reviews, and work orders initiated to resolve CRs, to verify that the licensee had identified and implemented timely and appropriate corrective actions to address problems. The inspectors verified that the corrective actions were properly documented, assigned, and tracked to ensure 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 attended various plant meetings to observe management oversight and daily functions of the corrective action process. These included Work Assessment Group (WAG) meetings, Condition Report Oversight Group (CROG) meetings, Corrective Action Program Coordinator (CAPCO) meetings, and Corrective Action Program Performance Monitoring meetings. The inspectors also held discussions with various personnel to evaluate their threshold for identifying issues and entering them into the CAP.

Documents reviewed are listed in the Attachment.

(2) Assessment

Identification of Issues

The inspectors determined that the licensee was generally effective in identifying problems and entering the issues into the corrective action program. However, for equipment performance issues that required the initiation of both work orders and condition reports, the inspectors identified numerous examples where the licensee failed to initiate condition reports as required by procedure NAP-204, Condition Reporting. The failure to initiate condition reports is a weakness in that multiple barriers failed to adequately screen work orders and initiate condition reports as required by procedure NAP-204. The following barriers failed: the initiator, the supervisory review, the work request (WR) screening process, and the system engineer's review.

Concerning the WR screening process, the inspectors determined that WAG members were not aware of their procedural (0-ADM-068.1, On-Line Work Prioritization Process) responsibility to screen WRs for operability and condition report applicability. While attending various WAG meetings, the inspectors identified several WRs that required the initiation of a condition report and/or performance of an operability determination that were not identified by the WAG members. To address this issue the licensee provided immediate training of the WAG members, revised procedure 0-ADM-068.1, and initiated CR 2007-15742.

Enclosure 1 of NAP-204, which is titled Guidance on the Determination of Condition Report Significance Levels, provides examples of when to initiate condition reports. Some examples provided in the enclosure include: difficult to operate, oil leaks, repair of faulty pressure switches, instrument out of tolerance, and plant material deficiency that warrants trending. The inspectors identified 17 work orders where the licensee failed to initiate CRs as required procedure by NAP-204. The specific work orders are listed in the Attachment.

The inspectors noted that licensee procedure 0-ADM-533, Corrective Action Program Performance Monitoring and Trending Analysis, section 3.4.1 states in part that station personnel are responsible for supporting the trending process by implementing the corrective action process in order to provide adequate data for trending efforts. From the discussion provided above, the inspectors determined that the failure to initiate condition reports adversely affects the ability of the licensee to identify potential or adverse trends.

The team concluded the CAPCOs and CROG meetings had an appropriate focus on reactor safety. In some cases, the condition report investigation type or severity level was changed by the CROG (managers) from what was originally decided upon by the CAPCOs (department representatives). The inspectors noted that the last PI&R inspection report documented that there was no formal process to inform the CAPCOs of the change or the reason. During this inspection, it was observed that the CAPCO was promptly informed of the reason(s) for the change. From a two-week sample, the inspectors determined that approximately 12% of the CRs were returned to the CAPCO for changes in investigation type or severity level. The majority of changes were the result of inadequate problem descriptions and inconsistent interpretations of the requirements of the CAP procedure.

The inspectors also conducted system walkdowns, during which several deficiencies were identified; several instances of improperly erected scaffolding that was in contact with safety-related equipment; a residual heat removal (RHR) pump motor connection box was missing screws; and damaged lagging on RHR piping. The licensee initiated condition reports 2007-17169, 2007-17170, 2007-17253, 2007-17239, 2007-17273 and 2007-17453 for these conditions.

Prioritization and Evaluation of Issues

The team concluded that problems were generally prioritized and evaluated in accordance with the licensee's CAP procedures and NRC requirements. The team found that in the sample of root cause and apparent cause evaluations reviewed, the licensee was generally self-critical and thorough in evaluating the causes of the conditions adverse to quality. However, the team noted weaknesses in several evaluations where the licensee's evaluation identified issues, but failed to assign appropriate corrective actions. Examples of inadequate evaluations identified by the team include:

 CR 2006-9096 (Inadvertent actuation of a Unit 4 steam dump due to incorrect valve manipulation), the inspectors determined that the root cause evaluation

was inadequate because a procedural deficiency was not identified or corrected. The evaluation failed to identify that the attachment to procedure GMI/CMP-102.1, Troubleshooting Repair Guidelines does not require a peer check. Additionally, licensee procedure NAP-403, Conduct of Maintenance, specifies that each site will have a configuration control procedure that provides step-by-step instructions for conducting configuration changes in the plant including performance verification requirements. This site specific procedure does not exist. The licensee initiated CR 2007-16018.

- CR 2005-31103, 2006-6604, and 2006-7036 investigated three equipment failures and each evaluation identified the inadequate use of operating experience (OE). No corrective actions were assigned to address the ineffective use of OE. The licensee initiated CR 2007-18108.
- CR 2006-5465 (Emerging trend in equipment issues attributed to water intrusion), the evaluation concluded that in the past, water intrusion issues were handled on a case by case basis and that a more global approach was required to provide a permanent solution. The evaluation recommended a phased-approach with several options for a final corrective action plan. The evaluation was inadequate because it did not assign any corrective actions. The licensee initiated CR 2007-16980.
- CR 2006-07520 (Failure to establish communications between the Control Room and Containment during removal of the upper internals), the inspectors review of the apparent cause evaluation identified that: the evaluation was performed by the culpable shift manager; the evaluator had not received apparent cause training; the evaluation did not reveal that the licensed operator in containment was unaware of the communications requirement (a training concern); the evaluation did not reveal that communications were never established during the entire core alteration; and the extent of condition evaluation did not identify other applicable procedures. Also, the corrective actions were inadequate because the procedure was revised incorrectly. The licensee initiated CR 2007-17333 and CR 2007-17931.
- CR 2006-20649 (Quality control review of six water intrusion events into ICW motors over a 10-month period), the licensee's review of these six events revealed that no CR was initiated for four of these events. The evaluation was inadequate because it failed to fully evaluate and identify corrective actions for the failure to initiate condition reports.
- CR 2006-28918 (Human Performance Cross-Cutting Evaluation), the root cause evaluation identified inadequate procedures and work instructions as a contributing cause. The evaluation was inadequate because the assigned corrective action was focused on human performance improvements. The inspector's review of six departments' actions for this issue revealed that only the radiation protection department identified procedures to be reviewed. The licensee initiated CR 2007-17937.
- CR 2006-25531 (2006 PI&R Cross-Cutting Issues), the root cause evaluation identified that "work orders are not screened / managed with the same level of programmatic controls as condition reports" as a contributing cause and extent of condition issue. The evaluation was inadequate because it closed the issue to

another CR. The resulting CR was closed without any process changes being made. The licensee initiated CR 2007-15742.

Several evaluations reviewed by the team were not completed in a timely manner. However, the licensee had previously identified this issue as contributing to the "Red" status of the corrective action program health index. The licensee has developed department specific action plans to address this issue.

In addition, since March 2007 the licensee has taken actions to improve the quality of their evaluations. The licensee has provided apparent cause and root cause training; mentoring; department level review boards that grade evaluations; and additional management reviews. Due to the recent implementation of these changes, the inspectors were not able to determine their effectiveness.

Lastly, the inspectors reviewed the licensee's site and department trend reports to ensure the thresholds were adequate for evaluation of potential trends. No issues were identified.

Effectiveness of Corrective Actions

In general, corrective actions developed and implemented for problems were timely and effective, commensurate with the safety significance of the issues. For significant conditions adverse to quality, the corrective actions directly addressed the cause and effectively prevented recurrence. However, for some conditions adverse to quality, the team found examples where corrective actions were not performed in a timely manner due to the station's backlog. Examples are listed below:

- CR 2003-2048 (Start-up rate (SUR) meter indication out of calibration), the 2003 evaluation documented that the SUR meters had no record of being calibrated. The corrective action to calibrate the meters was repeatedly delayed until 2006 when Unit 3's SUR circuit was calibrated. Unit 4's SUR circuit was calibrated during a forced outage in June 2007.
- There were 104 open items in the boric acid control program 17 were greater than two years old even though there were two outages in the past year.
- For the fire protection system, the system health report stated that there were 253 outstanding work orders of which approximately 33 were greater than two years old.
- In 2003, the fire main was identified to have leakage that is greater than the sites acceptance criteria of 2 gpm the current leakage is approximately 45 gpm.
- CR 2006-25427 (Procedure enhancement for procedure 3/4 EOP-ECA-1.1, Loss of Emergency Coolant Recirculation), which was initiated in September 2006 identified that a revision is required for procedure 3/4 EOP-ECA-1.1. The revision will provide procedural guidance for emergency core cooling system pump suction swap-over to the re-fueling water storage tank from the other unit. Currently, operators would use skill of the craft and drawings to perform this action. Interviews identified that the procedure has not been revised due to the backlog of procedure changes. The licensee has plans to hire additional personnel to address the backlog.

• The site's Corrective Action Program Self-Assessment identified that the corrective action backlog continues to increase. The licensee reported that a significant portion of the backlog includes revisions to operating procedures and drawings. The licensee has established department specific action plans to address this issue.

Also, during the inspectors' walk-down of the plant, several scaffolding deficiencies were identified. The licensee initiated CRs 2007-17170, 2007-17239, 2007-17273, 2007-17385, and 2007-17569 to address the discrepancies. The inspectors noted that two previous NRC findings in 2004 and 2006 (NCV 05000250,251/2004004-01 and NCV 05000250,251/2006007-01) had documented similar scaffolding deficiencies. The inspectors determined the previous corrective actions were inadequate because the site continues to have problems with the erection, inspection, evaluation, and identification of scaffold deficiencies.

- (3) <u>Findings</u>
- (i) <u>Introduction</u>. The NRC identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedure, and Drawings. Specifically, the inspectors identified several conditions adverse to quality where the licensee failed to initiate condition reports as required by procedure.

<u>Description</u>. Procedure 0-ADM-068.1, On-Line Work Prioritization Process is the licensee's procedure for the administration of the work order (WO) process. Section 5.2.3 states, in part, that the screening committee will review all work requests (WR) for CAP applicability and operability / reportability.

Procedure NAP-204, Condition Reporting is the licensee's procedure for the administration of the corrective action program (CAP). Enclosure 1 of NAP-204, titled Guidance on the Determination of Condition Report Significance Levels, provides instructions for the initiation of condition reports. Specifically, for equipment reliability, plant performance, and performance and trend issues, the enclosure provides examples for when to initiate CRs for conditions adverse to quality on safety-related and maintenance rule components. The enclosure includes issues such as: difficult to operate, oil leaks, repair of faulty pressure switches, instrument out of tolerance, and plant material deficiency that warrants trending.

Procedure 0-ADM-533, Corrective Action Program Performance Monitoring and Trending Analysis is the licensee's procedure for the administration of the CAP trending program. Section 3.4.1 of 0-ADM-533, states, in part, that station personnel are responsible for supporting the trending process by implementing the corrective action process in order to provide adequate data for trending efforts.

On May 22, the inspectors attended the WR screening meeting and observed that the WR screening members were not aware of their procedural responsibility to screen WRs for CR applicability / operability. While attending the meeting, the inspectors identified several WRs that required the initiation of a condition report and/or

performance of an operability determination. As a result of this observation, during the weeks of May 21 - 25 and June 4 - 8, the inspectors performed a detailed review of WR/WOs for select systems. The inspectors identified numerous WRs/WOs where the licensee failed to initiate condition reports. Listed below are three examples:

- WO 36008096 (3/24/06) and WO 37002740 (2/14/07) documented that the 3A/3B Intake Cooling Water (ICW) pump temperature switches for the lower motor bearing alarm in the Control Room at the Main Control Board (MCB) read low. The inspector's review revealed the following: both temperature alarm switches are reading low by approximately 30-40F; their temperature readings will alarm the MCB annunciators non-conservatively; the operators were unaware of the deficiencies; the 2007 instrument failure was the same as the 2006 failure; neither deficiency was corrected; no CR was initiated for either deficiency; no operability evaluation was performed. The licensee initiated CR-2007-17504 to document this issue.
- WO 36027542 (12/22/06) documented that the Unit 3 Auxiliary Feedwater (AFW) flow indicator to "B" Steam Generator (S/G) is not sealed at panel 3C222A. The inspector's review revealed the following: the flow indicator was not properly mounted in its panel, therefore it is not weather tight; the life-span of all three flow indicators in that panel are reduced due to weather exposure; these indicators are RG 1.97, Category 1 commitments; and no CR was initiated. The licensee initiated CR 2007-18622 to document this issue.
- WO 37009738 (5/4/07) documented that the 4C charging pump breaker racking shutter will not close. The inspector's review revealed that operator error while racking the breaker was the cause and that no CR was initiated to address the human performance issue.

<u>Analysis</u>. The failure(s) to screen WRs for CR applicability and initiate CRs for conditions adverse to quality as required by procedures NAP-204, and 0-ADM-068.1 is a performance deficiency. This finding is greater than minor because, if left uncorrected, the issue would become a more significant safety concern involving programmatic and equipment issues. The failure to initiate condition reports adversely impacts the licensee's ability to utilize the CAP for evaluating issues, for establishing timely corrective actions, and for detecting trends. In addition, the inspectors determined that the Mitigating Systems Cornerstone attribute of equipment performance to ensure the availability and reliability systems that respond to initiating events to prevent undesirable consequences was adversely affected.

The inspectors determined that the finding was not suitable for SDP evaluation because the failure to initiate the condition reports did not directly result in degraded or inoperable equipment. Therefore, this finding was reviewed by Regional Management, in accordance with IMC 0612 Section 05.04c, and determined to be of very low safety significance. This finding directly involved the cross-cutting area of PI&R, in the corrective action component under the aspect of implementing a CAP with a low threshold for identifying issues, in that the licensee failed to initiate condition reports as required by procedures NAP-204, Condition Reporting and 0-ADM-068.1, On-Line Work Prioritization Process [P.1(a)].

<u>Enforcement</u>. 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, and drawings. Contrary to this requirement, the licensee failed to screen WRs for CR applicability and initiate CRs as required by procedures NAP-204, Condition Reporting and 0-ADM-068.1, On-Line Work Prioritization Process. Because this violation is of very low safety significance and has been entered into the licensee's corrective action program as CR-2007-15742, this issue is being treated as a non-cited violation (NCV) consistent with Section VI.A.1 of the Enforcement Policy. This item will be tracked as NCV 05000250, 251/2007008-01, Failure to Initiate Condition Reports for Conditions Adverse to Quality as Required by Procedure.

(ii) <u>Introduction</u>. The NRC identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for failure to promptly correct a previously identified water intrusion trend which resulted in the failure of a safety-related component.

Description: An emerging trend in equipment issues attributed to water intrusion had been previously identified and entered into the licensee's corrective action program on February 24, 2006, as CR 2006-5465. The problem description stated that 68 CRs had been generated from October 2004 to December 2005 documenting water intrusion events that impacted equipment such as cables, breaker cubicles, motors, insulated piping, conduits, and plant structures. The evaluation for CR 2006-5465, completed on July 10, 2006, concluded that in the past, water intrusion issues were handled on a case-by-case basis and that a more global approach was required to provide a permanent solution. The evaluation recommended a phased-approach with several options for a final corrective action plan. CR 2006-5465 was closed on August 6, 2006 with no actions taken. The licensee provided additional information that the action plan for CR 2006-5465 was being tracked and implemented with a combination of the corrective action plan from CR 2005-7332 and change authorization request (CAR) 05-050. The inspectors review of CR 2005-7332 and CAR 05-05 revealed that CR actions had been closed with incomplete actions and that CAR 05-050 had been extended twice with an annotation that no progress had been made to date.

On June 1, 2007, the AC input breaker to the 4B1 125 VDC battery charger was found open (tripped free). Further investigation by the licensee determined water leaking from an electrical conduit located above the battery charger had leaked into the battery charger causing the AC input breaker to trip. The water was determined to be rainwater that entered the conduit from a degraded seal on an electrical junction box that is exposed to the outside environment.

<u>Analysis</u>: The inspectors determined that the failure to take appropriate corrective actions to address adverse water intrusion trends in a timely manner was a performance deficiency. The inspectors concluded that the finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the

availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding is of very low safety significance (Green) using the SDP because the finding is not a design or qualification deficiency, it did not represent a loss of safety function because the redundant train was available, it did not represent an actual loss of safety function of a single train for greater than the TS allowed outage time, and the finding was not potentially risk significant due to external events. The finding directly involved the cross-cutting area of PI&R under the appropriate and timely corrective actions aspect of the corrective action component, in that appropriate corrective actions to address adverse water intrusion trends were not taken in a timely manner [P.1.(d)].

<u>Enforcement</u>: 10 CFR 50 Appendix B, Criterion XVI, Corrective Action, states, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, defective material and equipment and non-conformances are promptly identified and corrected. Contrary to the above, the licensee failed to correct a previously identified water intrusion trend which resulted in the 4B1 battery charger failure on June 1, 2007. Because this finding is of very low safety significance and because it was entered into the licensee's corrective action program as CR 2007-16980, this violation is being treated as an NCV, consistent with Section VI.A of the NRC Enforcement Policy: NCV 05000251/2007008-02, Corrective Actions Associated with Water Intrusion Trends Were Not Taken in a Timely Manner.

(iii) <u>Introduction</u>. The inspectors identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to identify and implement effective corrective actions to prevent recurring deficiencies associated with the erection of scaffolding near safety-related equipment.

<u>Description</u>. During the inspection period of May 21 - June 8, 2007, the inspectors performed multiple walkdowns of the plant and identified four examples where scaffolding was not installed or properly evaluated in accordance with procedure 0-ADM-012, Scaffold Control. The procedure requires that scaffolding be installed a minimum of two inches from fragile items including but not limited to valves and instrument lines. For instances where the two-inch criteria cannot be met, Section 5.2. requires that an engineering evaluation be performed. The four examples included:

- Scaffolding erected adjacent to the Unit 4 Refueling Water Storage Tank (RWST) which had one cross-member almost touching (<1/4 inch) the RWST. The scaffold was built in March 2007 and had not received an engineering evaluation. After NRC identification, engineering performed the required evaluation.
- Scaffolding erected adjacent to the 3B residual heat removal (RHR) heat exchanger which did not meet the two-inch spatial requirement from the heat exchanger, RHR piping and flanges in numerous locations. The scaffold was built and inspected on June 5, 2007. The inspectors determined that the engineering evaluation was inadequate because the evaluation did not take into account thermal expansion or seismic movement of the heat exchanger or piping.

- Permanent scaffold platform built adjacent to a Unit 3 component cooling water (CCW) heat exchanger which had members in contact with valve 3-50-368 (inlet isolation to FI-1408 for ICW discharge from the 3B CCW heat exchanger). The inspectors determined that the engineering evaluation was inadequate because it did not take into account the thermal expansion/contraction of the piping.
- Permanent scaffold platform built adjacent to a Unit 4 CCW heat exchanger which was in direct contact with conduit containing ICW temperature cables. The inspectors determined that an engineering evaluation was not performed.

The inspectors determined that the four examples pertained to the failure of the licensee to properly follow procedure 0-ADM-012 to ensure adequate erection, inspection, evaluation, and identification of scaffold deficiencies. In all cases, the licensee initiated condition reports for the deficiencies.

Also, the team noted that two previous NRC findings (NCV 05000250,251/2004004-01 and NCV 05000250,251/2006007-01) have documented similar scaffolding deficiencies. For the two previous non-cited violations, the licensee initiated numerous CRs to address scaffold installation discrepancies and procedure deficiencies.

<u>Analysis</u>. The inspectors determined that the failure to identify and implement effective corrective actions to prevent recurring deficiencies is a performance deficiency. The inspectors concluded that the finding is more than minor because it is associated with the external factors (seismic) and equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance because, while improperly installed scaffolding has the potential to adversely affect mitigation systems, the specific examples identified did not result in an actual loss of safety function of a mitigating system and did not render equipment inoperable due to a seismic event. The finding directly involved the cross-cutting area of PI&R under the appropriate corrective actions aspect of the corrective action component, in that previous corrective actions for scaffolding have not instituted a process that will ensure the proper erection, evaluation, or identification of scaffold deficiencies [P.1.(d)].

Enforcement: 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action, states in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to this, the licensee did not identify and correct recurring scaffold deficiencies which could potentially affect safety-related components. During the May 21 - June 8, 2007 inspection, the inspectors identified four examples of scaffolds and permanent platforms, over or adjacent to safety related components, which did not comply with installation requirements specified in Procedure 0-ADM-012 and which had not been evaluated as being acceptable. Because this finding is of very low safety significance and because it has been entered into the licensee's corrective action program as CRs 2007-17170, 2007-17239, 2007-17273, 2007-17385, and 2007-17569, this violation is being treated as a NCV, consistent with

Section VI.A of the NRC Enforcement Policy: NCV 05000250, 251/2007008-03, Failure to Prevent Recurring Scaffolding Installation Deficiencies.

- b. Assessment of the Use of Operating Experience
- (1) <u>Inspection Scope</u>

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 focused on NRC generic communications and OE items associated with recent industry operating experience for a detailed review to verify issues were appropriately evaluated and entered into the CAP. The inspectors also reviewed a sampling of the items the licensee had submitted for OE to verify the information accurately reflected the event(s).

(2) Assessment

In general, the inspectors determined that OE items were adequately identified, evaluated, and utilized. However, the two items listed below reveal recent weaknesses in the OE program.

- CR 2005-31103, CR 2006-6604, and CR 2006-7036 investigated three equipment failures that identified the inadequate use of OE. None of the evaluations assigned corrective actions to address the ineffective use of OE. The licensee initiated CR 2007-18108.
- Self Assessment 2006-916 (Maintenance Use of OE), identified the need to develop a database of OE to be used on a regular basis in the maintenance department. Without appropriate justification, the corrective action was closed with no action taken due to lack of resources (an employee resignation). The licensee initiated CR 2007-17936.

During a review of the OE screening program, the inspectors were briefed on a newly developed component of the plant computer system dedicated to industry OE. This effort will aid in the timely review, evaluation, and dissemination of OE data. This newly developed process for the review of operating experience will be reviewed during future inspections.

(3) <u>Findings</u>

No findings of significance were identified.

- c. Assessment of Self-Assessments and Audits
- (1) Inspection Scope

The inspectors conducted a review of the licensee's Self-Assessments and Audit programs to verify actions were completed in accordance with licensee procedures

NAP-202, Self-Assessments and QI 18 QAD 3, Scheduling of Quality Assurance Department Audit Activities. The inspectors reviewed a sampling of self-assessments and audits to verify that identified deficiencies and areas needing improvement were entered into the CAP tracking system.

(2) Assessment

The inspectors verified that self-assessments and audits were adequately performed to identify deficiencies and areas needing improvement. For the deficiencies and areas needing improvement, the inspectors confirmed that the items were entered into the CAP tracking system.

(3) <u>Findings</u>

No findings of significance were identified.

- d. Assessment of Safety-Conscious Work Environment
- (1) <u>Inspection Scope</u>

The inspectors randomly interviewed approximately 30 on-site workers, focusing on their knowledge of the problem identification process at Turkey Point. Interviewees were questioned on their understanding and their willingness to initiate condition reports or raise safety concerns through the employee concerns program (ECP). 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 41 ECP files for completeness, adequacy of the investigation, file documentation, responsiveness to the concerned individuals, responses to "recommended corrective actions" by station management, and to verify that employee concerns remain anonymous. The inspection included verification that concerns were being properly reviewed; identified deficiencies were being resolved; and issues were entered into the CAP when appropriate.

(2) Assessment and Observations

The inspectors determined, through interviews, a reluctance of site personnel to identify low level issues that may result in increases to the high corrective action and work order backlog. The employees' concerns with the backlog are consistent with the weaknesses identified by the inspectors in the Identification and Resolution of Problems section of this report. Specifically, the failures: to adequately screen WOs and initiate CRs; to assign appropriate corrective actions for issues identified during an evaluation; and to complete corrective actions in a timely manner due to the station's backlog. However, the interviews also revealed that for significant conditions adverse to quality, employees would enter the issue into the CAP.

Through discussions held with the Performance Improvement Department (PID) the inspectors reviewed / discussed the results of the last two SCWE surveys. The SCWE surveys reveal that the site has a declining confidence in nuclear safety, a declining confidence in the corrective action program, and a declining confidence in the employee concerns program. Currently, the licensee is developing and implementing actions to address the survey results. These actions will be reviewed during future inspections. Overall, the results of the SCWE surveys are consistent with the information that the inspectors revealed through the inspection of the corrective action program and the SCWE interviews.

Lastly, through the review of ECP files and interviews, the inspectors noted a reluctance by several departments to utilize the ECP because they felt that the program only represented management's interest. However, all interviewed stated that they would find some method/process to voice their concerns for resolution.

(3) Findings

No findings of significance were identified.

4OA6 Management Meetings

On June 8, 2007, the inspectors presented the inspection results to Mr. W. Jefferson, and other members of his staff who acknowledged the findings. The inspectors informed the licensee that proprietary information that was examined during the inspection will not be included in the report.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTARY INFORMATION

KEY POINTS OF CONTACT

Licensee personnel:

- J. Antignano, Fire Protection Supervisor
- W. Burrows, Acting Maintenance Manager
- J. Connolly, Acting Licensing Manager
- S. Greenlee, Engineering Manager
- D. Hoffman, Operations Superintendent
- W. Jefferson, Site Vice-President
- M. Moore, Corrective Actions Supervisor
- M. Murray, Emergency Preparedness Supervisor
- J. Molden, Operations Manager
- K. O'Hare, Radiation Protection and Safety Manager
- M. Pearce, Plant General Manager
- W. Pravat, Work Controls Manager
- G. Warriner, Quality Manager
- B. Webster, Senior Vice President, Operations

NRC personnel

- C. Casto, Director, Division of Reactor Projects, RII
- S. Stewart, Senior Resident Inspector, Turkey Point

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LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

| 05000250, 251/2007008-01 | NCV | Failure to Initiate Condition Reports for Conditions Adverse to Quality as Required by Procedure (4AO2.c (I)) |
|--------------------------|-----|---|
| 05000251/2007008-02 | NCV | Corrective Actions Associated with Water Intrusion Trends Were Not Taken in a Timely Manner (4AO2.c (ii)) |
| 05000250, 251/2007008-03 | NCV | Failure to Prevent Recurring Scaffolding Installation Deficiencies (4AO2.c (iii)) |

A-3

LIST OF DOCUMENTS REVIEWED

| <u>Procedures</u> | |
|-------------------|---|
| ADM-10.02 | Plant Work Request / Order Origination |
| ECP-1 | Employee Concerns Program |
| EDI-SE-005 | System Health Reports |
| ENG-QI-3.2 | Quality Instruction Nuclear Engineering Drawing Control |
| NAP-201 | Human Performance |
| NAP-202 | Self Assessments |
| NAP-204 | Condition Reporting |
| NAP-403 | Conduct of Maintenance |
| NAP-414 | Operating Experience Program |
| NAP-424 | Employee Concerns Program |
| QI 2-PTN-1 | Quality Assurance Program |
| QI 5-PTN-1 | Instructions, Procedures, and Drawings |
| QI 6-PTN-1 | Document Control, Approved |
| WI-PTN-001 | Control of Drawing Update and Document Management System, Approved |
| 0-ADM-068.1 | On-Line Work Prioritization Process |
| 0-ADM-533 | Corrective Action Program Performance Monitoring and Trending |
| | Analysis |
| 0-ADM-016 | Fire Protection Program |
| 0-ADM-068.1 | On-Line Work Prioritization Process |
| 0-ADM-701 | Control of Plant Work Activities |
| 0-ADM-012 | Scaffold Control |
| 0-ADM-518 | Condition Reports |
| 0-ADM-533 | Corrective Action Program Performance Monitoring and Trending Analysis |
| 0-GMM-043.12 | Reactor Vessel, Installation of Upper Internals |
| 0-GMM-043.9 | Reactor Vessel, Removal of Upper Internals |
| 0-GME-005.1 | 4Kv Grounding and Testing |
| 0-GMI-102.1 | Troubleshooting and Repair Guidelines |
| 0-OP-040.9 | Uncoupling/Coupling Full Length Control Rods |
| 3-OP-038.9 | Refueling Activities Checkoff List |
| 3-OP-038.1 | Preparation for Refueling Activities |
| 3-ARP-097 | Control Room Annunciator Response for ICWP A/B/C Motor Brg Hi Temp |
| 3-PME-004.2 | Unit 3 Startup Transformer Grounding |
| 4-PMI-074-19 | Calorimetric Instrumentation Periodic Calibration |
| | |

Self Assessments and Audits

| 2006-931 | 2006 Fire Protection Assessment |
|----------------|---|
| 2006-9134 | Turkey Point Security Training Assessment |
| 2006-912 | Plant Change Control / Modification Process |
| 2006-926 | Operating Experience Use in PTN Maintenance (SITRIS) |
| QAO-PTN-06-009 | Corrective Action Functional Area |
| QAO-PTN-06-007 | Equipment Reliability and Work Management Functional Area Audit |
| QAO-PTN-06-001 | Security Functional Area Audit |

Attachment

Root Cause Evaluations

| 2006-28918 | Human Performance Cross Cutting Evaluation |
|------------|--|
| 2006-25531 | 2006 Cross-Cutting Issues |
| 2005-30750 | B P2B AFW Pump Bearing Installed Incorrectly |
| 2007-4073 | 4B Reactor Coolant Pump Vibration Issues |
| 2006-7091 | Unit 3 EDG in Droop Mode with Startup Transformer Grounded |
| 2006-91096 | Atmospheric Dump Valve Actuation During I&c Maintenance |

Condition Reports:

| 2000-1013 | 2005-32840 | 2006-118 | 2006-33907 | 2007-1473 | 2007-15150 |
|--------------|------------|------------|------------|------------|------------|
| 2001-1518 | 2006-36448 | 2006-9986 | 2006-6789 | 2007-13676 | 2007-11428 |
| 2002-2008 | 2006-36500 | 2006-3172 | 2006-32040 | 2007-1586 | 2007-17931 |
| 2002-2076 | 2006-6522 | 2006-36019 | 2006-2649 | 2007-7735 | 2007-17333 |
| 2003-3919 | 2006-33378 | 2006-2567 | 2006-16856 | 2007-9825 | 2007-12640 |
| 2003-1215 | 2006-6537 | 2006-24623 | 2006-16852 | 2007-6767 | 2007-13882 |
| 2003-2048 | 2006-26741 | 2006-35673 | 2006-16858 | 2007-14210 | 2007-18622 |
| 2003-1697 | 2006-25347 | 2006-17266 | 2006-24561 | 2007-12295 | 2007-14515 |
| 2003-0995 | 2006-6811 | 2006-17466 | 2006-21843 | 2007-11685 | 2007-14874 |
| 2004-12917 | 2006-8482 | 2006-36515 | 2006-33246 | 2007-2368 | 2007-14872 |
| 2004-11886 | 2006-23402 | 2005-1419 | 2006-8701 | 2007-5176 | 2007-00713 |
| 2004-7845 | 2006-9958 | 2006-36486 | 2006-34045 | 2007-9848 | 2007-02718 |
| 2004-3365 | 2006-22755 | 2006-28919 | 2006-20649 | 2007-13622 | 2007-14071 |
| 2004-3656 | 2006-3541 | 2006-18675 | 2006-20370 | 2007-16167 | 2007-14760 |
| 2004-0157 | 2006-2197 | 2006-9986 | 2006-29120 | 2007-8676 | 2007-14902 |
| 2004-04073 | 2006-33467 | 2006-3556 | 2006-9415 | 2007-6420 | 2007-14884 |
| 2005-33550 | 2006-3540 | 2006-20551 | 2006-19228 | 2007-16780 | 2007-14732 |
| 2005-33569 | 2006-34059 | 2006-9986 | 2006-7036 | 2007-7279 | 2007-00548 |
| 2005-16396 | 2006-26634 | 2006-10540 | 2006-35513 | 2007-16246 | 2007-15143 |
| 2005-446 | 2006-9410 | 2006-19909 | 2006-13427 | 2007-067 | 2007-14877 |
| 2005-3589 | 2006-18390 | 2006-18704 | 2006-5465 | 2007-7703 | 2007-04737 |
| 2005-22776 | 2006-10317 | 2006-23027 | 2007-6818 | 2007-6384 | 2007-15082 |
| 2005-17021 | 2006-7580 | 2006-3556 | 2007-11632 | 2007-6379 | 2007-17504 |
| 2005-27024 | 2006-12302 | 2006-1081 | 2007-01961 | 2007-6378 | 2007-15742 |
| 2005-35214 | 2006-042 | 2006-7520 | 2007-3756 | 2007-15517 | |
| 2005-31103 | 2006-073 | 2006-32157 | 2007-1104 | | |
| Work Orders: | | | | | |
| 3601488 | 3600451 | 37009738 | 37005808 | 36008096 | 37001267 |
| 36024055 | 36027542 | 37005518 | 37009078 | 36014009 | 37001900 |
| 36006693 | 34013552 | 36014229 | 37010313 | 36014010 | 37001903 |
| 36007909 | 35029267 | 37009942 | 37010537 | 36016991 | 37002399 |
| 33003292 | 37009423 | 37010326 | 37010621 | 36020035 | 36013722 |
| 36005373 | 36020964 | 37010472 | 37010627 | 36022857 | 36013723 |
| 36019762 | 36009307 | 37010663 | 37010530 | 36022858 | 36016758 |
| 36025194 | 37009735 | 37010526 | 37005409 | 36022860 | 36016873 |
| 37009965 | 37005476 | 37010920 | 37002740 | 36026852 | 36020534 |
| | | | | | |

Attachment

| 36020744 | 37006026 | 37008859 |
|----------|----------|----------|
| 36021714 | 37007135 | 36019035 |
| 36021560 | 37010664 | 36009462 |
| 37003376 | 35018725 | 37010223 |
| 37005978 | 35018724 | |

Work Orders with No Condition Report Initiated:

| Inboard bearing lube oil at low mark for 4K4B EDG |
|--|
| 4C charging pump breaker racking shutter will not close |
| 4K4A EDG generator stator temperature monitor switch alarm |
| 3K4A EDG oil leak from top of diesel |
| ERDADS AFW flow indication to A S/G, channel B voltage is low |
| ICW basket strainer to the Component Cooling Water (CCW) Heat |
| Exchanger (HX) drain valve is hard to operate |
| ICW basket strainer to the Component Cooling Water (CCW) Heat |
| Exchanger (HX) drain valve is hard to operate |
| ICW conduit panel is corroded |
| 3B ICW pump manual discharge isolation valve gear box is leaking |
| grease |
| 3A ICW pump manual discharge isolation valve gear box is leaking |
| grease |
| Manual isolation valve for the ICW/CCW HX's is leaking grease |
| 4B ICW pump packing needs to be adjusted or re-packed |
| 3A ICW pump temperature switch for the lower motor bearing alarm at |
| the Main Control Board (MCB) in the control room reads low |
| 3B ICW pump temperature switch for the lower motor bearing alarm at |
| the Main Control Board (MCB) in the control room reads low |
| B AFW pump base cracked requiring repair and paint |
| Unit 3 AFW flow indicator to "B" Steam Generator (S/G) is not sealed at panel |
| A AFW pump lube oil had elevated particulate count following a sample |
| |

System Health Reports:

Fire Protection Intake Cooling Water Emergency Diesel Engine and Oil System Emergency Diesel Generator System

Miscellaneous Documents

Apparent Cause Evaluation Handbook Root Cause Evaluation Handbook List of open work orders for systems 016, 017, and 019 Corrective Action Program Expectations Handbook Condition Report Oversight Group Member Job Familiarization Guide PTN 4/23 Core Reload Management Expectations QA 0-ADM-217 checklist for Unit 4, Cycle 23 Core Reload, Reactor Side and SFP Side Fuel Assembly Movement

Intake Operator (ANPO) Turnover sheet for 6/7/2007

Supervisor Talking Points, Corrective Action Program Expectations

Change Authorization Request (CAR) 03-094, Replacement of BS-3/4-1400&1401

Change Request Notice (CRN) No. E-17354, Introduce Vendor Drawings into the FPL Drawing System, Approved 12/5/06

Security Department Performance Improvement Health Report 1st Quarter 2007 May 2007, Security Monthly Health Report

Turkey Point Corrective Action Program Self-Assessment

Licensee Event Reports

2006-002-00 2006-002-01 2006-009-00 2006-003-00 2006-004-00 2006-005-00 2006-007-00 2005-006-00 2006-002-00