



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

November 5, 2009

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

SUBJECT: PUBLIC MEETING SUMMARY – FLORIDA POWER AND LIGHT COMPANY –  
ST. LUCIE AND TURKEY POINT NUCLEAR PLANTS – 05000335, 05000389  
AND 05000250, 05000251

Dear Mr. Nazar:

This refers to the meeting conducted at our request at the Region II Office in Atlanta, Georgia on October 20, 2009. The purpose of the meeting was to discuss the Florida Power and Light Company processes for addressing employee concerns. Enclosed are a list of attendees and the presentation handouts.

The discussions focused on the following topics: Current Situation, Overview Timeline, Recent History, Root Cause Approach, Analytical Methods, Summary of Results, Causes and Corrective Actions, Effectiveness of Past Actions, Communications Plan, and Summary of Key Corrective Actions. The meeting was informative and did not result in any specific action items or decisions.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter will be available electronically for public inspection in the NRC Public Document Room (PDR) or from the Publicly Available Records (PARS) component of 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).

Should you have any questions concerning this meeting, please contact me at 404-562-4629.

Sincerely,

/RA/

Marvin D. Sykes, Chief  
Rector Projects Branch 3  
Division of Reactor Projects

Docket Nos.: 50-335, 50-389 and 50-250, 50-251  
License Nos.: DPR-67, NPF-16 and DPR-31, DPR-41

Enclosures: 1. List of Attendees  
2. Handout- Addressing Employee Concerns

cc w/encls: See page 2

cc w/encl:

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Site Vice President  
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cc w/encl. (continued next page)

cc w/encl. (continued)  
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Robert J. Hughes  
Plant General Manager  
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Eric Katzman, Licensing Manager  
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Faye Outlaw, County Administrator  
St. Lucie County  
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Jack Southard, Director  
Public Safety Department  
St. Lucie County  
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## LIST OF ATTENDEES

### Nuclear Regulatory Commission (NRC)

L. Reyes, Regional Administrator, Region II (RII)  
V. McCree, Deputy Regional Administrator, RII  
L. Wert, Director, Division of Reactor Projects (DRP), RII  
K. Kennedy, Director, Division of Reactor Safety (DRS), RII  
O. DeMiranda, Senior Allegation Coordinator, EICS, RII  
L. Jarriel, Agency Allegation Advisor, Office of Enforcement  
M. Sykes, Chief, Reactor Projects Branch 3 (RP3), DRP  
T. Hoeg, Senior Resident Inspector, St. Lucie, RII \*  
S. Stewart, Senior Resident Inspector, Turkey Point, RII \*  
J. Hamman, Project Engineer, RP3, DRP, RII  
M. Checkle, Allegation Coordinator, EICS, RII  
J. Dymek, Reactor Inspector, DRS, RII  
D. Merzke, Acting Branch Chief, RP7, RII

### Florida Power and Light (FP&L)

M. Nazar, Senior Vice President Nuclear and Chief Nuclear Officer, FP&L  
G. Johnston, Site Vice President, St. Lucie, FP&L  
M. Kiley, Site Vice President, Turkey Point, FP&L  
R. Kundalkar, Vice President, Fleet Organizational Support, FP&L  
D. Lowens, Director Nuclear Assurance, FP&L  
G. Hollinger, Manager Projects, FP&L  
H. Casper, Senior Staff Engineer, FP&L  
M. Ross, Vice President, General Counsel – Nuclear, FP&L  
R. Anderson, Vice President, Nuclear Plant Support, FP&L

### Public Attendance

Two members of the Public \*

\*Teleconference call



**FPL**

# Addressing Employee Concerns

**October 20, 2009**

## FPL Attendees

- Mano Nazar Chief Nuclear Officer
- Gordon Johnston Vice President, St. Lucie
- Mike Kiley Vice President, Turkey Point
- Raj Kundalkar Vice President, Fleet Organizational Support
- Dave Lowens Director, Nuclear Assurance
- Gary Hollinger Manager Projects
- Hugh Casper Senior Staff Engineer
- Mitch Ross Vice President, General Counsel - Nuclear



## Agenda

- Opening Remarks
- Current Situation
- Overview Timeline
- Recent History
- Root Cause Approach
- Analytical Methods
- Summary of Results
- Causes and Corrective Actions
- Effectiveness of Past Actions
- Communications Plan
- Summary of Key Corrective Actions
- Closing Remarks



## Current Situation

- Employees have respect for nuclear safety
- FPL is committed to safe and reliable operation of our nuclear plants
- Current activities did not identify any nuclear safety issues requiring immediate action



## Overview Timeline

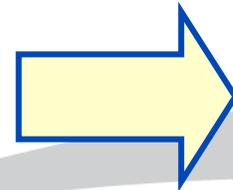
1995 – 2007 Cyclic  
ECP Performance

2008 Employee  
Engagement  
Survey

2008 Survey Analysis  
and Corrective  
Actions

NRC Allegations  
Continue, Internal  
Avenues Bypassed

2009 Root Cause



## Recent History

- 2008 employee engagement survey issues
  - Ability to challenge management decisions
  - Management expectation for nuclear safety v. performance reward system
  - Effectiveness of the corrective action program
  - Effectiveness of the employee concerns program
- Action plans established for St. Lucie, Turkey Point, and ECP
- Action plans reviewed by SCWE industry expert (Rail - 8/09)
- Implementation of actions still in progress
- FPL determined additional actions and a broader review of NSC required



## Root Cause Approach

- FPL developed a charter to complete a root cause evaluation investigating recent feedback on employee concerns
- The root cause evaluation focused on the following areas:
  - Effectiveness of the corrective action program
  - Effectiveness of the employee concerns program
  - Effectiveness of senior management



## Root Cause Approach

- The root cause team composition included:
  - Root cause team
    - Juno Beach lead, with site support teams representing both bargaining/non-bargaining employees, and contract personnel at St. Lucie and Turkey Point
    - Supported by three independent root cause experts
  - Internal oversight
    - FPL executive team to monitor progress of the root cause activities
  - Consultation with ex-nuclear executive
  - Consultation with former senior NRC official
  - Employee concerns program expert report used in root cause evaluation

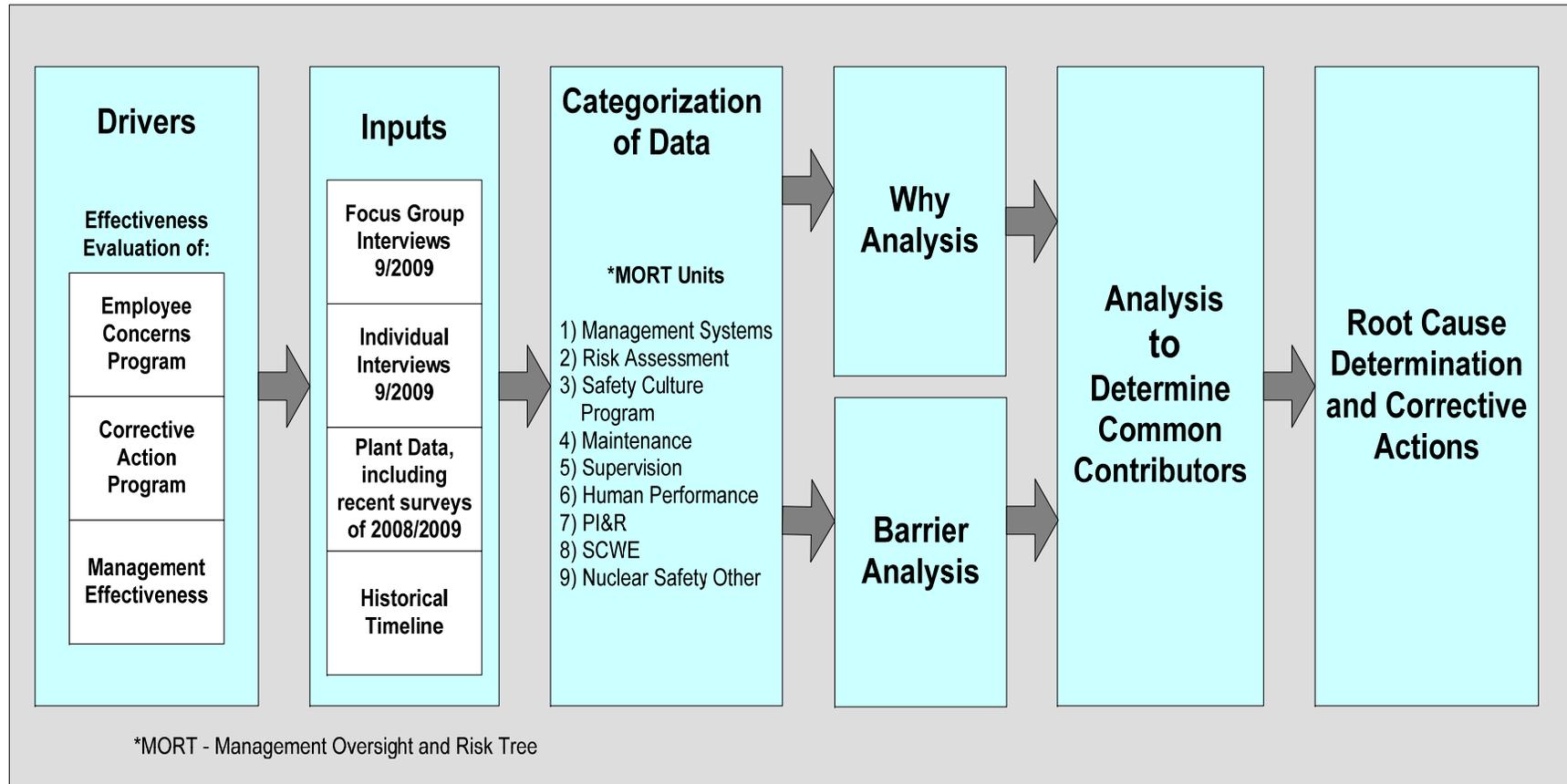


## Analytical Methods

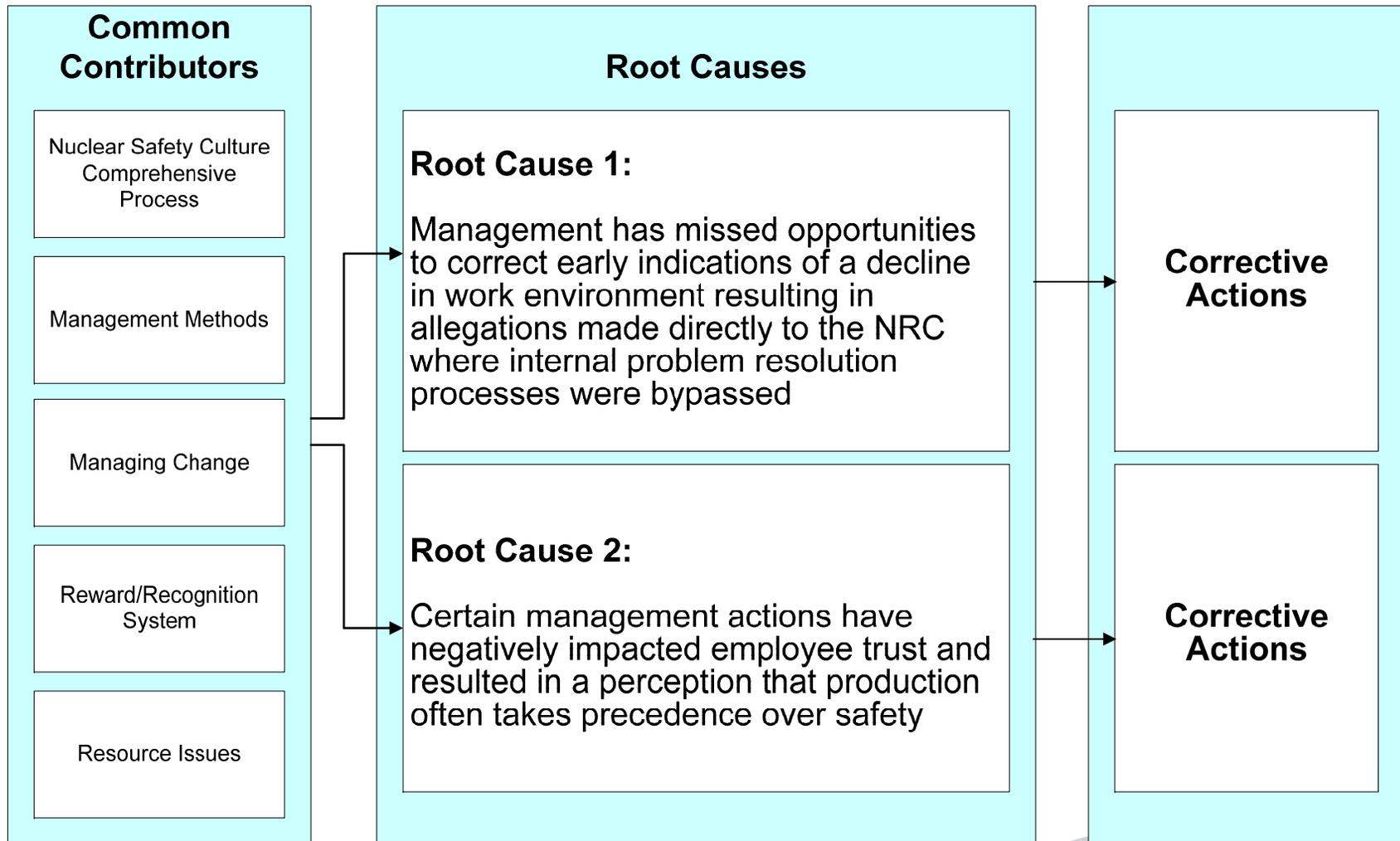
- Root cause evaluation used:
  - Management oversight and risk tree (MORT)
    - Management oversight and risk tree questions
    - Safety culture supplement to MORT questions
    - NRC Inspection Manual Chapter 0305
  - Why staircase analysis
  - Barrier analysis



# Analytical Methods



# Summary of Results



## Causes and Corrective Actions

### Root Cause 1

Management has missed opportunities to correct early indications of a decline in work environment resulting in allegations made directly to the NRC where internal problem resolution processes were bypassed

Contributing Causes	Key Corrective Actions
1.1 A comprehensive, integrated process for routine monitoring of all the essential elements for a healthy nuclear safety culture currently does not exist	a) Create a comprehensive, integrated nuclear safety culture process, including key NSC metrics  b) Design and conduct training on NSC process to employees and senior/executive management team

## Causes and Corrective Actions

### Root Cause 1

Management has missed opportunities to correct early indications of a decline in work environment resulting in allegations made directly to the NRC where internal problem resolution processes were bypassed

Contributing Causes	Key Corrective Actions
1.2 Inconsistent prioritization of nuclear safety culture issues	<ul style="list-style-type: none"><li>a) Establish an oversight group to monitor NSC issues</li><li>b) Review total work order backlog for proper prioritization</li><li>c) Review backlogs of procedure change requests, condition report actions, and preventive maintenance change requests for proper prioritization consistent with NSC aspects</li><li>d) Conduct periodic employee focus group meetings to assess progress on safety culture feedback</li></ul>



## Causes and Corrective Actions

### Root Cause 1

Management has missed opportunities to correct early indications of a decline in work environment resulting in allegations made directly to the NRC where internal problem resolution processes were bypassed

Contributing Causes	Key Corrective Actions
1.3 Corrective actions have not fully resolved nuclear safety culture issues	a) Ensure any NSC/SCWE evaluations/analyses and corrective actions are captured in corrective action program with special emphasis for resolution  b) Develop trending for NSC issues

## Causes and Corrective Actions

### Root Cause 1

Management has missed opportunities to correct early indications of a decline in work environment resulting in allegations made directly to the NRC where internal problem resolution processes were bypassed

Contributing Causes	Key Corrective Actions
1.4 Oversight organizations do not consistently monitor /evaluate essential elements of a nuclear safety culture in aggregate	a) Incorporate key NSC elements into oversight group charters b) NSC oversight group to review employee exit interviews c) NSC oversight group to present the content and conclusions of this root cause evaluation at a CNRB meeting d) NSC review included as a standing agenda item for CNRB meetings

## Causes and Corrective Actions

### Root Cause 1

Management has missed opportunities to correct early indications of a decline in work environment resulting in allegations made directly to the NRC where internal problem resolution processes were bypassed

Contributing Causes	Key Corrective Actions
1.5 There is no alternative process for documenting and addressing dissenting or differing perspectives on key management decisions	a) Develop and implement a process for differing professional opinions (DPO) b) Assign an NSC executive sponsor to periodically meet with senior leadership team to identify and discuss any NSC issues and reinforce expectations to challenge issues that could threaten NSC

## Causes and Corrective Actions

### Root Cause 1

Management has missed opportunities to correct early indications of a decline in work environment resulting in allegations made directly to the NRC where internal problem resolution processes were bypassed

Contributing Causes	Key Corrective Actions
1.6 The ECP is perceived to lack effectiveness. At St. Lucie the ECP is perceived to be too closely aligned with site management	<p><u>Improve Effectiveness</u></p> <ul style="list-style-type: none"><li>a) Move ECP offices into the protected area at each site</li><li>b) Require a documented and approved formal investigation plan for ECP investigations of a complex nature</li><li>c) Revise the process for out-of-scope referrals to ensure thorough issue resolution</li><li>d) Implement a process to obtain face-to-face feedback from concernees on adequacy of service provided</li></ul> <p><u>Improve Perception of Independence</u></p> <ul style="list-style-type: none"><li>a) Reinvigorate ECP by increasing program visibility (employee outreach meetings, workforce presentations, developing and posting new ECP communications)</li><li>b) ECP to meet regularly with senior management team to discuss program status, training, and outreach</li></ul>

## Causes and Corrective Actions

### Root Cause 2

Certain management actions have negatively impacted employee trust and resulted in a perception that production often takes precedence over safety

Contributing Causes	Key Corrective Actions
2.1 There is an organizational perception of inconsistent accountability for senior management, both in terms of performance and behaviors, that has eroded employee trust	a) Establish an oversight group to monitor NSC b) HR to monitor expected management behaviors for improving employee trust c) Develop and implement a procedure for onboarding new senior/executive managers to include attributes of NSC, union history, corporate culture, SCWE culture, and key historical division events and station operations

## Causes and Corrective Actions

### Root Cause 2

Certain management actions have negatively impacted employee trust and resulted in a perception that production often takes precedence over safety

Contributing Causes	Key Corrective Actions
2.2 Many operational and other management decisions have been perceived to place emphasis on production at the expense of safety	a) Revise operational decision-making process to include enhanced: <ul style="list-style-type: none"><li>• Risk criteria</li><li>• Communication requirements</li><li>• Effectiveness review</li><li>• Criteria for management deviation from recommendation</li></ul> b) Implement a procedure for DPO

## Causes and Corrective Actions

### Root Cause 2

Certain management actions have negatively impacted employee trust and resulted in a perception that production often takes precedence over safety

Contributing Causes	Key Corrective Actions
2.3 Employees perceive that management has created an urgency to implement change and react immediately to issues without considering resources and work environment impact	a) Implement a structured process to frequently evaluate competing priorities  b) Review and implement a long and short term strategic plan aligning business objectives and major initiatives consistent with available resources

## Causes and Corrective Actions

### Root Cause 2

Certain management actions have negatively impacted employee trust and resulted in a perception that production often takes precedence over safety

Contributing Causes	Key Corrective Actions
2.4 The reward and recognition system is perceived to be heavily weighted toward production over safety	a) Re-evaluate current reward system to ensure measures of NSC are considered

## Causes and Corrective Actions

### Root Cause 2

Certain management actions have negatively impacted employee trust and resulted in a perception that production often takes precedence over safety

Contributing Causes	Key Corrective Actions
2.5 There is evidence that a lack of vertical and horizontal alignment between management and supervision on key decisions is having a negative impact on trust	<ul style="list-style-type: none"><li>a) Establish a program/process for supervisor/manager alignment meetings</li><li>b) Develop a plan to communicate on-going progress</li><li>c) Reinforce the importance of open communications for all personnel</li><li>d) Administer a station cultural assessment in 2010 and establish corrective actions based on the results</li></ul>

## Effectiveness of Past Actions

- Past actions on SCWE/NSC issues were narrowly focused
- Sites were asked to assess their areas individually
- Corrective actions were low-level and site-specific
- New approach involves a comprehensive, corporate/site approach
  - Use of formal root cause methodology
  - Multiple industry root cause experts
  - Focus groups, individual interviews provided real-time input
  - Broader NSC scope of investigation
  - Monitoring of comprehensive NSC metrics
  - Leveraged industry operating experience



## Communications Plan

- Communicated formation and purpose of the root cause team to employees
- Site-specific communications and engagement plans
  - SVP/PGM to frequently attend department meetings; increase frequency of all-hands meetings and “walk arounds” to engender trust
  - Integrate key safety culture messages into all site communications
- Communicate lessons learned from root cause, actions to close gaps
  - Reinforce messages through executive communications, all-hands meetings, newsletters, small employee meetings
- Refresh ECP identity through updated posters, handouts, outreach meetings, and workforce presentations
- Issue regular updates on status of program implementation, key milestones met, and issues resolved



## Summary of Key Corrective Actions

- Reinvigorate the ECP by increasing program visibility
- Aggressive close-out of personnel safety work orders at St. Lucie
- Define the essential elements of a comprehensive, integrated nuclear safety culture process
- Enhance operational decision-making process
- Review major initiatives to align resources
- Re-evaluate current reward system to ensure measures of NSC
- Use surveys and focus groups to monitor safety culture
- Status update to NRC in mid-summer 2010



Questions?



## NSC Indicators

<p>Workforce willingness to raise concerns using normal problem resolution process</p>	<ul style="list-style-type: none"> <li>• Total action requests initiated by month</li> <li>• Condition report initiation</li> </ul>
<p>Management effectiveness at resolving concerns using normal problem resolution process</p>	<ul style="list-style-type: none"> <li>• Action requests with GWE code for less than adequate actions</li> <li>• Correct condition/prevent recurrence (CC/PR) backlog</li> <li>• Quality of corrective actions</li> <li>• Condition report correct condition/prevent recurrence related actions overdue</li> <li>• Condition report timeliness – age of open condition reports</li> </ul>
<p>Effectiveness of the alternate resolution process</p>	<ul style="list-style-type: none"> <li>• Employee concerns</li> <li>• Contacts</li> <li>• Hotline reports</li> <li>• Allegations</li> <li>• Labor grievances</li> </ul>
<p>Management effectiveness at detecting and preventing retaliation</p>	<ul style="list-style-type: none"> <li>• Nuclear safety culture cause codes for significant condition reports</li> <li>• Anonymous concerns</li> <li>• Harassment, intimidation, retaliation, discrimination (HIRD)</li> </ul>
<p>General work environment</p>	<ul style="list-style-type: none"> <li>• Action requests distribution by general work environment category</li> <li>• Industrial safety work orders – burn off</li> <li>• Operator aggregate index</li> <li>• Change management</li> <li>• Key management turnover</li> <li>• Modification backlog</li> </ul>