



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

August 25, 2008

Mr. J. Art Stall  
Senior Vice President Nuclear and Chief Nuclear Officer  
Florida Power and Light Company  
St. Lucie Nuclear Plant  
P.O. Box 14000  
Juno Beach, FL 33408-0420

**SUBJECT: ST. LUCIE NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION AND  
RESOLUTION INSPECTION REPORT 05000335/2008006 AND  
05000389/2008006**

Dear Mr. Stall:

On July 25, 2008, 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 July 25, 2008 with Mr. Johnston 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 plant equipment and activities, and interviews with personnel.

Based on the results of this inspection, no findings of significance were identified. However, a licensee identified violation which was determined to be of very low safety significance is listed in this report. NRC is treating this violation as a non-violation (NCV) consistent with Section VI.A.1 of the NRC Enforcement Policy because of the very low safety significance of the violation and because it is entered into your corrective action program. If you contest this non-cited violation, you should provide a response within 30 days of the date of this inspection report, with basis of your denial, to the 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 20555-001; and the NRC Resident Inspector at the St. Lucie Nuclear Plant.

The team concluded that in general, your corrective action program processes and procedures were effective; thresholds for identifying issues were appropriately low; and problems were properly evaluated and corrected within the problem identification and resolution program (PI&R). However, several examples of minor problems were identified where elective and corrective maintenance work orders associated with corrective actions have not been performed in a timely manner.

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 <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

**/RA/**

Steven J. Vias, Chief  
Reactor Projects Branch 7  
Division of Reactor Projects

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

Enclosure: Inspection Report 05000335/2008006 and 05000389/2008006  
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

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

Sincerely,

**/RA/**

Steven J. Vias, Chief  
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NAME	R Taylor	S Atwater	N Staples	S Sanchez	SVias		
DATE	08/18/2008	08/19/2008	08/21/2008	08/21/2008	08/25/2008	9/ /2008	9/ /2008
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

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Report to J. A. Stall from Steven J. Vias dated August 25, 2008

SUBJECT: ST. LUCIE NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION AND  
RESOLUTION INSPECTION REPORT 05000335/2008006 AND  
05000389/2008006

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**U. S. NUCLEAR REGULATORY COMMISSION**

**REGION II**

Docket Nos.: 05000335, 05000389

License Nos.: DPR-67, NPF-16

Report Nos.: 05000335/2008006 and 05000389/2008006

Licensee: Florida Power & Light Company (FPL)

Facility: St. Lucie Nuclear Plant, Units 1 & 2

Location: 6501 South Ocean Drive  
Jensen Beach, FL 34957

Dates: July 7 - 11, 2008  
July 21 - 25, 2008

Inspectors: R. Taylor, Senior Project Inspector, Team Leader  
S. Atwater, Senior Project Inspector  
N. Staples, Reactor Inspector  
S. Sanchez, Resident Inspector, St. Lucie

Accompanied By: A. Rao, Resident Inspector Development Program

Approved by: Steven J. Vias, Chief  
Reactor Projects Branch 7  
Division of Reactor Projects

Enclosure

## SUMMARY OF ISSUES

IR 05000335/2008-006, 05000389/2008-006; 07/097/2008 – 07/25/2008; St. Lucie Nuclear Plant, Units 1 & 2; Identification and Resolution of Problems.

The inspection was conducted by two senior project inspectors, one reactor inspector, and one resident inspector. No findings of significance were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

### Identification and Resolution of Problems Summary

The team concluded that in general, problems were properly identified, evaluated, prioritized, and corrected within the licensee's corrective action program (CAP). However, the team identified an example where a condition report (CR) was classified as priority 2 when the CR should have been classified as priority 1 per licensee guidance. Evaluations of issues were generally comprehensive and technically adequate. Formal root cause evaluations for issues classified as significant adverse conditions were comprehensive and detailed. The team reviewed the licensee's corrective action program improvement plan and actions to address evaluation quality, timeliness, and overall CAP effectiveness. Overall, corrective actions developed and implemented for issues were effective in correcting the problems. However, the team identified examples where elective and corrective maintenance work orders associated with corrective actions were not performed in a timely manner.

The team determined that thresholds for identifying issues were appropriately low. Nuclear Assessment Section audits and departmental self-assessments were effective in identifying issues and directing attention to areas that needed improvement. Licensee identified weaknesses and issues in self-assessments were appropriately entered into the CAP and addressed.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors did not identify any reluctance to report safety concerns.

#### A. NRC-Identified and Self-Revealing Findings

No findings of significance were identified.

#### B. Licensee-Identified Violations

One violation of very low safety significance was identified by the licensee and has been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. The violation is discussed in Section 4OA7 of this report.

Enclosure

## REPORT DETAILS

### .4 OTHER ACTIVITIES (OA)

#### 4OA2 Problem Identification and Resolution

The team based the following conclusions, in part, on issues identified during the period, August 25, 2006, (the last biennial problem identification and resolution inspection) to the end of the inspection on July 25, 2008. In addition, the team reviewed problems for selected systems, which were identified outside this assessment period whose significance may be age-dependent.

##### a. Assessment of the Corrective Action Program (CAP)

#### (1) Inspection Scope

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

The inspectors selected CRs for review which involved issues covering the seven cornerstones of safety identified in the NRC's Reactor Oversight Process (ROP). The selected samples involved various licensee classified severity levels and site departments. The inspectors also conducted a detailed review of CRs for risk significant systems which were selected based on risk insights from the licensee's probabilistic safety assessment and discussions with the Senior Resident Inspector. The systems selected for review included the Intake Cooling Water System (ICW), Emergency Diesel Generators (EDG), 480 VAC, Heating Ventilation and Air Conditioning system (HVAC), and Emergency Core Cooling System (ECCS). The inspectors reviewed CRs, maintenance history, completed work orders (WOs) for the systems, and reviewed associated system health reports. These reviews were performed to verify that problems were being properly identified, appropriately characterized, and entered into the CAP. Items reviewed generally covered a two-year period of time; however, in accordance with the inspection procedure, a five-year review was performed for selected systems for age-dependent issues.

The inspectors conducted plant walkdowns of equipment associated with the selected systems to assess the material condition and to look for any deficiencies that had not been 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. Operator Workarounds and Operator Burdens screenings were reviewed and the inspectors verified compensatory measures for deficient equipment were being implemented in the field.

Enclosure



The inspectors reviewed CRs, including root and apparent cause evaluations, site and department trend reports, and observed other activities to verify that the licensee appropriately prioritized and evaluated problems in accordance with their risk significance. The inspection was intended 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, and extent of condition.

The review included the appropriateness of the assigned significance, the timeliness of resolutions, the 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 those actions had been appropriately prioritized.

The inspectors reviewed a sample of selected licensee effectiveness reviews and work orders initiated to resolve CRs to verify the licensee had identified and implemented timely and appropriate corrective actions to address problems. The inspectors verified that the corrective actions were properly assigned, documented, and tracked to ensure completion. The review was also conducted to verify the adequacy of corrective actions to address equipment deficiencies and maintenance rule (MR) functional failures of risk significant plant safety systems.

The inspectors attended various plant meetings to observe management oversight functions of the corrective action process. These included Initial screening Team (IST) meetings, as well as Management Review Committee (MRC) meetings.

Furthermore, the inspectors verified that issues identified by internal and external operating experience, licensee audits and self-assessments, and the employee concerns program were entered into and dispositioned by the CAP, as appropriate. The team also reviewed corrective action packages related to previously issued non-cited violations and licensee event reports.

Documents reviewed are listed in the Attachment.

(2) Assessment

Identification of Issues

The team determined that the licensee was generally effective in identifying problems and entering them into the CAP. There was no threshold for entering issues into the CAP and employees were encouraged to initiate CRs for any reason. Trending was generally effective in monitoring equipment performance.

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 Component Cooling Water Facility, the inspectors noted that oil pads had been placed inside of the annular vent opening of the 2A and 2B CCW motor outboard bearings. Though these areas were frequently walked down by operations staff, this issue was not identified by licensee personnel. The licensee initiated a CR 2008-23670 documenting this concern.

During walkdown of the ICW intake structure NRC inspectors identified WO 3801084 (2A screen wash pump delayed start/no start). This WO was classified as elective maintenance; however, it was not formally entered into the corrective action process through CR initiation. Inspectors concluded that per NAP-204 guidance this WO should have initiated a CR in the licensee formal corrective action process, and considered the initiation of WOs to fix degraded plant conditions without entering them into the formal corrective action process an additional weakness in the area of problem identification.

These issues were screened in accordance with NRC Inspection Manual Chapter 0612 and determined to be minor in nature.

#### 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. Each CR written was assigned a priority level at the IST meeting, which was chaired by the Plant Improvement Department. Management reviews of CRs conducted by the MRC were thorough, and adequate consideration was given to system or component operability and associated plant risks. However, the team did identify examples where CRs were not prioritized in accordance with licensee guidelines. These examples were all minor in nature as they did not adversely impact plant safety.

- CR 2008-12657 was written as a result of HVS-4B (Reactor Auxiliary Building Area Supply Fan) failing to start during monthly surveillance testing. This CR was given a priority of 2B. Per guidance in NAP 204 Enclosure 1, Guidance on the Classification of Condition Reports, a Significant Condition Adverse to Quality (SCAQ) is defined as, "Any significant failure, defect, deviation, malfunction, or deficiency of plant equipment that has or reasonably could have the direct adverse effect on safety or reliability of the plant per the Operating Licensee and Technical Specifications." More specifically, a SCAQ is defined as a Technical Specification required structure, system or component, complete loss of safety function. The team determined that the failure of HVS-4B meets the definition of SCAQ per NAP-204 and should have been assigned a priority level of 1.
- An additional example of incorrect prioritization was identified by the licensee in CR 2008-20135, which was written as a result of a Quality Assurance (QA) audit of the licensee's work order process. This CR identified the fact that CR 2008-3563 was not screened and prioritized in accordance with NAP 204, in that the justification provided for taking no further action did not adequately address the stated problem and the criteria for closure to trending were not sufficiently met.

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.

#### Effectiveness of Corrective Actions

The team determined that overall, corrective actions were effective in correcting plant problems, and that most corrective actions implemented by the licensee were appropriate for the severity and risk significance of the problem identified. For significant conditions adverse to quality, the corrective actions directly addressed the cause and

effectively prevented recurrence. However, the team identified one example was found of untimely corrective actions associated with implementation of Molded Case Circuit Breakers (MCCB) Preventative Maintenance (PM) activities. CR 2005-10929 was written to assess the need for implementation of enhanced PMs and testing, however, to date, the licensee has not implemented any PMs or testing MCCBs.

The team identified multiple examples where elective and corrective maintenance work orders (WOs) associated with corrective actions had not been performed in a timely manner. However, the deficient conditions and the associated corrective actions identified were all minor in nature.

- CR 2005-24762: Damper L-7A –Unit 2 ECCS Area Emergency Exhaust Damper Degraded By Corrosion. Recommended corrective actions are to remove corrosion products, repair/replace seals and blading, and apply protective coatings (WO 35022689). Work has yet to be performed and the WO remains open.
- CR 2004-4773: HVS-5A/B Supply Fans Blowing Rust Particles from Plenum Into Electrical Equipment Room. Recommended corrective actions are to remove corrosion products and apply protective coatings (WO 340136420). Work has yet to be performed and the WO remains open.
- CR 2005-16249: The damper for exhaust fan RV-5 does not open. WO 35014113 was written to address the deficiency. WO has been assigned and reassigned several times. Work has yet to be performed and the WO remains open.
- CR 2003-0536: Roof Ventilator For Electrical Equipment Room Degraded By Corrosion Products. Recommended corrective actions are to clean corrosion products and apply coatings (WO 33003433). Work has yet to be performed and the WO remains open.

(3) Findings

No findings of significance were identified.

b. Assessment of the Use of Operating Experience

(1) Inspection Scope

The team examined licensee programs for reviewing industry operating experience, reviewed the licensee's operating experience database, and interviewed the Operating Experience Coordinator, to assess the effectiveness of how external and internal operating experience data was handled at the plant. In addition, the team selected operating experience documents (e.g., NRC generic communications, 10 CFR Part 21 reports, licensee event reports, vendor notifications, and plant internal operating experience items, etc.), which had been issued since August 25, 2006, to verify whether

the licensee had appropriately evaluated each notification for applicability to the St. Lucie plant and whether issues identified through these reviews were entered into the CAP. Documents reviewed are listed in the Attachment.

(2) Assessment

The team determined that the licensee was effective in screening operating experience for applicability to the plant. The inspectors verified that the licensee had entered those items determined to be applicable into the CAP and taken adequate corrective actions to address the issues. Operating experience was adequately utilized and considered as part of formal root cause evaluations for supporting the development of lessons learned and corrective actions for CAP issues.

(3) Findings

No findings of significance were identified.

c. Assessment of Self-Assessments and Audits

(1) Inspection Scope

The inspectors reviewed licensee QA audits conducted by the Nuclear Assurance Department, 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

QA audits and departmental self-assessments were effective in identifying issues and directing attention to areas that needed improvement. Licensee identified weaknesses and issues in self-assessments were appropriately entered into the corrective action program and addressed. The team determined that the self-assessments and audits were critical, insightful, and persistent at identifying issues and entering them into the CAP. Based on the weaknesses and recommendations identified by the licensee, the team determined the self-assessments were thorough and comprehensive.

(3) Findings

No findings of significance were identified.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

The team randomly interviewed 20 on-site workers regarding their knowledge of the corrective action program at St. Lucie and their willingness to write CRs or raise safety concerns through other available methods. During technical discussions with members of the plant staff, the inspectors conducted interviews to develop a general perspective of the safety-conscious work environment at the site. The interviews were also

conducted to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. These interviews were performed using questions provided in Inspection Procedure 71152, Identification and Resolution of Problems. The inspectors reviewed the licensee's employee concerns program (ECP) and interviewed the ECP manager. Additionally, the inspectors reviewed a sample of completed ECP reports to verify that concerns were being properly reviewed and identified deficiencies were being resolved and entered into the CAP when appropriate.

(2) Assessment

Based on this inspection and the CR reviews, the team determined that licensee management emphasized the need for all employees to identify and report problems using the appropriate methods established within the administrative programs, including the CAP and ECP. These methods were readily accessible to all employees. Based on discussions conducted with a sample of plant employees from various departments, the inspectors determined that employees felt free to raise issues and felt that management encouraged employees to place issues into the CAP for resolution. The inspectors did not identify any reluctance on the part of the licensee staff to report safety concerns.

(3) No findings of significance were identified.

4OA6 Exit Meeting

On July 25, 2008, the inspectors presented the inspection results to Mr. Johnston and other members of his staff who acknowledged the results. The inspectors confirmed that proprietary information was not provided or retained following the inspection.

4OA7 Licensee Identified Violations

The following finding of very low safety significance (Green) was identified by the licensee and is a violation of NRC requirements which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as a NCV:

- 10 CFR Appendix B, Criterion V, Instructions, Procedures, and Drawings, requires 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. On December, 27, 2007, operations Component Cooling Water (CCW) system valve, TCV-14-4B failed its quarterly stroke time surveillance. The cause of this failure was attributed to the installation of an o-ring not designed for the application. This installation of an unapproved o-ring was a deviation from the requirements of site procedure QI-8-PR/PSL-1. This violation is of very low safety significance because it did not result in actual loss safety function for the B Train ICW for greater than its Technical Specification allowed outage time.

ATTACHMENT: SUPPLEMENTAL INFORMATION

**SUPPLEMENTARY INFORMATION**

**KEY POINTS OF CONTACT**

Licensee Personnel

G. Johnston, Site Vice-President  
C. Cotanzo, Plant General Manager  
D. Cechett, Licensing  
C. Nale, Performance Improvement  
R. Filipek, Engineering  
D. Layni, Operations  
R. Strack, Training  
V. Vincek, Maintenance  
J. Gallagher, Employee Concerns

NRC Personnel

S. Vias, Branch Chief, Division of Reactor Projects, Region II  
T. Hoeg, Senior Resident Inspector, St. Lucie

**ITEMS OPENED, CLOSED, AND DISCUSSED**

Opened and Closed

None

## LIST OF DOCUMENTS REVIEWED

### Procedures

NAP-201	Human Performance, Rev. 5
NAP-202	Self-Assessment, Rev. 11
NAP-204	Condition Reporting, Rev. 19
NAP-414	Operating Experience Program, Rev. 4
NAP-424	Employee Concerns Program, Rev. 2
QI-8-PR/PSL-1	Identification Control of Materials, Parts, and Components, Rev. 40A
MPG-001	Plant Work Order Planning, Rev 15A
ADM-10.03	Work Week Management, Rev 19B
0-ADM-533	Corrective Action Program Performance Monitoring and Trend Analysis
0-ADM-710	Control of Preventive Maintenance
ENG-QI 2.3	Operability Determinations, Rev. 8
ENG-QI 2.5	Condition Reports, Rev. 22
ODI-CO-040	Operator Workarounds and Operator Burdens

### Other Documents

Control Room Deficiency Log, Units 1 and 2  
Operator Burdens List  
Operator Workarounds List  
Operator Workarounds/Operator Burdens Screening Checklist

### Operator Workarounds (OWA)

Operator Workaround 2-007-3 (WO 37027028)  
Operator Workaround 2-007-4 (WO 37022753)

### Operating Experience (OE)

26055	26083	26195
26069	26123	
26076	26162	

### Condition Reports

2005-10929	2007-5323	2007-14972
2006-17344	2007-7494	2007-14981
2006-34743	2007-9798	2007-15009
2007-1804	2007-9889	2007-15368
2007-4176	2007-15034	2007-16503
2007-5072	2007-14202	2007-16708
2007-18941	2007-33836	2008-20315
2007-19491	2007-35026	2008-3563
2007-20283	2008-12604	1996-1339
2007-20402	2008-12620	1997-0672
2007-24129	2008-21976	2001-1567
2007-27968	2008-22068	2001-2826
2007-30864	2008-23652	2002-0182
2007-33219	2008-23383	2002-1958

2003-0536	2007-38496	2007-17363
2003-1719	2007-24457	2008-3080
2004-0128	2007-33107	2007-20141
2004-4773	2007-42630	2007-20096
2004-8499	2008-4030	2007-37632
2004-9733	2008-12657	2007-37505
2004-1324	2007-6684	2008-7054
2005-1469	2007-4647	2007-20652
2005-3077	2007-7570	2008-12882
2005-16249	2007-20586	2008-13573
2005-24762	2007-30054	2008-15611
2007-4383	2007-6684	2008-18683
2007-4799	2007-28776	2008-21749
2007-14916	2007-28391	2008-2206

### **Condition Reports Generated as a Result of Inspection**

2008-23670, Oil Absorbent Pads on 2A and 2B CCW Pump Outboard Vent Openings  
 2008-23797, Issue Screening Associated with Significant Conditions Adverse to Quality  
 2008-23792, Unit 2 CCW Pump Oil Leaks  
 2008-23900, Timeliness of Corrective Actions Associated with MCCB's

### **Work Orders**

31019407	35003298	37022796
32002250	35014113	37025462
33003433	35015026	37026422
33008835	35022689	38000177
33016758	36010540	38008561
34019920	37009086	38009174
340136420	37009970	38003249
35003297	37010695	