



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

April 15, 2004

Florida Power and Light Company
ATTN: Mr. J. A. Stall, Senior Vice President
Nuclear and Chief Nuclear Officer
P. O. Box 14000
Juno Beach, FL 33408-0420

**SUBJECT: TURKEY POINT NUCLEAR PLANT - NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 050000250/2004006 AND
05000251/2004006**

Dear Mr. Jones:

On March 26, 2004, the U. S. Nuclear Regulatory Commission (NRC) completed a team inspection at your Turkey Point Nuclear Plant, Units 3 and 4. The enclosed inspection report documents the inspection findings, which were discussed on March 25, 2004 with Mr. Terry Jones and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, the inspectors concluded that in general, problems were properly identified, evaluated, and corrected within the problem identification and resolution programs (PI&R). There was one Green finding identified during this inspection associated with corrective actions that were not identified and implemented to prevent repetitive failures of charging pumps. The finding was determined to be a violation of NRC requirements. However, because of the very low safety significance and because the finding was entered into your corrective action program, the NRC is treating the violation as a non-cited violation (NCV) consistent with Section VI.A.1 of the NRC Enforcement Policy. If you contest the non-cited violation, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the United States Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Turkey Point Nuclear Plant.

In accordance with 10 CFR 2.390 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

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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.gov/reading-room/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Joel T. Munday, Chief
Reactor Projects Branch 3
Division of Reactor Projects

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

Enclosure: Inspection Report 05000250/2004006 and 05000251/2004006
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

cc w/encl:

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Turkey Point Nuclear Plant
Florida Power and Light Company
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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.: 05000250, 05000251

License Nos.: DPR-31, DPR-41

Report Nos.: 05000250/2004006 and 05000251/2004006

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 8-12 and March 22-26, 2004

Inspectors: E. Guthrie, Senior Resident Inspector, Lead Inspector
C. Rapp, Senior Project Engineer
B. Norris, Senior Reactor Inspector, Region I
K. Weaver, Senior Resident Inspector

Approved by: Joel Munday, Chief
Reactor Projects Branch 3
Division of Reactor Projects

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SUMMARY OF FINDINGS

IR 05000250/2004006, 05000251/2004006; 03/08/2004 - 03/26/2004; Turkey Point Nuclear Plant, Units 3 & 4; Identification and Resolution of Problems. A violation was identified in the area of problem identification.

The inspection was conducted by two senior resident inspectors, a Region I senior reactor inspector, and a senior project engineer. One Green finding of very low safety significance was identified during this inspection and was classified as a non-cited violation (NCV). The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after 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 licensee was generally effective at identifying problems at a low threshold and entering them into the corrective action program. One exception was noted regarding the failure to identify and implement effective corrective actions to prevent recurring charging pump valve seat functional failures. The licensee adequately prioritized issues and performed evaluations that were technically accurate and of sufficient depth. One negative observation was identified for not consistently classifying Condition Reports (CRs) at an appropriate significance level as warranted, in accordance with the corrective action program procedure guidance. The inspectors concluded that the licensee was vulnerable to repetitive equipment failures by routinely not performing root cause evaluations when it is warranted, based on the significance of the condition. A second negative observation was identified involving a weakness in documentation in the reviewed CRs, primarily related to severity level classification justification. Formal root cause evaluations for significant conditions adverse to quality were normally thorough and detailed. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program. Based on discussions conducted with plant employees from various departments the inspectors did not identify any reluctance to report safety concerns.

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

- Green: The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to identify and implement effective corrective actions to prevent recurring charging pump valve seat functional failures. These failures constituted repetitive significant conditions adverse to quality.

This finding is greater than minor because it affected the equipment performance attribute and impacted the Mitigating System cornerstone objective to ensure availability of systems that respond to initiating events to prevent undesirable

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consequences. The charging pump valve seat failures were determined to be of very low safety significance because the failures did not reduce the number of available pumps below that required for the system to perform its safety function. (4OA2.a)

B. Licensee Identified Violations

None

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

a. Effectiveness of Problem Identification

(1) Inspection Scope

The inspectors reviewed the licensee's associated corrective action program (CAP) procedures which described the administrative process for initiating and resolving problems primarily via Condition Reports (CRs). The inspectors reviewed selected CRs, and attended meetings where CRs were screened for significance, to determine whether the licensee was identifying, accurately characterizing, and entering problems into the corrective action process at an appropriate threshold. The sample of CRs were selected starting from the date corresponding to the end of the last NRC Problem Identification and Resolution team inspection, which ended in August, 2002.

The inspectors selected CRs for review covering the seven cornerstones of safety identified in the NRC's Reactor Oversight Process (ROP), licensee classified severity levels, and site departments. The inspectors also conducted a detailed review of CRs for six risk significant systems. These systems were selected based on equipment performance history, Maintenance Rule (MR) considerations, and risk significance insights from the licensee's probabilistic safety assessment. The systems were the Auxiliary Feedwater System (AFW), the 125 volt vital DC system, the Emergency Diesel Generator and supporting systems, the Service Water System (ICW), the Chemical Volume and Control System (CVCS), and the Charging system. The inspectors reviewed the maintenance history and selected completed Work Orders (WOs) for the six systems and reviewed associated system health reports. Additional CRs were selected associated with MR evaluations and problems previously identified by NRC. The inspectors also reviewed NRC inspection results of CRs documented in NRC reports over the last two year time period. These reviews were performed to verify that problems were being properly identified, appropriately characterized, and entered into the CAP. In addition to the two year review, in accordance with the inspection procedure a five year review was performed for the ICW, EDG, and Charging systems.

The inspectors also conducted plant walkdowns of equipment associated with the six selected systems to assess the material condition and to look for any deficiencies that had not been entered into the CAP. Control Room walkdowns were performed by the inspectors to verify the main control room (MCR) deficiency list and to ascertain whether deficiencies were entered into the CAP.

The inspectors reviewed selected industry operating experience items associated with the six systems, including NRC generic communications, to verify that these were appropriately evaluated for applicability and whether issues identified through these reviews were entered into the CAP.

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The inspectors reviewed licensee Quality Assurance audits, Quality Assurance quality reports, and department self-assessments including those which focused on problem identification and resolution to verify that findings were entered into the CAP and to verify that these findings were consistent with the NRC's assessment of the licensee's CAP.

The inspectors attended various plant meetings to observe management oversight functions of the corrective action process. These included morning meetings, a Plant Nuclear Safety Committee meeting, Condition Report Oversight Group (CROG) meetings, and Corrective Action Program Coordinator (CAPCO) meetings. The inspectors also held discussions with various personnel to evaluate their threshold for identifying issues and entering them into the CAP.

Documents reviewed are listed in the Attachment.

(2) Assessment

The inspectors determined that the licensee was generally effective in identifying problems and entering them into the CAP. The threshold for initiating CRs was low and employees were encouraged by management to initiate CRs. Equipment performance issues were generally being identified at an appropriate level and entered into the CAP. One exception is described in Section (3).

The licensee was effective in evaluating internal and external industry operating experience items for applicability and entering issues into the CAP.

Department self-assessments were self-critical and, along with Quality Assurance audits, were effective in identifying value added issues that were entered into the CAP where appropriate. Site management was actively involved in the CAP process and focused appropriate attention on significant plant issues. A 78 percent increase in the number of CRs, starting in August 2003, was attributed to a renewed management reinforcement of the CAP. The inspectors concluded that this increase was attributed to managements reinforcement of the CAP since only minor changes were made to the CAP procedure during the same period. The CROG and CAPCO meetings provided valuable insights and oversight of the CAP process. The recent establishment of the CAPCO concept for departmental ownership of the process was considered a significant positive change in the program.

(3) Findings

Introduction: The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to identify and implement effective corrective actions to prevent recurring charging pump valve seat functional failures. These failures constituted repetitive significant conditions adverse to quality

Description: The inspectors reviewed the circumstances surrounding multiple failures of charging pump valve seats for both Unit 3 and Unit 4 as documented in several CRs. During the review the inspectors found that on August 12, 2001, charging pump 3A was taken out of service to repair an oil leak. During the post-maintenance test on August 16, 2001, pressure fluctuations were observed and the pump was removed from service. On August 18, 2001, a cracked outboard discharge valve seat was identified during disassembly. The licensee stated that repairs were conducted, however, no cause for the cracked valve seat was determined and the pump was subsequently returned to service on August 21, 2001. A condition report was not generated to document either the pressure fluctuations or the cracked valve seat. On August 26, 2001, the pump failed again in the same manner. As a result of questioning by the inspectors, the licensee assembled a team to investigate the August 16 and August 26, 2001, 3A charging pump failures as well as other functional failures of the charging pump valve seats previously documented. The licensee concluded that had the August 16, 2001 cracked valve seat issue been entered into the corrective action program for failure evaluation, the August 26, 2001 failure may have been prevented.

Analysis: This finding is greater than minor because it affected the equipment performance attribute and impacted the Mitigating System cornerstone objective to ensure availability of systems that respond to initiating events to prevent undesirable consequences. The charging pump valve seat failures were evaluated by the significance determination process and were determined to be of very low safety significance because the failures did not reduce the number of available pumps below that required for the system to perform its safety function.

Enforcement: 10 CFR 50, Appendix B, Criteria XVI, Corrective Actions, requires in part, that measures be established to assure that conditions adverse to quality are promptly identified and corrected. Further, in the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. Contrary to the above, the licensee failed to identify the 3A charging pump cracked valve seat failure on August 16, 2001, as a significant condition adverse to quality, and therefore measures were not taken to assure the cause of the condition was determined or corrective actions taken to prevent the subsequent failure of the pump on August 26, 2001. The licensee entered both of the pump valve failures into the corrective action program in CR-04-1758. This violation is being treated as a NCV in accordance with Section VI.A.1 of the NRC Enforcement Policy: NCV 05000250/2004006-01, Failure to Identify and Implement Effective Corrective Actions to Prevent Recurring Charging Pump Functional Failures.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The inspectors reviewed site and department trend reports along with the inspections discussed in Section 4OA2.a to verify that the licensee appropriately prioritized and evaluated problems in accordance with their risk significance. The inspection was intended to verify that the licensee adequately determined the cause of the problems,

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including root cause where appropriate, and adequately addressed operability, reportability, common cause, generic concerns, extent of condition, and extent of cause. The review included the appropriateness of the assigned significance, the timeliness of resolutions, and the scope and depth of the causal analysis. The review was also performed to verify that the licensee appropriately identified corrective actions to prevent recurrence and that these actions had been appropriately prioritized.

(2) Assessment

The inspectors determined that the licensee adequately prioritized issues entered into the CAP. Generally, the licensee performed evaluations that were technically accurate and of sufficient depth. Formal root cause evaluations were generally adequate in determining the root cause of the problem.

A negative observation was identified by the inspectors due to the licensee not consistently classifying CRs at the significance level warranted by the CAP procedure guidance. The inspectors reviewed the appropriateness of the assigned significance levels for the selected samples of CRs and independently determined the severity level classification. The severity level classification of CRs was considered to be important to the CAP because the severity level determined the type of cause investigation that was performed and the completion time of the associated CR. The inspectors compared the CAP guidance as well as industry guidance, such as NUMARC 93-01, Industry Guideline For Monitoring The Effectiveness of Maintenance At Nuclear Power Plants, against the severity level classifications of the selected CRs. Many of the selected CRs did not follow the CAP procedure guidance or industry guidance. For example, the CAP procedure guidance specified performing a root cause investigation and classification of conditions that exceeded the licensee's MR a(1) threshold criteria as severity level one CRs. However, for seven CRs associated with charging pump valve seat problems that exceeded the MR a(1) threshold criteria only apparent causes were performed by the licensee for all of the CRs. The inspectors observed that the licensee routinely classified MR a(1) criteria threshold equipment conditions as severity level two CRs, which received only apparent cause investigations. Although the licensee CAP procedure defined an apparent cause investigation as a logical assumption of cause it did not have the level of investigation that a root cause investigation would have performed.

The CAP procedure allowed for management judgement to be applied for severity level classification. The inspectors recognized the need for management flexibility to adequately implement the CAP, however, deviation from the CAP procedure did not appear to be warranted in all cases. Further, the reason for the deviations were not documented to justify the decision to deviate from the CAP procedure severity level classification guidance.

The inspectors did not find an example of problem recurrence that was a result of not performing a root cause investigation or an example of an issue where it could be concluded that the actual root cause had not been determined. During the inspection, the inspectors questioned whether the root cause to prevent recurrence had been

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identified for the charging pump valve seats since only an apparent cause was performed each time. The licensee performed an assessment of the apparent cause determinations and concluded that they had identified the root cause.

The inspectors concluded that the licensee was vulnerable to repetitive equipment failures by routinely not performing root cause evaluations when it is warranted based on the procedure guidance. The licensee indicated, and the inspectors agreed, that undue pressure may be put on the licensee staff by not performing root cause evaluations because the staff was expected to determine the root cause on the first attempt of an apparent cause investigation without the application of proven classical approaches to determining a root cause.

The inspectors identified a second negative observation involving a weakness in documentation in the reviewed CRs. Examples of weak documentation primarily existed in the Trend Only classified CRs. The classification of many Trend Only CRs were difficult to assess because no documentation was provided to explain the classification level when the problem statement did not appear to warrant the classification. The inspectors found over a broad range of severity level classifications that the classifications in some of the CRs were determined after clarification of the problem statement was obtained or the licensee initiated corrective actions. This was during the period of time after the origination of the condition and before the classification level was determined by the CAPCO and CROG. The additional information or corrective actions were not documented in the CR to explain the justification for the determination of the classification level. The inspectors verified the appropriate classification through interviews with appropriate licensee personnel. Except for the Trend Only CRs, the inspectors did not find licensee identified examples of the above documentation issues in the licensee audits and self-assessments that were performed.

The inspectors determined that site and department trend reports were thorough and adequate thresholds were established for evaluation of potential trends.

(3) Findings

No findings of significance were identified.

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The inspectors reviewed a sample of the open CRs and Plant Managers Open Action Items (PMAIs), selected licensee effectiveness reviews, a list of Work Orders tied to CRs, along with the inspections discussed in Section 4OA2.a and b, to verify that the licensee had identified and implemented timely and appropriate corrective actions to address problems. The inspectors verified that the corrective actions were properly documented, assigned, and tracked to ensure completion. The review was also to verify the adequacy of corrective actions to address equipment deficiencies and MR functional failures of risk significant plant safety systems.

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(2) Assessment

In general, corrective actions developed and implemented for problems were timely and effective, commensurate with the safety significance of the issues. Generally, the corrective actions directly addressed the cause and effectively prevented recurrence for significant conditions adverse to quality.

(3) Findings

No findings of significance were identified.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

During technical discussions with members of the plant staff the inspectors conducted interviews to develop a general perspective of the safety-conscious work environment at the site. The interviews were also to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors also reviewed the licensee's employee concerns program (ECP) which provided an alternate method to the CAP for employees to raise concerns and remain anonymous. The inspectors interviewed the ECP Manager and reviewed a select number of ECP reports completed in 2002 and 2003 to verify that concerns were being properly reviewed and identified deficiencies were being resolved and entered into the CAP when appropriate.

(2) Assessment

The inspectors concluded that licensee management emphasized the need for all employees to promptly identify and report problems using the appropriate methods established within the administrative programs. The inspectors did not identify any reluctance to report safety concerns.

(3) Findings

No findings of significance were identified.

4OA6 Management Meetings

On March 25, 2004, the inspectors presented the inspection results to Mr. Terry Jones, and other members of his staff who acknowledged the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTARY INFORMATION

KEY POINTS OF CONTACT

Licensee personnel

J. Cadogan, Engineering Supervisor
M. Cornwell, Training Manager
M. Downs, Speakout Manager
R. Earl, Corrective Action Group Supervisor
O. Hanek, Licensing Engineer
B. Johns, Security Manager
M. Laca, Operations Manager
J. Manso, Maintenance Supervisor
M. Moore, Performance Improvement Department Manager
W. Parker, Licensing Manager
M. Pearce, Plant Manager
G. Scheffing, System Engineer
B. Stamp, Operations Supervisor
R. Tucker, Operations Supervisor
G. Warriver, Site Quality Manager

NRC personnel

V. McCree, Director, Division of Reactor Projects, RII

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000250/2004006-01	NCV	Failure to Identify and Implement Effective Corrective Actions to Prevent Recurring Charging Pump Functional Failures (4AO2.a).
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LIST OF DOCUMENTS REVIEWED

Procedures

NAP-400	Condition Reports
0-ADM-518	Condition Reports
0-ADM-059	Root Cause Analysis
0-ADM-002	Nuclear Safety Speakout Program
0-ADM-068	Work Week Management
0-ADM-728	Maintenance Rule Implementation
0-ADM-100	Preparation, Revision, Review, Approval and Use of Procedures and Forms, dated 01/22/04
0-ADM-215	Plant Surveillance Tracking Program, dated 12/15/03
0-ONOP-105	Control Room Evacuation, dated 10/19/03
0-OP-003.1	125V Vital DC System, dated 12/09/03
0-OSP-023.3	Equipment Operability Verification with an Emergency Diesel Generator Inoperable, dated 08/13/02
0-SME-003.3	125VDC Station Battery Quarterly Maintenance, dated 05/15/03
0-SME-003.7	125VDC Station Battery Weekly Maintenance, dated 07/24/02
3-OP-023	Emergency Diesel Generator, dated 12/19/03
3-OSP-023.2	Diesel Generator 24 Hour Full Load Test and Load Rejection, dated 05/05/03
3-OSP-201.3	NPO Daily Logs, dated 02/07/01
4-OP-023	Emergency Diesel Generator, dated 12/19/03
BD-0-ONOP-105	Basis Document for 0-ONOP-105, dated 04/24/02
BD-3-OP-023	Basis Document for 4-OP-023, dated 07/28/03
BD-4-OP-023	Basis Document for 4-OP-023, dated 01/11/03
0-PMM-047.8	Charging Pump Valve Inspection and Overhaul
3-EOP-E-0	Reactor Trip or Safety Injection
0-GMM-102.1	Valve Repacking
0-OSP-075.12	AFW Manual Valve Operability Test
3-OP-075	Auxiliary Feedwater System

Condition Reports (* denotes a CR generated as a result of this inspection):

1997-1212	2002-1488	2003-0101	2003-1994	2003-3398	2003-4309
1997-1856	2002-1781	2003-0199	2003-2072	2003-3562	2003-4346
2001-1171	2002-1967	2003-0689	2003-2226	2003-3614	2004-0030
2001-2211	2002-1988	2003-1016	2002-2089	2003-3728	2004-0063
2002-0123	2002-2081	2003-0737	2003-1516	2003-3772	2004-0090
2002-0311	2002-2151	2003-0876	2003-2274	2002-2381-1	2004-0434
2002-1065	2002-2157	2003-0885	2003-2294	2003-1343	2004-0473
2002-1111	2002-2224	2003-1196	2003-2306	2003-3961	2004-0566
2002-1114	2002-2338	2003-1658	2003-2862	2003-3803	2003-0255
2002-1240	2002-2403	2003-1676	2003-2888	2003-3869	2003-4246
2002-1242	2003-0007	2003-1722	2003-3188	2003-4086	2004-0566
2002-1393	2003-0020	2003-1787	2003-3254	2003-4205	2004-0611
2002-1459	2003-0030	2003-1931	2003-3350	2003-4221	2002-0476

2002-1207	2004-0006	2003-0035	2003-3966	2003-3197-1	2004-1099*
2003-0304	2004-0695	2002-2116	2003-0997	2003-3197-2	2004-1101*
2003-1004	2004-0815	2002-2239	2003-0018	2003-3747	2004-1102*
2003-4028	2003-0740	2003-1649	2003-1536	2004-1271	2004-1112*
2000-1022-1	2003-0293	2003-2352	2003-0022	2001-1383	2004-1125*
2000-1022-2	2003-0648	2003-4176	2003-2408	2002-0803	2004-1140*
2003-2345	2003-0574	2003-4174	1998-0067	2002-0858	2004-1007*
2003-2733	2003-0494	2002-2452	2003-4028	2003-4119-1	2004-1285*
2003-1136	2003-0500	2003-2408	2004-1007	2004-1097*	2004-1325*
2003-1138	2002-2152-1	2002-1677	2004-0032		

Work Orders:

32011495	33014725	33016354	30020666	33020570	28052010
32019423	33016358	32006966	33016359	32011706	30010840
32021918	32007195	32012479	33016356	34004296	34002155
33003475	33016360	33016357	33017152	34004298	34004295
33008994	33016349	33016355	31015780	32004297	

Backlogged Items:

Open PMAIs - CR Related
Open RTS - CR Related
Work Orders Tied to CRs

Non-Cited Violations/LER Reviewed:

NCV 50-250,251/2003-07-01 Failure to Update UFSAR with SBO Mitigation Information
NCV 50-250,251/2003-07-02 Inadequacies in SBO Mitigation Procedures
NCV 50-250,251/2003-05-01 Failure to Identify and Use an Appropriate Acceptance Criteria for the Main Oil Pump Internals Clearances and Main Oil Pump Suction Check Valve Leakage
NCV 50-250,251/2003-04-01 Failure to Maintain Design Documentation to Prevent Inadvertent Loss of Both Trains of AFW Actuation Logic and Relays
LER 50-250/2003-010 3C Charging Pump Tripped On Low Oil Pressure When Placed In Service
LER 50-250/2003-006 Excessive Leakage Through The Closed Letdown Isolation Valves

Operating Experience:

NRC Event Number 40451, CR 04-0381,	Potential Gas Binding of Centrifugal Charging Pump, During Routine 31- Day ECCS Venting
Potential Part 21, CR 04-0105,	Potential Part 21 Notification Associated With Charging Pump Plunger Coating From David Brown Union Pumps Company
CR-04-0300	AFW Pump Recirculation Line Flow Orifices
CR-04-0288	AFW Undersized Pump Shaft
CR-03-2983	AFW Trip and Throttle Valve Cracking
5610-075-DB-001	Flowserve letter dated March 23, 2004
	FPL letter dated February 24, 2004

System Health Reports:

046/CVCS Boron Addition Period 2003-2
 046/CVCS Boron Addition Period 2003-4
 046/CVCS Boron Addition Period 2003-3
 046/CVCS Boron Addition Period 2003-1
 046/047, CVCS (Boric Acid, Charging & Letdown) Period 4th Quarter 2002
 046/047, CVCS (Boric Acid, Charging & Letdown) Period 3rd Quarter 2002
 075, Aux Feedwater Period 2003-4
 019, Intake Cooling Water Period 2003-4

Audits and Self-Assessments:

QAO-PTN-02-005 Corporate QA Audit of Turkey Point Corrective Action Program
 QAO-PTN-03-005 Corporate QA Audit of Turkey Point Corrective Action Functional Area
 QRNo 04-0014 Implementation of Corrective Action Program Improvement Plan
 QRNo 03-0104 Review of Corrective Action Effectiveness for SL-1 CR 02-1692
 QRNo 03-0099 Outage Corrective Action Summary
 QRNo 03-0096 Implementation of Performance Improvement Initiative - Corrective Action Program Plan
 QRNo 03-0052 Effectiveness Review of Corrective Actions from SL-1 CR 02-2332
 QRNo 03-0041 Corrective Action, Use of Trend Only Condition Reports
 QRNo 03-0039 Condition Report Work Orders
 QRNo 03-0036 Degraded and Nonconforming Conditions
 QRNo 03-0015 Operating Experience Feedback Program - Incorporation of Operating Experience into Outage Activities
 QRNo 03-0029 Outage-Related Corrective Action Review
 SA-MGMT 03-01 Corrective Action Program Effectiveness
 SA-PID 03-001 Problem Identification and Resolution

Trend Reports/ Performance Indicators:

Turkey Point Nuclear Power Plant Performance Improvement Indicators
 Turkey Point Plant Health Report 1st Quarter 2002
 Turkey Point Plant Health Report 2nd & 3rd Quarter 2002
 Turkey Point Plant Health Report Annual 2002
 Turkey Point Plant Corrective Action Program Trend Report Annual 2003
 Nuclear Chemistry Human Performance Corrective Action Rollup 2nd Quarter 2003
 Nuclear Chemistry Human Performance Corrective Action Rollup 2nd Quarter 2003
 Nuclear Chemistry Human Performance Corrective Action Rollup 3rd Quarter 2003
 Engineering Department Human Performance Corrective Action Rollup 1st Quarter 2003
 Engineering Department Human Performance Corrective Action Rollup Update 2003
 Health Physics Human Performance Corrective Action Rollup 1st Quarter 2003
 Health Physics Human Performance Corrective Action Rollup 2nd Quarter 2003
 Health Physics Human Performance Corrective Action Rollup 3rd Quarter 2003
 Health Physics Human Performance Corrective Action Rollup 4th Quarter 2003
 Maintenance Department Human Performance Corrective Action Rollup 1st Quarter 2003
 Maintenance Department Human Performance Corrective Action Rollup 2nd Quarter 2003
 Maintenance Department Human Performance Corrective Action Rollup 3rd & 4th Quarter 2003

Operations Department Human Performance Corrective Action Rollup 1st Quarter 2003
Operations Department Human Performance Corrective Action Rollup 2nd Quarter 2003
Operations Department Human Performance Corrective Action Rollup Aug-Dec 2003
Training Department Human Performance Corrective Action Rollup 1st Quarter 2003
Training Department Human Performance Corrective Action Rollup 2nd Quarter 2003
Work Control Department Human Performance Corrective Action Rollup 1st Quarter 2003
Work Control Department Human Performance Corrective Action Rollup 2nd Quarter 2003
Work Control Department Human Performance Corrective Action Rollup 3rd Quarter 2003
Work Control Department Human Performance Corrective Action Rollup 4thQuarter 2003

Miscellaneous Documents:

Operator Workaround Summary, Feb. 12, 2004
Calculation PTN-BFSE-92-004, PTN Units 3 & 4 EDG Loading Charts for use During Eighteen
Month Surveillance Tests, Revision 2
Saint Lucie CRs - CR 2002-3180, CR 2002-3197, CR 2003-0924, CR 2003-2949
Updated Final Safety Analysis Report, Section 9.11 and Section 14.1.11

LIST OF ACRONYMS

ACE	Apparent Cause Evaluation
CFR	Code of Federal Regulations
CR	Condition Report
EDG	Emergency Diesel Generator
FIN	Finding
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PI&R	Problem Identification and Resolution
PMAI	Plant Managers Action Item
RCA	Root Cause Analysis
ROP	Reactor Oversight Process
SBO	Station Blackout
SDP	Significance Determination Process
TP	Turkey Point
TS	Technical Specifications
UFSAR	Updated Final Safety Analysis Report
vac	Volts Alternating Current
vdc	Volts Direct Current
WO	Work Order