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

March 17, 2006

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 050000250/2006007 AND 05000251/2006007

Dear Mr. Stall:

On February 17, 2006, 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 February 17, 2006 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 your corrective action program processes and procedures were effective; thresholds for identifying issues were appropriately low; and problems were properly evaluated and corrected within the problem identification and resolution program (PI&R).

Based on the results of this inspection, one finding of very low significance (Green) was identified involving 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 this finding as a non-cited violation (NCV), consistent with Section VI.A of the NRC Enforcement Policy. If you contest the violation or the significance of the 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.

A lowered threshold for identifying problems was evident by the large number of condition reports entered in the last two years. However, minor problems were noted including; the thoroughness of some problem evaluations; the timeliness of some evaluations; corrective actions which were delayed or incomplete; and a lack of risk assessment for significant maintenance in the switchyard.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC web site at http://www.nrc.gov/reading-rm/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 05000250/2006007 and 05000251/2006007
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

cc w/encl:
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DATE	03/17/2006	03/15/2006	03/15/2006	03/17/2006	03/15/2006	3/ /2006	3/ /2006
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U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.:	05000250, 05000251
License Nos.:	DPR-31, DPR-41
Report Nos.:	05000250/2006007 and 05000251/2006007
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:	January 30-February 3 and February 13-14, 2006
Inspectors:	T. Hoeg, Senior Resident Inspector, Lead Inspector B. Holbrook, NRC Region II Contractor T. Kolb, Resident Inspector C. Patterson, Senior Resident Inspector J. Rivera-Ortiz, Reactor Inspector
Approved by:	Joel Munday, Chief Reactor Projects Branch 3 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000250/2006007, 05000251/2006007; 01/30/2006 - 02/17/2006; Turkey Point Nuclear Plant, Units 3 & 4; Biennial Baseline Inspection of the Identification and Resolution of Problems. A finding was identified in the area of effectiveness of corrective actions.

The inspection was conducted by two senior resident inspectors, a resident inspector, one reactor safety inspector, and a contractor. One Green noncited violation of very low safety significance was identified during this inspection. 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 team concluded that in general problems were properly identified, evaluated, prioritized, and corrected within the licensee's problem identification and resolution program. One exception was noted regarding the failure to identify and implement effective corrective actions to prevent recurring scaffolding installation deficiencies. Additionally, the licensee has been challenged to thoroughly assess and correct the large increase in issues, since the threshold for problem identification was lowered when the new corrective action management program was implemented.

The processes and procedures of the licensee's corrective action program were generally adequate; thresholds for identifying issues were appropriately low, and in most cases, corrective actions were adequate to address conditions adverse to quality. Several negative observations were identified by the team including; an increasing trend in the number of licensee open corrective action items; CAP process timeliness goals not being met; problem evaluations lacking thoroughness for those issues not warranting a root cause or apparent cause evaluation; and a lack of risk assessment for significant maintenance in the switchyard.

Based on discussions and interviews 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 for recurring problems related to the construction of scaffolding in the proximity of safety related equipment. For the examples identified the licensee either removed or adjusted the scaffolding to correct the condition.

  This finding was determined to be more than minor because it was associated with the mitigating system cornerstone attributes of (1) protection against

external factors such as a seismic event and (2) equipment performance such as reliability. In addition, the finding affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance because, while improperly installed scaffolding has the potential to adversely affect mitigation systems, the specific examples identified did not result in an actual loss of safety function of a mitigating system and did not render equipment inoperable due to a seismic event. This finding directly involved a cross-cutting aspect of problem identification and resolution, that being ineffective corrective actions.

B. Licensee Identified Violations

None

REPORT DETAILS

4 OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

The team based the following conclusions, in part, on issues identified during the period, March 26, 2004 (the last biennial problem identification and resolution inspection) to the end of the inspection on February 17, 2006. In addition, the team reviewed problems, for selected systems, which were identified outside this assessment period whose significance might be age dependent.

a. Effectiveness of Problem Identification

(1) Inspection Scope

The inspectors reviewed the licensee's corrective action program (CAP) procedures which described the administrative process for initiating and resolving problems through the use of 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 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 assigned site departments. The inspectors also conducted a detailed review of CRs for four 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 selected were the Auxiliary Feedwater System (AFW), the Emergency Diesel Generator (EDG) including starting air systems, the High Pressure Safety Injection System, and the 240kV Start-Up Transformer and associated switchgear systems. The team reviewed the maintenance history and selected completed Work Orders (WOs) for the four systems as well as the associated system health reports. Additional CRs were selected associated with MR evaluations and problems previously identified by NRC. The inspectors also reviewed issues documented in NRC inspection reports and licensee event reports over the last two years. In addition to the two year review and in accordance with the inspection procedure a five year review was performed for the selected systems for age dependant issues.

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

The inspectors conducted a review of the licensee's Operating Experience (OE) program to verify actions were completed in accordance with licensee procedures NAP-414, Operating Experience Program and EDI-SE-011, Receipt, Processing, and Approval of Vendor Documentation, and regulatory requirements. The inspectors reviewed a sampling of the 60 items the licensee had submitted for OE in 2005 to verify the information accurately reflected the events, were appropriately evaluated, and documented in their CAP. The inspectors also focused on NRC generic communications and OE items associated with the four systems selected for a detailed review.

The inspectors reviewed licensee quality assurance audits, quality assurance quality reports, INPO 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, 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 their CAP. The threshold for initiating CRs was low and employees were encouraged by management to initiate CRs.

The inspectors observed a significant increase in the number of condition reports over the last two years. From 2004 to 2005 almost a 35 percent increase was noted. This appeared to be attributed to site management's reinforcement of the CAP and the use of a newer electronic condition report management system, SITRIS. The team considered the newer SITRIS program to be an improvement from the former system. However, the team noted that the number of issues documented increased faster than expected and the licensee was challenged to complete the required reviews and evaluations in a timely manner and in accordance with program requirements.

The team concluded the CAP related meetings were well attended and participating members seemed to be prepared. Assignment of significance level and investigation types to condition reports appeared to be in accordance with CAP procedures and guidance. In general, there was good discussion and interaction among the group members with an appropriate focus on reactor safety. In some cases the condition report investigation type was changed by the condition report oversight group (CROG) from what was originally decided upon by the corrective action program coordinators (CAPCOs) at the screening meeting. The inspectors noted that there was no formal

process to inform the CAPCOs of the change or the reason. As a result of this lack of feedback, the CAPCOs could inappropriately assess future similar issues in a like manner.

The inspectors also conducted system walkdowns, during which several issues were identified, including examples of improper mechanical fastener thread engagement noted on high head safety injection system flanges and on a Unit 3 emergency diesel generator jacket water pipe hanger. The licensee initiated condition reports 2006-2863 and 2006-4379 respectively and performed operability reviews with engineering analysis on these conditions and concluded the systems were operable. The team also identified examples where scaffolding was improperly erected or in contact with safety related equipment. The scaffolding was either removed or adjusted and condition reports written by the licensee. Scaffolding deficiencies are discussed in more detail in section 4OA2.c. Lastly, the team identified that setscrews associated with the auxiliary feedwater pump linkage were not staked as required by a previous CR corrective action. The inspector determined that a maintenance procedure was supposed to have been revised in 2004 in accordance with CR 2004-10674, however, the revision had been extended multiple times and as a result, the corrective action had not been implemented. Because the setscrews not being staked did not affect operability of the system, the issue was considered minor.

Additionally, the inspectors determined that the licensee was generally effective in appropriately identifying, evaluating, and documenting OE items. However, the inspectors identified a few examples where the licensee's assessment was not thorough and as a result equipment deficiencies or failures occurred. Some of these examples are documented in section 4OA2.b of the report. Additionally, the inspectors identified that the licensee had no formal process to document, trend, or track OE items that had been screened out as "not applicable" by the corrective action program coordinators.

The inspectors reviewed several department self-assessments and QA audits and concluded they were self-critical and effective in identifying areas for improvement. Additionally, issues identified were appropriately entered into the CAP.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The inspectors reviewed condition reports, including root and apparent cause evaluations, site and department trend reports, and observed other activities as 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, including root cause analysis 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, level of effort in the investigation, 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 team concluded that problems were generally prioritized and evaluated in accordance with the licensee's corrective action program guidance and NRC requirements. The team found that in the sample of root cause evaluations reviewed, the licensee was generally self critical and thorough in evaluating the causes of the conditions adverse to quality with appropriate corrective actions taken. The team noted the level of effort and detail devoted to some apparent cause evaluations were equivalent to that required of a root cause analysis as prescribed in licensee procedure NAP-204, "Condition Reporting." In some cases the team felt the extra level of effort in the apparent cause evaluations was necessary to fully evaluate the condition and perhaps the issue should have been initially designated as requiring a root cause evaluation due to it's significance. The inspectors did not find any examples of problem recurrence that were the result of not performing a root cause investigation or a recent example of an issue where it could be concluded that the actual root cause had not been determined.

However, the team concluded that some issues which did not receive an apparent or root cause evaluation lacked enough evaluation to completely resolve the issue or prevent recurrence. Consideration of the extent of the condition, generic implications, common cause, and previous occurrences were not always addressed by the licensee for a number of condition reports reviewed by the team. Additionally, the team noted that many CR evaluations were not conducted in accordance with CAP timeliness requirements. Some examples identified by the team included:

- 2004-261, the licensee documented, in part, that there existed a capacitor aging problem associated with emergency diesel generator (EDG) annunciator panels that affected EDG speed switches. Previous operating experience information regarding capacitor aging failures and recommended preventive maintenance practices were screened out as not applicable by the licensee with no engineering justification. Subsequently, a capacitor failed which rendered the 4A EDG inoperable.

- 2005-17486, the licensee documented, in part, that the 4A emergency diesel generator fuel oil storage tank low alarm had been in an alarm condition for two days. The corrective action section of the CR stated that the condition had been corrected. There was no documentation as to what the problem was or what was done to correct the problem.

- 2005-15115, the licensee documented, in part, that the 4B emergency diesel generator electric air compressor had tripped and breaker 45220 would not go to the Off, Reset, or On position. The CR was assigned to engineering to troubleshoot the equipment failure. The corrective action was to determine the failure mechanism by performing PWO 35012850-01 and to add additional

corrective actions as required. The CR initiated on May 22, 2005, was still open, with a due date of March 27, 2006. After discussions with engineering, the inspectors learned that the CR failed to indicate extensive troubleshooting that had taken place shortly after the compressor tripped and that the compressor had been placed back in service.

- 2005-4705, the licensee documented, in part, that the 3A high head safety injection pump thrust bearing spacer was not identified in plant procedures, drawings, or the vendor manual. The licensee concluded the spacer was installed by the manufacturer during the last pump overhaul for unknown reasons. The CR evaluations determined it to be a non-conforming condition, but operable and not degraded without a clear justification.

- 2005-6339, the licensee documented, in part, that an auxiliary feedwater pump oil pump site glass level was low. The CR evaluation was assigned to evaluate the condition in March of 2005 which was extended 3 times without justification before being completed during this inspection.

- 2004-5818, the licensee documented, in part, that a weakness existed in the formal training of its CAPCO members. The evaluation concluded the CAPCO training was acceptable and that because the St. Lucie and Seabrook Stations did not have a formal training program no corrective action was needed.

- 2005-30813, the licensee documented, in part, that not all switchyard work was evaluated and included in the work week risk assessment and risk monitor. This CR was closed out to CR 2005-30677 which was also closed without correcting the problem. Upon identification by the NRC, the licensee began assessing switchyard activities in the daily risk assessment.

In addition, the team identified examples of evaluations which were incomplete or not otherwise in accordance with program guidelines. As a result, during this inspection period, the licensee implemented another level of closeout reviews by having the performance improvement department (PID) supervisor or assignee review Severity Level 1 and 2 condition reports for completion prior to closeout.

Lastly, the inspectors reviewed the licensee's site and department trend programs and reports to ensure the thresholds were adequate for evaluation of potential trends. No issues were identified.

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The inspectors reviewed a sample of CRs, selected licensee effectiveness reviews, and Work Orders initiated to resolve CRs, 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.

(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. However, for some conditions adverse to quality, the team found examples where corrective actions were not performed in a timely manner or were not adequate to prevent recurrence. The team noted that implementation of corrective actions were often extended which resulted in the backlog of open action items increasing each month. At the end of this inspection approximately 800 open items existed.

Failure to Prevent Recurring Scaffolding Installation Deficiencies Around Safety Related Systems, Structures, and Components

Introduction: The inspectors identified a Green 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 deficiencies associated with their placement of scaffolding around safety related equipment.

Description: On January 31, 2006 and February 7, 2006, during walkdown inspections, the inspectors identified two examples where scaffolding was not installed in accordance with scaffold control procedure 0-ADM-012, Scaffold Control, Sections 5.1.1.2 and 5.2.1.2. Procedure section 5.1.1.2 required installed scaffolding to be a minimum of 2 inches from fragile items including but not limited to valves and instrument lines. Section 5.2.1.2 required an engineering evaluation to be performed when scaffolding was built that cannot meet these requirements. The first example involved scaffolding erected within 2 inches of the Unit 3 Refueling Water Storage Tank (RWST) safety related suction valves (MOV-3-864 A/B). The second example involved scaffolding built around relief valve RV-3-213A that was in contact with an EDG starting air system pipe hanger. The inspectors observed that the pipe hanger had actually been impacted which caused it to deflect along its axis. The team further identified that no engineering evaluations were performed to evaluate these conditions as required by section 5.2.1.2 of the scaffold control procedure. In both cases, the licensee either removed or adjusted the subject scaffolding and initiated condition reports 2006-2863 and 2006-3520 to evaluate the inspection team's findings and initiate interim corrective actions.

To assess past performance in this area, the team reviewed past condition reports associated with improper scaffolding installation and found that on August 31, 2004, the licensee initiated CR 2004-7630 to address corrective actions for several previous scaffold installation deficiencies that resulted in NCV, 05000250, 251/2004004-01. The team determined that the corrective actions taken in 2004 were narrowly focused on the training of the scaffold installers. The ambiguity of the scaffold control procedure regarding scaffolding requirements around fragile equipment was not addressed.

As a corrective action for both scaffold issues described above, the licensee removed the scaffolds and revised procedure 0-ADM-012 to clarify the clearance requirements between scaffolding and plant equipment and also to emphasize the requirement to perform an engineering evaluation when the procedure requirements could not be met. Additionally, the licensee eliminated the definition of "fragile items" and established a minimum clearance requirement of 2 inches for all plant equipment.

Analysis: This finding was determined to be more than minor because it was associated with the mitigating system cornerstone attributes of (1) protection against external factors such as a seismic event and (2) equipment performance such as reliability. In addition, the finding affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance because, while improperly installed scaffolding has the potential to adversely affect mitigation systems, the specific examples identified did not result in an actual loss of safety function of a mitigating system and did not render equipment inoperable due to a seismic event. This finding directly involved a cross-cutting aspect of problem identification and resolution, that being ineffective corrective actions.

Enforcement: 10 CFR, Part 50, Appendix B, Criterion XVI, Corrective Action, states in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to this, when CR 2004-7630 was closed on October 28, 2004, the licensee did not effectively correct a recurring problem with scaffolds being erected in noncompliance with Procedure 0-ADM-012, Scaffold Control, which could potentially affected safety-related components. On January 31 and February 7, 2006, the inspectors identified two scaffolds, over or adjacent to safety related components, which did not comply with installation requirements specified in Procedure 0-ADM-012 and which had not been evaluated as being acceptable. These two scaffold issues were not previously identified by the licensee. Because this finding is of very low safety significance and because it has been entered into the licensee's corrective action program as CR 2006-2863 and CR 2006-3520, this violation is being treated as a NCV, consistent with Section VI.A of the NRC Enforcement Policy: NCV 05000250, 251/2006007-01, Failure to Prevent Recurring Scaffolding Installation Deficiencies. The licensee took immediate corrective action by removing the scaffolding.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

The team randomly interviewed over 40 on-site workers regarding their knowledge of the corrective action program at Turkey Point and their threshold to write condition reports or raise safety concerns. Additionally, 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 team also reviewed the licensee's employee concerns program (ECP). The inspectors also interviewed the ECP Manager and reviewed a select number of ECP reports completed in 2004 and 2005 to verify that concerns were being properly reviewed and identified deficiencies were being resolved and entered into the CAP when appropriate.

(2) Assessment and Observations

Based on this inspection and the CR reviews, 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 also concluded that the Speakout files were complete and adequate.

4OA6 Management Meetings

On February 17, 2006, 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

W. Johns, Security Manager
M. Cornwell, Training Manager
M. Downs, Speakout Manager
A. Pell, Equipment Reliability Manager
R. Earl, Corrective Action Group Supervisor
O. Hanek, Licensing Engineer
D. Sileo, Maintenance Programs Department Head
C. Melchor, Engineering Rapid Response Team Engineer
W. Prevatt, Work Control Supervisor
B. Webster, VP of Operations
T. Jones, Site VP
J. Hamm, Engineering Systems Department Manager
R. Leckey, FPL Speakout Program Manager
B. Johns, Security Manager
M. Navin, Operations Manager
M. Moore, Performance Improvement Department Manager
W. Parker, Licensing Manager
M. Pearce, Plant Manager
B. Stamp, Operations Supervisor
G. Warriver, Site Quality Manager

NRC personnel

C. Casto, Director, Division of Reactor Projects, RII
J. Shea, Deputy Director, Division of Reactor Projects, RII
J. Munday, Branch Chief, Director, Division of Reactor Projects, RII
S. Stewart, Senior Resident Inspector, Turkey Point

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000250, 251/2006007-01	NCV	Failure to Identify and Implement Effective Corrective Actions to Prevent Recurring Scaffolding Installation Deficiencies (4AO2.c)

Attachment

LIST OF DOCUMENTS REVIEWED

Procedures

3-OSP-75.2	Auxiliary Feedwater Train 2 Operability Verification
3-OSP-022-3	Emergency Diesel Generator Fuel Oil Cross-Connection Line Test
3-OP-022-4	EDG Fuel Oil Transfer Pum,p and Valve Inservice Test
3-OP-023	Emergency Diesel Generator
4-OSP-023.1	EDG Monthly Operability Surveillance Test
0-OSP-75.12	AFW Manual Valve Operability Test
4-OP-75	Auxiliary Feedwater System Procedure
NAP-204	Condition Reporting
EDI-ENG-010	System Performance Monitoring
NAP-406	On-Site Review Committee
4-ARP-09	Alarm Response Procedure, EDG Lockout Relay
0-ADM-40	Facility Staff Qualifications
0-ADM-02	Nuclear Speakout Program
0-ADM-533	Condition Report Trending
0-ADM-012	Scaffold Control, Revision 8/1/05
0-CMM-062.1	High Head SIS Pump Rotating Element Replacement, Revision 6/13/05
3-OSP-62.5	Safety Injection Gas Intrusion Valve Testing, Revision 9/02/04
0-ADM-216	PTN and PTF Shared System Work Control and Switchyard Access
0-ADM-215	Online Risk Assessment and Management
0-0N0D- 004.6	Degraded Switchyard Voltage
0-ADM-518	Condition Reports
0-ADM-059	Root Cause Analysis
0-ADM-068	Work Week Management
0-ADM-728	Maintenance Rule Implementation
0-OSP-075.2	AFW Train 2 Operability Verification
3-OP-075	Auxiliary Feedwater System

Miscellaneous Documents

Maintenance Rule Action Plan DG-CR-04-261
OE-16045, EDG Speed Switch Erratic Operation
OE-16119, EDG Voltage spikes
QAO-PTN-03-005, Corrective Action Functional Area Audit
QAO-PTN-04-005, Corrective Action Functional Area Audit
QAO-PTN-05-006, Corrective Action Functional Area Audit
QAO-PTN-05-004, Configuration Management Functional Area Audit
QAS-CA-05-01, Quality Assurance Audit Report
Corrective Action Program Trend Report, 3rd Quarter 2005
Corrective Action Program Coordinator Mentoring Guide
Vendor Information Bulletin 04-41, Susceptibility of Synchro-Start ESSB to DG Noise
MPR-2299, Replacement Interval and Shelf Life of Electrolytic Capacitors, 2001
TSA-04-04-023-06, Alternate Method of Supplying 120 volt AC 60 Hz to PS-a for 4A EDG
SPEC—004, Maintenance Bolting Specification for Turkey Point Units 3&4
PTN Daily Quality Summary, 1/17/2006

Turkey Point Condition Report Trending Guideline, ½7/2006
System 02/240 kV Switchyard 2004 4th Quarter Health Reports
System 02/240 kV Switchyard 2005 4th Quarter Health Reports
INPO Report July 2004 Evaluation
Turkey Point Plant Root Cause Evaluation Handbook
Turkey Point Plant Apparent Cause Evaluation Handbook
Turkey Point SOER 02-04 Self Assessment
SPEC-04, “Maintenance Bolting Specification for St. Lucie Units 1 & 2 and Turkey Point Units 3 & 4," Revision 10
SA-PID 03-001,Problem Identification and Resolution Assessment

Condition Reports:

2001-01305	2004-03535	2004-10326	2005-05662	2005-15820	2005-28825
2001-01387	2004-03587	2004-10451	2005-05758	2005-16403	2005-28829
2001-02463	2004-03840	2004-10467	2005-06339	2005-16678	2005-28930
2002-00115	2004-04035	2004-10674	2005-06561	2005-16931	2005-29054
2003-00885	2004-04071	2004-10880	2005-06844	2005-17117	2005-29696
2003-01821	2004-04117	2004-11011	2005-07352	2005-17134	2005-30677
2003-02102	2004-04406	2004-11609	2005-08033	2005-17256	2005-30774
2003-02103	2004-04843	2004-11867	2005-08704	2005-17486	2005-30813
2003-02104	2004-04965	2004-12567	2005-08720	2005-18289	2005-31532
2003-02105	2004-05431	2004-13573	2005-09700	2005-19070	2005-32191
2003-02174	2004-05818	2004-15431	2005-09711	2005-19143	2005-32226
2003-02349	2004-05820	2004-15477	2005-09878	2005-19383	2005-32416
2004-00032	2004-05821	2004-15565	2005-09985	2005-20282	2005-32667
2004-00179	2004-05822	2004-16338	2005-10218	2005-20624	2005-32883
2004-00261	2004-05827	2004-17314	2005-10558	2005-20853	2005-33566
2004-00273	2004-05911	2004-17483	2005-11514	2005-21104	2005-33855
2004-00361	2004-06130	2004-17819	2005-11906	2005-21798	2005-33873
2004-00412	2004-06288	2004-17947	2005-11946	2005-22253	2005-34562
2004-01008	2004-06306	2004-20869	2005-12031	2005-22811	2005-34623
2004-01052	2004-06356	2004-30593	2005-12049	2005-23465	2005-34636
2004-01316	2004-06824	2005-00152	2005-12291	2005-23545	2005-34862
2004-01432	2004-06939	2005-01480	2005-12766	2005-23700	2005-35178
2004-01469	2004-07424	2005-02646	2005-13590	2005-23701	2005-35223
2004-01644	2004-07613	2005-02783	2005-13777	2005-24286	2006-00046
2004-01650	2004-07630	2005-03467	2005-13787	2005-24355	2006-00166
2004-02096	2004-08132	2005-04027	2005-14036	2005-25358	2006-00327
2004-02357	2004-08371	2005-04705	2005-14071	2005-25655	2006-00338
2004-02412	2004-08512	2005-04868	2005-14274	2005-26052	2006-00365
2004-02571	2004-08598	2005-04909	2005-14308	2005-27921	2006-00719
2004-02746	2004-08622	2005-04965	2005-14339	2005-28019	2006-01245
2004-03137	2004-08773	2005-05315	2005-14467	2005-28026	2006-01250
2004-03230	2004-08902	2005-05328	2005-14648	2005-28354	2006-01319
2004-03253	2004-09420	2005-05414	2005-15115	2005-28636	2006-01344
2004-03361	2004-10034	2005-05434	2005-15585	2005-28656	2006-01515

2006-02295	2006-02580	2006-02916	2006-03209	2000-00801	2006-04583
2006-02302	2006-02863	2006-03161	2006-03812	2006-04460	
2006-02307	2006-02915	2006-03179	2006-04379	2006-04571	

Work Orders:

32017703	34010920	34018335	35007399	35013839	35020177
33030122	34011774	34018340	35010215	35015344	35020308
34009265	34015275	34019650	35010216	35015602	35021570
34009287	34015295	35005460	35012490	35015623	5015705
34009289	34018100	35006890	35012834	35016875	
34009294					

Non-Cited Violations, Findings, and LERs Reviewed:

NCV 50-250,251/2003-07	Failure to Update UFSAR with SBO Mitigation Information Service
NCV 50-250/2005-04	Inadequate Installation of a Seal Assembly Resulted in an Oil Fire and Reactor Trip
NCV 50-250/2005-04	Inadequate Technical Specification Guidance to a Vendor Cause Cooling Water Gasket Failure That Affected Safety Equipment and Resulted in a Reactor Trip
NCV 50-250,251/2004-05	High Head Safety Injection Pump Inoperable Due to Increase in Previously Identified Oil Leak
NCV 50-250,251/2003-11	Failure to Implement Adequate Test Controls
NCV 50-250,251/2004-11	Failure to Use Adequate I&C Procedures for Refurbishment of Westinghouse Modules
NCV 50-250/2004-06	Failure to Identify and Implement Effective Corrective Actions to Prevent Recurring Charging Pump Functional Failures
FIN 50-250,251/2004-06	Identification and Resolution of Problems
LER 50-251/2005-005	Loss of Offsite Power Causes Engineered Safety Feature Actuations
LER 50-250/2003-006	Excessive Leakage Through The Closed Letdown Isolation Valves
LER 50-251/2005-005-00	Loss of Offsite Power Causes Engineered Safety Features Actuations

System Health Reports:

Unit 3 and 4 High Head Safety Injection System 2004, 2005 Quarters 1 thru 3
Unit 3 and 4 Auxiliary Feedwater System 2004, 2005 Quarters 1 thru 3
240 kV Offsite Power System 2004, 2005 Quarters 1 thru 3
Unit 3 and 4 Emergency Diesel Generator System 2004, 2005 Quarters 1 thru 3

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