



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION II
245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

July 2, 2010

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

**SUBJECT: TURKEY POINT NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000250/2010006 AND
05000251/2010006**

Dear Mr. Nazar:

On May 21, 2010, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection at your Turkey Point Nuclear Plant Units 3 and 4. The enclosed report documents the inspection results which were discussed on May 21, 2010, and again on June 29, 2010, with Mr. P. Rubin 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, 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.

On the basis of the sample selected for review, the team concluded that in general, problems were properly identified, evaluated, and resolved within your corrective action program. There was one green finding identified during this inspection associated with the inadequate implementation of a procedure during a visual inspection of a safety-related snubber. The failure to identify missing, detached, loosened support items, or full thread engagement of all mechanical connections led to a snubber failure. This finding was determined to involve a violation of NRC requirements. Additionally, one licensee-identified violation of very low safety significance (Green) is listed in this report. However, because of the very low safety significance of these findings and because they have been entered into your corrective action program, the NRC is treating them as non-cited violations, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you contest any NCV in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN.: Document Control Desk, Washington DC 20555-001; with copies to the Regional Administrator Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspectors at Turkey Point.

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

Sincerely,

/RA/

George T. Hopper, Chief
Reactor Projects Branch 7
Division of Reactor Projects

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

Enclosure: Inspection Report 05000250/2010006 and 05000251/2010006
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

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/RA/

George T. Hopper, Chief
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cc w/encl: (See page 3)

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Letter to Mano Nazar from George T. Hopper dated July 2, 2010

SUBJECT: TURKEY POINT NUCLEAR PLANT – NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000250/2010006 AND
05000251/2010006

Distribution w/encl:

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OE Mail

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.: 50-250, 50-251

License Nos.: DPR-31, DPR-41

Report No: 05000250/2010006, 05000251/2010006

Licensee: Florida Power & Light Company (FP&L)

Facility: Turkey Point Nuclear Plant, Units 3 & 4

Location: 9760 S. W. 344th Street
Florida City, FL 33035

Dates: May 3 to 21, 2010

Inspectors: R. Taylor, Senior Project Inspector, Team Leader
M. Barillas, Resident Inspector, Turkey Point
T. Lighty, Project Engineer
S. Sanchez, Resident Inspector, St. Lucie

Approved by: George T. Hopper, Chief
Reactor Projects Branch 7
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000250/2010006, 05000251/2010006; 05/03/2010 – 05/21/2010; Turkey Point Nuclear Plant, Units 3 and 4; biennial inspection of the identification and resolution of problems.

The inspection was conducted by one senior project inspector, two resident inspectors, and one project engineer. One green finding of very low safety significance was identified. The significance of most findings is indicated by its color (Green, White, Yellow, Red) using the Significance Determination Process in Inspection Manual Chapter (IMC) 0609, Significance Determination Process (SDP). The cross-cutting aspect was determined using IMC 0305, Operating Reactor Assessment Program. Findings for which the Significance Determination Process 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 4, dated December 2006.

Identification and Resolution of Problems

The team concluded that, in general, problems were properly identified, evaluated, prioritized, and corrected. The threshold for initiating condition reports (CRs) was appropriately low, as evidenced by the types of problems identified and the number of CRs entered annually into the Corrective Action Program (CAP). Employees were encouraged by management to initiate CRs. However, the team identified deficiency's associated with preventative maintenance (PM) scheduling in that a number of PMs were inadvertently scheduled past their due dates when the licensee began using the PM scheduling tool LCP.net. In addition, the team identified several examples of minor equipment issues that had not been identified by the licensee and entered into the CAP. When identified, the licensee entered these issues into the CAP. Generally, prioritization and evaluation of issues were adequate, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner.

The team determined that, overall, audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and in most cases, appropriate corrective actions were developed to address the issues identified. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work and plant operations.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel felt free to raise safety concerns to management and use the CAP to resolve those concerns.

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Cornerstone: Mitigating Systems

- Green. The NRC identified a non-cited violation of 10 CFR 50, Appendix B, Criterion V, for the licensee's failure to implement procedures during a visual inspection of safety related seismically qualified snubber SN-4-1039. Specifically, the licensee failed to identify missing, detached, loosened support items, or full thread engagement of all mechanical connections that led to a snubber failure as prescribed in procedure 0-OSP-105.1, Visual Inspection, Removal and Reinstallation of Mechanical Shock Arrestors, section 7.2.1.3.d. The snubber would not have been able to perform its design function to arrest shocks of the main steam piping to the C Steam Generator during seismic events or transients, such as sudden isolation of the main steam isolation valve. The licensee implemented immediate corrective actions which included replacing the snubber in containment, adding specific instructions in procedure 0-OSP-105.1 to specifically inspect the locking ring and correct installation, and to include emphasis on FPL expectations from vendor provided snubber inspection services. The licensee documented this in condition report CR 2008-31372.

The performance deficiency was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone in that the licensee did not ensure reliability of the snubber to respond to initiating events to prevent undesirable consequences in that the snubber would not have been able to perform its design function to arrest shocks of the main steam piping to the C Steam Generator during seismic events or transients. The finding was screened using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and was determined to have a very low safety significance (Green) because the system remained operable and capable of meeting its design function with no loss of safety function of the C main steam system. This finding was reviewed for cross-cutting aspects and none were identified. (4OA2).

One violation of very low safety significance (Green), identified by the licensee, has been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. This violation and associated corrective actions are listed in Section 4OA7 of this report.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA2 Problem Identification and Resolution

a. Assessment of the Corrective Action Program (CAP)

(1) Inspection Scope

The inspectors reviewed the licensee's CAP procedures which described the administrative process for initiating and resolving problems using condition reports (CRs). To verify that problems were being properly identified, the inspectors toured plant areas, including the main control rooms and accompanied operations personnel on routine daily rounds to verify that issues were identified and documented in the CAP. Daily plant status reports were reviewed and plant issues were checked for appropriate documentation in the CAP. A sampling of work orders and surveillance tests since 2008 was checked to assure that identified problems were documented and resolved in the CAP. Further, the inspectors verified that issues were appropriately characterized, and screened in accordance with the significance of the issue. The inspectors included a detailed review of selected CRs associated with four risk-significant systems: Auxiliary Feedwater (AFW), Component Cooling Water (CCW), Intake Cooling Water (ICW), and Station Batteries. In these systems and in other selected cases, a review of issues as far back as 5 years or more was done. The inspectors conducted plant walkdowns of equipment associated with selected systems to look for any deficiencies that had not been previously entered into the CAP. System health reports, condition reports, engineering walkdown reports and interviews with personnel were done to assess effectiveness of problem resolution. Also, work order and corrective action backlogs were checked to assess if risk-significant issues were being promptly addressed. Where possible, the inspectors independently verified that the corrective actions were implemented as intended. The inspectors also reviewed selected common causes and generic concerns associated with root cause evaluations to determine if they had been appropriately addressed. To help ensure that samples were reviewed across all cornerstones of safety, the team selected a representative number of CRs that were identified and assigned to the major plant departments, including operations, maintenance, engineering, emergency preparedness, health physics, and security. These CRs were reviewed to assess each department's threshold for identifying and documenting plant problems, thoroughness of evaluations, and adequacy of corrective actions.

The inspection included a detailed review and evaluation of CRs associated with significant conditions adverse to quality (screened as significance level 1 by the licensee and requiring root cause evaluation). The inspectors assessed if the licensee had adequately determined the cause(s) of identified problems and had adequately addressed operability, reportability, common cause, generic concerns, extent-of-condition, and extent-of-cause. The use of operating experience (OE) in assessing significant conditions was evaluated. The review also assessed if the licensee had appropriately identified and prioritized corrective actions to prevent recurrence.

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Control room walkdowns were also performed to assess the main control room (MCR) deficiency list and to ascertain if deficiencies were being tracked to resolution. A sample of operator workarounds and operator burden screenings were reviewed and the inspectors verified compensatory measures for deficient equipment were being implemented in the field.

The team reviewed selected industry operating experience items, including NRC generic communications and Part 21 reports, to verify that they had been appropriately evaluated for applicability or used in licensee activities and that issues identified through these reviews had been entered into the CAP.

The team reviewed site trend reports, to determine if the licensee effectively trended identified issues and initiated appropriate corrective actions when adverse trends were identified.

Documents critically reviewed are listed in the Attachment.

(2) Assessment

Identification of Issues

The team determined that the licensee was effective in identifying problems and that plant staff had a low threshold for entering issues into the CAP. This conclusion was based on observation of daily summaries of issues documented in the CAP during the inspection and in discussion with management on the expectation that employees initiate CRs for any reason. Site management was actively involved in the CAP and focused appropriate attention on significant plant issues. The inspectors observed that trending was generally effective in monitoring equipment performance.

During plant walkdowns the NRC inspectors identified several minor issues that were not previously identified by operators or system engineers during routine rounds and system walkdowns. Examples included general corrosion of AFW pipes, insulation damage, incidental acid deposits on two 4B battery cells, and several minor housekeeping issues. The issues were subsequently evaluated by the licensee and determined not to have a current adverse impact on reliability of equipment.

NRC inspectors identified several discrepancies associated with PMs scheduled past their due date. These discrepancies were due to the licensee's use of PM scheduling tool LCP.net. Approximately 3300 PMs were aligned via LCP.net, including some 1500 PMs without a current next required due date (first performance). Many current existing PMs were affected. Although the intent of assigning new due/late dates by LCP.net was to schedule and perform the rescheduled PMs prior to their original date, there was no physical barrier in place to prevent performance of any of the effected PMs past their original late date. The significance is that there is potential for equipment failures/deficiencies due to those delayed PMs. However, the team did not identify any failures or deficiencies associated with PMs scheduled past their due date. As part of the immediate corrective actions the licensee performed a review and evaluated the rescheduled dates to determine if the rescheduled due dates were appropriate. Dates

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that were determined to be inappropriate were returned to their original due date based on the engineering review.

Prioritization and Evaluation of Issues

The inspectors concluded that problems were prioritized and evaluated in accordance with the licensee's CAP procedures. Each CR was assigned a priority level using station procedures.

The team determined that station personnel had conducted root cause and apparent cause analyses in compliance with the licensee's CAP procedures and assigned cause determinations were appropriate, considering the significance of the issues being evaluated. A variety of formal causal-analysis techniques were used depending on the type and complexity of the issue consistent with 0-ADM-059, Root Cause Evaluation.

The team determined that, generally, the licensee had performed evaluations that were technically accurate and of sufficient depth. The team further determined that operability, reportability, and degraded or non-conforming condition determinations had been completed consistent with the guidance contained in Procedures are PI-AA-01, Corrective Action Program and Condition Reporting, PI-AA-204, Condition Identification and Screening Process, and PI-AA-205, Condition Evaluation and Corrective Actions. The use of operating experience was appropriate and obvious in cause evaluations.

Effectiveness of Corrective Actions

Based on a review of corrective action documents, interviews with licensee staff, and verification of completed corrective actions, the team determined that overall, corrective actions were timely, commensurate with the safety significance of the issues, and effective, in that conditions adverse to quality were corrected and non-recurring. For significant conditions adverse to quality, the corrective actions directly addressed the cause and effectively prevented recurrence in that a review of performance indicators, CRs, and effectiveness reviews demonstrated that the significant conditions adverse to quality had not recurred. Effectiveness reviews for corrective actions to prevent recurrence (CAPRs) were sufficient to ensure corrective actions were properly implemented and were effective.

(3) Findings

i. Inadequate Procedure Implementation Resulted in Snubber Failure

Introduction: A green NRC identified Non-Cited Violation (NCV) of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, was identified for failing to implement procedures during a visual inspection of safety-related seismically-qualified snubber SN-4-1039. The licensee failed to identify missing, detached, loosened support items or full thread engagement of all mechanical connections as prescribed in procedure 0-OSP-105.1, Visual Inspection, Removal and Reinstallation of Mechanical Shock Arrestors that led to a snubber failure.

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Description: On October 11, 2008, during a Unit 4 Containment Leak Inspection walkdown as part of a plant shutdown, snubber SN-4-1039 was found to be detached from its transition piece on the 4C steam generator main steam line. The licensee entered Technical Specification 3.7.6 action statement for an inoperable snubber and replaced the inoperable snubber within 72 hours. On April 22, 2008, the snubber had been inspected during a visual ASME code VT-3 inspection using procedure 0-OSP-105.1. Section 7.2.1.3.d of 0-OSP-105.1, stated “visually inspect snubber for missing, detached, loosened support items, verify full thread engagement of all mechanical connections and weld integrity.” During inspection the examiner failed to identify any missing, detached or loosened support items, or disengagement of any mechanical connections. As a result, the snubber had an improperly fastened connection that eventually allowed the snubber cylinder to become detached from its transition piece. The NRC determined that the instruction in 0-OSP-105.1 was sufficient for a VT-3 qualified inspector to verify proper engagement of all mechanical connections. The licensee implemented immediate corrective actions which included adding specific instructions in procedure 0-OSP-105.1; to specifically inspect the locking ring and correct installation; and to include emphasis on FPL expectations from vendor provided snubber inspection services. The licensee documented this in condition reports CR 2008-31372 and CR 2010-13596.

Analysis: The failure to identify missing, detached, loosened support items or full thread engagement of all mechanical connections as prescribed in procedure 0-OSP-105.1, that led to a snubber failure was a performance deficiency. The performance deficiency was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone in that the licensee did not ensure reliability of the snubber to respond to initiating events to prevent undesirable consequences in that the snubber would not have been able to perform its design function to arrest shocks of the main steam piping to the C Steam Generator during seismic events or transients. The inspectors evaluated the finding using NRC Inspection Manual 0609, Attachment 0609.04, SDP Phase 1 Screening and Characterization of Findings. The finding was determined to be of very low safety significance because the loss of the snubber during the seismic or transient event it was intended to mitigate would not have caused a plant trip and would not have degraded one or more trains that support a safety system or function. This finding was reviewed for cross-cutting aspects and none were identified.

Enforcement: 10 CFR 50 Appendix B, Criterion V, Instructions, Procedures, and Drawings, states, in part, 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, or drawings. The licensee meets this requirement by implementing procedure 0-OSP-105.1, Visual Inspection, Removal and Reinstallation of Mechanical Shock Arrestors. Contrary to the above, on April 22, 2008, the licensee failed to accomplish an activity affecting quality in accordance with applicable procedures, specifically, operating procedure 0-OSP-105.1 was not adequately implemented during a visual inspection of safety related seismically qualified snubber SN-4-1039. The licensee failed to identify missing, detached, loosened support items, or full thread engagement of all mechanical connections as prescribed in procedure 0-OSP-105.1, that resulted in snubber failure. Because the failure to comply with 10 CFR 50, Appendix B, criterion V, is of very low safety

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significance and has been entered into the licensee's corrective action program as CR 2008-31372 and CR 2010-13596, this violation is being treated as an NCV, consistent with Section VI.A of the NRC Enforcement Policy: NCV 05000250/2010-006-01, Inadequate Procedure Implementation Resulted in Snubber Failure.

b. Assessment of the Use of Operating Experience (OE)

(1) Inspection Scope

The team examined the licensee's use of industry operating experience to assess the effectiveness of how external and internal operating experience data was used to prevent similar or recurring problems at the plant. In addition, the team selected operating experience documents (e.g., NRC generic communications, 10 CFR Part 21 reports, licensee event reports, and plant internal operating experience items), which had been issued since 2008 to verify whether the licensee had appropriately evaluated each notification for applicability to the Turkey Point plant, and whether issues identified through these reviews were entered into the CAP. The inspectors checked if operating experience was appropriately incorporated into cause evaluations and integrated into plant operations through pre-job briefs and other activities. Documents reviewed are listed in the Attachment.

(2) Assessment

Based on observations of activities and interviews with station personnel and a review of documentation related to operating experience issues, the team determined that the licensee was effective in screening operating experience for applicability to the plant. OE issues requiring action (e.g., Part 21 reports) were entered into the CAP for evaluation, tracking, and closure. In addition, operating experience was included in apparent cause and root cause evaluations in accordance with licensee procedures. OE was evident in plant operations activities, such as pre-job briefings and turnover meetings.

(3) Findings

No findings of significance were identified.

c. Assessment of Self-Assessments and Audits

(1) Inspection Scope

The team reviewed the licensee's audit and self-assessment reports, including those which focused on problem identification and resolution, to assess if the licensee was identifying problems at an appropriately low threshold and to verify that problems identified through those activities were entered into the CAP and prioritized for resolution in accordance with licensee procedures. The team verified that recommendations from self-assessments reviewed had been entered into the CAP, evaluated, and verified that actions had been completed consistent with those evaluations.

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(2) Assessment

The team determined that the scopes of assessments and audits were technically sound and appropriate. Self-assessments were generally detailed and critical. Condition reports were created to document the results and associated recommendations from the final reports. The team also determined that the licensee had adequately prioritized self-assessment and audit issues entered into the CAP.

(3) Findings

No findings of significance were identified.

d. Assessment of Safety Conscious Work Environment

(1) Inspection Scope

The inspectors assessed the station's safety conscious work environment (SCWE) through review of the station's Employee Concern Program (ECP), discussions with coordinators of the ECP, interviews with personnel from various station departments, and reviews of station performance indicators. The inspectors checked the status of FPL's evaluation and actions related to improving the corporate safety culture, including upgrades to the Employee Concerns Program.

(2) Assessment

The inspectors found that individuals remained aware of the processes available to raise safety issues and that no reluctance to raise safety concerns was identified. Improvements to the employee concerns program and initiatives to improve the FPL safety culture were proceeding.

The inspectors found, through interviews with site workers, that they were willing to raise nuclear safety concerns, had initiated CAP items, and had been involved in the safety culture surveys. Interviews also revealed that plant workers were knowledgeable of the various available methods for raising nuclear safety concerns. Furthermore, the workers communicated recent improvement in station supervision's support of the workers' raising issues. None of the workers indicated that their co-workers or they had been retaliated against for raising safety concerns.

The inspectors met with the station ECP coordinator. The ECP coordinator indicated activities that would facilitate more awareness and understanding of the ECP including introducing the program with onsite staff and contractor groups at departmental meetings. Furthermore, the ECP office had been recently relocated within the plant protected area and procedures had been developed for uptake of concerns and management of concern resolution. The new process required closeout of the concern with the concerned individual, typically in a face-to-face meeting.

(3) Findings

No findings of significance were identified.

4OA6 Meetings, Including Exit

On May 21, 2010, the inspectors provided the results of the inspection to Mr. P. Rubin and other members of the site staff. On June 28, 2010 a re-exit was completed per phone call to discuss the final resolution of the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

4OA7 Licensee Identified Violations

The following violation of very low safety significance (Green) was identified by the licensee and constituted a violation of NRC requirements which met the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as a Non-Cited Violation.

- Technical Specification 6.8.1 requires that procedures required by the Florida Power and Light Quality Assurance Topical Report (QATR) be implemented. The QATR includes procedures listed in Appendix A of NRC Regulatory Guide 1.33 Revision 2. Contrary to the above, on November 26, 2009, during PMT of the New Analog Rod Position Indication System (NARPI), the control room received indication that the H6 and H10 control rods dropped from the fully withdrawn position and did not enter the required off-normal procedure ONOP-28.3, "Dropped RCC," when the two control rods (H6 and H10) were confirmed to be dropped during the Unit 4 Outage. The licensee eventually entered the procedure when directed by management and tripped the reactor as required by the procedure. The non-compliance was identified by the licensee following issuance of LER 2010-001-0 on January 25, 2010, and entered into the corrective action process. During the post modification test Unit 4 was in Mode 3 (Hot Standby) and was borated such that all control rods could be withdrawn and the reactor would not go critical, eliminating any safety concern with two dropped control rods. The issue was screened to be of very low safety significance (Green). The issue was documented in condition report 2010-3782 and additional corrective actions were identified. Because the licensee identified the issue and documented it in their corrective action program and because the finding is of very low safety significance, this violation is being treated as a licensee-identified NCV consistent with Section VI.A of the NRC Enforcement Policy.

ATTACHMENT: SUPPLEMENTAL INFORMATION

Enclosure

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

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M. Crosby, Quality Assurance
R. Everett, Licensing
E. Fisher, Work Control
J. Garcia, Engineering
M. Guth Engineering
J. Herrera, Performance Improvement
K. Mohindroo, Engineering
P. Rubin, Plant Manager
J. Shafer, Health Physics
S. Shaffer, Assistant Operations Manager
B. Stamp Operations
B. Tomonto, Licensing Manager
M. Wayland, Work Control Manager

NRC

S. Stewart, SRI Turkey Point
G. Hopper, DRP Branch Chief, Region II

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000250&251/2010-006-01 NCV

Inadequate procedure implementation
resulting in snubber failure.

LIST OF DOCUMENTS REVIEWED

Procedures

3-OSP-200.3, Secondary Plant Periodic Tests
3-OSP-206.2, Quarterly Inservice Valve Testing
0-GMM-043.13, Reactor Vessel Head Installation, Revision 6
0-GMM-043.08 Reactor Vessel Head Lifting, Revision 7
0-PMM-030.10, Component Cooling Water System Relief Valve Testing and Refurbishment
0-ADM-717, Heavy Load Handling, Revision 1
0-ADM-726, Rigging Operations, Revision 1B
0-ADM-732, Protective Coatings, Revision 1A
0-ADM-115, Notification of Plant Events
SY-AA-102-1008, Security Drills and Exercises, Revision 1
SY-AA-102-1017, Safeguards Event Reporting, Revision 2
SFI-1103, Security Shift Supervisor, Revision 38
4-ONOP-028.3 Dropped RCC
0-ADM-503 Temporary System Alteration

Maintenance Work Orders

38027203	21002158	37011911	39024185	38027034	16000056
21002158	39024185	38027033	37011911	39001094	38002469
38002031	37022204	37005637	37017243	36001404	37009484
37010134	36001404	21002158	25000796	37011911	38027033
37010484	35009266	35008354	35004463	38008361	35008361
35008142	35009273	35008359	35004465	35008360	35007140
35008141	35008363	35008364	36004245	36004528	36004533
35009276	35009281	35004473	35008146	35009277	35009279
35004471	35009280	35008144	35008365	35008366	35004032
39001094	36013459	35023612	25007796	36002516	36002524
36002520	36002223	36002741	25014764	36004009	36003589
36003590	36003591	35020176	16000130	33013824	38016796
38017598	30014933	38017591	37012154	37012162	21002619
36013527	36013530	35020099	20003182	37014480	37014139
37014138	37001906	36009562	36007358	35020335	35020376
35020386	36009631	36013445	38020629	21003084	36023306
33013593	37002201	37002206	35020286	20004435	37009957
36017892	33010418	34002035	36017899	34002036	34002019
25025173					

Condition Reports

2010-2783	2009-33606	2008-26826	2010-1745	2009-371	2008-15351
2008-29162	2008-29035	2009-21726	2008-15644	2008-30686	2008-28450
2009-31977	2009-15873	2009-14936	2009-33606	2008-26826	2008-29525
2008-21904	2008-15431	2008-17305	2007-9449	2008-16450	2008-18837
2009-15873	2008-28058	2008-27014	2009-29049	2009-22907	2008-2858
2008-27755	2008-11175	2008-32228	2009-1192	2008-8623	2008-35577

2005-2863	2010-11137	2009-1213	2008-31372	2009-22140	2008-38241
2005-20893	2008-18658	2005-20893	2008-27771	2010-6118	2006-31359
2007-13385	2008-31036	2009-29217	2008-27274	2009-24597	2008-23983
2009-20396	2008-18474	2009-16336	2008-4714	2008-1749	2009-19367
2009-15784	2009-11481	2009-15970	2008-37585	2008-27422	2008-18837
2008-29658	2009-15695	2008-4825	2008-4807	2008-25246	2008-10845
2008-26811	2009-20396	2009-27880	2008-24596	2009-2551	2008-3656
2008-4669	2008-17423	2009-10284	2009-3690	2009-3447	2009-10284
2009-22909	2009-13028	2009-29216	2008-4825	2008-11365	2008-17166
2008-17222	2008-18474	2008-27944	2008-25246	2008-27020	2007-17534
2007-139	2008-9728	2006-10961	2003-3634	2006-29298	

Other

System Health Report for Unit 3 Intake Cooling Water
 System Health Report for Unit 3 Intake Cooling Water
 System Health Report for Unit 3 Component Cooling Water
 System Health Report for Unit 4 Component Cooling Water
 LER U4 2010-001-00 Two Shutdown Bank Rods Were Dropped from Fully Withdrawn Position
 Unit 4 Operator Logs dated 11/26/09-11/27/09
 FPL/FPLE QA Surveillance Report dated 09/17/2007
 Licensee Event Report Common 2008-S01-00
 Licensee Event Report Common 2008-S02-00
 Licensee Event Report Common 2009-S01-00
 Licensee Event Report Unit 3 2008-003-00
 Licensee Event Report Unit 4 2008-003-00
 Licensee Event Report Unit 3 2008-003-01
 LER U3 2008-002-00 Containment Purge Penetration Fails Leak Rate Test Due to Inadequate Preventative Maintenance on Isolation Valve
 LER U3 2008-004-00 Emergency Containment Filter Inoperable due to control Circuit Length
 LER U4 2008-004-00 Undervoltage Trip Time Delay Relays Cause Loss of Function
 LER U4 2009-001-00 4B Emergency Diesel Generator Inoperable Due to Airbound Main Fuel Pump
 FPL-1 Quality Assurance Topical Report Revision 6
 Turkey Point Nuclear Plant Preventative Maintenance Action Plan PowerPoint 06/06/2009
 CRN E17939 Changes in Loading due to Rod Position Indication Replacement
 FPL Observation Results & Event Code Trending Unit 4-25 Outage Roll-Up PowerPoint
 Human Performance Oversight Group Meeting Minutes 06/22/09, 12/21/09-12/22/09
 Operator Work Arounds List
 Operator Burdens List
 U3 and U4 Control Room Deficiency Log
 Operator Workarounds/Burdens Audit dated 5/29/08
 Operator Workarounds/Burdens Audit dated 3/11/08
 ODI-CO-040, Operator Workarounds and Operator Burdens
 Operations Shift Turnover Report (focused on compensatory measures for equipment in workarounds and burdens list requiring comp. measures)

Operator Workarounds/Operator Burden Screening checklist and associated CRs:

- U3 Turbine Bearing High Temp.-2007-36812
- U3 Main Generator Hydrogen leak-2007-043
- U3A/3B ICW pump motor bearing temp.-2007-17534
- U4 Instrument Air dew point meter reading is suspect-2008-4241

Maintenance Rule Expert Panel Meeting Agenda for Thursday June 12, 2008

MR (a)(1) Action Plan systems status chart

EDI-ENG-020, Determination of SSCs within scope of MR

EDI-ENG-023, Establishing (a)(1) corrective actions and goals

EDI-ENG-024, Monitoring Performance of SSCs within scope of MR to performance criteria and goals

Maintenance Rule Report for Condensate System

Maintenance Rule Report for Steam System