FPL Energy Point Beach, LLC, 6610 Nuclear Road, Two Rivers, WI 54241

FPL Energy
Point Beach Nuclear Plant

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U.S. Nuclear Regulatory Commission
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Point Beach Nuclear Plant, Units 1 and 2
Dockets 50-266 and 50-301
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Response to NRC 2008 Mid-Cycle Assessment Letter

Reference: NRC to FPL Energy Point Beach Letter Dated September 2, 2008, "Mid-Cycle Performance Review and Inspection Plan," (ML082460289)

The referenced letter provides a mid-cycle assessment of the safety performance of the Point Beach Nuclear Plant (PBNP) for the period January 1 to June 30, 2008 ("2008 mid-cycle letter"). Specifically, the 2008 mid-cycle states that it is the third consecutive assessment letter which identifies a substantive cross-cutting issue in human performance, and the second consecutive assessment letter identifying a substantive cross-cutting issue in problem identification and resolution.

The 2008 mid-cycle requests that FPL Energy Point Beach provide a written response within 30 days of receipt of the letter that addresses the identified substantive cross-cutting issues. The NRC Staff requested that the response include the causal evaluations, action plans, and timetables to address the issues and demonstrate sustainable performance in these areas. The enclosure to this letter provides the required FPL Energy Point Beach response.

Please contact Mr. James Costedio at 920/755-7427 if you have questions or require additional information.

There are no new or revised regulatory commitments contained in this letter.

Very truly yours,

FPL Energy Point Beach, LLC

Larry Meyer
Site Vice President

Enclosures

ENCLOSURE

FPL ENERGY POINT BEACH, LLC
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

RESPONSE TO
2008 MID-CYCLE PLANT PERFORMANCE REVIEW REPORT
SUBSTANTIVE CROSS-CUTTING ISSUES

Background

On September 2, 2008, the NRC staff provided a mid-cycle assessment of the safety performance of the Point Beach Nuclear Plant (PBNP) for the period January 1 to June 30, 2008. Specifically, the letter stated that the 2008 mid-cycle assessment is the third consecutive assessment letter identifying a substantive cross-cutting issue in the human performance area and the second consecutive assessment letter identifying a substantive cross-cutting issue in the problem identification and resolution area.

The mid-cycle assessment letter further stated that the substantive cross-cutting issue associated with the aspect of inadequate documentation, H.2(c), continued during the assessment period with only a nominal decrease in the number of findings and that a second theme related to human performance in the aspect of non-conservative decision making, H.1(b), was also identified, with five total findings associated with this aspect during the 12-month assessment period. Of the five non-conservative decision making findings, three were primarily associated with the Operations organization. The letter's discussion of the human performance issue also stated that the development of causal evaluations and implementation of corrective actions continue to be ineffective in demonstrating sustainable performance in the H.2(c) and H.1(b) areas.

The mid-cycle assessment of PBNP performance also stated that the substantive cross-cutting issue associated with the aspect of timely and effective corrective actions, P.1(d), continued during the assessment period and that the number of findings remained constant with a lack of progress in this aspect.

The 2008 mid-cycle requests that FPL Energy Point Beach provide a written response within 30 days of receipt of the letter that addresses the identified substantive cross-cutting issues. The NRC Staff requested that the response include the causal evaluations, action plans, and timetables to address the issues and demonstrate sustainable performance in these areas.

The following discussion provides the FPL Energy Point Beach response.

FPL Energy Response

Human Performance Substantive Cross-Cutting Issues

H.1(b), Conservative Assumptions

A root cause evaluation (RCE) was performed for the five findings comprising this substantive cross-cutting issue. Two of the findings were identified during the first half of the current 12-month assessment period and dealt with engineering issues that occurred in 2007. The results of an FPL Energy Point Beach common cause evaluation showed that the two engineering findings had a recurring theme regarding inadequate operability recommendations. Both of the operability recommendations were not sufficiently comprehensive and needed to be revised and/or supplemented.

Three of the findings were identified during the second half of the 12-month assessment period; specifically during the U2R29 outage, and dealt with non-conservative decision making by the Operations staff.

The RCE concluded that standards for adhering to strong principles for operational decision making needed improvement.

The following immediate and interim corrective actions were taken:

1. Apparent cause evaluations were performed for the two engineering operability recommendation-related non-cited violations that occurred during the first half of the current 12-month assessment period. Corrective actions associated with these events have been completed.

2. Site-wide stand-downs were conducted on April 25-26, 2008, and written communications were issued in response to the operational event associated with failure to maintain containment closure during the Unit 2 core reload. These communications emphasized the lessons learned from the event.

3. Following the containment closure event, walkdowns were conducted of the Unit 2 residual heat removal system and support systems, with operability being verified.

4. Operations Managers provided additional oversight during the remainder of the U2R29 outage.

5. The Operations Manager led a conservative decision making discussion during the spring licensed operator requalification training cycle.

6. Procedures for operation of the plant with a reduced inventory in the reactor coolant system (RCS) were revised to eliminate ambiguity regarding use of instruments provided for RCS level indication.

7. The FPL fleet Operational Decision Making procedure (ODMI) was adopted at PBNP on August 15, 2008.

8. The FPL fleet Operability Determination procedure was adopted at PBNP on August 22, 2008. Prior to adoption of the fleet procedure, reviews of operability determinations were performed by the corporate Engineering chiefs organization to improve product quality.

9. A meeting was held between site senior management and the Shift Managers on September 15, 2008. This meeting aided in driving understanding of the issues and acceptance of the needed behavior changes vertically in the Operations organization.

The following results have been achieved:

1. There have been no further events that have occurred to date that have resulted in findings associated with this cross-cutting aspect.

2. The revised ODMI process has been used effectively to address several operational issues. An example is a high temperature condition that occurred in the station battery and inverter room in August 2008.

3. There have been several recent instances of note where the station exercised conservative operational decision making practices. These included a power reduction on Unit 1 in early June to repair a potential crack in the condensate pump seal water return injection line; declaring the P-32B service water pump inoperable on September 26 when it was identified there was a small movement of the pump base; and reducing the power level of both units over the weekend of September 26 when it was identified in the corrective action program that the current feedwater operating temperatures appeared to exceed the assumptions in the accident analyses.

The following additional corrective actions will be taken:

1. Operations Managers will provide senior management day and night oversight coverage during the upcoming Unit 1 refueling outage.

2. Operations peer personnel, external of PBNP, will provide additional support to the site operators during the upcoming U1R31 outage by observing and mentoring site Operations on conservative decision making.

3. An initial dynamic evaluation activity (DEA) will be developed and administered on operational decision making. The initial training will be provided to personnel who are enrolled in the supervisory leadership development program (SLDP) and higher. The SLDP population includes all supervisors and managers. The training is scheduled to be developed and administered by 3Q09.

Closure Effectiveness Measures and Timetable:

- Sound and conservative decisions during U1R31 (Fall 2008) refueling outage - December 2008.

H.2(c), Documentation

An RCE was performed during the second half of 2007 when the cross-cutting aspect associated with Documentation was initially identified and documented in the 2007 mid-cycle assessment letter.

When additional events associated with documentation/procedures continued to occur, a follow-up investigation revealed that the original evaluation did not appropriately address the aspect of human performance associated with documentation, and specifically, with procedure quality. Accordingly, another RCE was chartered to address the specific substantive cross-cutting documentation aspect, with emphasis on procedure quality.

The RCE concluded that detail and rigor in documentation, primarily in maintenance procedures, for the installation, overhaul, and refurbishment of safety-significant plant equipment, are not sufficient.

The following immediate and interim corrective actions have been taken:

1. DEAs for procedure use and adherence have been conducted. Over 280 station personnel participated in these DEAs.

2. Training on the use of "not applicable" (N/A) in procedures has resulted in no additional identified findings associated with inappropriate use of "not applicable" in performance of Maintenance procedures since the training was conducted.

3. Senior craft level maintenance personnel, who possess critical knowledge, skills and abilities, are performing reviews of new procedures and procedures that are going to be used by site contractor personnel during the upcoming U1R31 outage.

4. Procedure processes were revised to correct existing flaws and inefficiencies.

5. Maintenance management has reinforced expectations for performance of job walkdowns that include critical step identification, use of the pre-job brief database, performance of post-job briefs and feedback to the procedure processes.

The following results have been achieved:

1. Workers are demonstrating the desired behavior of stopping work in the field when they are uncertain as to how to proceed forward.

2. Initiation of procedure change requests has significantly increased. There has been a commensurate increase in the number of procedure-related corrective action documents as well as an increase in the number of procedure temporary change requests.

3. Results from observations of work in the field have determined that there has been a decrease in the number of procedure-related issues affecting work activities.

4. The dynamic evaluation activity has served to increase station awareness of the opportunities to correct procedures prior to use.

5. Observations of work in the field by Nuclear Oversight have been mostly positive regarding worker behaviors in stopping to have procedure issues addressed.

The following additional corrective actions will be taken:

1. Maintenance senior craft personnel will review procedures associated with the installation, overhaul and refurbishment of safety-significant plant equipment to identify improvements that will enhance the detail and rigor of these documents. This activity will include development of a milestone schedule that supports timely completion of revisions. This action will be completed by 2Q09.

2. The site's "Coach the Coach" observation and feedback program will be extended to include lead craft level personnel in the Maintenance department. This will enhance the quality of field observations and reinforce the human performance tool that personnel "stop when unsure" during conduct of field activities. It is planned that this program change will be implemented by 1Q09.

3. Training on the reverse pre-job concept will be developed and administered by 2Q09. This format will reinforce engagement of craft and supervisory personnel in the field.

4. Procedure change requests will be prioritized to align with the work management process so procedure revisions are completed prior to walk-down in the field to support planned work. This action will begin following completion of the upcoming Unit 1 refueling outage. The action will enable additional document revisions, if required, to be made prior to work being performed.

Closure Effectiveness Measures and Timetable:

- Procedures enhancement backlog reduced by approximately 50% - 4Q08

- Satisfactory appraisal of quality of upgraded procedures monitored for errors using KPI - 2Q09

Problem Identification and Resolution Cross-Cutting Issue

P.1(d), Corrective Action

A common cause evaluation was performed in December 2007 when the station identified a third example of weaknesses in problem identification and resolution aspect P.1(d), associated with timely and effective corrective actions. Actions taken as a result of this causal evaluation did not result in sustainable improvements in corrective action program performance. There have been five additional findings identified as associated with this aspect, bringing the total to eight. Accordingly, an RCE was performed to address the root and contributing causes for the lack of sustainable progress in this area.

The RCE concluded that station management has not provided the training, focus, accountability, and oversight necessary to effectively implement the corrective action program (CAP).

The following immediate and interim corrective actions have been taken to date:

1. Positive feedback is being provided to individuals who exhibit strong CAP implementation behaviors.

2. Corrective actions coming due within the next week are provided at the station's senior management meeting on a weekly basis (Plan of the Day).

3. Work-down curves for CAP backlogs have been developed. These work-down curves are being monitored by the Performance Improvement Department to ensure that actions are being closed as projected.

4. The Site Vice President conducted a corrective action program "breakthrough" meeting on September 11, 2008. At this meeting, the Site Vice President communicated going-forward expectations for CAP performance. Attendees at this meeting included managers, supervisors and departmental CAP personnel, including IST members.

5. The FPL two-tiered approach to CAP screening was adopted and implemented. The two-tiered approach features the following:

   A. An Initial Screening Team (IST) screens each CAP document to identify whether it is a condition adverse to quality.

   B If it is quality-related, the issue's relative significance from both a quality and a nuclear safety viewpoint is determined.

   C. The initial screening recommends the level of causal evaluation required, if appropriate, or corrections if an evaluation is not required.

   D. Alternatively, the initial screening may determine whether the issue can be closed with no action or pursued outside of the CAP as a non-CAP activity.

   E. During initial screening, additional information is obtained, if required, in order to effectively recommend follow-on activities.

   F. Following IST activities, CAP documents are reviewed by the Management Review Committee (MRC) where the recommendations of the IST are accepted, returned for additional work by the IST, or modified.

6. Daily feedback is provided to CAP initiators following screening by the MRC via an e-mail that summarizes the results of the MRC review and disposition of each CAP.

7. A corrective action status report is provided each day at the station's senior management meeting. At this meeting, significant CAPs affecting safety-related equipment and CAPs that focus upon sensitive issues are also presented and discussed by the senior management team.

8. Root and apparent cause evaluations are reviewed by the station senior managers at weekly corrective action review board (CARB) meetings before acceptance of the evaluations and closure of the actions.

9. A departmental level corrective action program health report is reviewed on a weekly basis at the station's senior management meeting.

10. Nuclear Oversight has initiated reviews of selected corrective actions to assess the quality of the closeouts.

11. New metrics have been established and implemented to monitor CAP at the departmental level as well as the site level.

The following results have been achieved:

1. There is a continued low threshold and a high CAP initiation rate.

2. There has been a 90% reduction in the total number of overdue CAP assignments.

3. Several long-standing issues have been addressed. These issues have included an aging station battery being replaced, the cabling for the 2X04 high voltage station auxiliary transformer being routed above the ground to eliminate concerns for failure associated with submergence in water; Unit 2 rod position indication being repaired; and Unit 2 control rod drive mechanism shroud fans being repaired.

The following additional corrective actions will be taken:

1. Training, along with testing to demonstrate knowledge retention, will be developed and administered to cause evaluators, reviewers and approvers of evaluations and corrective actions. In order to maintain consistency and quality of evaluations, a limited population of the site staff will become "evaluation qualified." These actions are currently scheduled to be completed by 2Q09.

2. An ACE review board will be established to review apparent cause evaluations and selected condition evaluations by 4Q08.

3. Departmental corrective action review boards will be established to review department quality and metrics associated with implementation of CAP. This action has been implemented already by some departments and is scheduled to be fully implemented by 4Q08.

4. Process changes to support the corrective actions contained in the RCE will be implemented by 4Q08.

5. Management performance appraisal criteria for CAP quality and timeliness will be implemented in the performance plans for managers and directors by 1Q09.

Closure Effectiveness Measures and Timetable:

- Corrective Action Review Board acceptance rate sustained for three months - 85% or greater

- Average age of evaluations and actions:
  - Evaluations ≤30 days
  - Corrective actions ≤135 days

- The above actions will be complete in 2Q09

Conclusions

FPL Energy Point Beach is committed to resolving these cross-cutting issues. The actions to address these cross-cutting aspects are captured in the corrective action program and will be monitored by the management team. FPL Energy Point Beach expects to demonstrate sustainable performance in these areas by 2Q09.