

January 19, 2005

Mr. Mark E. Warner
Site Vice President
c/o Mr. James M. Peschel
FPL Energy Seabrook, LLC
Seabrook Station
P.O. Box 300
Seabrook, NH 03874

SUBJECT: SEABROOK STATION - NRC PROBLEM IDENTIFICATION AND RESOLUTION
INSPECTION REPORT NO. 05000443/2004008

Dear Mr. Warner:

On December 17, 2004, the NRC completed a team inspection at your Seabrook Nuclear Power Station. The enclosed inspection report presents the results of that inspection, which were discussed with Mr. G. St. Pierre and other members of your staff on December 17, 2004.

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, the team concluded that in general, problems were properly identified, evaluated, and corrected. The team identified one finding of very low safety significance (Green). This finding was associated with the failure to implement effective corrective actions after buried cables and pipes were struck during site excavations. This finding was determined to be a violation of NRC requirements. However, because of the very low safety significance and because it was entered into your corrective action program, the NRC is treating this finding as a non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001, with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Seabrook Nuclear Power Station.

In addition, some examples of minor problems were identified by the team and entered into the corrective action program by your staff. Some of these items involved corrective actions that were ineffectively tracked, issues that had not been rigorously evaluated, or inconsistent application of the corrective action program by Seabrook personnel. None of these minor deficiencies resulted in a challenge to system operability or reliability.

Mr. Mark E. Warner

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If you have any questions, please contact me at 610-337-5108.

Sincerely,

/RA/

Christopher G. Cahill, Chief
Performance Evaluation Branch
Division of Reactor Safety

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

Enclosure: Inspection Report 05000443/2004008
w/Attachment: Supplemental Information

cc w/encl:

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No: 50-443

License No: NPF-86

Report No: 05000443/2004008

Licensee: Florida Power & Light Energy Seabrook, LLC (FPL)

Facility: Seabrook Nuclear Power Station, Unit 1

Location: Post Office Box 300
Seabrook, NH 03874

Dates: November 29 through December 17, 2004

Inspectors: G. Bowman, DRS, Reactor Inspector (Team Leader)
C. Patterson, RII DRP, Senior Resident Inspector (Farley)
S. Shaffer, DRP, Seabrook Resident Inspector
D. Werkheiser, DRS, Reactor Inspector

Approved by: Christopher G. Cahill, Chief
Performance Evaluation Branch
Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

IR 05000443/2004-008; 11/29/2004 - 12/17/2004; Seabrook Station, Unit 1; biennial baseline inspection of the identification and resolution of problems. One finding was identified in the area of corrective actions.

This inspection was conducted by two regional inspectors and two resident inspectors. One finding of very low safety significance (Green) was identified during this inspection and was classified as a non-cited violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process (SDP)." Findings for which the SDP 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 3, dated July 2000.

Identification and Resolution of Problems

The team determined that Seabrook was generally effective at identifying problems and placing them in the corrective action program. Once entered into the system, these items were screened and prioritized in a timely manner using established criteria, and they were properly evaluated commensurate with their safety significance. Overall, the evaluations reasonably identified the causes of the problem, assessed the extent of condition, and developed appropriate corrective actions. However, the team did identify some minor instances where problem evaluation could have been strengthened. Corrective actions were typically implemented in a timely manner, but the team found that in some cases, corrective actions were not effectively used to resolve and prevent recurrent problems. The inspectors found that Seabrook's self-assessments and audits were self-critical and consistent with the team's observations.

A. NRC Identified and Self-Revealing Findings

Cornerstone: Initiating Events

- Green. The team identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because Seabrook failed to take adequate corrective actions to prevent damage to underground utilities and equipment during site excavations. Following a series of issues where contract personnel hit buried cables and pipes while excavating, Seabrook failed to take effective corrective actions and later hit a safety-related control building ventilation line. This finding was associated with the cross-cutting area of problem identification and resolution.

This finding was more than minor because it affected the Initiating Events Cornerstone objective of limiting events that upset plant stability and challenge critical safety functions. Specifically, an underground utility or buried equipment could be damaged and result in an initiating event. The finding was determined

to be of very low safety significance since it did not contribute to both an increased likelihood of a reactor trip and an increased likelihood that mitigating equipment would be unavailable. (Section 4OA2.c.2.1)

B. Licensee-Identified Violations

None.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

Effectiveness of Problem Identification

a. Inspection Scope

The inspectors reviewed the procedures describing the corrective action program (CAP) at FPL's Seabrook Nuclear Power Station. Seabrook identifies problems by initiating condition reports (CRs) for conditions adverse to quality, plant equipment deficiencies, industrial or radiological safety concerns, or other significant issues. Condition reports are subsequently screened for operability, categorized by significance level (A through E), and assigned to personnel for evaluation and resolution.

The inspectors reviewed items selected across the seven cornerstones of safety in the NRC's Reactor Oversight Program to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The team selected items from the licensee's maintenance, operations, engineering, emergency planning, security, radiological control, and oversight programs to ensure that Seabrook was appropriately considering problems identified in each. The team considered risk insights from Seabrook's probabilistic risk assessment to focus the sample selection and system walkdowns on risk-significant components. The inspectors used this information to select a risk-informed sample of CRs that had been issued since the last NRC Problem Identification and Resolution inspection, which was completed in October 2002.

The inspectors reviewed a sample Seabrook's nuclear oversight audits and self-assessments, including a recently issued audit of the corrective action program. This review was conducted to determine if problems identified through these evaluations were entered into the CAP, and whether the corrective actions were properly completed to resolve the deficiency. The effectiveness of the audits and self-assessments was evaluated by comparing audit and self-assessment results against self-revealing and NRC-identified findings. The inspectors observed daily Condition Report Oversight Group (CROG) meetings, in which Seabrook managers reviewed incoming condition reports and evaluated completed corrective action analyses. The team also attended Seabrook's fourth quarter CR trending meeting and a portion of the December 14 Corporate Nuclear Review Board (CNRB) meeting.

For selected risk-significant systems, the inspectors reviewed applicable system health reports, work requests, engineering documents, plant log entries, and results from surveillance tests and maintenance tasks. For these selected systems, the inspectors also interviewed cognizant station personnel and completed system walkdowns to assess material condition and system performance.

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The inspectors also reviewed operator logs, control room deficiencies, operator work-arounds, and procedures. In addition, the inspectors interviewed plant staff and management to determine their understanding of and involvement with the CAP. The specific documents reviewed and referenced during the inspection are listed in the attachment to this report.

The team conducted a limited review of Seabrook's safety-conscious work environment (SCWE). As part of this review, the team conducted interviews with Seabrook staff to assess their willingness to raise safety concerns without the fear of reprisal.

b. Observations and Findings

No findings of significance were identified.

The inspectors concluded that the station was generally effective at problem identification. Seabrook staff generally had adequate knowledge of the CAP and identified problems and entered them into the program at the appropriate threshold. The team's SCWE review did not identify any examples of unwillingness by Seabrook staff to use the CAP. There were relatively few deficiencies identified by the team that had not been previously identified by Seabrook. Station staff promptly initiated CRs, as appropriate, in response to deficiencies or issues raised by the inspection team. The CRs that were generated in response to the team's activities are listed in the attachment to this report.

The team identified two minor examples where Seabrook inconsistently applied the problem identification aspect of the CAP. These minor deficiencies are discussed below:

- The team determined that Seabrook's Emergency Preparedness (EP) department used a threshold for writing CRs for emergency siren failures that was inconsistent with CAP expectations and guidance. Specifically, the acceptance criteria in procedure SIR.10, "Siren Biweekly Functional Test," did not require a CR unless more than 50% of the tested sirens had failed. From discussion with EP personnel, the team determined that siren failures were tracked and corrected, but only a major problem or a 50% failure would result in a CR. This practice was not consistent with the threshold used at the rest of the site, or with the guidance in Seabrook's CAP procedures, and would limit management review of siren deficiencies through the CROG. This was discussed with the licensee and CR 04-11888 was initiated.
- The team identified an area for improvement involving Seabrook's process for reviewing and assessing condition reports related to problems with security equipment. Additionally, security-related condition reports did not receive the same level of management oversight as other CRs. As a result of the team's finding, Seabrook has taken actions to strengthen communication between the Security department, Instrumentation and Control staff, and the CROG, to better evaluate trends and enhance performance in this area.

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The team found that self-assessments and audits were self-critical and generally consistent with the team's observations. Both the CNRB and the CR trending meeting provided effective oversight and critically assessed Seabrook's performance. In general, issues identified through audits, self-assessments, and management oversight were appropriately addressed in the CAP.

Prioritization and Evaluation of Issues

a. Inspection Scope

The inspectors reviewed the CRs listed in the attachment to this report to assess whether Seabrook adequately prioritized and evaluated problems. The team selected the CRs in areas to cover the seven cornerstones of safety in the NRC's Reactor Oversight Program. The team also considered risk insights from Seabrook's probabilistic risk assessment to focus the inspection sample. The reviews included the appropriateness of the assigned significance level, the timeliness of problem resolution, and the scope and depth of the causal analysis. For significant conditions adverse to quality, the inspectors reviewed Seabrook's assessment of the extent of condition and the determination of corrective actions to preclude recurrence. A portion of the items chosen for review were those that were age-dependent (boric acid corrosion and age-related degradation of enclosure air handling system dampers), and accordingly, the scope of the team's review was expanded to five years. Throughout the inspection, the team attended periodic licensee meetings to observe the CR review process and to understand the bases for assigned significance level and evaluation type.

In addition, the inspectors selected a sample of CRs written to address previous NRC non-cited violations (NCVs) to determine whether Seabrook evaluated and resolved problems associated with compliance to regulatory requirements. The inspectors reviewed Seabrook's evaluation of industry operating experience information for applicability to Seabrook. For applicable CRs, the inspectors reviewed Seabrook's assessment of equipment operability and reportability requirements.

b. Observations and Findings

No findings of significance were identified.

The inspectors concluded that, in general, Seabrook screened and evaluated problems contained within the CR process at the correct significance level. The staff was generally effective at classifying and performing operability evaluations and reportability determinations for discrepant conditions. Additionally, the team identified that the CROG was effective in reviewing and prioritizing CRs, and evaluating causal analyses. However, there were some instances in the screening and evaluation phases for CRs involving potentially risk-significant conditions, in which the station did not fully evaluate such factors as extent of condition and acceptability of past work. As a result, the prioritization and timeliness assigned to corrective actions were not always commensurate with the significance of the issues.

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The inspectors noted the following examples of less-than-thorough evaluations. These examples involved CRs that did not include a formal root or apparent cause analysis. They were of minor significance:

- C Seabrook staff wrote CR 04-07911 to address a problem encountered during emergency diesel generator (DG) surveillance testing. Specifically, when testing the 'B' DG, the operators received a blown fuse alarm on panel DG730 as the synchroscope selector switch was turned from the 'DG' to the 'OFF' position. Also, the voltage regulator lights switched from green to red, indicating a momentary transfer of the voltage regulator from automatic to manual mode. The inspectors noted that a similar problem had been corrected in 2002 by CR 02-16500 (a significance level 'B' CR), but that over the past several years there were numerous CRs discussing recurrence of this issue. CR 04-07911, a significance level 'C' CR, missed an opportunity to use the corrective action program to prioritize and denote a repeat problem that had been occurring over several years.

- C The inspectors determined that small bore air supply piping and large bore system piping which did not meet Seabrook's cleanliness requirements had been used during installation of the Condensate Polishing system. This issue was addressed in a significance level 'B' CR, but a formal causal analysis was not completed. While the CR addressed future actions to prevent installation of incorrect piping, it failed to evaluate the effect of the piping already installed in the plant. The use of improperly coated piping could result in chlorides and sulfides becoming entrained in the feedwater system, causing excessive steam generator corrosion. A more formal evaluation, which would have been reviewed by Seabrook management, may have identified this as an area to strengthen the corrective actions.

- C The inspectors reviewed CR 03-09516, which covered a remote safe shutdown panel key being left in the panel following testing. These keys are used to transfer control of critical components from the main control room to the remote safe shutdown panel if the main control room must be evacuated. Seabrook's corrective action was to coach and counsel the individuals involved. The inspectors noted that had the incident been treated as a loss of configuration control, the corrective actions would have included a briefing for all the operating crews on the incident and would have more thoroughly evaluated the cause of the issue to prevent recurrence.

The inspectors reviewed several root cause evaluations and found that they were generally adequate. In most cases, the evaluations were thorough and corrective actions would be reasonably expected to prevent recurrence.

Effectiveness of Corrective Actions

a. Inspection Scope

The team reviewed the corrective actions associated with selected CRs to determine whether the actions addressed the identified causes of the problems. The team reviewed CRs for repetitive problems to determine whether previous corrective actions were effective. The team also reviewed Seabrook's timeliness in implementing corrective actions and their effectiveness in precluding recurrence of significant conditions adverse to quality. Furthermore, the team assessed the backlog of corrective actions to determine if any, individually or collectively, represented an increased risk due to delays in implementation. The team also reviewed non-cited violations issued since the last inspection of Seabrook's corrective action program to determine if issues placed in the program had been properly evaluated and corrected.

b. Observations and Findings

Overall, the team concluded that Seabrook developed and implemented corrective actions that were appropriate and effective. Based on the sample reviewed, the team determined that, in general, corrective actions were completed in a timely manner. However, the team observed some instances in which corrective actions were not completed in a comprehensive manner or were not tracked appropriately.

One minor deficiency was identified related to inadequate documentation and tracking of corrective actions:

- NCV 02-11-01 was written because Seabrook failed to identify calculation errors regarding air void acceptance criteria in emergency core cooling system piping. These errors were missed during an independent review of the calculation. Seabrook wrote CR 02-14102 to address this NCV. The CR stated that the engineering staff, supervisors, and managers should review guidance concerning how to conduct independent reviews of calculations. However, no formal action was assigned by the CR to ensure completion of this item and track its status.

The team noted some instances in which corrective actions for previous events did not prevent recurrence because they were not effectively implemented.

Underground Utility and Equipment Damage During Excavation

Introduction. The team identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action" for failure to take adequate corrective actions to prevent damage to underground utilities and equipment during site excavations.

Description. On August 30, August 31, and September 14, 2004, contractors for Seabrook used procedure "Dig Safe SH 6.4," Revision 4, to perform site excavations to support modifications to the site. On August 30, contractors damaged a fire protection line during excavation work. On August 31, after resuming excavation work, they damaged a hydrogen line in the same area. On September 14, contractors damaged a 240 volt electrical line while excavating fence post holes. Following damage to the electrical line, the NRC issued NCV 04-04-02 for failure to follow excavation procedures.

Seabrook completed a formal root cause evaluation after the September 14 excavating incident. The corrective actions from the root cause evaluation included a procedural revision, multiple stand-downs, and training for the contractor personnel conducting excavations. The majority of the corrective actions, including all corrective actions to prevent recurrence, were completed by the end of October. In spite of this, on October 26, contractors cut a grounding cable with an excavator, and then on November 9, hit a 12-inch safety-related control building air handling (CBA) line during site excavation activities.

The team reviewed Seabrook's root cause evaluations for the September 14 event and for the CBA line hit. In both cases, the team determined that the root cause evaluations were adequate. However, a number of the causes for the first three issues were repeated during the subsequent events, including inadequate use of field drawings and ground penetrating radar, as well as insufficient training of contractors, indicating that Seabrook had not adequately implemented their corrective actions.

Analysis. The inspectors determined that Seabrook's failure to take adequate corrective actions to prevent damage to underground utilities and equipment during site excavations was a performance deficiency. Specifically, the licensee did not effectively implement the corrective actions identified in the root cause analysis initiated after contractors damaged the 240 volt electrical line. Traditional enforcement does not apply because the issue did not have any actual safety consequences or potential for impacting the NRC's regulatory function, and was not the result of a willful violation of NRC requirements or Seabrook's procedures.

The finding was more than minor because it affected the Initiating Events Cornerstone objective of limiting events that upset plant stability and challenge critical safety functions. Specifically, an underground utility or buried equipment could be damaged and result in an initiating event. This finding was evaluated using Phase 1 of the SDP for Reactor Inspection Findings for At-Power Situations. The finding was determined to be of very low safety significance (Green) since it did not contribute to both an increased likelihood of a reactor trip and an increased likelihood that mitigating equipment or functions would not be available.

Enforcement. 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," requires, in part, that measures be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to the above, Seabrook failed to take adequate corrective actions to resolve multiple instances of damage to underground utilities and equipment during site excavations. Because this issue was determined to

be of very low safety significance and has been entered into Seabrook's corrective action program (CR 04-11106), this violation is being treated as an NCV, consistent with Section VI.A of the NRC Enforcement Policy. **(NCV 05000443/2004008-01, Failure to Take Effective Corrective Action for Underground Utility and Equipment Damage During Excavation)**

4OA6 Meetings, including Exit

The team presented the inspection results to Mr. G. St. Pierre and other members of the Seabrook staff on December 17, 2004. No proprietary information was retained by the team.

ATTACHMENT: SUPPLEMENTAL INFORMATION

ATTACHMENT

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

B. Beuchel, Instrumentation and Control Project Manager
W. Bladon, Nuclear Oversight Manager
R. Bryant, Security System Engineer
T. Cassidy, Training Support Supervisor
A. Chesno, Maintenance Manager
R. Cole, Security Supervisor
E. Cooley, Senior Regulatory Compliance Engineer
P. Freeman, Engineering Manager
J. Giarrusso, Security Manager
J. Giarrusso Jr., Security Supervisor
M. Ginsburg, Security Supervisor
P. Hagan, Security Corrective Action Program Coordinator
P. Harvey, Chemistry Manager
G. Jasinski, Maintenance Corrective Action Program Coordinator
G. Kilby, Regulatory Compliance Engineer
B. Leary, Security Supervisor
N. Leon, Security Officer
C. Mello, Instrumentation and Control Design Manager
D. Merrill, Assistant Operations Manager
S. Morrissey, Assistant Operations Manager
M. Ossing, Engineering Support Manager
S. Perkins-Grew, Emergency Preparedness Manager
J. Peschel, Licensing Manager
V. Robertson, Regulatory Compliance Analyst
D. Robinson, Chemistry Technical Supervisor
G. St. Pierre, Station Director
R. Sherwin, Maintenance Manager
J. Sobotka, Performance Improvement Manager
R. Thurlow, Health Physics Supervisor
R. White, Design Engineering Manager

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Opened and Closed

05000443/2004008-01	NCV	Failure to Take Effective Corrective Action for Underground Utility and Equipment Damage During Excavation. (Section 4OA2.c.2.1)
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LIST OF DOCUMENTS REVIEWED

Procedures

MA 10.3, Boric Acid Corrosion Control Program, Revision 0
OE 3.6, Condition Reports, Revision 5
OE 4.0, Types of Evaluations, Revision 9
OE 4.3, Root Cause Analysis, Revision 13
OE 4.5, Operability Determination, Revision 11
OE 4.8, Apparent Cause Evaluation, Revision 12
OE 4.9, Plant Nonconformance/Degraded Condition Evaluation, Revision 8
OE 4.11, Initial Event Investigation, Revision 5
OE 7.2, Use of the Nuclear Network, Revision 4
OE 8.0, Work Control Practices, Revision 3
OE 8.4, Work Order Process, Revision 2
PEG-225, Enclosure Air Handling Performance Monitoring, Revision 0
1460.06, Winter Readiness Surveillance, Revision 2
CDI-013, Chemistry Limiting Condition for Continued Operation Timeline Generation Guidance
SIR.10, Siren Bi-weekly Functional Test, Revision 3

Audits and Self-Assessments

QRNO-03-22, Assessment of Seabrook Station's Boron Leakage Reduction Program
SBK-03-03, Functional Area Audit of the Security Plan
SBK-03-05, Functional Area Audit of the Corrective Action Program
SBK-04-01, Functional Area Audit of Radiation Protection/Process Control/Radwaste Programs
SBK-04-03, Functional Area Audit of the Security Plan
SBK-04-02, Functional Area Audit of Operations
SBK-04-04, Functional Area Audit of Engineering
SBK-04-07, Functional Area Audit of Maintenance
SBK-04-09, Functional Area Audit of the Emergency Plan
SBK-04-10, Functional Area Audit of the Corrective Action Program
02-0445, Maintenance Rule Program Self-Assessment
03-0026, Chemistry/Health Physics Human Performance Trending
04-0021, 2004 Boric Acid Corrosion Control (BACC) Program Self-Assessment
04-0036, March 2004 Maintenance Rule Self-Assessment
04-0044, Top 5 Engineering Workaround Items
04-0059, Assessment of Significance Level A, B, and C Closed CRs - April 2004
04-0065, Addendum to 50.54(q) Evaluations for Past EAL Changes

04-0066, Independent Assessment of Exercise Readiness
 04-0090, Assessment of Significance Level A, B, and C Closed CRs - May 2004
 04-0133, Operations Human Performance Trending
 04-0140, Apparent Cause Evaluations Completed in Design Engineering
 04-0143, Second Quarter 2004 Trends in Design Engineering and Engineering Support
 04-0149, Assessment of Significance Level A, B, and C Closed CRs - July 2004
 04-0171, Nuclear Oversight Staffing
 04-0183, Incoming Operating Experience Screening Self-Assessment

Corrective Action Reports

02-05315	03-05539	04-00596	04-09099
02-09729	03-05753	04-01509**	04-09230
02-12335	03-05791	04-01701	04-09350
02-13266	03-05854	04-01837	04-09361
02-13454	03-05892	04-02553	04-09361
02-13528	03-05980	04-02592	04-09362
02-13684	03-06043	04-02595	04-09386
02-13859	03-06513	04-02876	04-09428
02-14102	03-07314	04-03955	04-09701
02-15198	03-07724	04-03980	04-09748
02-16884	03-07914	04-04540	04-09749
02-17024	03-08317	04-04697	04-09792
02-17034	03-08317	04-04847	04-09828
03-00043	03-08602	04-04903	04-09860
03-00043	03-08630	04-04903	04-09902
03-00121	03-08737	04-05130	04-09910
03-00259	03-09138	04-05432	04-09919
03-00388	03-09217	04-05444	04-09965
03-00408	03-09298	04-05445	04-10113
03-00658	03-09423	04-05838	04-10136
03-01126	03-09466	04-05848	04-10266
03-01332	03-09516	04-05914	04-10312
03-01735	03-09529	04-06009	04-10444
03-01797	03-09626	04-06196	04-10499
03-02016	03-09732	04-06427	04-10583
03-02491	03-09736	04-06547	04-10706
03-02525	03-09798	04-06764	04-10855
03-03166	03-09823	04-06995	04-10861
03-03234	03-09865	04-07035	04-10887
03-04364	03-09976	04-07044	04-11106
03-04364	03-10061	04-07400	04-11222
03-04602	03-10072	04-07715	04-11301
03-04899	03-10142	04-08262	04-11888
03-05105	03-11171	04-08910	04-11894*
03-05214	04-00161	04-08910	04-11895*
03-05402	04-00326	04-08929	

* NRC Identified During Inspection

** Reopened During Inspection

Non-Cited Violations

50-443/02-04-01	50-443/03-02-01	50-443/03-03-03	50-443/03-06-02
50-443/02-05-01	50-443/03-02-02	50-443/03-05-01	50-443/03-06-03
50-443/02-05-02	50-443/03-03-01	50-443/03-05-02	50-443/04-06-01
50-443/02-11-01	50-443/03-03-02	50-443/03-06-01	

Operating Experience Documents and Condition Reports

NRC Bulletin 03-01, Potential Impact of Debris Blockage on Emergency Sump Recirculation at Pressurized-Water Reactors

NRC Generic Letter 89-13, Service Water System Problems Affecting Safety-Related Equipment

Seabrook's Response to Generic Letter 89-13

Supplementary Response to Generic Letter 89-13

Supplementary Response to Generic Letter 89-13 and 90-04

EE-03018, Response to NRC Bulletin 2003-01 - Potential Debris Blockage of Containment Sumps, Revision 0

OX1406.12, 18 Month Containment and Containment Spray Recirculation Sump Surveillance, Revision 5

OE 7.1, Operating Experience Review Program, Revision 7

Daily Operating Experience Summary - November 30, 2004

CR 02-16794

CR 03-05037

CR 03-05148

CR 03-08576

CR 03-09506

CR 04-00737

CR 04-04238

Work Orders

WO 0100374	WO 0235915	WO 0312210	WO 0404733
WO 0100376	WO 02A1009	WO 0329995	WO 0410445
WO 0210317			

Maintenance Rule (a)(1) Action Plans and Basis Documents

Emergency Feedwater

Safety-Related 4160 V Breaker Diode Failures

Service Air Compressor SA-SKD-137A/B

Maintenance Rule (a)(1) Improvement Plan for DG-01

Engineering Evaluation SS-EV-03-008, Risk Ranking of Maintenance Rule Functions from the SSPSS-2002, Revision 0

Health Reports

Enclosure Air Handling System Performance Report, October 2001
Boric Acid Corrosion Control Program (Third Quarter 2004)
Diesel Generator System (Third Quarter 2004)
Emergency Feedwater (Third Quarter 2004)
Post Accident Monitoring (Third Quarter 2004)
Electrical Switchgear (Third Quarter 2004)
Enclosure Air Handling (Third Quarter 2004)
Service Water (Third Quarter 2004)
Rod Control/Rod Position Indication (Third Quarter 2004)
Solid State Protection System (Third Quarter 2004)
Security Systems (Third Quarter 2004)

Miscellaneous

Minutes of Station Operation Review Committee Meeting 04-058
Florida Power and Light Company Corporate Nuclear Review Board Meeting 522 Minutes
Third Quarter 2004 Corrective Action Program Trend Report
HPSTID-04-008, WRGM Calibration Enhancements
Condition Report Oversight Group Agenda - November 30, December 15 and 16, 2004
ED-I-4 Trip Emergent Issue Action Summary – November 29 and 30, 2004
Maintenance Group Report – Period Ending October 31, 2004
Plant Health Committee Meeting Minutes - 2004-11, 12, and 13
Seabrook Station Daily Operating Report - November 30, 2004
Seabrook Station Daily Chemistry and Radiation Protection Report - November 30, 2004

LIST OF ACRONYMS

ADAMS	Agencywide Document Management System
CAP	Corrective Action Process
CBA	Control Building Air Handling
CFR	Code of Federal Regulations
CNRB	Corporate Nuclear Review Board
CR	Condition Report
CROG	Condition Report Oversight Group
DG	Emergency Diesel Generator
EP	Emergency Preparedness
IMC	Inspection Manual Chapter
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PARS	Publically Available Records
SCWE	Safety-Conscious Work Environment
SDP	Significance Determination Process