



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PA 19406-1415

November 12, 2010

Mr. Paul Freeman
Site Vice President, North Region
Seabrook Nuclear Power Plant
NextEra Energy Seabrook, LLC
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 05000443/2010008**

Dear Mr. Freeman:

On October 1, 2010, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection at Seabrook Station, Unit No. 1. The enclosed report documents the inspection results discussed on October 1, 2010, 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 operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, there were no findings identified during this inspection. The inspectors concluded that problems were, in general, properly identified, evaluated, and resolved within the corrective action program (CAP). NextEra personnel identified problems at a low threshold and entered them into the CAP. NextEra personnel screened issues appropriately for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Root and apparent cause analyses appropriately considered extent of condition, generic issues, and previous occurrences. Corrective actions addressed the identified causes and were typically implemented in a timely manner. However, the inspectors also identified a number of minor performance deficiencies that involved a lack of adherence to the procedures used to perform root cause analyses, self assessments and operating experience reviews.

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

P. Freeman

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Sincerely,

A handwritten signature in black ink, appearing to read 'Arthur L. Burritt', with a long horizontal flourish extending to the right.

Arthur L. Burritt, Chief
Projects Branch 3
Division of Reactor Projects

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

Enclosure: Inspection Report No. 05000443/2010008
w/ Attachment: Supplemental Information

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/RA/
Arthur L. Burritt, Chief
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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No.: 50-443

License No.: NPF-86

Report No.: 05000443/2010008

Licensee: NextEra Energy Seabrook, LLC

Facility: Seabrook Station, Unit No.1

Location: Seabrook, New Hampshire 03874

Dates: September 13, 2010 through October 1, 2010

Team Leader: Thomas Setzer, PE, Senior Project Engineer
Division of Reactor Projects (DRP)

Inspectors: Juan Ayala, Project Engineer, DRP
Jonathan Johnson, Seabrook Resident Inspector, DRP
Sammy McCarver, Project Engineer, DRP

Approved by: Arthur L. Burritt, Chief
Projects Branch 3
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000443/2010008; 09/13/2010 - 10/01/2010; 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 one resident inspector. 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 inspectors concluded that problems were, in general, properly identified, evaluated, and resolved within the corrective action program (CAP). NextEra personnel identified problems at a low threshold and entered them into the CAP. The inspectors determined that NextEra personnel screened issues appropriately for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Root and apparent cause 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 also identified a number of minor performance deficiencies that involved a lack of adherence to the procedures used to perform root cause analyses.

NextEra's audits and self-assessments reviewed by the inspectors were adequate to determine programmatic weaknesses and deficiencies. Additionally, the inspectors concluded that NextEra, in general, identified, reviewed, and applied relevant industry operating experience (OE) to the Seabrook Station. However, the inspectors also identified minor performance deficiencies that involved lack of adherence to the procedures that implemented the self assessment an OE programs. Based on interviews, observations of plant activities, and reviews of the CAP and the Employees Concerns Program (ECP), the inspectors did not identify any concerns with site personnel willingness to raise safety issues, nor did the inspectors identify conditions that could have had a negative impact on the site's safety conscious work environment (SCWE).

No findings were identified.

REPORT DETAILS**4. OTHER ACTIVITIES (OA)****4OA2 Problem Identification and Resolution (PI&R) (71152B)****.1 Assessment of the Corrective Action Program Effectiveness****a. Inspection Scope**

The inspectors reviewed NextEra's procedures that describe the CAP at the Seabrook Station. NextEra personnel identified problems by initiating condition reports (CRs) for conditions adverse to quality, plant equipment deficiencies, industrial or radiological safety concerns, etc. CRs were subsequently screened for operability and reportability, and categorized by significance. The significance levels included: 1 (significant condition adverse to quality, root cause); 2 (condition adverse to quality, apparent cause); and 3 (condition adverse to quality, fix/trend/close). Additional items screened for significance and assigned for resolution included conditions not adverse to quality (NCAQ), engineering change requests (ECR), routine work tracking (RWT), training work requests (TWR), procedure change requests (PCR), and preventive maintenance change requests (PMCR).

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 approximately 400 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 and programs that included Performance Improvement, Maintenance Rule, Security, Emergency Preparedness, Engineering, Maintenance, Operations, Chemistry, ECP, and Radiation Protection to ensure that NextEra 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 that was completed in December 2008. Insights from the station's risk analyses were also considered to focus the sample selection and plant walkdowns on risk-significant systems and components. The corrective action review was expanded to five years for evaluation of identified concerns within CRs relative to the boric acid corrosion control program (BACCP).

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 Maintenance Rule functional failure evaluations, operability determinations, system health reports, work orders (WOs), and issues entered into the ECP. Additionally, the inspectors performed a walkdown of plant areas including the turbine building, auxiliary feedwater rooms, emergency core cooling system rooms, emergency diesel generator rooms, 125 Vdc battery rooms, yard areas, and selected security areas.

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The inspectors reviewed CRs to assess whether NextEra personnel adequately evaluated and prioritized issues. The CRs reviewed encompassed the full range of evaluations, including root cause analyses, apparent cause analyses, and common cause analyses. A sample of CRs that were assigned lower levels of significance, which did not include formal cause evaluations (significance level 3, close to trend), were also reviewed by the inspectors to ensure they were appropriately classified. The inspectors' review included the appropriateness of the assigned significance, the scope and depth of the analysis, and the timeliness of resolution. The inspectors assessed whether the evaluations identified causes for the issues and identified appropriate corrective actions to address the identified causes. As part of this review, the inspectors interviewed station personnel to fully understand details within the evaluations and the proposed and completed corrective actions. The inspectors observed Initial Screening Team (IST) and Management Review Committee (MRC) meetings in which NextEra personnel reviewed CRs for prioritization and assignment. Further, the inspectors reviewed equipment operability determinations and extent-of-condition reviews for selected CRs to verify these specific reviews adequately addressed equipment operability and the extent of conditions.

The inspectors also reviewed CRs for adverse trends and repetitive problems to determine whether corrective actions were effective in addressing the broader issues. The inspectors reviewed NextEra's timeliness in implementing corrective actions and effectiveness in precluding recurrence for significant conditions adverse to quality. Lastly, the inspectors reviewed CRs associated with NRC non-cited violations (NCVs) and findings since the last PI&R inspection in December 2008 to determine whether NextEra personnel properly evaluated and resolved the issues. Specific documents reviewed during the inspection are listed in the Attachment to this report.

The inspectors reviewed the programmatic weaknesses identified in the NRC Supplemental Inspection report 05000443/2010007 (ML102250493)¹, dated August 13, 2010, which was associated with a White inspection finding involving a failure to establish adequate design control measures to modify a cooling water flange on the 'B' emergency diesel generator (EDG). This inspection was conducted in accordance with NRC inspection procedure 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area." The finding involved inadequate design control measures during a cooling water flange modification, which resulted in the failure of the 'B' EDG in February 2009 (ML092400410). The weaknesses identified in the 95001 report included: a lack of thoroughness in the cause analysis related to identification of root and contributing causes; inadequate extent of condition and extent of cause reviews; and failure to fully implement an identified corrective action. The inspectors reviewed most of the root cause evaluations completed since the last PI&R team inspection (December 2008) to determine if these weaknesses were evident in the conduct of other root cause analyses. Specifically, the inspectors performed reviews of corrective action documents (CRs, ARs, WOs), interviewed root cause team evaluators, and reviewed guidance contained in NextEra procedure OE 4.3, "Root Cause Analysis," Revision 21.

¹ Designation in parentheses refers to an Agencywide Documents Access and Management System (ADAMS) accession number. Documents referenced are publicly-available using the accession number in ADAMS.

b. Assessment

Effectiveness of Problem Identification

Based on the selected samples reviewed, plant walkdowns, and interviews of site personnel, the inspectors determined that, in general, NextEra personnel identified problems and entered them into the CAP at a low threshold. For the issues reviewed, the inspectors noted that problems or concerns had been appropriately documented in enough detail to understand the issues. Approximately 21,000 CRs had been written by NextEra personnel since the last NRC PI&R inspection in December 2008.

The inspectors observed managers and supervisors at MRC meetings appropriately questioning and challenging CRs to ensure clarity of the issues. The inspectors determined that NextEra personnel trended equipment and programmatic issues, and CR descriptions appropriately included reference to repeat occurrences of issues. The inspectors also concluded that personnel were identifying trends at low levels.

The inspectors toured plant areas including the turbine building, auxiliary feedwater rooms, emergency core cooling system rooms, emergency diesel generator rooms, 125 Vdc battery rooms, yard areas, and selected security areas to confirm that NextEra personnel identified plant issues at the proper threshold. The inspectors reviewed issues identified by the NRC during the last PI&R inspection in December 2008 to determine if the issues had been resolved. This included actions taken by NextEra to improve the control of transient combustibles in the plant, and the use of protective barriers for systems out of service for maintenance. During the plant tour, the inspectors determined there were no uncontrolled transient combustibles in safety-related areas. The inspectors also reviewed the protected trains of systems that were out of service for maintenance, and determined that NextEra had installed protective train barriers in accordance with site procedures to protect those systems from inadvertent manipulation or maintenance. Additionally, the site perimeter (yard area) was clean and free of transient combustible materials. No adverse conditions were found during the tours.

Effectiveness of Prioritization and Evaluation of Issues

The inspectors determined that, in general, NextEra personnel appropriately prioritized and evaluated issues commensurate with their safety significance. CRs were screened for operability and reportability, categorized by significance, and assigned to a department for evaluation and resolution. The CR screening process considered human performance issues, radiological safety concerns, repetitiveness, and adverse trends. The inspectors observed managers and supervisors at IST and MRC meetings appropriately questioning and challenging CRs to ensure appropriate prioritization.

CRs were categorized for evaluation and resolution commensurate with the significance of the issues. Based on the sample of CRs reviewed, the guidance provided by the NextEra implementing procedures appeared sufficient to ensure consistency in categorization of the issues. 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, in general, NextEra's root cause analyses were thorough, and corrective actions addressed the identified causes. Additionally, the identified causes were adequately supported.

The inspectors reviewed most of the root cause evaluations completed since the last PI&R team inspection in December 2008 and determined that the root causes in each evaluation were appropriately arrived at and supported. Extent of condition and extent of cause were also documented appropriately and supported. All root causes reviewed involved a significant level of effort, including analyzing and identifying failed barriers and event causes. However, based on the inspectors' review of these root causes, the following two observations were identified:

- NextEra procedure OE 4.3 requires root cause analyses to include the evaluation of issues associated with organizational and programmatic weaknesses in order to assign failure mode trend codes (PII failure modes). Many of the root cause evaluations reviewed by the inspectors had not completed this specific section.

Additionally, NextEra procedure OE 4.3 requires that the CR owner complete a checklist to verify all the root cause analysis sections in the report were completed. The inspectors determined that the checklists for all root cause evaluations were completed stating that all sections were complete; however, as stated earlier, many root cause evaluations had not completed the organizational and programmatic weaknesses section.

The inspectors questioned NextEra on why the organizational and programmatic weaknesses section and the associated checklist were not completed in accordance with NextEra procedure OE 4.3. Based on interviews with Performance Improvement personnel, approximately two years ago, NextEra had stopped utilizing the PII failure mode trend codes, but had not revised procedure OE 4.3 to remove the guidance requiring it. NextEra transitioned to an alternate set of failure mode trend codes associated with organizational and programmatic weaknesses when the PII failure mode trend codes were eliminated. NextEra expected to transition to a fleet level root cause procedure which removed the PII failure mode section; however, this transition did not occur and they did not revise the current procedure while the transition was expected to take place. As a result, NextEra did not complete the organizational and programmatic weaknesses section, and marked the checklist as complete because the root cause evaluation included all the sections they believed were required to be done. The inspectors determined that while NextEra had not utilized the PII failure mode trend codes as required by their procedure, they still had implemented trending of organizational and programmatic weaknesses through the use of alternate trend codes to be used in their CAP. NextEra had incorrectly interpreted the current procedure as a recommendation in lieu of a requirement.

The inspectors determined that the failure to follow the guidance contained in NextEra procedure OE 4.3 regarding completing the organizational and programmatic weaknesses section and associated checklists was a performance deficiency that was associated with all seven of the reactor safety cornerstones. The performance deficiency was not more than minor because it was not a precursor to a significant event, it would not lead to a more significant safety concern if left uncorrected and it did not adversely affect any of the ROP cornerstone objectives. Specifically, this issue was of minor significance because NextEra had implemented alternative failure mode trend codes and analyzed them for use in the CAP to prevent recurrence of the issues. NextEra documented this concern in CR 579854.

- The inspectors reviewed the training requirements for root cause evaluators and determined that NextEra procedure OE 4.3 requires root cause evaluator training to be completed annually. The inspectors found that there has been no classroom training for root cause evaluators since 2006. The inspectors questioned why the training had not been conducted in accordance with NextEra procedure OE 4.3 and determined that NextEra had relied upon on-the-job training as a way to satisfy the procedure requirement, but failed to ensure that root cause evaluators would receive the on-the-job training at least annually. The inspectors determined that only a small percentage of root cause evaluators had received on the job training in the past year. This was due to the number of root cause evaluations that were completed in the past year (six), which was not sufficient to ensure all root cause evaluators would receive individual on-the-job training within the last year. The inspectors reviewed training records for root cause evaluators and determined that all had received initial training, but had not had any documented classroom training since 2006. Based on a review of the six root cause evaluations completed last year, the inspectors did not identify any issues in the performance of root cause evaluations that could be associated with a lack of training.

The inspectors evaluated this issue and determined that the failure to provide annual training to root cause evaluators was a performance deficiency that was associated with all seven of the reactor safety cornerstones. The performance deficiency was not more than minor because it was not a precursor to a significant event, it would not lead to a more significant safety concern if left uncorrected and it did not adversely affect any of the ROP cornerstone objectives. Specifically, although root cause evaluators had not received annual training, the inspectors did not identify problems in the root cause evaluations reviewed during this inspection, that prevented NextEra from identifying adequate corrective actions for the issues that the root cause analysis team was directed to review.. NextEra documented this concern in CR 579854.

In accordance with NRC Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," the above issues constitute issues of minor significance that were not subject to enforcement action in accordance with the NRC's Enforcement Policy.

Overall, the inspectors determined that procedure adherence was a weakness in NextEra's performance of root cause analyses, and additionally within the conduct of self-assessments, audits and the evaluation of OE (examples provided in Section 4OA2.2 and 4OA2.3). However, the inspectors determined that, for the root cause analyses that the inspectors had reviewed, NextEra had reached supportable conclusions that resulted in appropriate corrective actions despite the lack of adherence to the root cause analysis procedure. After discussions with NextEra staff, the inspectors determined that the performance deficiencies identified in the conduct of root cause analyses were likely due to:

- The lack of annual refresher training of root cause evaluators;
- The belief that the root causes evaluation procedure provided recommendations, not requirements, for completion and documentation of a root cause analysis; and

- Multiple delays by Nextera corporate staff in revising a fleet root cause analysis procedure which led to the current Seabrook station guidance not being revised in a timely manner.

The inspectors reviewed NextEra's plans to address these causes. The review determined that NextEra scheduled root cause evaluator training for all root cause evaluators to be completed by the end of November 2010. This training will emphasize that the procedure for root cause evaluation includes requirements, and not recommendations, that must be adhered to when completing and documenting the results of a root cause analysis. Additionally, a revision to the current root cause analysis procedure is planned to be completed before the fleet root cause analysis procedure is implemented. The fleet root cause procedure is expected to be issued at the end of 2010. NextEra also plans to revise the current root cause analysis procedure before the fleet level procedure is issued in order to ensure the correct guidance is contained in the procedure while the station awaits issuance of the fleet level procedure. The inspectors concluded that these actions adequately addressed the causes of the root cause analysis performance deficiencies.

Effectiveness of Corrective Actions

The inspectors concluded that corrective actions for identified deficiencies were generally timely and adequately implemented. For significant conditions adverse to quality, corrective actions were identified to prevent recurrence. However, in the case of one of the issues reviewed, the inspectors determined timely and adequate correction actions were not completed:

- The inspectors questioned long-term clearance orders (systems and components tagged out for greater than 90 days) in the plant and identified 29 clearances that had been in the field for greater than 90 days, but had not been evaluated in accordance with 10 CFR 50.59. NextEra procedure OP-AA-101, "Clearance and Tagging," Revision 2, stated that if a component was tagged for greater than 60 days, then a CR shall be initiated to complete a 50.59 screening within 90 days from the time the tags were initially hung. Subsequent 50.59 and operability evaluations performed by NextEra and reviewed by the inspectors determined that all systems remained capable of performing their intended functions despite having various components tagged out. Additionally, the screenings NextEra ultimately performed determined that full 10 CFR 50.59 safety evaluations were not required. The inspectors determined that there was no adverse impact to any safety significant system as a result of the 29 outstanding clearance orders.

The inspectors determined that when the 60-day limit had elapsed, NextEra wrote CRs that directed completion of the 50.59 evaluations, but the corrective actions to complete the 50.59 screenings were not assigned for completion and were ultimately closed with no screening completed. The inspectors determined that this was a performance deficiency associated with the Mitigating systems cornerstone. The performance deficiency was not more than minor because it was not a precursor to a significant event, it would not lead to a more significant safety concern if left uncorrected and it did not adversely affect the Mitigating Systems cornerstone objective of ensuring the availability reliability and capability of systems that respond to initiating events. Specifically; for the 29 clearances identified, none involved safety-

related systems and none required full 50.59 evaluations. NextEra documented this concern in CR 583386.

In accordance with NRC Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," the above issue constitute an issue of minor significance that was not subject to enforcement action in accordance with the NRC's Enforcement Policy.

c. Findings

No findings were identified.

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

The inspectors selected a sample of CRs associated with the review of industry Operating Experience (OE) to determine whether NextEra personnel appropriately evaluated the OE information for applicability to Seabrook and had taken appropriate actions, when warranted. The inspectors reviewed CR evaluations of OE documents associated with a sample of NRC Regulatory Issues Summaries and Information Notices to ensure that NextEra adequately 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 activities. Specific documents reviewed during the inspection are listed in the Attachment to this report.

b. Assessment

The inspectors determined that, in general, NextEra staff appropriately considered industry OE information for applicability, and used the information for corrective and preventive actions to identify and prevent similar issues when appropriate. NextEra procedure PI-AA-102, "Operating Experience Program," requires that OE items that describe safety significant plant events receive priority in their screening and applicability review. However, the inspectors noted that NextEra personnel, in April 2010, identified that the staff did not screen approximately 2500 OE items from January 2009 through March 2010 in a timely manner. The inspectors determined that the items not screened by NextEra personnel during this period only included OE items associated with non-safety related equipment and industrial safety events that did not require immediate action per NextEra procedures. Additionally, the inspectors confirmed that, during the same period, OE items warranting immediate evaluation in accordance with site procedures were screened by NextEra and documented in the CAP in a timely manner. The inspectors' discussions with NextEra personnel identified that between January 2009 and March 2010, NextEra implemented the use of a new CR process database (NAMS) and, as a result, the NextEra OE coordinator had difficulty ensuring that the issues were entered into the database in a timely manner. This, in turn, impacted the ability of the organization to complete the required OE applicability reviews in a timely manner. The inspectors noted that NextEra had the option of entering these OE items manually into the new CR system; however, NextEra did not explore this option and fell behind in reviewing these non-safety related OE items.

The inspectors determined that the failure to screen the 2500 OE items from January 2009 through March 2010 was not timely and, as such, was a performance deficiency

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associated with the Mitigating systems cornerstone. The performance deficiency was not more than minor because it was not a precursor to a significant event, it would not lead to a more significant safety concern if left uncorrected and it did not adversely affect the Mitigating Systems cornerstone objective of ensuring the availability reliability and capability of systems that respond to initiating events. Specifically, the inspectors determined that NextEra had placed appropriate priority on screening safety significant OE items as required by procedure, but had not screened the non-safety related OE items in a timely manner. The inspectors also did not identify plant events that could be attributed to the failure to screen the non-safety related OE items in a timely manner.

In accordance with NRC Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," the above issue constitutes an issue of minor significance that is not subject to enforcement action in accordance with the NRC's Enforcement Policy. NextEra assembled a team to review all outstanding OE reports. The review is on track to complete all the backlog items by the end of November 2010. NextEra documented this concern in CR 219010.

c. Findings

No findings were identified.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors reviewed a sample of quick-hit self-assessments, focused self-assessments, Quality Assurance (QA) audits, 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, and whether corrective actions were initiated to address identified deficiencies. The effectiveness of the assessments was evaluated by comparing audit and assessment results against self-revealing and NRC-identified observations made during the inspection. A list of documents reviewed is included in the Attachment to this report.

b. Assessment

The inspectors concluded that QA audits and self-assessments were critical, thorough, and effective in identifying issues. The inspectors observed that these audits and self-assessments were completed by personnel knowledgeable in the subject areas and were completed to a sufficient depth to identify issues that were then entered into the CAP for evaluation. Corrective actions associated with the issues were implemented commensurate with their safety significance. NextEra managers evaluated the results and initiated appropriate actions to focus on areas identified for improvement. However, the inspectors identified two examples in which self-assessments were not completed as required by procedure:

- The inspectors identified that a self-assessment of the OE program had not been completed by NextEra since the fourth quarter of 2007. NextEra procedure PI-AA-102, "Operating Experience Program," states that a biennial self-assessment of the OE program shall be sponsored by the Performance Improvement Department Manager.

- The inspectors identified that a self-assessment of Industrial Safety had not been completed by NextEra since 2008. NextEra procedure PI-AA-101, "Self-Assessments and Benchmarking Program," states that an annual cross-functional self-assessment of the program is required to be done.

The inspectors questioned NextEra on why these self-assessments had not been completed in accordance with the procedures and determined that the Performance Improvement Department had not scheduled their completion with the proper periodicity (annual/biennial). The 2010 self-assessments for both of these programs was incorrectly scheduled into 2011. Quick-hit self-assessments, performed on a quarterly basis, continued to be completed as required. The inspectors questioned NextEra on the basis for performing quarterly quick-hit self-assessments in lieu of the annual/biennial self-assessments and determined that quick-hit self-self assessments did not meet the intent of the more rigorous annual/biennial assessments. NextEra reviewed the guidance for self-assessments and also concluded that the quick-hit self assessments did not meet the intent of their self-assessment procedure; in that, they did not contain the level of rigor or detail, or the required levels of review and approval, required by the procedures governing the annual/biennial self-assessments.

The inspectors determined that the failure to perform a biennial self-assessment of the OE program and an annual self-assessment of the Industrial Safety program was a performance deficiency that was associated with all seven of the reactor safety cornerstones. The performance deficiency was not more than minor because it was not a precursor to a significant event, it would not lead to a more significant safety concern if left uncorrected and it did not adversely affect any of the ROP cornerstone objectives. Specifically, the inspectors reviewed the condition reports that were initiated and the events that occurred in 2009 and 2010 and did not identify any significant plant or personnel safety issues that resulted from or were impacted by not performing the self-assessments in these two areas within the required periodicity. The inspectors also noted that during this time, quick-hit self-assessments continued to be performed in these two areas and issues identified during these assessments were entered into the CAP by NextEra for resolution. In accordance with NRC Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," the above issue constitutes an issue of minor significance that is not subject to enforcement action in accordance with the NRC's Enforcement Policy. NextEra documented this concern in CR 582848 and CR 583750. NextEra has scheduled both self-assessments to be completed by the end of 2010, and has assigned a corrective action to evaluate and determine why the assessments were scheduled incorrectly and not performed within the required periodicity.

c. Findings

No findings were identified.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors performed interviews with station personnel to assess the safety conscious work environment (SCWE) at Seabrook. Specifically, the inspectors interviewed personnel to determine whether they were hesitant to raise safety concerns to their

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management. The inspectors also interviewed the station Employee Concerns Program (ECP) coordinator to determine what actions were implemented to ensure employees were aware of the program and its availability with regard to raising concerns. The inspectors reviewed the ECP files to ensure that issues were entered into the CAP when appropriate. The inspectors reviewed a 2008 Engagement Survey to assess any adverse trends in department and site safety culture. A list of documents reviewed is included in the Attachment to this report.

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. All persons interviewed demonstrated an adequate knowledge of the CAP and ECP. Based on these limited interviews, the inspectors concluded that there was no evidence of SCWE concerns, and no significant challenges to the free flow of information.

The inspectors reviewed a 2008 Engagement Survey of roughly 500 NextEra employees to explore their perceptions of site SCWE. Overall, the survey revealed that the site SCWE is healthy, and that personnel took ownership to raise issues for resolution. The inspectors also reviewed NextEra's plan to maintain and further improve employee/leadership relationships through improved communication of significant events and human performance related issues. The inspectors did not identify any instances in which an employee indicated they would be hesitant to raise a safety concern, or any other indicators of an unhealthy SCWE.

c. Findings

No findings were identified.

4OA6 Meetings, Including Exit

On October 1, 2010, the inspectors presented the inspection results to Mr. Paul Freeman, Site Vice President, and other members of the NextEra staff. The inspectors verified that no proprietary information was documented in the report.

ATTACHMENT: SUPPLEMENTAL INFORMATION

Enclosure

SUPPLEMENTAL INFORMATION**KEY POINTS OF CONTACT**Licensee personnel

P. Freeman	Site Vice President
E. Metcalf	Plant General Manager
M. O'Keefe	Licensing Manager
D. Lynch	Senior Nuclear Analyst
B. Fielding	Security Supervisor
C. Moynihan	Senior Nuclear Analyst, Performance Improvement
V. Pascucci	Site Quality Manager, Nuclear Oversight
A. Chesno	Performance Improvement Manager
T. Pepin	Employee Concerns Program Coordinator
V. Brown	Licensing Engineer
D. Robinson	Chemistry Manager
K. Browne	Operation Manager
T. Waechter	Assistant Operations Manager
S. Samstag	Assistant Operations Manager
W. Meyer	Radiation Protection Manager
M. Scannell	Health Physics Specialist
D. Flahardy	Radiation Protection Supervisor
D. Hampton	Health Physics Specialist
J. Walsh	Engineering Supervisor
D. Nowicki	Engineering Supervisor

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSEDOpened and Closed

None

LIST OF DOCUMENTS REVIEWEDCondition Reports

48	8699	199817	210029	566755
118	8883	199904	210189	566758
144	9432	200205	210286	566760
333	9539	201099	210395	566833
390	9829	201220	210637	566880
464	11310	201221	210710	566920
1412	11561	201399	210981	566935
1477	12233	201430	211042	566943
1486	13999	201442	211049	566954

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1575	16542	201840	211050	566962
1658	16693	202255	211051	567139
1679	21169	202324	211950	567193
1750	21710	202333	212308	567281
1870	24718	202515	212452	567346
1878	30673	202699	212971	567363
1910	41162	202827	213435	567404
1938	46884	202828	213569	567512
1956	58517	202829	213589	567528
1993	66951	202832	213625	567543
2061	101996	202834	213933	568071
2094	114276	202938	214008	568120
2140	116383	203101	214548	568648
2144	127255	203214	214863	571554
2162	127753	203235	215195	571959
2231	130673	203286	216461	578758
2430	143290	203325	216541	578889
2507	155996	203479	217036	578903
2543	164397	203525	217040	578905
2562	168599	203585	217177	578961
2595	172891	203874	217275	578997
2682	186222	203926	217392	579854*
2835	191132	204076	217664	579925*
2867	191336	204151	217699	579927*
2885	192007	204317	217938	580184*
2886	192145	204347	217939	580246*
2887	192178	204487	217943	580260*
2923	192373	205178	217945	580276*
2944	192498	205260	217954	580280*
2953	192616	206035	218290	580288*
2956	192722	206051	218424	580311*
2975	192766	206051	218780	580448*
2988	193192	206131	218867	580553*
3001	193524	206328	218876	581954*
3019	193839	206329	218893	582525*
3051	194730	206507	218933	582848*
3096	194798	206719	219010	583176*
3118	195138	206789	219429	583386*
3127	195430	206909	219443	583750*
3133	195666	206922	219494	583804*
3135	195713	207002	219671	583806*

3142	195714	207006	220576	583865*
3155	195878	207432	220912	1190204
3161	195896	207564	221072	06-09997
3167	195907	207896	221185	08-01332
3184	196139	207998	221297	08-12150
3196	196164	208031	221321	08-14402
3210	196165	208042	221396	08-14403
3211	196167	208151	221440	08-14404
3228	196174	208172	221521	09-00183
3254	196176	208183	221589	09-00222
3301	196266	208242	222556	09-00322
3304	196869	208453	223078	
3306	197329	208508	223221	
3316	197333	208519	360090	
3325	197526	208823	391104	
3335	197555	208944	391131	
3341	197749	208961	391249	
3354	197779	208987	391693	
3508	197881	208992	392928	
3628	197917	209033	393043	
4081	197963	209034	393056	
4121	197966	209062	394662	
4594	198182	209078	394668	
4895	198276	209357	395888	
6268	198432	209613	561709	
6359	198613	393334	566424	
6374	198879	393673	566429	
6564	199068	209672	566482	
6570	199212	209681	566530	
8253	199672	209860	566570	

*CR written as a result of NRC inspection

Audits and Self-assessments

SBK 09-022	Oil Slinger Rings Issues and Safety Related Pump Motors, dated 5/11/2009
SBK 09-017	Corrective Action Effectiveness for the 'B' Emergency Diesel Generator Turbocharger Vibration, dated 04/09/2009
ORNO 09-0008	Assessment of Red and Yellow Work Orders, dated 2/20/2009
SBK 09-039	Emergency Preparedness Program Audit, dated 08/03/2009
SBK 10-016	Corrective Maintenance, dated 06/11/2010
SBK 09-053	Corrective Maintenance, dated 11/19/2009
SBK 10-013	Preventative Maintenance, dated 05/14/2010
SBK 09-053	OR 13 FME Controls, dated 10/30/2009

AR 219786	Monthly Clearance Audit Review
AR 223034	Monthly Clearance Audit Review
AR 220564	Quick Hit Assessment Report – Boric Acid Corrosion Control Program
QASR 09-06	Assessment of Operator Burdens and Operator Workarounds
SBK 10-12	Radiation Protection Program
SBK 10-15	Radioactive Waste Control
SBK 10-18	Plant Operations
SBK 10-19	Plant Reporting Technical Specification 6.8 and Technical Bases Control Program TS 6.7.6.J
SBK 09-36	Systematic Approach to Training Application for Operator Time Critical Action Tasks
SBK 09-38	Industrial Radiation Safety
SBK 09-42	Plant Operations Audit
SBK 08-021	QA Audit – Operating Experience
SBK 10-036	NRC PI&R Inspection Readiness
SBK 10-003	NOS Report – Site Security
SA 07-0153	Seabrook Station Operating Experience Self Assessment
SBK 09-031	Chemistry Control Program, Radiological Effluents Technical Requirements Program (RETRP) and Offsite Dose Calculation Manual Audit
SBK 09-067	Chemistry and Effluents Audit

Procedures and Specifications

SPEC-E-008	FPL Fleet Motor Repair/Refurbishment/Rewind Requirements Specification
QM 4.11	Verifying Qualifications,
MA-AA-101-1000	Foreign Material Exclusion Procedure
PEG-211	Diesel Generator Performance Monitoring,
PI-AA-101-1000	Focused Self Assessment Planning, Conduct, and Reporting,
WM-AA-200	Work Management Process Overview
WM-AA-201	Work Order Identification, Screening, and Validation
OS1090.05	Component Configuration Control
OS1000.15	Refueling Outage Cooldown
OS1090.02	System Venting, Draining, Temporary Sump Pump Installation & Blind Flange Removal / Installation
ON1029.03	Operation of Carbon Filters
MA10.3	Boric Acid Corrosion Control Program
MA10.1	Station Leakage Program
MA5.7	Station Barriers, Penetrations Seals, and Fire Barrier Wrap
MS0599.54	Cleaning & Inspection of Components Subjected to Boric Acid Leakage
SIIR	In-Service Inspection Reference, Relief Requests (Appendix F)
PI-AA-101	Self-Assessment and Benchmarking Program
PI-AA-203	Action Tracking Management
PI-AA-204	Condition Identification & Screening Process
PI-AA-205	Condition Evaluation and Corrective Action
NP-919	Boric Acid Corrosion Control
NAP 201	Human Performance
NAP 202	Self Assessments
NAP 402	Conduct of Operations

OP-AA-101	Clearance and Tagging
HD0958.38	Evaluation of Isotopic Mix
NAP412	Operational Decision-Making
SY-AA-102-1014	Threat Assessment and Reporting
WM-8.0	Work Control Practices
ER-AA-204-2003	Project Review Board Change Process
MA 4.10	Control of Temporary Equipment, Temporary Power, Job Setup and Plant Storage
WM 11.1	Protected Train and Guarded Equipment
GN1337.04	Control of Vehicles
OE 4.8	Apparent Cause Evaluations
PI-AA-102	Operating Experience Program
PI-AA-101	Self Assessment and Benchmarking Program
GT60191	Root Cause Analysis Methods – Training Guide
GT6034C	Annual Root Cause Refresher Training

Work Orders and Work Requests

110821	623053	810351	1197042
310995	626790	817502	1199620
538725	629198	836811	1202373
603686	629506	838040	1208382
618046	627401	844412	1210628
618307	627893	845082	94000837
618920	628400	848544	94004299
619183	628401	1165505	94004577
620011	628402	1173428	94004627
620087	628734	1173429	94004773
621040	700249	1174318	94004868
621207	803896	1185610	94005191
621598	808367	1194143	94005286

Other

HP1085	Boric Acid Corrosion Control Program
HP1074	Boric Acid Cleaning
CT1082	Low Contamination Boric Acid Cleaning
HP1165C	DCM Electronic Dosimeter Fundamentals
HPSTID01-12	Health Physics Study / Technical Information Document – Implementation of DCM-2000 Electronic Dosimeter
L5076C101	LORT Phase 10-01 Self-Study / Reading Package
SOO 09-14	Standing Operating Order, Procedure Compliance Policy
SOO 10-05	Interim Guidance for CEVA Boundary Door/Barrier Operation
PEG-10	System Walkdowns
ODI-87	Operations Management Expectations
ODI-89	Tagging Group Instructions
NPDI-01	Nuclear Projects Department Instruction – Expectations & Conduct of Business

MGDI007 Work Order Validation Walkdowns & Worker Walkdowns / Readiness Review
MGDI024 Maintenance Group Department Instruction – Pipe Thread Sealants, Thread Locking Compounds, Gasket Sealants, and Anti-Seize Lubricants
1-CS-FCV-121 Boric Acid Corrosion Control ASME Bolting Evaluation
Status Reports Boric Acid Corrosion Control
EDI No 30560 Boric Acid Evaluation

Seabrook Daily Operating Experience dated 03/06/09 and 08/14/09
System Health Reports for Supplemental Emergency Power Systems, ED/EDE 480 VAC US, Radiation Monitoring, Diesel Generator Building Air Handling, Service Water System, and 4160 VAC Electrical Distribution

06 MSE 076
08 MSE 055
DWG 1-CC-861-04
DWG 1-CC-834-02
DWG 1-CC-832-05
DWG 1-CC-781-01
P&ID 1-CC-D20213
P&ID 1-CC-D20207

2008 Engagement Survey – Nuclear Supplement Index Summary Report

Chemistry Department Improvement Plan 2009
Chemistry Department Improvement Plan 2010
Chemistry Department Excellence Plan 2010

LIST OF ACRONYMS

ADAMS	Agencywide Documents Access and Management System
AR	Activity Request
BACCP	Boric Acid Corrosion Control Program
CAP	Corrective Action Program
CFR	Code of Federal Regulations
CR	Condition Report
DRP	Division of Reactor Projects
ECP	Employee Concerns Program
ECR	Engineering Change Request
EDG	Emergency Diesel Generator
IR	Inspection Report
IST	Initial Screening Team
MRC	Management Review Committee
NCAQ	Condition not Adverse to Quality
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
OA	Other Activities
OE	Operating Experience
PARS	Publicly Available Records System
PCR	Procedure Change Request
PI&R	Problem Identification and Resolution
PMCR	Preventive Maintenance Change Request
QA	Quality Assurance
ROP	Reactor Oversight Process
RWT	Routine Work Tracking
SCWE	Safety Conscious Work Environment
TWR	Training Work Request
WO	Work Order
WR	Work Request