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U.S. Nuclear Regulatory Commission
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St. Lucie Nuclear Plant, Unit 2
Docket No. 50-389
Reply to a Notice of Violation; EA-05-009

Florida Power & Light Company (FPL), the licensee for the St. Lucie Nuclear Plant, hereby submits the following reply to the above-referenced Notice of Violation.

Please contact us if there are questions regarding this submittal.

Sincerely yours,

J.A. Stall
Senior Vice President and
Chief Nuclear Officer

cc: Regional Administrator, Region II
NRC Resident Inspector, St. Lucie Nuclear Plant

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FLORIDA POWER & LIGHT COMPANY
ST. LUCIE NUCLEAR PLANT, UNIT 2
DOCKET NO. 50-389
RESPONSE TO A NOTICE OF VIOLATION

Statement of Violation

St. Lucie Technical Specifications, Section 6.8.1(a), states in part, that written procedures shall be established, implemented and maintained covering the applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Revision 2, February 1978. Section 1, "Administrative Procedures" requires procedures be implemented covering procedure adherence and equipment clearance control.

St. Lucie Administrative Procedures, ADM-08.02, Conduct of Maintenance, Section 6.6, states in part that conduct of maintenance activities requires verification of clearance and procedure compliance.

Instrumentation Maintenance Procedure IMP-66-06, CEA System Meggering Coil and Resistance Testing, Revision 3, requires that prior to the performance of a megger test, the Nuclear Plant Supervisor be briefed on the objectives and scope of the work to be performed and a clearance is to be obtained for the system to be tested.

Contrary to the above requirements, the licensee failed to comply with the requirements established for the conduct of maintenance. Specifically, on May 26, 2003, megger testing was performed on the Control Element Assembly System without obtaining authorization from the Nuclear Plant Supervisor following an appropriate briefing and without obtaining the required clearance.

1. Reason for the Violation

Florida Power & Light Company concurs that the cited violation occurred as stated in the Notice of Violation.[1]

The violation occurred as a result of intentional actions by a Nuclear Digital Specialist (the Technician) in the Instrumentation and Controls Department (I&C). The Technician deliberately failed to adhere to plant procedures. Specifically, on May 26, 2003, the Technician performed megger testing on the Control Element Drive Mechanism Control (CEDMC) system without obtaining (1) a clearance on the CEDMC system, (2) a work order, or (3) informing anyone in

[1] Please note that the events in question occurred during the Spring 2003 Unit 2 refueling and maintenance outage and occurred in the Unit 2 CEDMCS room. The Notice of Violation references St. Lucie Unit 1.

management or in the Operations Department of his intended actions. The Technician's actions were entirely of his own initiative. There were no willful actions on the part of FPL supervisory or licensed personnel.

The Technician's actions violated FPL requirements. FPL's plant procedures incorporate safety directives, letters of instruction, and safe work practice rules. Contrary to these requirements, the Technician disregarded these procedures when he performed the megger testing on the CEDMC system on May 26, 2003.

2. Corrective Steps Taken and Results Achieved

Upon discovery of the Technician's actions on May 26, 2003, a first-line I&C Supervisor immediately confronted the Technician, who admitted that he had performed the megger test in the CEDMC room without a proper equipment clearance or work package. The first-line supervisor promptly coached and counseled the Technician on his improper actions. In addition, the Acting I&C Department Manager later wrote a Condition Report documenting that the megger testing by the Technician had violated company procedures. The Acting I&C Manager then conducted an all hands briefing for I&C personnel to remind them of the importance of obtaining work orders prior to performing work. The Acting I&C Manager also coached and counseled the Technician, reiterating that the Technician's actions contravened company expectations, and emphasized management's expectations for his performance in the future. As explained below, these steps did not meet senior management's expectations of the proper response to the actions that led to the violation.

3. Corrective Steps Taken to Avoid Further Violations

FPL has taken further corrective steps to avoid further similar violations.

On March 1, 2005, FPL's Senior Vice President, Nuclear and Chief Nuclear Officer (CNO) distributed a memorandum to all Nuclear Division personnel summarizing the basis for the NOV, and declaring that this violation of plant procedures is unacceptable. The CNO emphasized that his expectation of all FPL Nuclear Division employees is that they will never start work until they understand the work and how to do it safely. The CNO further informed all personnel that "[a]ny employee who deliberately violates a plant procedure will be subject to severe disciplinary action, up to and including termination of employment. Likewise, any supervisor or manager that knows of such behavior and fails to immediately notify senior management of such behavior will also face severe disciplinary action, up to and including termination of employment."

Senior FPL Nuclear Division management also met with representatives of the International Brotherhood of Electrical Workers, System Council U-4, the bargaining unit of which the Technician is a member. During those meetings FPL's management summarized the events leading up to the

NOV, and indicated that FPL will be taking a more aggressive response to such events in the future. FPL's management asked that the union reiterate to its membership that maintaining a safe workplace is the highest priority at FPL, and that employees must abide by FPL procedures at all times.

Furthermore, senior St. Lucie Plant management and representatives from the FPL Human Resources (HR) department met with the Technician to review the NOV with him, and to reemphasize that his conduct on May 26, 2003 was unacceptable. FPL emphasized that the Technician is expected to strictly follow plant procedures at all times. A copy of the NOV was placed in the Technician's personnel file, and the Technician was warned that any future failure to strictly comply with plant procedures will result in disciplinary action, up to and including termination of his employment with FPL.

Finally, the St. Lucie Site Vice President (SVP) and Plant General Manager (PGM) met with members of the Technician's reporting chain – the first and second line supervisors – to review the NOV and to emphasize that the serious nature of the Technician's actions warranted a more aggressive response on the part of supervision at the time of the incident. The SVP and PGM explained that members of the management team are expected to strictly reinforce FPL's expectations in the use of safe working practices and safety rules, and warned that future failures by supervision to timely address such violations in an appropriate manner will result in disciplinary action, up to and including termination.

4. Date When Full Compliance Was Achieved

Full compliance was achieved on March 1, 2005, when all of the above actions were completed.