



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

October 22, 2012

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

**SUBJECT: TURKEY POINT NUCLEAR PLANT UNIT 3 AND 4 – U.S. NUCLEAR  
REGULATORY COMMISSION INSPECTION PROCEDURES 95001  
SUPPLEMENTAL AND 92702 FOLLOW UP INSPECTIONS - INSPECTION  
REPORT 05000250/2012012 AND 05000251/2012012, AND ASSESSMENT  
FOLLOW-UP LETTER**

Dear Mr. Nazar:

On September 13, 2012, the U.S. Nuclear Regulatory Commission (NRC) staff completed the supplemental and follow up inspections pursuant to Inspection Procedures 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," and 92702, "Follow Up on Traditional Enforcement Actions Including Violations, Deviations, Confirmatory Action Letters, Confirmatory Orders, and Alternate Dispute Resolution Confirmatory Orders," at your Turkey Point Nuclear Plant, Units 3 and 4. The enclosed inspection report documents the inspection results, which were discussed at the exit meeting on September 13, 2012, with Mr. M. Kiley and other members of your staff. Implementation of corrective actions was discussed during a Regulatory Performance Meeting on September 13, 2012, immediately following the exit meeting.

As required by the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed because a finding of low to moderate safety significance (White) was identified in the fourth quarter of 2011. This issue was documented previously in NRC Inspection Reports (IR) 05000250/2011005, 05000251/2011005, 05000250/2012010, and 05000251/2012010. The NRC was informed on July 31, 2012, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were: (1) to provide assurance that the root causes and contributing causes of risk significant performance issues are understood; (2) to provide assurance that the extent of condition and extent of cause of risk significant performance issues are identified; (3) to provide assurance that your corrective actions for risk significant performance issues are sufficient to address the root and contributing causes and prevent recurrence. The objectives of the follow up inspection were to provide assurance that: (1) adequate corrective actions have been implemented for the traditional enforcement violation; (2) the root causes of this enforcement action has been identified, that their generic implications have been addressed, and that the licensee's programs and practices have been appropriately enhanced to prevent recurrence. The inspection consisted of examination of activities conducted under your license as they related to safety, compliance with the Commission's rules and regulations, and the conditions of your operating license.

The inspectors determined that your staff performed an adequate evaluation of the Severity Level (SL)-III violation and White finding. Your staff's evaluation identified the root cause of the issue to be that the Technical Support Center ventilation equipment requirements were not embedded in station processes for evaluation of conditions and performance of maintenance. The inspectors found the extent of condition and extent of cause reviews were adequate, and the corrective actions implemented were adequate. The inspectors concluded that you re-established compliance. All immediate and long term corrective actions have been completed with the exception of: (1) complete continuing training needs analyses and subsequent training materials; (2) incorporate Emergency Preparedness department instructions into the station procedure system; (3) complete corrective action effectiveness reviews.

Based on the results of this inspection, no findings were identified.

After reviewing the performance in addressing the White finding documented in this inspection report, the NRC concluded your actions met the inspection objectives. Therefore, in accordance with the guidance in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," the White finding will only be considered in assessing plant performance for a total of four quarters. As a result, the NRC determined the performance at Turkey Point Units 3 and 4 to be in the Licensee Response Column of the ROP Action Matrix as of the fourth quarter of 2012.

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 ADAMS is accessible from the NRC Website at <http://www.nrc.gov/reading-rm/adams.html> (the <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room)).

Sincerely,

*/RA/*

Brian R. Bonser, Chief  
Plant Support Branch 1  
Division of Reactor Safety

Docket No. 50-250, 50-251  
License No. DPR-31, DPR-41

Enclosure:  
Inspection Report 05000250/2012012,  
05000251/2012012 w/Att.: Supp. Info.

cc w/encl: (See page 3)

cc w/encl

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Nuclear Licensing  
Florida Power & Light Company  
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**U.S. NUCLEAR REGULATORY COMMISSION**

**REGION II**

Docket Nos.: 05000250, 05000251

License Nos.: DPR-31, DPR-41

Report No.: 05000250/2012012 and 05000251/2012012

Licensee: Florida Power and Light Company

Facility: Turkey Point Nuclear Power Plant, Units 3 and 4

Location: Florida City, FL

Dates: September 10, 2012, through September 13, 2012

Inspectors: M. Speck, Senior Emergency Preparedness Inspector  
D. Berkshire, Emergency Preparedness Inspector

Approved by: Brian Bonser, Chief  
Plant Support Branch 1  
Division of Reactor Safety

Enclosure

## SUMMARY OF FINDINGS

IR 05000250/2012012 and 05000251/2012012; 09/10/2012 – 09/13/2012; Turkey Point Nuclear Power Plant, Units 3 and 4; Supplemental Inspection for a White finding in the Emergency Preparedness Cornerstone and Traditional Enforcement Action Follow Up.

Two emergency preparedness inspectors performed this inspection. No findings were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

### **Cornerstone: Emergency Preparedness**

The NRC staff performed the supplemental inspection in accordance with IP 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with the failure to maintain adequate emergency response facilities and equipment as required by 10 CFR 50.54(q) and the licensee's emergency plan. This resulted in portions of the TSC ventilation system being removed from service for extended periods rendering it non-functional in the event of a radiological emergency. The NRC staff previously characterized this issue as having low to moderate safety significance (White), as documented in NRC IR 05000250/2012010 and 05000251/2012010. In addition, NRC staff performed the follow up inspection for the Severity Level (SL) III violation for failure to report the condition to the NRC, in accordance with IP 92702, "Follow Up on Traditional Enforcement Actions Including Violations, Deviations, Confirmatory Action Letters, Confirmatory Orders, and Alternate Dispute Resolution Confirmatory Orders."

During these inspections, the inspectors determined that your staff performed an adequate evaluation of the causes of the SL-III violation and White finding. Your staff's evaluation identified the root cause of the issue to be that TSC ventilation equipment requirements were not embedded in station processes for evaluation of conditions and performance of maintenance. The inspectors found the extent of condition and extent of cause reviews were adequate, and the corrective actions implemented were adequate. All immediate and long term corrective actions have been completed except for: (1) complete continuing training needs analyses and subsequent training materials (ECD 12/31/2012; (2) incorporate Emergency Preparedness department instructions into the station procedure system (ECD 11/1/2012; and (3) complete corrective action effectiveness reviews ECD 12/31/2012 and 4/30/2013.

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

No findings were identified.

#### B. Licensee-Identified Violations

No findings were identified.

## REPORT DETAILS

### 4. OTHER ACTIVITIES

#### 4OA4 SUPPLEMENTAL INSPECTION (95001)

##### .01 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure (IP) 95001 to assess the licensee's evaluation of a White finding that affected the emergency preparedness cornerstone in the reactor safety strategic performance area. The inspection objectives were to provide assurance that the:

- root causes and contributing causes of risk significant performance issues were understood;
- extent of condition and extent of cause of risk significant performance issues were identified; and
- licensee's corrective actions for risk significant performance issues were sufficient to address the root and contributing causes and prevent recurrence.

The licensee entered the Regulatory Response Column of the NRC's Action Matrix in the fourth quarter of 2011, as a result of one inspection finding of (low to moderate safety significance (White). The finding was associated with the failure to adequately maintain emergency response facilities, specifically the TSC ventilation system was determined to be incapable of being placed in emergency recirculation mode during two extended periods, potentially exposing emergency response personnel to greater than 5 Rem dose had a radiological emergency occurred. The finding was characterized as having (White) safety significance as discussed in NRC IR 05000250/2012010 and 05000251/2012010.

The licensee informed the NRC staff on July 31, 2012, that they were ready for the supplemental inspection. In preparation for the inspection, the licensee performed a root cause investigation, documented in Action Request (AR) 1701357, to identify weaknesses that existed in various organizations and processes that resulted in the risk-significant (White) finding.

The inspectors reviewed the licensee's Root Cause Evaluation (RCE) and other assessments conducted in support of, and as a result of the investigation. The inspectors reviewed corrective actions taken to address the identified root and contributing causes. The inspectors interviewed licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood and corrective actions were appropriate to address the causes and preclude repetition.

.02 Evaluation of Inspection Requirements

02.01 Problem Identification

- a. Determine that the evaluation identifies who (i.e., licensee-identified, self-revealing, or NRC-identified) and under what conditions the issue was identified.

The licensee accurately characterized the failure to adequately maintain the Technical Support Center functional during ventilation system maintenance as licensee-identified.

The inspectors verified that this information was documented in the licensee's evaluation.

- b. Determine that the evaluation documents how long the issue existed and prior opportunities for identification.

The licensee identified on October 27, 2011, that the TSC ventilation system had been rendered non-functional on October 10, 2011, and promptly restored it to service on October 28, 2011. A subsequent investigation determined that the TSC had been similarly rendered non-functional from December 4, 2010, until July 13, 2011. Both times the system was removed from service by planned equipment clearance orders. Placing these clearance orders were determined to be opportunities for prior identification.

The inspectors determined that the licensee's evaluation and assessments were adequate with respect to identifying how long the issue existed and the prior opportunities for identification and did not identify any additional opportunities.

- c. Determine that the evaluation documents the plant-specific risk consequences, as applicable, and compliance concerns associated with the issue.

The NRC determined this issue was a White finding as documented in NRC IR 05000250/2012010 and 05000251/2012010 dated April 9, 2012, and the licensee also documented the associated finding in their Reply to Notice of Violation: EA-12-001 dated May 9, 2012. In addition, the RCE documented the consequences of the issue, including potential adverse impacts on the ability of the site to mitigate the effects of events during an emergency, and the licensee's responsibility to protect the health and safety of the public. At the time the condition was identified, the ventilation system had been restored to service.

The inspectors concluded that the licensee appropriately documented the risk consequences and compliance concerns associated with the finding.

- d. Findings

No findings were identified.

## 02.02 Root Cause and Extent of Condition Evaluation

- a. Determine that the problem was evaluated using a systematic methodology to identify the root and contributing causes.

The licensee investigation was initially performed by a diverse, qualified team of five members using licensee procedure PI-AA-100-1005, Root Cause Analysis, Revision 5. The investigation was subsequently revised by a similar team of three members. The following systematic methods and tools were used to perform the causal evaluation:

- Event Time Line/Chronology
- Event and Causal Factor Chart
- Extent of Condition Tool
- Human Performance Evaluation
- Extent of Cause Evaluation
- Nuclear Safety Culture Evaluation Form

The licensee performed an interim effectiveness review (AR 1753570, Assignment 31) and a focused self-assessment of the completed RCE to assure all issues were addressed and documented.

The inspectors determined that the licensee evaluated the issue using a systematic methodology to identify root and contributing causes.

- b. Determine that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.

The Root Cause Evaluation was detailed in terms of the scope of investigation and included the following activities in support of the evaluation:

- Conducted interviews with key personnel involved with the issue.
- Performed searches and reviews of the corrective action database for Emergency Preparedness identified items, Training department lesson plans and supporting documents to include Emergency Preparedness, Work Control, and Operations procedures.
- Incorporated an independent contractor into the evaluation team to provide an independent perspective to the evaluation process.
- Performed reviews of industry operating experience, internal operating experience, and emergency preparedness internal change documentation.

A cause and effect analysis was used to analyze two events: TSC ventilation system not functional from December 4, 2010, to July 13, 2011, and from October 10, 2011, to October 28, 2011; and the failure to report the non-functional status of the TSC ventilation to the NRC. Analysis of the two events identified one root cause and three additional contributing causes. The following represent a synopsis of the significant contributors and/or causes:

Root Cause:

TSC ventilation system equipment requirements not embedded in station processes for evaluation.

Contributing Causes:

Inadequate TSC ventilation system surveillance procedures;

Station staff knowledge gap existed regarding TSC ventilation system licensing basis; and

Station staff did not employ a questioning attitude regarding TSC ventilation system status.

Based on a review of the root cause evaluation and supporting documentation, the inspectors concluded that the evaluation was conducted to a level of detail commensurate with the significance of the problem.

- c. Determine that the root cause evaluation included a consideration of prior occurrences of the problem and knowledge of prior operating experience.

The root cause evaluation included a review of plant corrective action databases and industry databases and found no prior occurrences with the same root cause, however the prior occurrence from December 2010, until July 2011, was discovered. The evaluation reviewed three instances of Operating Experience for potential impact on the subject issue and determined that none would have prevented the subject Turkey Point issue.

Based on the licensee's detailed evaluation and conclusions, the inspectors determined that the licensee's root cause investigation included a consideration of prior occurrences of the problem and knowledge of prior operational experience.

- d. Determine that the root cause evaluation addressed the extent of condition and the extent of cause of the problem.

The licensee's evaluation limited the extent of condition review to the evaluation of conditions and performance of maintenance on equipment important to Emergency Preparedness. All of the Turkey Point Emergency Response Facilities were reviewed as part of the root cause evaluation. The extent of condition revealed concerns for communication of EOF capability issues, poor physical condition of the primary power supply to the TSC, and several deficiencies in the TSC mechanical equipment room that could impact the TSC ventilation system. The licensee entered these deficiencies into

their corrective action program as ARs 1753570 (complete), 1702646 (complete), and WR 94039269.

The inspectors performed an independent review of procedure 0-ADM-117, "Equipment Important to Emergency Preparedness," to determine if all equipment identified in NUREG 0696 was included in the procedure. The inspectors identified that a continuous air monitor and the Health Physics Network telephone were not included in the licensee procedure. These observations were added to the licensee's corrective action program.

The inspectors concluded that the licensee's root cause investigation adequately addressed the extent of condition and the extent of cause of the issue.

e. Determine that the root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture components as described in IMC 0305.

Associated with the root cause, the licensee found weaknesses in the following cross-cutting aspects:

- Human Performance (HU) component of Decision Making, H1(a) and (b): This related to the lack of a systematic process in making decisions regarding TSC ventilation and identifying possible unintended consequences.
- HU component of Resources, H2(a) and (d): This related to longstanding equipment issues, and adequate and available facilities and equipment.
- HU component of Work Control, H3(a) and (b): This related to the failure to appropriately plan work activities by incorporating risk insights that may impact plant structures, systems, and components, and the human-system interface; the need for planned contingencies and compensatory actions.
- Problem Identification and Resolution (PI&R) P1(c) and (d): This related to the failure to thoroughly evaluate problems and to take appropriate corrective actions.

Associated with the contributing causes, the licensee found weaknesses in the Decision-Making, Resources, Work Control, Corrective Action Program, and Other Safety Culture cross-cutting aspects:

The inspectors determined that the licensee's root cause investigation appropriately considered whether weaknesses in any safety culture component was a root cause or significant contributing cause of the issue and were determined to not be a significant contributor.

f. Findings

No findings were identified.

### 02.03 Corrective Actions

- a. Determine that appropriate corrective actions are specified for each root and contributing cause or that the licensee has an adequate evaluation for why no corrective actions are necessary.

As an immediate corrective action, the licensee returned the TSC ventilation system to functional status.

The licensee identified the following root cause and implemented the corresponding corrective action:

- TSC ventilation system equipment requirements not embedded in station processes for evaluation: As a corrective action, the licensee developed procedure 0-ADM-117, "Equipment Important to EP," to clearly identify equipment important to EP, revised site Operations and Maintenance procedures instructing procedure users to consult 0-ADM-117 when evaluating EP equipment functionality, and reporting requirements and when prioritizing work; and revised fleet Operations procedure for users to consult applicable procedures when evaluating EP equipment functionality.

The licensee developed corrective actions to address contributing causes as summarized below:

- Inadequate TSC ventilation system surveillance procedures: Operations and Maintenance procedures were revised to require consideration of procedure 0-ADM-117 when evaluating reporting requirements and when prioritizing work.
- Station staff knowledge gap existed regarding TSC ventilation system licensing basis: EP staff will conduct periodic reviews of the station's performance for processing EP-related issues.
- Station staff did not employ a questioning attitude regarding TSC ventilation system status; Provided training to personnel regarding the root cause evaluation, the importance of Emergency Preparedness equipment, and the reporting requirements for the equipment; and revised 10 CFR 50.59 applicability/ screening forms to consider if a proposed activity involves a change to the Emergency Plan.

The inspectors determined that the corrective actions were appropriate and addressed the root and contributing causes in the licensee's detailed evaluation and conclusions. The inspectors determined that the licensee's root cause investigation included an appropriate consideration of prior occurrences of the problem and knowledge of prior operational experience.

- b. Determine that corrective actions have been prioritized with consideration of risk significance and regulatory compliance.

The licensee immediately restored the Technical Support Center to fully functional and full regulatory compliance. The licensee completed a root cause evaluation and a subsequent assessment to determine contributing causes and developed appropriate corrective actions. These corrective actions were appropriately prioritized with consideration of risk significance.

The inspectors determined that the corrective actions were adequately prioritized with consideration of the risk significance and regulatory compliance.

- c. Determine that a schedule has been established for implementing and completing the corrective actions.

The licensee established due dates for the corrective actions in accordance with their corrective action program. The inspectors reviewed the status of each corrective action assignment and determined that an appropriate schedule had been established for implementing the corrective actions with the only remaining action actions being: (1) complete continuing training needs analyses and subsequent training materials - ECD of December 31, 2012; (2) incorporate Emergency Preparedness department instructions into the station procedure system - ECD of November 1, 2012; (3) complete corrective action effectiveness reviews - ECDs of December 31, 2012, and April 30, 2013.

- d. Determine that quantitative or qualitative measures of success have been developed for determining the effectiveness of the corrective actions to prevent recurrence.

The licensee established an effectiveness review plan and completed an interim effectiveness review. Final effectiveness reviews are scheduled to be completed by April 30, 2013.

The inspectors observed that the effectiveness review plan as written would verify and validate that no additional failures-to-report occurred, however, there did not appear to be a positive test of the new processes put in place. The inspectors also noted that the individual assigned to perform the effectiveness review was the root-cause evaluator and that an independent review may be more appropriate. These observations were discussed with the licensee and added to the corrective action program.

- e. Determine that the corrective actions planned or taken adequately address a Notice of Violation (NOV) that was the basis for the supplemental inspection, if applicable.

The licensee's response described: (1) corrective actions taken and the results achieved; (2) actions which will be taken; (3) the date when full compliance as achieved; and (4) the reasons for the violation. During this inspection, the inspectors confirmed that the licensee's root cause investigation and actions completed or planned adequately addressed the NOV. The licensee restored full compliance on July 15, 2011.

- f. Findings

No findings were identified.

#### 4OA5 Follow up Inspection (92702)

##### .01 Inspection Scope

The NRC staff performed this follow up inspection in accordance with IP 92702 to assess the licensee's evaluation of the traditional enforcement SL-III violation for failure to make a required notification in accordance with 10 CFR 50.72. The inspection objectives were to:

- determine that adequate corrective actions have been implemented for the traditional enforcement violations;
- verify that the root causes of these enforcement actions have been identified;
- determine if their generic implications have been addressed; and
- determine that the licensee's programs and practices have been appropriately enhanced to prevent recurrence.

The licensee was informed by inspection report 05000250/2012010 and 05000251/2012010, dated April 9, 2012, of the traditional enforcement violation which was previously discussed in inspection reports 05000250/2011005, and 05000251/2011005. This violation was associated with the failure to notify the NRC of a major loss of radiological event assessment capability in accordance with 10 CFR 50.72.

The NRC staff was informed on July 31, 2012, of the licensee's readiness for the supplemental inspection. In preparation for the inspection, the licensee performed a root cause evaluation (RCE) for Action Request (AR) 1753570, to identify the root causes, contributing causes, organizational weaknesses, programmatic weaknesses, extent of condition and extent of cause, that existed and resulted in the White finding, and the SL-III violation. The licensee also evaluated safety culture components and identified immediate corrective actions and corrective actions to prevent recurrence.

The inspectors reviewed the licensee's RCE in addition to other evaluations conducted in support of and as a result of the RCE. The inspectors reviewed corrective actions that were taken and implemented to address the identified causes. The inspectors also conducted walk-downs of on-site emergency response facilities and held discussions with various licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood. The inspectors verified that corrective actions planned and implemented were appropriate to address the causes and prevent recurrence.

##### .02 Evaluation of the Inspection Requirements

###### 02.01 Corrective Actions

- a. The NRC issued a NOV to the licensee on April 9, 2012. The licensee provided the NRC written responses to the NOV on May 9, 2012. The licensee's responses described: (1) reasons for the violation; (2) corrective steps taken to avoid further

violations and the results achieved; (3) the date when full compliance was achieved. During this inspection the inspectors confirmed that the licensee's RCEs listed planned and corrective actions implemented to address the NOV. The inspectors concluded that the licensee restored full compliance on April 10, 2012.

- b. Inspectors determined that follow up corrective actions were specified and scheduled in the RCE (AR 1753570).

#### 02.02 Root Cause Analysis

- a. The licensee's RCE used event and causal factor charting, why-analysis, and barrier analysis to determine the root and contributing causes. This analysis was supported by use of aspects of Management Oversight and Risk Tree (MORT) methodology. The inspectors determined that the licensee evaluated the issue using a systematic methodology to identify root and contributing causes.

The inspectors determined that the licensee's RCE included a consideration of prior internal and external occurrences of the problem and available operating experience (OE); addressed the extent of condition and the extent of cause of the issue; and included a proper consideration of whether a weakness in any safety culture component was a root cause or a significant contributing cause of the issue.

During this inspection, the inspectors confirmed that the RCE listed completed and planned corrective actions to address the NOV. The inspectors concluded that the RCEs were adequate and conducted to a level of detail commensurate with the significance of the problem. The licensee restored full compliance on April 10, 2012.

- b. Findings and Observations

The inspectors reviewed the SL-III violation, VIO 05000250, 251/2011005-03, failure to report a major loss of emergency response assessment capability. The inspectors concluded that the RCE was adequate and conducted to a level of detail commensurate with the significance of the problem, and that the corrective actions identified were adequate to prevent recurrence.

#### 02.03 Generic Implications Analysis

- a. The licensee's RCE considered the extent of condition and extent of cause associated with the failure to evaluate and therefore, the fail to report the loss of TSC function. Other aspects of TSC functionality as well as other emergency response facilities were considered. Both taking equipment out of service for planned maintenance, as well as unplanned equipment failures were evaluated in terms of whether licensee processes were adequate to determine the need for NRC reporting. Corrective actions were implemented to close observed gaps.

An operating experience review was also performed by the licensee. The licensee's RCE included an evaluation of internal and external OE. The licensee considered prior occurrences and industry OE. As a result of this review, the licensee determined that OE was used to evaluate both reportability and compliance with design bases; however, an incorrect conclusion had been reached. Additional corrective actions were put in place to close that gap.

b. Findings and Observations

The inspectors concluded that the licensee's RCE adequately addressed the generic implications of the issue in the extent of condition analysis, extent of cause analysis, and in their review of operating experience.

4OA6 Exit Meeting

On September 13, 2012, the inspectors presented the inspection results to Mr. M. Kiley and other members of the staff who acknowledged the results. The inspectors asked the licensee if any of the material examined during the inspection should be considered proprietary. The licensee did not identify any proprietary information. At the conclusion of the exit meeting, Mr. C. Christenson, Deputy Director, Division of Reactor Safety, conducted a regulatory performance meeting with licensee management to discuss the issue and actions taken and proposed.

ATTACHMENT: SUPPLEMENTAL INFORMATION

**SUPPLEMENTAL INFORMATION**

**KEY POINTS OF CONTACT**

Licensee

M. Allen, Cycle Manager, Work Control  
J. Alvarez, Manager of Performance Improvement  
F. Burke, Quality Control Supervisor  
P. Czaya, Licensing Engineer  
A. Diaz, System Engineer  
M. Epstein, EP Manager  
C. Feldman, Security Shift Supervisor  
M. Jones, Operations Director  
M. Kiley, Site Vice President  
D. Mothena, Fleet Emergency Preparedness Director  
C. Navarro, Performance Improvement Supervisor  
L. Nicholson, Director of Nuclear Licensing  
M. Pearson, Licensing consultant  
J. Rodriguez, Security Operations Coordinator  
R. Tomonto, Licensing Manager  
J. Wingate, EP Specialist

**ITEMS OPENED AND CLOSED**

Opened

None

Closed

05000250, 251/2011005-02;	VIO	Failure to Maintain TSC Habitability
05000250, 251/2011005-03;	VIO	Failure to Make Required 8 hour NRC Report

## DOCUMENTS REVIEWED

### Plans and Procedures

0-OSP-301.1, Technical Support Center Emergency Ventilation System Filter Performance Test, Rev. 4  
 0-OSP-301.2, Technical Support Center Emergency Ventilation System Operational Test, Rev. 3  
 0-OSP-301.1, Technical Support Center Emergency Ventilation System Filter Performance Test, Rev. 1 performance dated 7/24/2011  
 0-OSP-301.2, Technical Support Center Emergency Ventilation System Operational Test, Rev. 2 performance dated 5/29/2012  
 0-ADM-115, Notification of Plant Events, Rev. 6  
 0-ADM-117, Equipment Important to Emergency Preparedness, Rev. 3  
 0-ADM-213, Technical Specification Related Equipment and Risk Significant SSC Out-of-Service Logbook, Rev. 3  
 0-ADM-560, 10 CFR Regulatory Reportability Requirements, Rev. 1  
 EN-AA-203-1001, Operability Determination/Functional Assessment  
 LI-AA-06, FPL Nuclear Policy – NRC Reportability, Rev. 0  
 MA-AA-203, Work Order Planning Process, Rev. 13  
 NA-AA-213-1000, Missed Opportunity Reviews, Rev. 1  
 OP-AA-101-1000, Clearance and Tagging, Rev. 5  
 PI-AA-100, Condition Assessment and Response, Revision 4  
 PI-AA-100-1005, Root Cause Analysis, Revision 5  
 PI-AA-101-1000, Focused Self Assessment Planning, Conduct, and Reporting, Rev. 9  
 PI-AA-204, Condition Identification and Screening Process, Revision 17  
 PI-AA-205, Condition Evaluation and Corrective Action, Revision 16

### Corrective Action Documents (Action Request(AR) – Condition Report(CR))

AR 473638, TSC damper failure  
 AR 473976, TSC recirc damper full open  
 AR 1651232, Drawing error  
 AR 1661442, TSC HVAC operability concern  
 AR 1699378, TSC Ventilation surveillance not performed  
 AR 1702468, EPU modification to TSC HVAC system  
 AR 1713449, TSC mechanical room deficiencies  
 AR 1766102, Incorrect TSC functionality assessment  
 AR 1796185, 1796196, 1796213;TSC material condition issues  
 AR 1796394, TSC habitability design basis questions  
 AR 1799465, Configuration management of TSC equipment  
 AR 1796952, Seismograph failure  
 AR 1802012, RCE revisions are not graded  
 AR 1802165, Mock 95001, 95002 procedure improvement  
 AR 1802184, RCE procedure improvement  
 AR 1802360, Revise 0-ADM-117 to include TSC continuous air monitor  
 AR 1802547, RCE team member not on MRC approved RCE charter  
 AR 1802563, Improvements to RCE effectiveness review plan  
 AR 1802601, Admin error on completed surveillance test  
 CR 1737860, Missed Opportunity Review on TSC Ventilation Recirculation Capability Lost

**Miscellaneous Documents**

Root Cause Evaluation Report (Revision 2), 1701357  
Root Cause Evaluator qualification records  
Turkey Point Daily Quality Summary dated 8/8/2012  
Nuclear Oversight Audit Checklist, Emergency Planning  
Nuclear Oversight Audit Checklist, Security  
Drawing 5610-A-57, Technical Support Center HVAC, Rev. 5  
Training Case Study materials, Failure to Maintain a Functional TSC  
Turkey Point 95001 Mock Inspection report

**ACRONYMS**

EAL	Emergency Action Level
ECD	Expected Completion Date
IP	Inspection Procedures
IR	Inspection Report
NCR	Nuclear Condition Report
NRC	Nuclear Regulatory Commission
NOV	Notice of Violation
OE	Operating Experience
PARS	Publicly Available Records
RCE	Root Cause Evaluation