



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION**

REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PA 19406-1415

January 16, 2009

Mr. Gene St. Pierre  
Site Vice President  
FPL Energy Seabrook, LLC  
Seabrook Station  
c/o Mr. Michael O'Keefe  
P.O. Box 300  
Seabrook, NH 03874

**SUBJECT: SEABROOK STATION, UNIT NO. 1 - NRC PROBLEM IDENTIFICATION AND  
RESOLUTION INSPECTION REPORT 05000443/2008009**

Dear Mr. St. Pierre:

On December 5, 2008, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at the Seabrook Station, Unit No. 1. The enclosed report documents the inspection results, which were discussed on December 5, 2008, with you and other members of your staff.

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 license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

There were no findings of significance identified during this inspection. On the basis of the samples selected for review, the inspectors determined that, in general, Florida Power and Light Energy (FPLE) personnel identified problems and entered them into the corrective action program at a low threshold. The inspectors also determined that, in general, FPLE personnel prioritized and evaluated issues commensurate with the safety significance of the problems and implemented timely and effective corrective actions. The inspectors did, however, identify several examples of minor conditions involving identification of issues and implementation of corrective actions.

In accordance with Title 10 of the Code of Federal Regulations Part 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available

Mr. G. St. Pierre

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Sincerely,

**/RA/**

Raymond J. Powell, Chief  
Technical Support & Assessment Branch  
Division of Reactor Projects

Docket No. 50-443  
License No. NPF-86

Enclosure: Inspection Report No. 05000443/2008009  
w/ Attachment: Supplemental Information

cc w/encl:

J. A. Stall, FPLE Senior Vice President, Nuclear & CNO  
M. Warner, Vice President, Nuclear Operations  
R. S. Kundalkar, FPLE Vice President, Nuclear Technical Svcs  
M. Mashhadi, Senior Attorney, Florida Power & Light Company  
M. S. Ross, Managing Attorney, Florida Power & Light Company  
M. O'Keefe, Manager, Regulatory Programs  
P. Freeman, Plant General Manager  
K. Wright, Manager, Nuclear Training, Seabrook Station  
R. Poole, FEMA, Region I  
Office of the Attorney General, Commonwealth of Mass  
K. Ayotte, Attorney General, State of NH  
O. Fitch, Deputy Attorney General, State of NH  
P. Brann, Assistant Attorney General, State of Maine  
R. Walker, Director, Radiation Control Program, Dept. of Public Health, Commonwealth of MA  
C. Pope, Director, Homeland Security & Emergency Management, State of NH  
J. Giarrusso, MEMA, Commonwealth of Mass  
D. O'Dowd, Administrator, Radiological Health Section, DPHS, DHHS, State of NH  
J. Roy, Director of Operations, Massachusetts Municipal Wholesale Electric Company  
T. Crimmins, Polestar Applied Technology  
R. Backus, Esquire, Backus, Meyer and Solomon, NH  
Town of Exeter, State of New Hampshire  
Board of Selectmen, Town of Amesbury  
S. Comley, Executive Director, We the People of the United States  
R. Shadis, New England Coalition Staff  
M. Metcalf, Seacoast Anti-Pollution League

Mr. G. St. Pierre

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**SUNSI Review Complete: RJP** (Reviewer's Initials)

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OFFICE:	RI/DRP/Br3	RI/DRP/BC/Br3		RI/DRP/BC/TSAB
NAME:	D Schroeder / *	A Burritt / ALB		R Powell / RJP
DATE:	01/15/09 via Telecon	01/13/09		01/16/09

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No.: 50-443

License No.: NPF-86

Report No.: 05000443/2008009

Licensee: FPL Energy, Seabrook, LLC (FPLE)

Facility: Seabrook Station, Unit No. 1

Location: Seabrook, New Hampshire 03874

Dates: November 17 through December 5, 2008

Team Leader: Daniel Schroeder, Salem Senior Resident Inspector, DRP

Inspectors: Jonathon Johnson, Resident Inspector, DRP  
Justin Hawkins, Project Engineer, DRP  
Sammy McCarver, Project Engineer, DRP  
Sherlyn Ibarrola, Reactor Engineer, DRP

Approved by: Raymond J. Powell, Chief  
Technical Support & Assessment Branch  
Division of Reactor Projects

Enclosure

## SUMMARY OF FINDINGS

IR 05000443/2008-009; 11/17/2008 – 12/05/2008; Seabrook Station Unit No. 1; Biennial Baseline Inspection of the Identification and Resolution of Problems.

This team inspection was performed by three NRC regional inspectors and two resident inspectors. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, December 2006.

### Identification and Resolution of Problems

The inspectors concluded that FPLE was effective in identifying, evaluating, and resolving problems. Seabrook personnel generally identified problems and entered them into the Corrective Action Program (CAP) at a low threshold, and had taken actions to address previous NRC findings. The inspectors determined that FPLE appropriately screened issues for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Causal analyses appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors determined that corrective actions addressed the identified causes and were typically implemented in a timely manner. However, the inspectors noted several examples of minor material condition issues that had not been identified by FPLE. Corrective actions were initiated for all issues identified by the NRC inspectors.

FPLE's audits and self-assessments were generally thorough and probing. The inspectors concluded that FPLE adequately identified, reviewed, and applied relevant industry operating experience. Based on interviews, observations of plant activities, and reviews of the CAP and the Employees Concerns Program (ECP), the inspectors determined that site personnel were willing to raise safety issues and to document them in the CAP.

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

None

#### B. Licensee-Identified Violations

None

## REPORT DETAILS

### 4. OTHER ACTIVITIES

#### 4OA2 Problem Identification and Resolution (PI&R) (71152B)

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

###### a. Inspection Scope

The inspectors reviewed the procedures that describe FPLE's CAP at the Seabrook Power Station. FPLE identified problems for evaluation and resolution by initiating condition reports (CRs) that were entered into the condition reporting system. The CRs were subsequently screened for operability, categorized by significance, and assigned for further evaluation, resolution and/or trending.

The inspectors evaluated the process for assigning and tracking issues to ensure that issues were screened for operability and reportability, prioritized for evaluation and resolution in a timely manner commensurate with their safety significance, and tracked to identify adverse trends and repetitive issues. In addition, the inspectors interviewed plant staff and management to determine their understanding of, and involvement with, the CAP.

The inspectors reviewed CRs selected across the seven cornerstones of safety in the NRC's Reactor Oversight Process (ROP) to determine if site personnel properly identified, characterized, and entered problems into the CAP for evaluation and resolution. The inspectors selected items from functional areas that included chemistry, emergency preparedness, engineering, maintenance, operations, physical security, radiation safety, and oversight programs to ensure that FPLE appropriately addressed problems identified in these functional areas. The inspectors selected a risk-informed sample of CRs that had been issued since the last NRC Problem Identification and Resolution (PI&R) inspection conducted in November 2006. The inspectors considered risk insights from the station's risk analyses to focus the sample selection and plant tours on risk-significant systems and components. Inspector samples focused on these systems, but were not limited to them. The corrective action review was expanded to five years for evaluation of FPLE's actions taken to mitigate groundwater intrusion.

The inspectors selected items from various processes at Seabrook to verify that they were appropriately considered for entry into the CAP. Specifically, the inspectors reviewed a sample of engineering requests, operator workarounds, operability determinations, work orders (WOs), the employee concerns program, and system health reports. The inspectors also reviewed completed work packages to determine if issues identified during the performance of preventive and corrective maintenance were entered into the corrective action program. In addition, the inspectors reviewed plant operator logs, chemistry logs, and security logs to determine whether problems described in the logs were entered into the CAP.

Enclosure

The inspectors reviewed CRs to assess whether FPLE personnel adequately evaluated and prioritized identified problems. The issues reviewed encompassed the full range of evaluations, including root cause analyses, apparent cause evaluations, and common cause analyses. CRs that were assigned lower levels of significance which did not include formal cause evaluations were also reviewed by the inspectors to ensure they were appropriately classified. The inspectors reviewed a sample of 15 CRs of a low significance level associated with the emergency diesel generators, component cooling, and safety injection systems and verified that they were classified appropriately. The inspectors' review included the appropriateness of the assigned significance, the scope and depth of the causal analysis, and the timeliness of resolution. The inspectors assessed whether the evaluations identified likely causes for the issues and identified appropriate corrective actions to address the identified causes. The inspectors observed daily CR screening meetings in which FPLE personnel reviewed new CRs for prioritization and assignment. The inspectors also observed Management Review Committee (MRC) meetings during which FPLE managers reviewed root cause evaluations, as well as selected apparent cause evaluations and corrective action assignments. Further, the inspectors reviewed equipment operability determinations, reportability assessments, and extent-of-condition reviews for selected problems to verify these processes adequately addressed equipment operability, reporting of issues to the NRC, and the extent of problems.

The inspectors reviewed the corrective actions associated with selected CRs to determine whether the actions addressed the identified causes of the problems. The inspectors reviewed CRs for adverse trends and repetitive problems to determine whether corrective actions were effective in addressing the broader issues. The inspectors reviewed FPLE's timeliness in implementing corrective actions and effectiveness in precluding recurrence for significant conditions adverse to quality. The inspectors further reviewed CRs associated with selected non-cited violations (NCVs) and findings to determine whether FPLE personnel properly evaluated and resolved the issues. The CRs and other documents reviewed, as well as key personnel contacted, are listed in the Attachment to this report.

b. Assessment

Identification of Issues

Based on the samples selected, the inspectors determined that FPLE personnel identified problems and entered them into the CAP at a low threshold. In most cases, problems were documented appropriately in CRs. The inspectors observed managers at Issue Screen Team (IST) meetings appropriately questioning and challenging CRs that did not contain sufficient information. The inspectors determined that FPLE appropriately trended equipment and programmatic issues. The inspectors concluded that personnel were identifying trends at low levels, and did not identify trends or repetitive issues that FPLE had not self-identified.

However, the inspectors noted several examples of minor material condition and housekeeping issues that had not been previously identified by FPLE personnel. FPLE

initiated corrective actions for all problems identified by the NRC inspectors. One minor violation of station requirements is provided as an example of these issues. During a tour of the facility inspectors identified a small quantity of wood, weighing approximately two pounds, located inside the fuel handling building was not fire retardant. The wood was being used to provide a form for concrete repair under work order (WO) 0627933. This was a performance deficiency because FPLE Seabrook procedure FP 2.2, "Control of Combustible Materials," Revision 8, states in section 4.3 that wooden materials, including dunnage or scaffolding shall be fire retardant. It further states that wood purchased for such use in the protected area shall be fire retardant. Contrary to this requirement, the identified small quantity of wood was not fire retardant. FPLE Seabrook removed the wood from the fuel handling building and the protected area. FPLE Seabrook promptly entered the issue into their corrective action program as CR 08-15842. The inspectors verified that FPLE Seabrook assigned appropriate significance and priority to the issue, and that the wood was removed from the fuel handling building. The inspectors determined that because these transient combustibles could not affect equipment important to safety, were not in a combustible free zone required for separation of redundant trains, and did not exceed any licensing basis requirements, this performance deficiency was minor and not subject to enforcement action in accordance with the NRC's Enforcement Policy.

#### Prioritization and Evaluation of Issues

The inspectors determined that, in general, FPLE appropriately prioritized and evaluated issues commensurate with the safety significance of the problem. The inspectors reviewed the packages for a random sample of ten MRC meetings and five IST meetings conducted since the last inspection. CRs were screened for operability and reportability, categorized by significance, and assigned to a department for evaluation and resolution. The various CR screening and management review groups considered human performance issues, radiological safety concerns, repetitiveness, and adverse trends during the conduct of reviews.

Items were categorized for evaluation and resolution commensurate with the significance of the issues and guidance for categorization was sufficiently definitive for consistent implementation. Operability and reportability determinations were performed when conditions warranted and the evaluations supported the conclusions. Causal analyses appropriately considered extent of condition, generic issues, and previous occurrences. During this inspection, the inspectors noted that FPLE's root cause analyses (RCAs) were generally thorough, and additional corrective and preventive actions addressed the identified causes.

However, there were a few examples of corrective action timeliness issues and completion extensions approved without adequate justification documented in the associated CR. For example, CA-01 for CR 05-12215 was rescheduled many times since December 19, 2005. This CR was for the review of a Westinghouse technical bulletin that identifies an issue whereby failure of a capacitor in certain control circuits has caused undesired reactor trips. FPLE Seabrook has subsequently reviewed this technical bulletin and determined that no short term corrective actions are required to mitigate the trip risk.



CR 05-14981, dealing with a circuit abnormality for the service water train "A" bypass switch, was similarly rescheduled over the past three years. This issue was closed on December 23, 2008.

### Effectiveness of Corrective Actions

The inspectors concluded that corrective actions for identified deficiencies were typically timely and adequately implemented. Administrative controls were in place to ensure that corrective actions were completed as scheduled and reviews were performed to ensure the actions were implemented as intended. The inspectors also concluded that FPLE conducted in-depth effectiveness reviews for significant issues to determine whether the corrective actions were effective in resolving the issue. In some cases, FPLE appropriately self-identified ineffective or improper closeout of corrective actions and re-entered the issue into the CAP for further action. The inspectors did identify a few minor cases where corrective actions were not fully effective in addressing underlying deficiencies. For significant conditions adverse to quality, the inspectors noted that FPLE's actions were comprehensive and thorough, and generally successful at preventing recurrence. However, corrective actions taken to resolve the groundwater intrusion issue at Seabrook have not been fully effective. Groundwater intrusion at the station could cause degradation of a structure, system, or component (SSC) that is important to plant safety. Potential degradation of SSCs due to groundwater intrusion has been evaluated by FPLE Seabrook on a case by case basis following identification. A comprehensive evaluation of long term degradation of SSCs due to groundwater intrusion has not been performed by FPLE Seabrook.

#### c. Findings

No findings of significance were identified.

### .2 Assessment of the Use of Operating Experience

#### a. Inspection Scope

The inspectors selected a sample of industry operating experience (OE) issues to confirm that FPLE had evaluated the OE information for applicability to Seabrook and had taken appropriate actions, when warranted. The inspectors reviewed OE documents to ensure that FPLE appropriately considered the underlying problems associated with the issues for resolution via their CAP. The inspectors also observed plant activities to determine if industry OE was considered during the performance of routine and infrequently performed activities. A list of the documents reviewed is included in the Attachment to this report.

#### b. Assessment

The inspectors determined that FPLE appropriately considered industry OE information for applicability, and used the information for corrective and preventive actions to identify and prevent similar issues. The inspectors assessed that OE was appropriately applied and lessons learned were communicated and incorporated into plant operations.

The inspectors observed that industry OE was routinely considered during the performance of plant activities. For example, during shift briefing activities, relevant industry OE was reviewed and discussed before the commencement of shift activities.

c. Findings

No findings of significance were identified.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors reviewed a sample of Quality Assurance (QA) audits, including the most recent audit of the CAP, and a variety of self-assessments focused on various plant programs. These reviews were performed to determine if problems identified through these assessments were entered into the CAP, when appropriate, and whether corrective actions were initiated to address identified deficiencies. The effectiveness of the audits and assessments was evaluated by comparing audit and assessment results against self-revealing and NRC-identified observations made during the inspection.

The inspectors also reviewed the most recent Safety Culture Survey report and discussed actions taken and planned with FPLE management in order to determine whether appropriate action had been taken to address identified issues. A list of documents reviewed is included in the Attachment to this report.

b. Assessment

The inspectors concluded that self-assessments, QA audits, and other assessments were critical, thorough, and effective in identifying issues. The inspectors observed that these audits and self assessments were completed in a methodical manner by personnel knowledgeable in the subject. The audits and self-assessments were completed to a sufficient depth to identify issues that were entered into the CAP for evaluation. Corrective actions associated with the issues were implemented commensurate with their safety significance.

The inspectors determined that the Safety Culture Survey provided insights into the safety culture of the site workforce. FPLE managers evaluated the results and initiated appropriate actions to focus on areas identified for improvement.

c. Findings

No findings of significance were identified.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

During interviews with many of the station personnel, the team assessed the safety conscious work environment (SCWE) at Seabrook. Specifically, the team interviewed personnel to determine whether they were hesitant to raise safety concerns to their management and/or the NRC, due to a fear of retaliation. The team also interviewed the station ECP coordinator to determine if employees were aware of the program and had used it to raise concerns. The team reviewed the ECP files, anonymous CRs, and NRC related documents from November of 2006 until November of 2008 to ensure that issues were entered into the CAP, as appropriate.

b. Assessment

During interviews, plant staff expressed a willingness to use the CAP to identify plant issues and deficiencies and stated that they were willing to raise safety issues. The inspectors noted that no one interviewed stated that they personally experienced or were aware of a situation in which an individual had been retaliated against for raising a safety issue. All persons interviewed demonstrated an adequate knowledge of the CAP and ECP. Based on these limited interviews, the team concluded that there was no evidence of an unacceptable SCWE and no significant challenges to the free flow of information.

c. Findings

No findings of significance were identified.

4OA6 Meetings, Including Exit

On December 5, 2008, the team presented the inspection results to Mr. Gene St. Pierre, Site Vice President, and to other members of the Seabrook staff. The team verified that no proprietary information was documented in the report.

ATTACHMENT: SUPPLEMENTAL INFORMATION

**SUPPLEMENTAL INFORMATION**

**KEY POINTS OF CONTACT**

Licensee personnel

G. St. Pierre	Site Vice President
P. Freeman	Plant General Manager
K. Whitney	Principal Engineer
D. Lynch	Senior Nuclear Analyst
R. Arn	System Engineer
B. Brown	Engineering Supervisor
D. Master	Senior Engineer
B. Fielding	Security Supervisor
P. Brangiell	Senior Engineering Analyst
G. Sessler	Principal Engineer
P. Brown	Principal Engineer
R. Jamison	Principal Engineer
C. Moynihan	Senior Nuclear Analyst, Performance Improvement
V. Pascucci	Site Quality Manager, Nuclear Oversight
A. Chesno	Performance Improvement Manager
B. Martel	Employee Concerns Program Coordinator
B. McAllister	System Engineer
D. Willson	Engineering Supervisor
J. Ball	Maintenance Rule Coordinator
J. Berg	Chemistry Supervisor
D. Robinson	Chemistry Manager
S. Folsom	SFIN Supervisor
S. Samtag	Operations Tagging Supervisor
P. Nardone	Engineering Supervisor
T. Rossignol	System Engineer
M. Nadeau	System Engineer
A. Kodal	Principal Engineer
V. Brown	Licensing Engineer

**LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED**

Opened and Closed

None

## LIST OF DOCUMENTS REVIEWED

### Audits and Self-Assessments

Assessment of 2007 Backlog Reduction Plan for Corrective Actions >12 Months, QRNO 07-0068, 9/20/07

2007 Nuclear Industry Evaluation Program (NIEP) Audit of FPL Energy Seabrook Nuclear Oversight Department Audit Report No. SBK-07-05, 09/10/2007

Nuclear Oversight Audit No. SBK-07-01, Functional Area Audit of QA Programs and Management Controls, 03/22/2007

Nuclear Oversight Audit No. SBK-07-08, Functional Area Audit of Corrective Action Program, 12/24/2007

Nuclear Assurance Quality Report No. QRNO 07-0009, Fire Protection Systems Maintenance, Surveillance, and Testing, 02/07/2007

Nuclear Assurance Quality Report No. QRNO 07-0018, Leakage Reduction Program, 02/21/2007

Corrective Action Program Audit, SBK 06-11

Self-Assessment 08-0059 Fleet SOFA CAP Self-Assessment 7/31/08

SBK Functional Area Audit of Operations Audit Report No. SBK-08-02 1/14/08 to 2/14/08

Emergency Preparedness Interface, Communications, Training and Qualification, SBK-08-07

Emergency Preparedness Program Drills and Performance, SBK-08-12

Functional Area Audit of Emergency Preparedness, SBK-07-06

### Calculations

C-S-1-E-0161, DG Maximum Allowable Fuel Oil Consumption Rate, Rev. 14

### Completed Surveillances

OX1426.22, Emergency Diesel Generator 1A 24 Hour Load Test and Hot Restart Surveillance, July 3, 2008

### Condition Reports

02-11214	05-00710	06-06664	06-14211
03-03404	05-01921	06-07971	06-14217
03-03496	05-01954	06-09133	06-14287
03-05735	05-02074	06-10791	06-14372
03-05823	05-05302	06-12055	06-14445
03-08159	05-06338	06-12071	06-14479
03-08797	05-10391	06-12094	06-14563
03-10808	05-12215	06-12389	06-14615
04-01957	05-13220	06-12727	06-14768
04-02388	05-13457	06-13201	06-14811
04-02701	05-14717	06-13506	06-14893
04-02862	05-14981	06-13616	06-14905
04-03619	05-15363	06-13996	06-14970
04-04626	06-02802	06-14013	06-15112
04-10727	06-03081	06-14145	06-15259
04-12061	06-04815	06-14175	06-15350
05-00574	06-06572	06-14176	06-15350

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06-15432	07-03258	07-11100	08-01001
06-15443	07-03276	07-11193	08-01013
06-15445	07-03278	07-11197	08-01019
06-15471	07-03411	07-11296	08-01189
06-15671	07-03594	07-11341	08-01195
06-15686	07-03597	07-11678	08-01321
06-15688	07-03637	07-12519	08-01471
06-15731	07-03750	07-12595	08-01996
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07-00487	07-04366	07-13999	08-02969
07-00830	07-04402	07-14282	08-03049
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07-01798	07-05623	07-14536	08-03482
07-02055	07-05626	07-14601	08-03511
07-02060	07-05708	07-14639	08-03513
07-02193	07-05934	07-14830	08-03536
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07-02546	07-09025	07-27386	08-04458
07-02645	07-09176	08-00275	08-04657
07-02755	07-09183	08-00340	08-05068
07-02907	07-09255	08-00591	08-05101
07-02967	07-09303	08-00743	08-05102
07-02985	07-09308	08-00825	08-05104
07-03117	07-10155	08-00847	08-05312
07-03179	07-10524	08-00894	08-05313
07-03180	07-10594	08-00913	08-05431
07-03207	07-10606	08-00944	08-05459

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08-05751	08-13271	08-14661	08-15477
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08-06270	08-13461	08-14708	08-15603
08-06409	08-13462	08-14729	08-15604
08-06496	08-13504	08-14730	08-15606
08-06634	08-13526	08-14736	08-15663
08-06657	08-13580	08-14747	08-15681
08-06695	08-13724	08-14749	08-15682
08-06788	08-13736	08-14750	08-15698
08-06883	08-13737	08-14767	08-15701
08-06920	08-13742	08-14770	08-15727
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08-08673	08-14079	08-14987	08-15801*
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08-09007	08-14225	08-14992	08-15842*
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08-09315	08-14286	08-15037	08-15902*
08-09479	08-14362	08-15041	08-15948*
08-09912	08-14364	08-15094	08-15979
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08-10886	08-14367	08-15146	08-16040
08-11140	08-14369	08-15227	08-16041
08-11277	08-14396	08-15228	08-16125
08-11279	08-14426	08-15231	08-16260
08-11486	08-14451	08-15297	08-16347*
08-11781	08-14472	08-15368	08-16348*
08-11848	08-14485	08-15369	08-16407*
08-12067	08-14486	08-15371	08-16458*
08-12414	08-14498	08-15376	08-16459*
08-12508	08-14545	08-15377	08-16460*
08-12532	08-14555	08-15387	08-16461*
08-12638	08-14570	08-15433	08-16462*
08-12972	08-14627	08-15460	08-16463*
08-13085	08-14636	08-15463	
08-13121	08-14648	08-15464	

\*NRC Identified During Inspection

Drawings

1-NHY-310231, Sheet 6b, Motor/Load Misc Relays 13.8kV SWGR Bus 1-ED-SWG-1, Rev. 14  
1-NHY-310231, Sheet 7b, Misc Relays 13.8kV SWGR Bus 1-ED-SWG-2, Rev. 11  
1-NHY-310231, Sheet 9b, Misc Relays 4.16kV SWGR Bus 1-ED-SWG-3, Rev. 7  
1-NHY-310231, Sheet 10b, Misc Relays 4.16kV SWGR Bus 1-ED-SWG-4, Rev. 7  
1-NHY-310231, Sheet 11a, Motor/Load 5kV SWGR 1-EDE-SWG-5, Rev. 17  
1-NHY-310231, Sheet 11b, Motor/Load 5kV SWGR 1-EDE-SWG-5, Rev. 6  
1-NHY-310231, Sheet 12a, Motor/Load 5kV SWGR 1-EDE-SWG-6, Rev. 12  
1-NHY-310231, Sheet 12b, Motor/Load 5kV SWGR 1-EDE-SWG-6, Rev. 6  
1-NHY-310231, Sheet 12c, Miscellaneous Relays 4.16kV Switchgear Bus 1-EDE-SWG-6, Rev. 6  
422-851, Gas System Schematic 345kV (1050 KV BIL) SF6, Rev. 3

ECP Program Review

FPL Nuclear Division Nuclear Administrative Procedure NAP-424 ECP Rev. 2 09/10/07  
Florida Power and Light Company (FPL) Nuclear Division ECP-1 Rev. 1 08/31/07  
ECP Coordinator Review of Anonymously written CRs from 2007  
ECP Coordinator Review of Anonymously written CRs from 2006  
ECP Closed Investigations Log for SBK 11/1/06 – 11/1/08  
ECP Referral Log for SBK 11/1/06 – 11/1/08

ECP Concern Investigation Reports:

ECP-SBK-08-001	ECP-SBK-08-002	ECP-SBK-08-003
ECP-SBK-08-004	ECP-SBK-08-005	ECP-SBK-08-006
ECP-SBK-08-007	ECP-SBK-08-008	ECP-SBK-06-003
ECP-SBK-07-001	ECP-SBK-07-002	ECP-SBK-07-003
ECP-SBK-07-004	ECP-SBK-07-005	ECP-SBK-07-006

Evaluations

Root Cause Evaluation, Firearm Discharge, CR 07-12047  
Root Cause Evaluation, Diesel Generator B Tripped on High Lube Oil Temperature, CR 08-10421  
Apparent Cause Evaluation, Unexpected Decrease in B Diesel Generator Load during Maintenance Run, CR 08-09385  
Apparent Cause Evaluation, Train B CC Heat Exchanger Outlet Valve Drifted Closed, CR 07-15319  
Root Cause Evaluation A 06-13475, RCS Dilution Event, 12/07/2006  
Root Cause Evaluation A 08-00894, Reactor Trip Due to Fault on 345 KV Bus 3, 07/10/2008  
Root Cause Analysis 08-06260 for Reach Rod Operated Valve CS-V-1190 Not fully  
Root Cause Analysis 08-06270 for RCA Primary Fluid Loss Through CS-V-299  
Apparent Cause Evaluation B 07-01338, While performing Turbine Generator Shutdown, breaker found in unexpected position, 02/23/2007  
Apparent Cause Evaluation B 07-03179, Oversight has not consistently complied with audit and Independent Technical Review (ITR) internal department procedures, 04/11/2007  
Apparent Cause Evaluation B 07-03925, Potential adverse trend in contamination events - 16 CRs have been initiated since the outage associated with contamination control, 04/12/2007



Apparent Cause Evaluation B 07-12916, Rad Posting RCA Tunnel entrance to the WPB found on wrong side of door W200, 11/13/2007  
Apparent Cause Evaluation B 08-05108, Wrong precalibrated overload relays installed during thermal overload relay replacement on 1-FW-FV-4244-B, 06/04/2008  
Apparent Cause Evaluation: CR 08-08940, CVCS Total M/U Controller (CS-FIC-111) found in Manual/Remote  
Apparent Cause Evaluation 08-04634, Performance of Caution tag steps resulting in auto closure of SGBD CIVs  
Apparent Cause Evaluation CR 08-08424, More caustic added then desired using wrong pump  
Apparent Cause Evaluation CR 08-01472, MS MSIVs inop due to improper tagout  
Apparent Cause Evaluation CR 08-04961, ACE Unexpected voltage in SW-V-74 during testing  
Apparent Cause Evaluation CR 03-08317, Seal injection flow lost while swapping injection filters  
Apparent Cause Evaluation 07-09078, I&C Wet leg Calibrator over-pressurization

LERs

LER-2005-001-00  
LER-2006-004-00  
LER-2007-001-00  
LER-2007-002-00

Miscellaneous

Change Authorization Request 06CAR007, Ground Water Inflow Collection and Diversion to Sump - Electrical Tunnel East Stairwell Area, 04/21/2006  
Presentation to CNRB Meeting #587 FPLE Seabrook Nuclear Oversight Summary of Quality Performance April 2008 – October 2008, 11/18/2008  
Presentation to CNRB Meeting #587 Seabrook Engineering Manager's Report, 11/18/2008  
Presentation to CNRB Meeting #587 Seabrook Maintenance Manager's Report, 11/18/2008  
Presentation to CNRB Meeting #587 Seabrook Operations Manager's Report, 11/18/2008  
Presentation to CNRB Meeting #587 Seabrook Performance Improvement Manager's Report, 11/18/2008  
Presentation to CNRB Meeting #587 Seabrook Work Controls Manager's Report, 11/18/2008  
Maintenance Support Evaluation 05 MSE 044, Ground Water Collection Troughs, 03/30/2005  
Nuclear Industry Evaluation Program Guidelines NQML 07-002, Rev. 1  
Nuclear Industry Evaluation Program Performance Objectives and Attributes NQML 07-001, Rev. 1  
NRC Information Notice IN 2006-13, Ground-Water Contamination Due to Undetected Leakage of Radioactive Water, 07/10/2006  
Seabrook Corrective Action Program Daily Issue Screening Team Report for Management Review Committee, 03/28/2008  
Seabrook Corrective Action Program Daily Issue Screening Team Report for Management Review Committee, 05/08/2008  
Seabrook Corrective Action Program Daily Issue Screening Team Report for Management Review Committee, 07/08/2008  
Seabrook Corrective Action Program Daily Issue Screening Team Report for Management Review Committee, 09/02/2008  
Seabrook Corrective Action Program Daily Issue Screening Team Report for Management Review Committee, 11/03/2008

Seabrook Management Review Committee Agenda, 05/07/2007  
Seabrook Management Review Committee Agenda, 07/31/2007  
Seabrook Management Review Committee Agenda, 09/21/2007  
Seabrook Management Review Committee Agenda, 11/30/2007  
Seabrook Management Review Committee Agenda, 01/11/2008  
Seabrook Management Review Committee Agenda, 03/28/2008  
Seabrook Management Review Committee Agenda, 05/08/2008  
Seabrook Management Review Committee Agenda, 07/08/2008  
Seabrook Management Review Committee Agenda, 09/02/2008  
Seabrook Management Review Committee Agenda, 11/03/2008  
Seabrook Management Review Committee Agenda, 11/20/2008  
Westinghouse Technical Bulletin TB 04-5, Westinghouse RCP Motor Recommended 1-Year, 5-Year, and 10-Year Inspection and Maintenance, 03/11/2004  
Job Briefing Guideline WM 8.0A Rev. 6  
Run-to-failure analysis for Stow Remote Valve Operators AP 913

Non-Cited Violations

50-443/08-03-03, Failure to Control a High Radiation Area as a Locked High Radiation Area  
50-443/07-05-02, Inadequate Evaluation of Low Strength Bolts in the RHR System

Procedures

SDI0043.00, Routine Shift Responsibilities and Turnover, Rev. 03  
IS1616.490, PCCW Temperature Valve Actuator Repair, Rev. 02  
GN1337.05, Operation of the Security Gatehouse, Rev. 00  
MA10.3, Boric Acid Corrosion Control Program, Rev. 02  
MS0517.10, Insulation Removal, Installation, and Repair, Rev.03  
NODI-430, Performance of Quality Assurance Audits, Rev. 18  
OE 4.3, Root Cause Analysis, Rev. 21  
MA 4.2, SBK Station Administrative Procedure Equipment Tagging and Isolation Rev. 20 Chg 05  
MA 4.5, SBK Station Administrative Procedure Configuration Control Rev. 13 Chg. 03  
ODI-87, Operations Department Instruction Rev. 15  
Operations standing order 08-10 Reach Rod operated valves  
FP 3.1, Fire Protection Maintenance and Surveillance Testing, Rev 02, Chg. 01  
FP2.2 Control of Combustible Materials, Rev 08, Chg. 03  
WM 8.4, Work Order Process (R04 / C07)  
MA 4.2, Equipment Tagging and Isolation (R20 / C02)  
OE 3.6, Condition Reports (R16 / C00)  
OE 4.0, Types of Evaluations (R14 / C00)  
OE 4.3, Root Cause Evaluations (R21 / C00)  
OE 4.5, Prompt Operability Determinations (R13 / C00)  
OE 4.8, Apparent Cause Evaluations (R18 / C00)  
OE 7.1, Operating Experience Review Program (R09 / C00)  
PI-AA-01, Corrective Action Program and Condition Reporting  
PI-AA-02, Self-Assessment  
PI-AA-03, Operating Experience  
PI-AA-204, Condition Identification and Screening Process (R01 / C 00)  
PI-AA-205, Condition Evaluation and Corrective Action (R00 / C00)

SSMA, Maintenance Manual (R134)  
NAP 402, Conduct of Operations (R6 / C0)  
NAP 403, Conduct of Maintenance (R5 / C0)  
MDGI.0018, Maintenance Group Standards and Expectations  
SBK-08-13, Maintenance Bench Stock Identification and Control of Materials  
SBK-08-09, Measuring and Test Equipment  
SBK-08-08, Preventative Maintenance  
SBK-08-14, Post Maintenance Testing

Work Orders

0801497	0709511	0413835	0305735
0843688	0729692	0813327	0305823
0342248	0734850	0813329	0703655
0400646	0803630	0312432	0700325
0513045	0804850	0312472	0643139
0627079	0810006	0428315	0643093
0627083	0813512	0505534	0722456
0633206	0817589	0543691	0727386
0635251	0413799	0704545	0825735
0704534	0413834	0303404	

**LIST OF ACRONYMS**

ADAMS	Agencywide Documents Access and Management System
CAP	Corrective Action Program
CNRB	Company Nuclear Review Board
CR	Condition Report
DRP	Division of Reactor Projects
ECP	Employee Concerns Program
FPLE	Florida Power and Light Energy
IST	Issue Screen Team
IN	NRC Information Notice
LER	Licensee Event Report
MRC	Management Review Committee
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
OE	Operating Experience
PARS	Publicly Available Records System
PI&R	Problem Identification and Resolution
QA	Quality Assurance
RCA	Root Cause Analysis
RHR	Residual Heat Removal
ROP	Reactor Oversight Program
SCWE	Safety Conscious Work Environment
WO	Work Order