



**UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET SW SUITE 23T85
ATLANTA, GEORGIA 30303-8931**

April 19, 2001

Florida Powder & Light Company
ATTN: T. F. Plunkett
President - Nuclear Division
PO Box 14000
Juno Beach, FL 33408-0420

**SUBJECT: TURKEY POINT NUCLEAR PLANT- NRC INSPECTION REPORT
50-250/01-03 AND 50-251/01-03**

Dear Mr. Plunkett:

On March 30, 2001, the NRC completed an inspection at your Turkey Point Nuclear Plant. The enclosed report documents the inspection findings which were discussed on March 30, 2001, with Mr. R. Hovey 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 selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, there were no findings of significance identified during this inspection. Most problems were properly identified, evaluated, and resolved within the corrective action program. The inspectors identified a few minor problems in the identification and resolution aspects of some condition reports. These condition reports did not fully identify or evaluate all pertinent deficiencies involved with the issues. Two minor problems related to corrective action effectiveness were also identified. The inspectors noted that issues regarding an increased number of human errors were appropriately captured in the condition report system and were receiving high levels of management attention.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's document system (ADAMS). Adams is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Leonard D. Wert, Chief
Reactor Projects Branch 3
Division of Reactor Projects

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

Enclosure: Inspection Report 50-250/01-03, 50-251/01-03

Attachments: 1. NRC's Revised Oversight Process
2. List of Documents Reviewed
3. List of Requested Material

cc w/encl:

Plant General Manager
Turkey Point Nuclear Plant
Florida Power and Light Company
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Site Vice President
Turkey Point Nuclear Plant
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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 50-250, 50-251

License Nos: DPR-31, DPR-41

Report Nos: 50-250/01-03, 50-251/01-03

Licensee: Florida Power & Light Company (FPL)

Facility: Turkey Point Nuclear Plant, Units 3 & 4

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

Dates: March 19- 30, 2001

Inspectors: B. Desai, Senior Resident Inspector, Robinson Nuclear Plant
(Lead Inspector)
R. Reyes, Resident Inspector, Turkey Point Nuclear Plant
E. Girard, Senior Reactor Inspector, Division of Reactor Safety,
Region II

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

Summary of Findings

ADAMS Template:

IR 05000250-01-03, IR 05000251-01-03, on 03/19-03/30/2001, Florida Power & Light Company, Turkey Point, Units 3 and 4, annual baseline inspection of the identification and resolution of problems. No findings were identified. The corrective action program was acceptable with some negative observations.

The inspection was conducted by a senior resident inspector, the Turkey Point resident inspector, and a regional senior reactor inspector. No significant findings were identified.

Identification and Resolution of Problems:

The licensee was effective at identifying problems at a low threshold and entering them into the corrective action program. Problems entered into the program were adequately evaluated and appropriate corrective actions were identified. Formal root cause evaluations and corrective actions for significant issues were thorough and detailed. Corrective actions were generally implemented in a timely manner, commensurate with their safety significance. The inspectors identified a few minor problems. Several condition reports did not identify or evaluate all pertinent deficiencies involved with issues, and two minor problems related to corrective actions were identified. Licensee audits and assessments were effective. Operating event information was effectively utilized. Recent problems related to human errors were receiving high levels of licensee management attention. Overall, a safety conscious work environment was present. Discussions with workers and other information indicated that employees were not reluctant to report nuclear safety issues.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Effectiveness of Problem Identification

a. Inspection Scope

The inspectors reviewed licensee corrective action activities performed since February 1, 2000. This review included issues documented in NRC inspection reports and Licensee Event Reports within the past twelve months. Problem identification and resolution effectiveness during this period was also discussed with the resident inspectors who routinely observed these activities as part of the baseline NRC inspection program.

The inspectors reviewed the Unit 3 and Unit 4 operating logs for February and March, 2001, selected plant system health reports, maintenance rule a(1) listings, in-service test failure results, and open temporary modifications to determine if identified deficiencies were being entered into the corrective action program (CAP). In addition, the inspectors conducted tours of the facility during both day shift and back shift periods to determine if deficiencies existed which had not been entered into the CAP.

The inspectors reviewed selected condition reports (CRs) and work orders (WOs) for several systems identified as risk significant in the licensee's probabilistic risk assessment, including auxiliary feedwater, charging, component cooling water, intake cooling water, high head safety injection, low pressure safety injection, and emergency diesel generators. In addition, the inspectors screened and reviewed numerous CRs associated with items identified in the areas of operations, maintenance, chemistry, health physics, security, engineering, emergency preparedness and personnel safety to determine the licensee's threshold for identifying problems.

The inspectors reviewed industry operating experience, including NRC Information Notices (IN) Generic Letters, NRC daily event reports, 10 CFR Part 21 reports, and vendor reports and bulletins that were issued during the past year to determine if they had been appropriately evaluated for applicability and entered into the CAP.

The inspectors reviewed several Quality Assurance audits and licensee self-assessments to determine if the findings were consistent with those identified by the NRC. The inspectors also verified the findings had been appropriately entered into the CAP.

In addition, the inspectors had discussions with various plant personnel during the inspection activity to verify that other processes were not being utilized to address problems that should have been included in the CAP. The inspectors attended the Condition Report Oversight Group meeting to determine the level of management attention and oversight given to issues entered into the CAP. The inspectors also attended a plant status review meeting attended by senior licensee management and a safety meeting attended by plant personnel.

b. Issues and Findings

The inspectors determined that the licensee's threshold for identifying problems and entering them into the CAP was sufficiently low. Operating experience was routinely reviewed for applicability and documented in the CAP. Audits and self-assessments were sufficiently critical and focused on safety. The inspectors identified the following minor deficiencies during the inspection:

- A functional failure on demand of the Unit 4 main steam isolation bypass valve had occurred in January 2001. A WO had been initiated and corrective actions initiated; however, a CR had not been initiated for the functional failure as required by licensee maintenance rule procedures. A CR was initiated by the licensee upon identification.
- A CR associated with a pressurizer drain down incident during cold shutdown was reviewed. The CR adequately addressed the root cause and the corrective actions were appropriate. The cold calibrated level instrument associated with the pressurizer had maintenance performed while the unit was in hot shutdown, six months prior to the outage requiring the unit to be placed in cold shutdown. The inspectors noted that a deferred post maintenance test request (to be performed at the cold shutdown period) was not initiated following the maintenance. The CR had not addressed this deficiency.
- A CR evaluating a valve wiring issue had not identified a post maintenance testing deficiency involving a valve interlock. A supplement to the CR was initiated.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The inspectors reviewed the CRs identified in Attachment 2 to determine if they had been properly characterized, prioritized, and evaluated for resolution. Plant WOs and maintenance rule documents were reviewed to determine if systems within the scope of the maintenance rule were being periodically reviewed and identified issues were being repaired in a timely fashion. The inspectors attended a plant status review meeting and several Condition Report Oversight Group meetings. The inspectors also reviewed minutes from several Plant Nuclear Safety Committee (PNSC) meetings to determine if identified issues were being adequately reviewed and receiving appropriate management attention.

b. Issues and Findings

Overall, the licensee's CAP was effective at prioritizing and resolving conditions adverse to quality. Root cause analyses were thorough and detailed. For most issues, the licensee's system of prioritization ensured timely resolution commensurate with safety significance. The inspectors identified a minor deficiency involving the timeliness of the inspection of a safety related pipe support on Unit 4. A similar support on Unit 3 had been determined to be degraded, but operable per Generic Letter 91-18 evaluation. A prompt inspection of the

Unit 4 pipe support was not conducted. When the Unit 4 support was inspected approximately 14 months later, it too was found to be degraded and an operability evaluation had to be performed per Generic Letter 91-18. The prioritization code assigned to the WO for the Unit 4 support inspection contributed to the delay. The licensee initiated a CR to evaluate this problem. Additionally, the inspectors identified that a CR evaluation of a motor operated valve had not fully addressed the potential for damage to the actuator or valve due to overload condition. A supplement to the original CR was initiated by the licensee. Subsequently, the actuator and valve loadings were determined to have been acceptable.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors reviewed the CRs identified in Attachment 2 to determine if the licensee had identified and implemented corrective actions commensurate with the safety significance of the issue, and where appropriate, evaluated the effectiveness of the actions taken. The inspectors also reviewed the backlog of open CRs and associated action items to determine if problems were being corrected in a timely fashion. Trend reports were also reviewed and discussed with the licensee to determine the causes of the various trends and the corrective actions taken. Corrective actions in response to Licensee Event Reports and NRC violations were reviewed for adequacy and to determine if the extent of condition was sufficiently broad.

b. Issues and Findings

The inspectors concluded that the corrective actions for the CRs reviewed were appropriately focused to correct the condition and implemented in a timely manner commensurate with the safety significance of the issue. A minor corrective action deficiency related to an overtime issue was identified by the inspectors. The corrective action resulting from a previously identified overtime issue in the maintenance department was the implementation of a software program to provide a second check on the use of overtime. The inspectors noted that the software program had not been implemented due to software problems. However, the procedure governing overtime had been changed to require overtime monitoring through the software program and the Plant Manager Action Item (PMAI) tracking the corrective action had been closed. Upon identification, a CR was generated to address the issue.

Additionally, with regard to effectiveness of corrective actions, the inspectors noted a high number of human errors had occurred, some of them contributing to recent events that were documented in the routine baseline inspection reports. These included: problems encountered during bearing replacement on a high head safety injection pump, reactor trip following dropped control rods, and pressurizer level drain down problems. The inspectors' assessment of the licensee's effectiveness in addressing these issues was consistent with that of the resident inspectors. The inspectors noted that some human error problems continue to occur as documented in CRs. The inspectors confirmed that the licensee had recognized the overall trend and is addressing this problem. Human performance is receiving high levels of licensee management attention.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors reviewed licensee audits, assessments, and issues identified in CRs, and had discussions with licensee employees during the inspection to determine whether any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors also reviewed several issues addressed in the employee concerns program.

b. Issues and Findings

No findings were identified. The inspectors determined that licensee employees were familiar with the CAP and employee concerns programs and generally were not reluctant to raise safety issues.

4OA6 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. R. Hovey, Site Vice President, and other members of licensee management at the conclusion of the inspection on March 30, 2001. Proprietary information is not included in this report.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

E. Avella, Work Control Manager
R. Earl, Corrective Action Group Supervisor
S. Franzone, Licensing Manager
G. Hollinger, Protection Services Manager
R. Hovey, Site Vice-President
D. Jernigan, Plant General Manager
T. Jones, Maintenance Manager
J. Kirkpatrick, Training Manager
M. Lacal, Operations Manager
R. Leckey, Speakout Supervisor
D. Lowens, Quality Assurance Manager
E. Lyons, Engineering Supervisor
E. Thompson, License Renewal Project Manager
D. Tomaszewski, Site Engineering Manager
S. Wilsa, Health Physics/Supervisor
A. Zielonka, System Engineering Manager

NRC

V. McCree, Deputy Director, Division of Reactor Projects, Region II
S. Ninh, Senior Project Engineer, Region II
C. Patterson, Senior Resident Inspector, Turkey Point Nuclear Plant
L. Wert, Chief, Reactor Project Branch 3, Division of Reactor Projects, Region II

ITEMS OPENED AND CLOSED

None

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety	Radiation Safety	Safeguards
<ul style="list-style-type: none">● Initiating Events● Mitigating Systems● Barrier Integrity● Emergency Preparedness	<ul style="list-style-type: none">● Occupational● Public	<ul style="list-style-type: none">● Physical Protection

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

LIST OF DOCUMENTS REVIEWED

Procedures:

0-ADM-518, "Condition Reports"

0-ADM-011, "Event Response Team (ERT) Organization"

4-OSP-050.2, "Residual Heat Removal System In-service Test"

0-ADM-054, "PMAI Corrective Action Tracking Program"

0-ADM-701, "Control of Plant Work Activities"

JPN-PTN-SEMS-91-019, "Residual Heat Removal System In-Service Testing Safety Evaluation"

0-ADM-728, "Maintenance Rule Implementation"

0-ADM-054, "PMAI Corrective Action Tracking Program"

0-ADM-515, "Operating Experience Feedback (OEF) Program"

0-ADM-533, "Condition Report Trending"

0-ADM-701, "Control Of Plant Work Activities"

0-ADM-730, "Foreign Material Exclusion Controls"

QI 16-PTN-1, "Corrective Action"

Operating Experience

Information Notice (IN) 98-21, "Potential Deficiency of Electrical Cable/Connection Systems"

IN 99-21, "Recent Plant Events Caused By Human Performance Errors"

IN 00-08, "Inadequate Assessment of the Effect of Differential Temperature on Safety-Related Pumps"

IN 2000-09, "Steam Generator Tube Failure At Indian Point"

IN 2000-14, "Non-Vital Bus Fault Leads To Fire and Loss Of Offsite Power"

SOER 99-1, "Loss of Grid"

SER 1-0, "Significant Reactor Coolant System Leakage Resulting From RHR Piping Failure"

SER 2-00, "Recurring Operational Events During Outages"

SER 4-00, "Continued Operations When Conditions Called For Manually Scramming The Reactor"

SEN 211, "Mis-positioned Valve Causes Inadvertent Drain Down Of The RCS As Shutdown Cooling Is Place In Service"

SEN 210, "Reactor Scram Caused by Rapid Injection Of Cold Feedwater"

SEN 214, "Stuck Open Relief Valve Causes Reduction in Reactor Coolant Inventory"

SEN 217, "Emergency Diesel Generator Failure During Surveillance Testing"

NSAL 00-002, "Regenerative Heat Exchanger Tubesheet"

NRC Part 21 00-23-0, "Siemens Power, Pump Model Computer Code CONTRANSA2 Error"

NRC Part 21 00-19-0, "Eaton/Cutler Hammer, "Inadvertent Trip Of Westinghouse Breakers At TVA Sequoyah"

Condition Reports:

01-0169	01-0175	01-0185	01-0192	01-0200	01-0219
01-0220	01-0224	01-0243	01-0248	00-2247	00-2249
00-2253	00-2282	00-2389	00-2394	01-0012	01-0023
01-0078	01-0093	01-0116	01-0135	01-0147	01-0153
01-0157	01-0158	01-0179	01-0264	01-0277	00-0104
00-0391	00-1022	00-2013	00-1789	00-1888	00-1950
00-1951	00-1969	00-1971	00-1974	00-2029	00-2100
00-2116	00-2145	00-2175	00-2177	00-2230	00-2234
01-0683	01-0428	98-0963	98-1319	99-0494	99-1588
99-0807	00-0009	00-0036	00-0140	00-0159	00-0194
00-0200	00-0235	00-0452	00-0497	00-0506	00-0507
00-0529	00-0578	00-0588	00-0694	00-0711	00-0787
00-0826	00-0833	00-0883	00-0910	00-1002	00-1054
00-1127	00-1129	00-1153	00-1162	00-1163	00-1182
00-1194	00-1214	00-1266	00-1282	00-1336	00-1351
00-1387	00-1388	00-1397	00-1422	00-1423	00-1477
00-1498	00-1512	00-1543	00-1592	00-1741	00-1759
00-1846	00-1849	00-1925	00-1944	00-1966	00-1997
00-2063	00-2178	00-2247	00-2296	01-0021	01-0074
01-0086	01-0110	01-0124	01-0153	01-0174	01-0200
01-0219	01-0222	01-0314	01-0352	01-0424	01-0588
99-0635	99-0635-1	99-1516	00-0065	00-0065-1	00-0131
00-0135	00-0194	00-0194-1	00-0194-2	00-0235	00-0289
00-0376	00-0852	00-0935	00-0962	00-0994	00-1022

00-1265	00-1475	00-1507	00-1507-1	00-1841	00-1888
00-1908	00-2313	00-2313-1	00-2353	00-2393	01-0183
01-0224	01-0243	01-0417	01-0442	01-0625	01-0749

CR Trending Reports:

June 2000
 July 2000
 August 2000
 September 2000
 October 2000
 November 2000
 December 2000
 Year 2000 Report
 January 2001

Plant Work Orders:

30016415	30002449	30021933	30011834	30021457	30009334
31000396	30003748	30022465	31001605	30007514	30014890
30010793	30014335	30020903	30015066	31007488	29010212
29018547	98014763	98014765	98014785	98014786	30011468
30011494	30017327	30017876	30018454	30018838	30018839
30018840	30020090	30023096	30021017	30021018	30021022
30021025	30022159	30022161	30022738	31000346	31000947
31001127	31001376	31002648	31004270	31004508	31005186
31005194	31006647	31006808	31007022		

Licensee Quality Assurance Audits and Self Assessments

QAO-PTN-00-010 (Maintenance Functional Area Audit)

QAO-PTN-00-003 (Chemistry)

QAO-PTN-00-007 (Corrective Action)

00-01 Operations

Quality Department Quarterly Report - First Quarter 2000

Quality Department Quarterly Report - Second Quarter 2000

Quality Department Quarterly Report - Fourth Quarter 2000

Quality Report (QR) 00-0030, Corrective Actions Associated with Condition Reports, dated 2/21/00.

QR 00-0086, Corrective Action Surveillance, dated 4/12/00.

QR 00-0093, Evaluated 12 Condition Report Dispositions That Affected Changes in Disposition Category for Maintenance Rule Components, dated 4/27/00.

QR 00-0104, Review of Plant Manager Action Items, dated 5/22/00.

QR 00-0107, Safety Injection System and Residual Heat Removal Systems Corrective Action Program Effectiveness, dated 5/26/00.

QR 00-0129, Review of Condition Reports Assigned to Significance Level 2 and Designated Nonconformance, dated 7/26/00.

QR 00-0209, Condition Report Monthly Surveillance, dated 12/27/00.

Self Assessment ENG 00-03, Evaluation of System Engineering NRC Performance Indicators.

Temporary Modifications

TSA 03-00-50-09, Places a mechanical valve stem lock on HCV-3-758 to maintain valve in open position should the valve shaft key to actuator arm fail.

TSA 03-00-90-004, Temporary control room indication of recorder R-3-347 points 7 and 8, Exciter hot air temperatures

Miscellaneous Documents

Instrument Air, Intake Cooling Water, Emergency Diesel Generator, and Component Cooling Water, and Auxiliary Feedwater System Checklist/Health Reports for the Fourth Quarter of 2000.

List of all outstanding PMAs assigned to Engineering for action.

CSI Metallurgical Laboratory Report MET-99-155, Failed Nipple to Valve 3-702F.

Compilations of human performance error data and trends provided in:

- Operations 2001 CAP Rollup
- Handout from Turkey Point Nuclear Plant Status Meeting, March 27, 2001
- Human Performance Error Rate trend plot, January 1999 - February 2001, for Turkey Point Operations Department Rollup
- Corrective Action 4th Quarter Rollup (Maintenance Department), Inter-Office Correspondence, February 21, 2001.

Plant Manager Action Items

PM00-07-008

PM00-06-077

PM00-04-047

PM99-11-001

PM01-03-075

Inservice Test Results

List of inservice testing failures since January 2000 from licensee's inservice testing database.

Inservice testing database plot of differential pressure measured since January 2000 for the 4B intake cooling water pump.

Inservice testing database plot of 3A intake cooling water pump differential pressure measured from October 19, 1998 to March 13, 2001, and results after pump replacement March 17, 2001.

Inservice testing database plot of stroke times measured since January 2000 for air operated valves POV-3/4-4882 and 4883.

LIST OF REQUESTED MATERIAL

Turkey Point Problem Identification and Resolution Inspection Requested Documents

Inspection Dates: First Week Onsite - 03/19 thru 03/23/01
Second Week Onsite - 03/26 thru 03/30/01

Inspection Members: Binoy B. Desai (Lead Inspector), SRI Robinson Nuclear Plant
Rogerio Reyes, RI Turkey Point Nuclear Plant
Edward Girard, Senior Reactor Inspector, RII

The following is a list documents we will need to prepare for our inspection:

- 1) Any licensee followup actions based on last corrective action program review (IR 00-01)
- 2) A list of Audits and self assessments from 2/1/00 -2/1/01
- 3) A list of Event Review Team reports from 2/1/00 -2/1/01
- 4) A list of CRs from 2/1/00-2/1/01, sorting by significance level
- 5) A list of PWOs from 2/1/00-2/1/01
- 6) Maintenance Rule Expert Panel Minutes from 2/1/00-2/1/01
- 7) A list of OE items from 2/1/00-2/1/01
- 8) Corporate safety review committee minutes for year 2/1/00-2/1/01
- 9) Last two quarters of CAP reports and trending reports.
- 10) Completed CRs and status of corrective actions for LER's and NCV's for year 2000.
- 11) List/location/time of regularly scheduled plant meetings - such as shift turnovers, plan of the day, safety review committee, corrective action program, etc.
- 12) List of top ten most risk significant systems.