



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001

September 20, 1995

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MGRS  
GIBSON  
JON & STEW + SUK  
[Signature]

MEMORANDUM TO: Steven A. Varga, Director  
Division of Reactor Projects, I/II, NRR

Jack W. Roe, Director  
Division of Reactor Projects, III/IV, NRR

Richard W. Cooper, Director  
Division of Reactor Projects, RI

Ellis W. Merschoff, Director  
Division of Reactor Projects, RII

William L. Axelson, Director  
Division of Reactor Projects, RIII

James E. Dyer, Director  
Division of Reactor Projects, RIV

FROM: *for* Bruce A. Boger, Director  
Division of Reactor Controls  
and Human Factors, NRR

*Jared S. Wernick*

SUBJECT: HUMAN PERFORMANCE INFORMATION FOR SMM PREBRIEFINGS

By memorandum dated March 21, 1995, I provided you with human performance information developed by the Human Factors Assessment Branch (HHFB) using their Human Factors Information System (HFIS) for your use in preparing for the prebriefings for the June 1995 Senior Management Meeting. Based on the favorable responses I received from that information, I am providing in Attachment 1 similar information for your use in preparing for the prebriefings for the January 1996 Senior Management Meeting.

LER and inspection report data are provided for all the plants in each region for the most recent 12-month periods for which data are available. The data, numbers of LERs involving human performance and numbers of human performance items in inspection reports, are compared to values of twice the national average. HHFB's analyses of the data are provided for plants that exceed that threshold. In addition, available data for previous years are provided in tabular form for use in trending.

It is important to remember that the information provided is somewhat subjective in nature and should only be used for insights or to validate information from other sources. To assist you in interpreting the analyses, Attachments 2 and 3 provide additional details on the types of information entered into HFIS for LERs and inspection reports, respectively.

If you need any additional information concerning the attached information, please contact Cecil Thomas, Chief, HHFB, at 415-2160.

cc. A. Thadani  
R. Zimmerman

Attachment: As stated

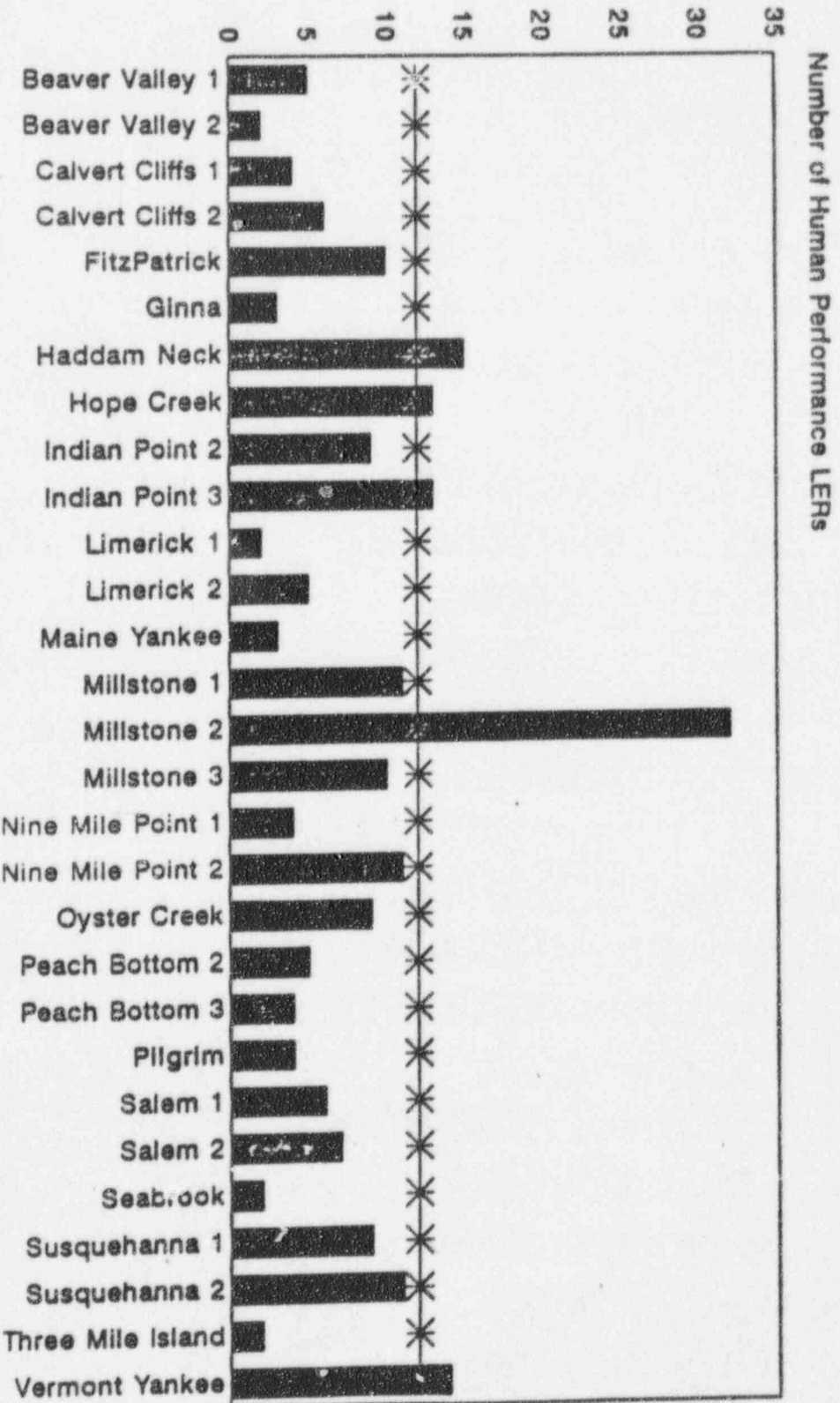
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## ATTACHMENT 1

### LER and Inspection Report Summaries

# Region I HFIS LER Data

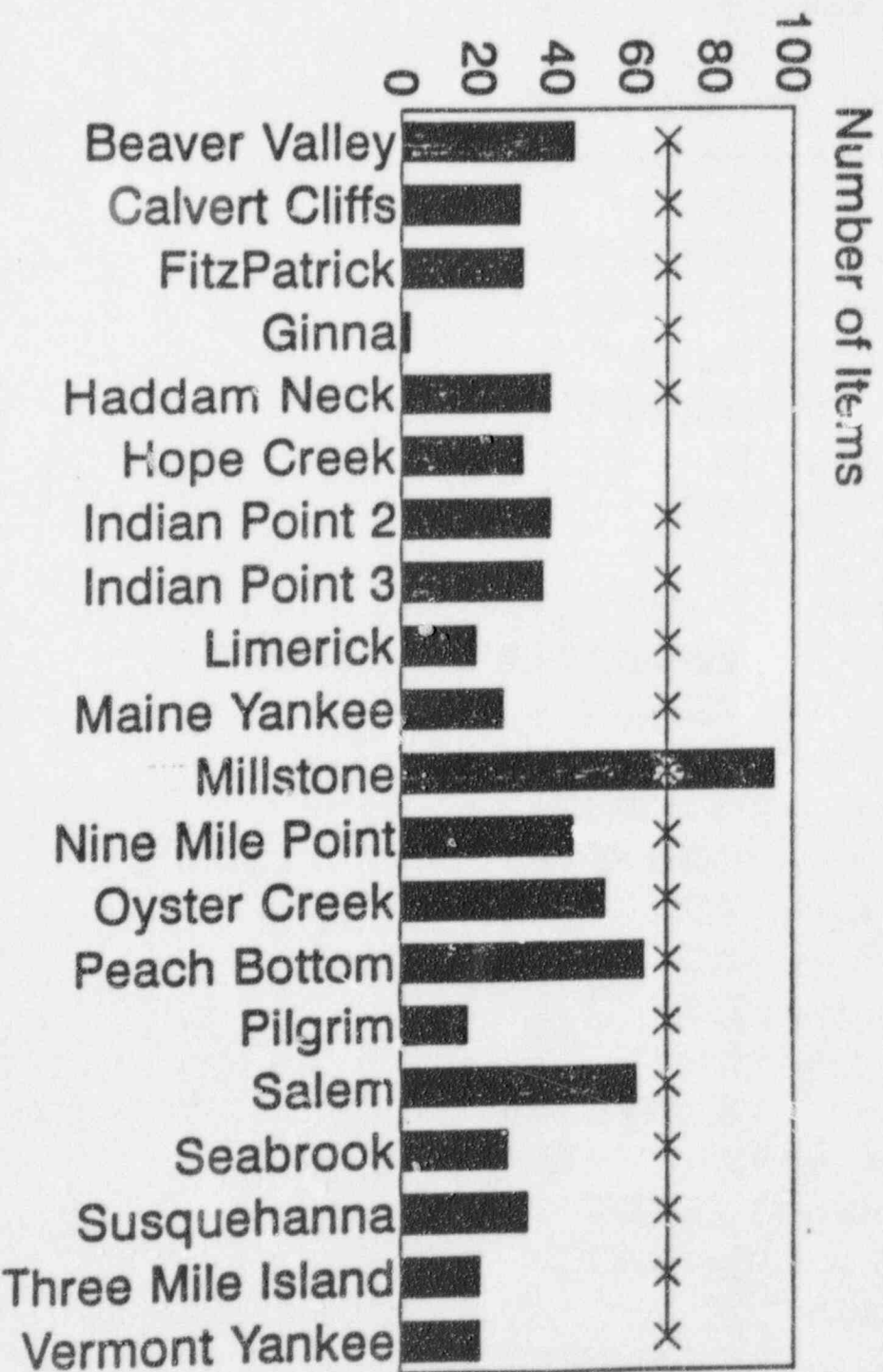
■ Aug 94 - Jul 95 \* Twice National Average



Aug 92 - Jul 93	13	8	1	6	17	1	11	7	5	24	6	6	8	7	11	14	10	6	7	3	6	9	10	7	16	8	5	5	9
Aug 93 - Jul 94	6	3	5	6	5	6	10	8	3	26	10	6	10	19	20	18	1	8	2	5	7	5	8	11	17	9	7	3	11
Aug 94 - Jul 95	5	2	4	6	10	3	15	13	9	13	2	5	3	11	32	10	4	11	9	5	4	4	6	7	2	9	11	2	14

# Region 1 HFIS Inspection Report Data

■ Sept 94 - Aug 95 \* Twice National Average



Sept 93 - Aug 94	20	20	3	6	6	12	7	30	45	3	44	6	14	12	5	13	13	20	61	6
Sept 94 - Aug 95	44	30	31	2	38	31	38	36	19	26	95	44	52	62	17	60	27	32	20	20

## REGION I PLANTS WITH AT LEAST TWICE THE NATIONAL AVERAGE OF LERS

### Haddam Neck - 15 LERS

The major groups of personnel involved in these events were licensed operator personnel (27%), engineering personnel (20%), and mechanical personnel (20%). Major contributing factors were management and planning (73%), written communications (27%), and inadequate procedures (20%). Task behaviors were knowledge-based (53%) and rule-based (40%). Work types were primarily operations (33%), engineering (27%), testing (13%), procedure development (13%), and modification (13%). Cognitive errors contributing to the events included misinterpretation of information (53%), false assumptions about conditions (27%), attention deficit (13%), and poor judgment (7%). Action errors were primarily those of omission (83%).

### Hope Creek - 13 LERS

The major groups of personnel involved in these events were I&C personnel (54%), and licensed operators (23%). Major contributing factors were procedures not followed (62%), management and planning (39%), inadequate training (31%), inadequate procedures (23%), work schedule (15%), and written communications (15%). Task behaviors were knowledge-based (54%) and rule-based ((46%). Work types were primarily testing (54%), operations (24%), and procedure development maintenance (24%). Cognitive errors contributing to the events included poor judgment (38%), attention deficit (31%), misinterpretation of information (23%), and false assumptions about conditions (23%). Action errors were primarily those of wrong action (54%) and omission (38%).

### Indian Point 3 - 13 LERS

The major groups of personnel involved in these events were other (46%), engineering personnel (31%), I&C personnel (23%) and electrical personnel (23%). Major contributing factors were management and planning (77%), inadequate procedures (38%), written communications (38%), and inadequate training (31%). Task behaviors were knowledge-based (77%) and rule-based (23%). Work types were primarily operations (46%), engineering (23%), and testing (23%). Cognitive errors contributing to the events included false assumption about conditions (54%), misinterpretation of information (38%), and attention deficit (23%). Action errors were primarily those of omission (69%) and wrong action (23%).

### Millstone 2 - 32 LERS

The major groups of personnel involved in these events were engineering personnel (25%), other personnel (which includes



management and supervision) (25%), mechanical maintenance (22%), electrical maintenance (13%), licensed operators (9.4%), and I&C personnel (9.4%). Major contributing factors were management and planning (69%) and procedures not followed (22%). Task behaviors were rule-based (47%) and knowledge-based (47%). Work types were primarily testing (28%), operations (25%), and engineering (16%). Cognitive errors contributing to the events included false assumption about conditions (47%), misinterpretation of information (25%) and poor judgment (16%). Action errors were primarily those of omission (53%) and wrong action (47%).

#### Vermont Yankee - 14 LERS

The major groups of personnel involved in these events were engineering personnel (19%) and mechanical personnel (21%). Major contributing factors were management and planning (50%), inadequate training (36%), and procedures inadequate (36%). Task behaviors were rule-based (50%) and knowledge-based (43%). Work types were primarily operations (57%), testing (14%), and engineering (14%). Cognitive errors contributing to the events included misinterpretation of information (57%) and false assumption about conditions (36%). Action errors were primarily those of omission (57%) and wrong action (36%).

#### REGION I SITES WITH AT LEAST TWICE THE NATIONAL AVERAGE OF INSPECTION ITEMS

##### Millstone - 95 Items

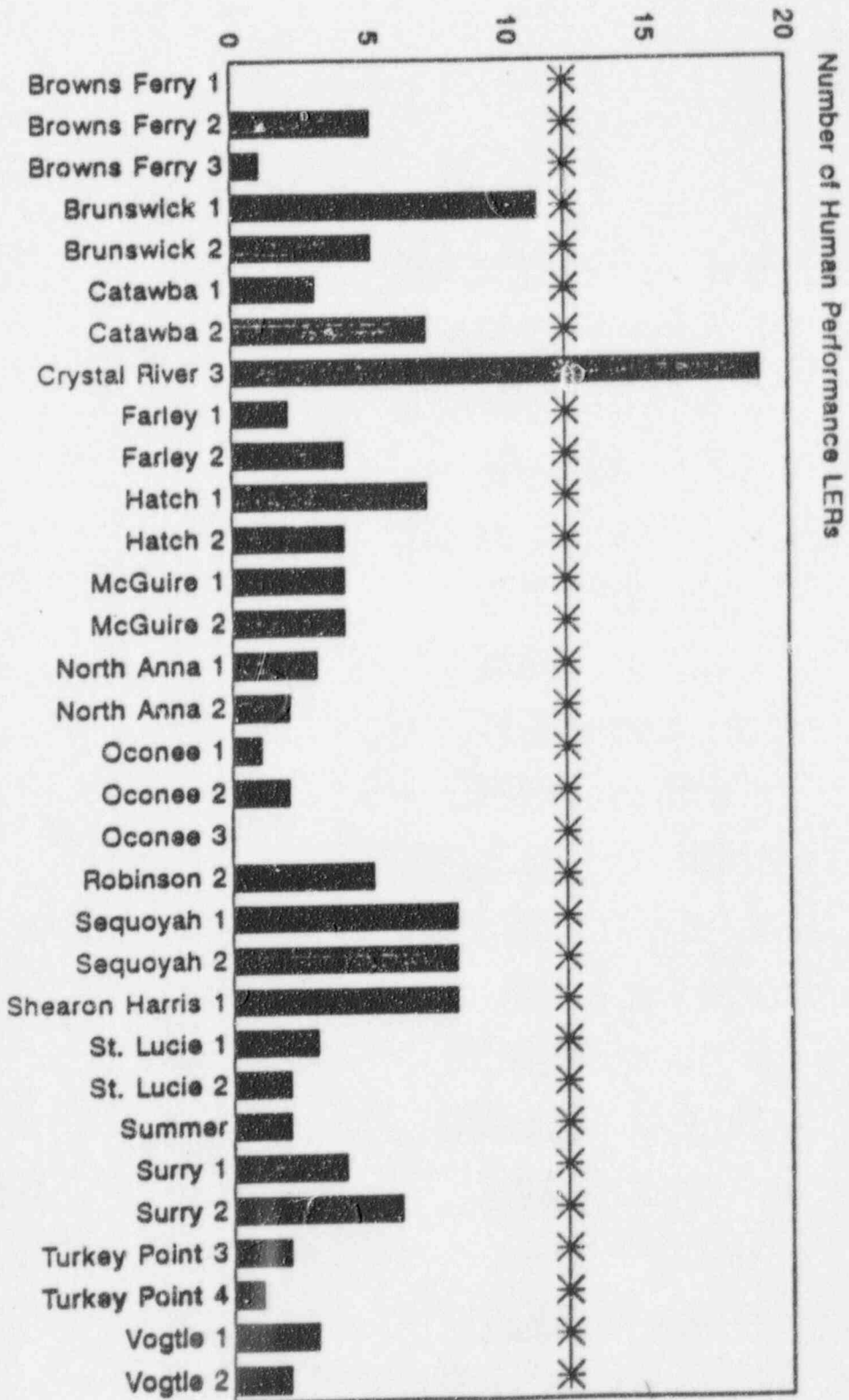
The major categories contributing to these items were procedures (59%) and management and supervision (25%). In these categories, the departments contributing the most were operations (38%) and mechanical (17%). The primary issues in the procedure category were failure to follow procedures (55%) and inadequate procedures (21%). The primary issues in the management and supervision category were work control (50%), corrective actions (25%), and attention and oversight (21%).

#### OTHER COMMENTS

The overall number of human performance-related LERs for Region I plants has shown a significant decrease notwithstanding Millstone 2.

# Region 2 HFIS LER Data

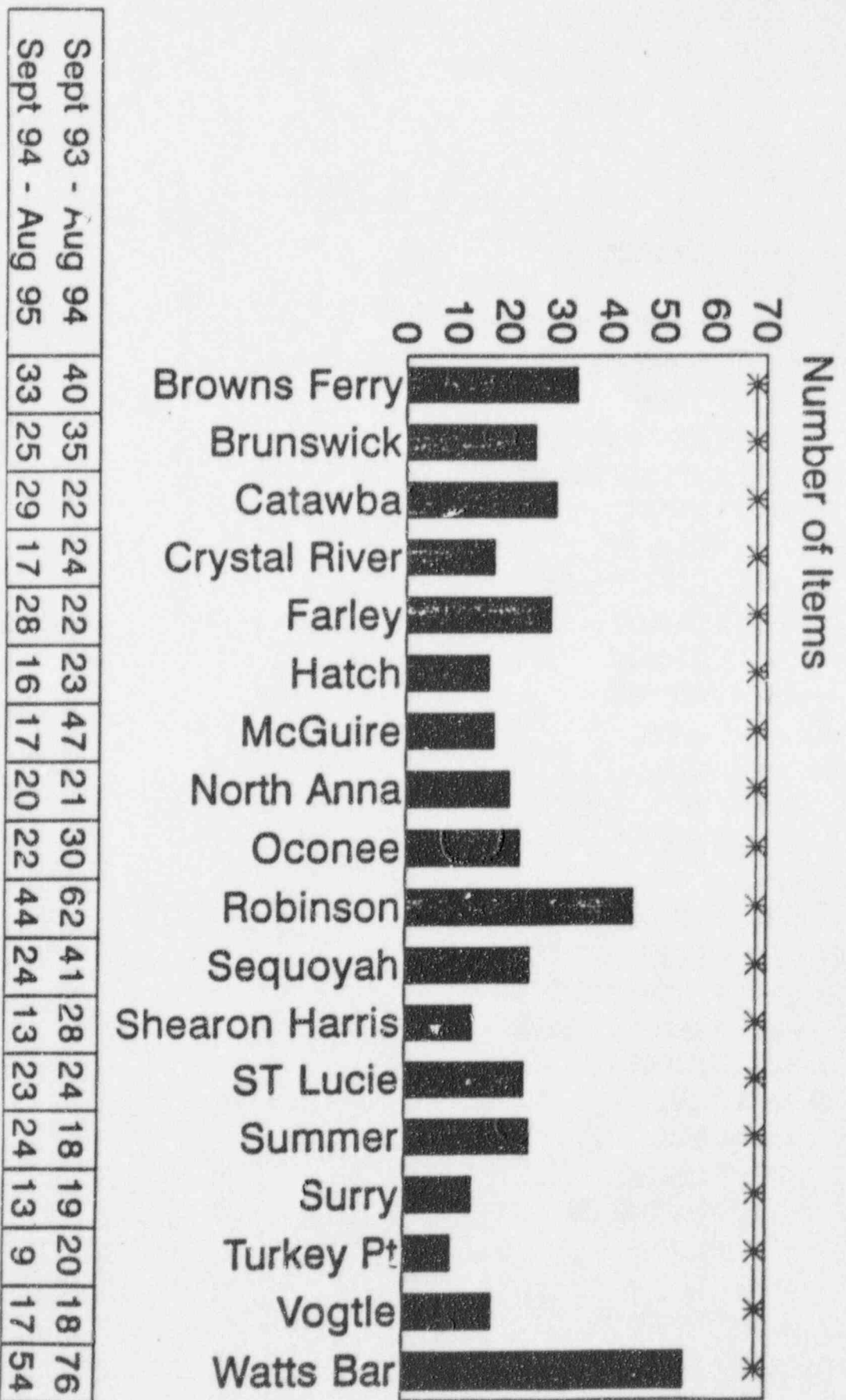
■ Aug 94 - Jul 95 \* Twice National Average



Aug 92 - Jul 93	7	11	7	10	11	5	5	13	4	5	7	7	6	5	18	9	10	7	6	5	26	17	10	2	7	3	4	5	8	6	7	4
Aug 93 - Jul 94	2	5	1	11	12	7	5	4	3	3	4	4	6	6	2	6	6	7	4	17	16	5	3	5	3	5	3	1	1	6	4	
Aug 94 - Jul 95	0	5	1	11	5	3	7	19	2	4	7	4	4	4	3	2	1	2	0	5	8	8	8	3	2	2	4	6	2	1	3	2

# Region 2 HFIS Inspection Report Data

■ Sept 94 - Aug 95 \* Twice National Average





REGION II PLANTS WITH AT LEAST TWICE THE NATIONAL AVERAGE OF LERS

Crystal River 3 - 19 LERS

The major groups of personnel involved in these events were mechanical personnel (23%) and engineering personnel (23%). Major contributing factors were inadequate procedures (29%), management and planning (20%), and inadequate training (17%). Task behaviors were rule-based (53%) and knowledge-based (47%). Work types were primarily operation (30%) and procedure development (30%). Cognitive errors contributing to the events included misinterpretation of information (50%) and false assumption about conditions (35%). Action errors were primarily those of omission (44%) and wrong action (44%).

REGION II SITES WITH AT LEAST TWICE THE NATIONAL AVERAGE OF INSPECTION ITEMS

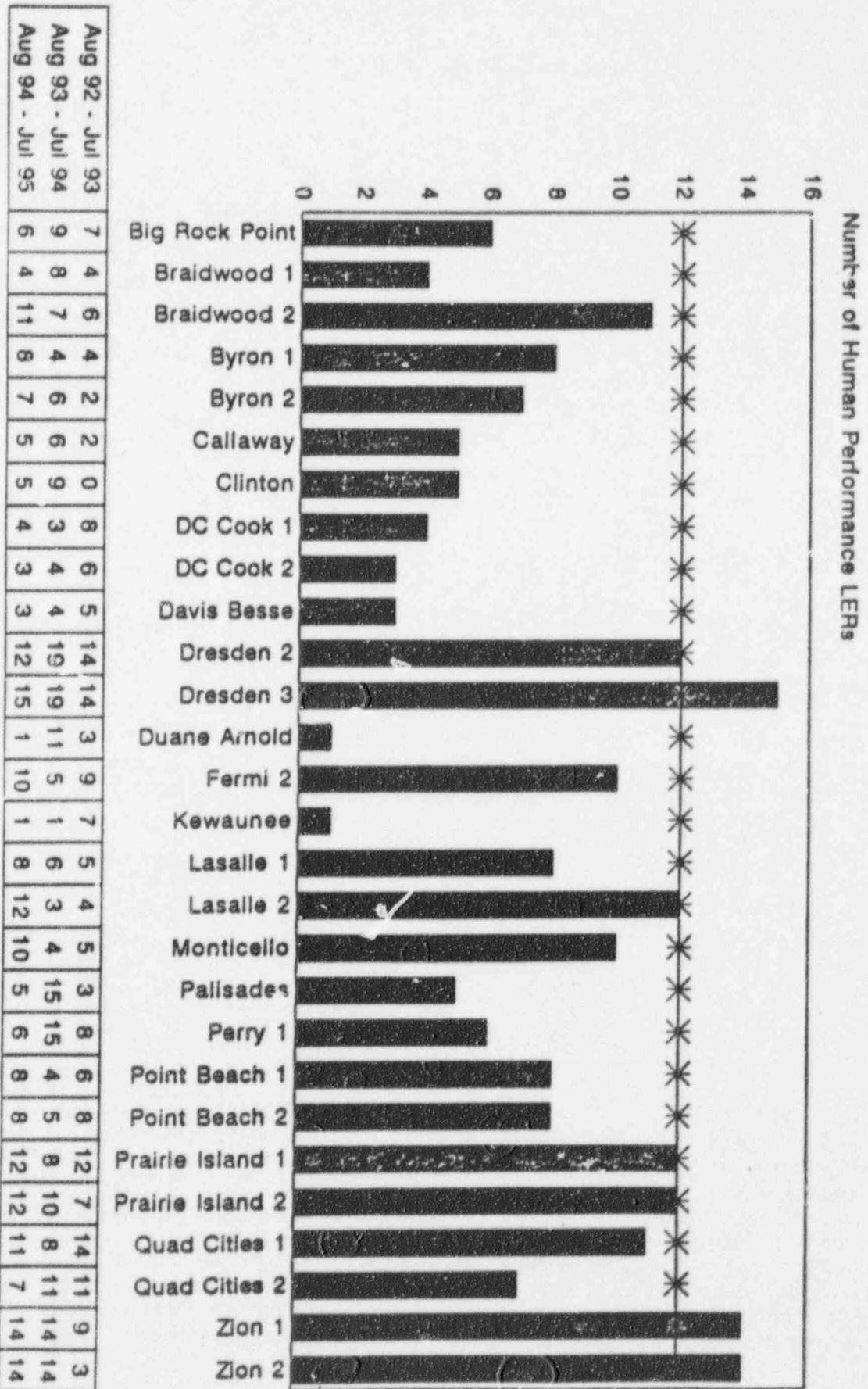
None.

OTHER COMMENTS

The number of human performance-related LERS for Region II plants has shown a significant downward trend over the last three years.

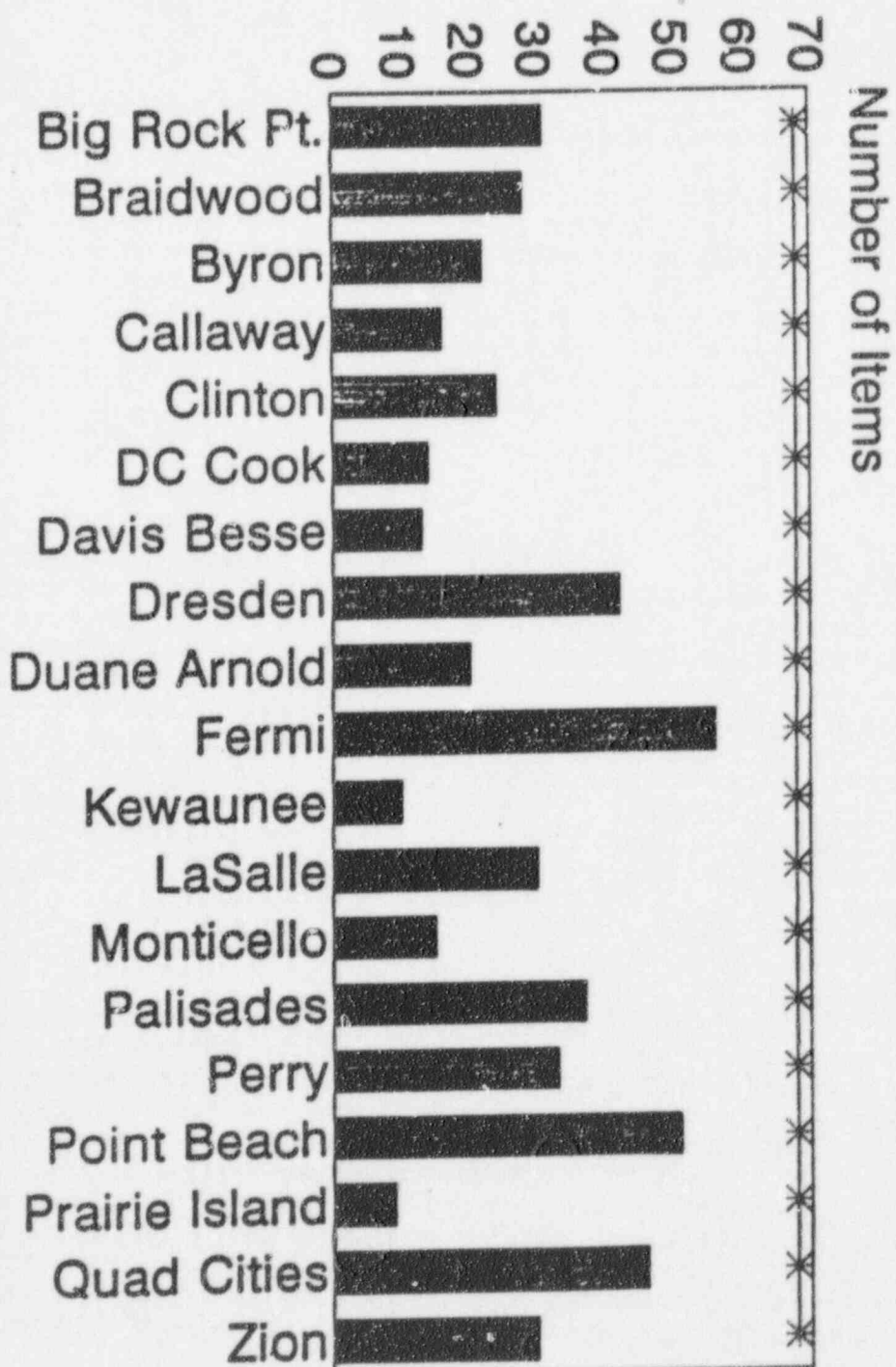
# Region 3 HFIS LER Data

■ Aug 94 - Jul 95 \* Twice National Average



# Region 3 HFIS Inspection Report Data

■ Sept 94 - Aug 95 \* Twice National Average



Sept 93 - Aug 94	33
Sept 94 - Aug 95	31

## REGION III PLANTS WITH AT LEAST TWICE THE NATIONAL AVERAGE OF LERS

### Dresden 2 - 12 LERS

The major groups of personnel involved in these events were licensed operator personnel (23%), engineering personnel (23%), and radiological protection personnel (23%). Major contributing factors were management and planning (35%) and procedures not followed (20%). Task behaviors were knowledge-based (58%) and rule-based ((42%). Work types were primarily operations (42%), testing (17%), procedure development (17%), and modification (17%). Cognitive errors contributing to the events included misinterpretation of information (41%), poor judgement (35%), and false assumptions about conditions (24%). Action errors were primarily those of wrong action (83%).

### Dresden 3 - 15 LERS

The major groups of personnel involved in these events were engineering personnel (28%), licensed operators (17%), non-licensed operators (17%), and mechanical personnel (17%). Major contributing factors were management and planning (30%), procedures not followed (17%), inadequate training (13%), and verbal communications (13%). Task behaviors were knowledge-based (67%) and rule-based ((33%). Work types were primarily operations (29%), troubleshooting (14%), and maintenance (14%). Cognitive errors contributing to the events included misinterpretation of information (37%), false assumptions about conditions (32%), and poor judgement (26%). Action errors were primarily those of wrong action (69%) and omission (31%).

### LaSalle 2 - 12 LERS

The major groups of personnel involved in these events were I&C personnel (25%) and engineering personnel (19%). Major contributing factors were procedures not followed (24%), inadequate training (20%), and management and planning (20%). Task behaviors were rule-based (53%) and knowledge-based (47%). Work types were primarily operations (33%) and testing (27%). Cognitive errors contributing to the events included false assumption about conditions (44%), attention deficit (25%), and misinterpretation of information (25%). Action errors were primarily those of wrong action (75%) and omission (25%).

### Prairie Island 1 - 12 LERS

The major groups of personnel involved in these events were I&C personnel (39%) and engineering personnel (21%). Major contributing factors were management and planning (40%) and procedures inadequate (30%). Task behaviors were rule-based (67%)

and knowledge-based (33%). Work types were primarily maintenance (27%), operations (18%), and testing (18%). Cognitive errors contributing to the events included misinterpretation of information (42%) and false assumption about conditions (42%). Action errors were primarily those of omission (67%) and wrong action (25%).

#### Prairie Island 2 - 12 LERS

The major groups of personnel involved in these events were I&C personnel (39%) and engineering personnel (21%). Major contributing factors were management and planning (40%) and procedures inadequate (30%). Task behaviors were rule-based (67%) and knowledge-based (33%). Work types were primarily maintenance (23%), operations (15%), and testing (15%). Cognitive errors contributing to the events included misinterpretation of information (42%) and false assumption about conditions (42%). Action errors were primarily those of omission (67%) and wrong action (25%).

#### Zion 1 - 14 LERS

The major groups of personnel involved in these events were engineering personnel (31%) and electrical personnel (25%). Major contributing factors were management and planning (52%) and procedures inadequate (24%). Task behaviors were rule-based (50%) and knowledge-based (50%). Work types were primarily maintenance operations (29%), testing (29%), and engineering (21%). Cognitive errors contributing to the events included false assumption about conditions (44%) and misinterpretation of information (38%). Action errors were primarily those of omission (50%) and wrong action (43%).

#### Zion 2 - 14 LERS

The major groups of personnel involved in these events were engineering personnel (33%) and electrical personnel (27%). Major contributing factors were management and planning (52%) and procedures inadequate (17%), and inadequate training (17%). Task behaviors were knowledge-based (57%) and rule-based (43%). Work types were primarily maintenance operations (29%), testing (29%), and engineering (21%). Cognitive errors contributing to the events included misinterpretation of information (47%) and false assumption about conditions (33%). Action errors were primarily those of omission (50%) and wrong action (43%).



REGION III PLANTS WITH AT LEAST TWICE THE NATIONAL AVERAGE OF  
INSPECTION ITEMS

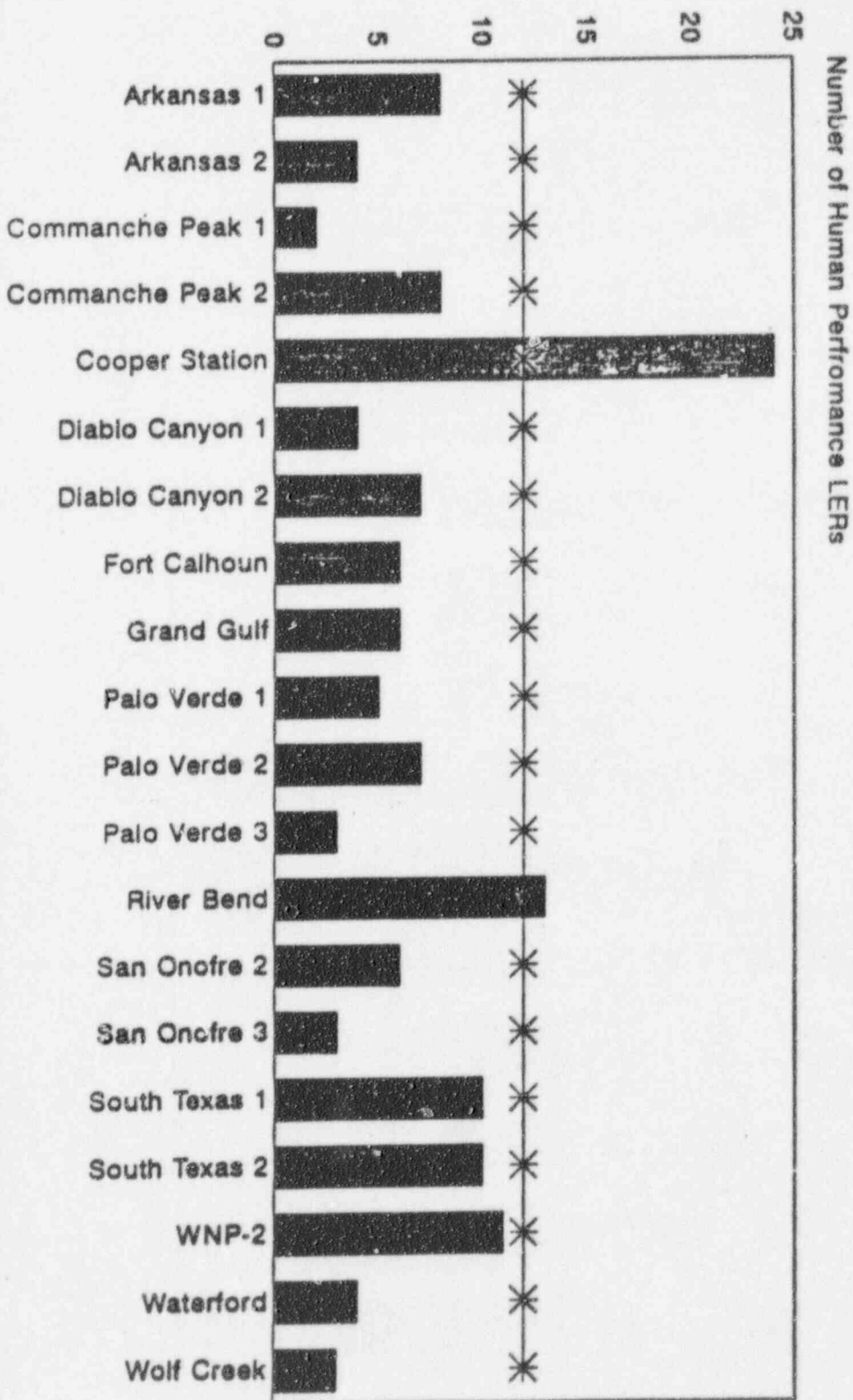
None.

OTHER COMMENTS

None.

# Region 4 HFIS LER Data

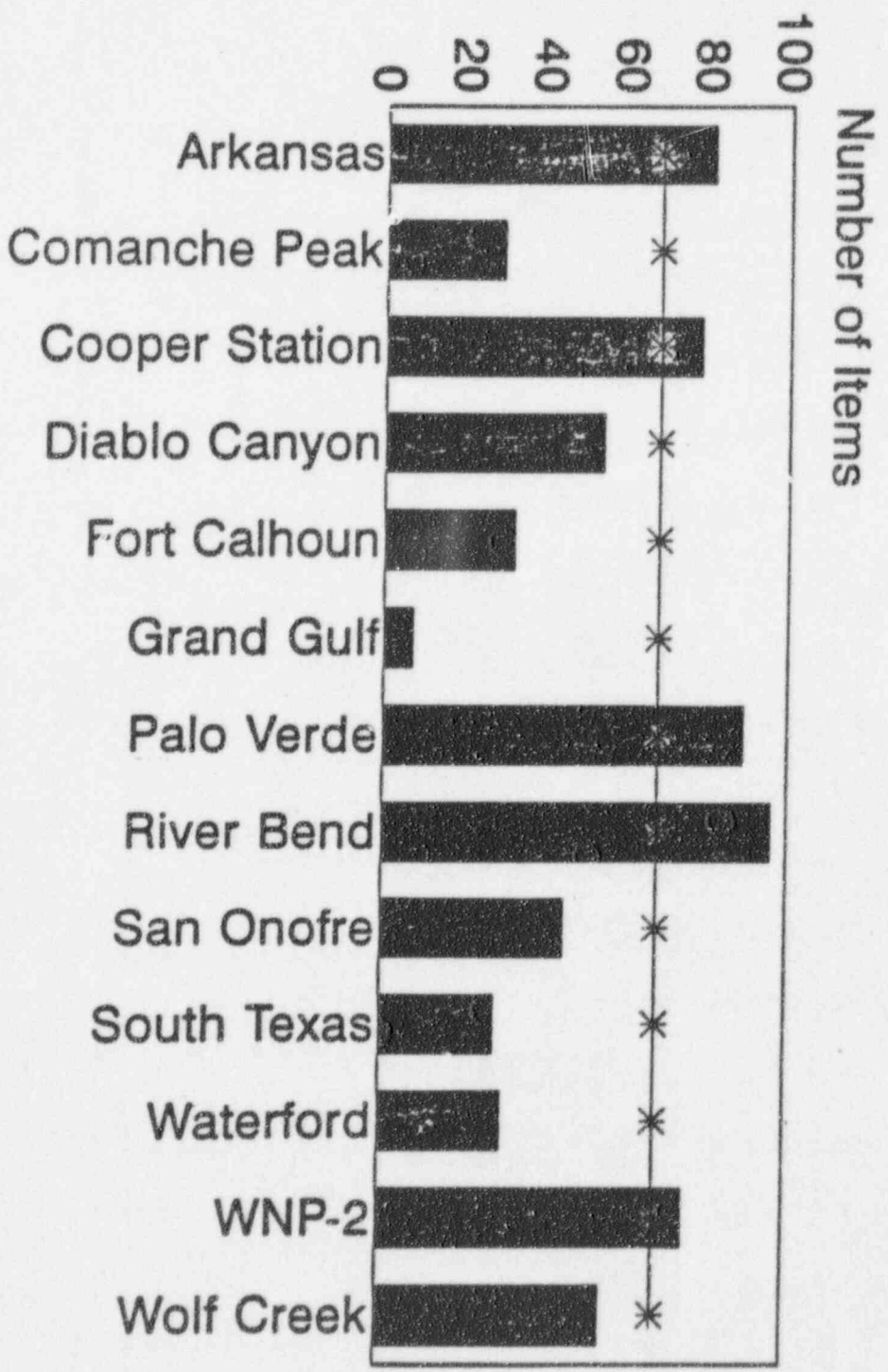
■ Aug 94 - Jul 95 \* Twice National Average



Aug 92 - Jul 93	1	5	9	5	19	15	12	10	3	6	4	6	21	4	3	30	20	24	7	11
Aug 93 - Jul 94	5	4	3	3	15	13	8	11	9	3	4	4	22	10	8	6	5	17	14	6
Aug 94 - Jul 95	8	4	2	8	24	4	7	6	6	5	7	3	13	6	3	10	10	11	4	3

# Region 4 HFIS Inspection Report Data

■ Sept 94 - Aug 95 \* Twice National Average



Sept 93 - Aug 94	42	16	50	39	25	14	55	71	33	82	18	29	39
Sept 94 - Aug 95	81	29	78	54	32	7	89	96	45	28	30	75	55

## REGION IV PLANTS WITH AT LEAST TWICE THE NATIONAL AVERAGE OF LERS

### Cooper Station - 24 LERS

The major groups of personnel involved in these events were I&C personnel (22%), mechanical personnel (23%), engineering personnel (23%), and electrical personnel (15%). Major contributing factors were management and planning (45%), inadequate procedures (23%), and inadequate training (20%). Task behaviors were knowledge-based (54%) and rule-based (46%). Work types were primarily engineering (27%), operation (19%), and testing (15%). Cognitive errors contributing to the events included misinterpretation of information (50%) and false assumption about conditions (46%). Action errors were those of omission (54%) and wrong action (46%).

### River Bend 1 - 13 LERS

The major groups of personnel involved in these events were mechanical personnel (25%), I&C personnel (19%), and other personnel (19%). Major contributing factors were procedures not followed (29%) and inadequate training (21%). Task behaviors were rule-based (62%) and knowledge-based (38%). Work types were primarily operation (31%) and testing (31%). Cognitive errors contributing to the events included misinterpretation of information (36%), false assumption about conditions (29%), and poor judgement (21%). Action errors were those of wrong action (54%) and omission (46%).

## REGION IV SITES WITH AT LEAST TWICE THE NATIONAL AVERAGE OF INSPECTION ITEMS

### Arkansas - 81 Items

The major categories contributing to these items were procedures (43%) and management and supervision (26%). In these categories, departments contributing the most were operations (35%), engineering (11%), and mechanical (10%). The primary issues in the procedure category were inadequate procedures (63%) and failure to follow procedures (37%). The primary issues in the management and supervision category were work control (52%), attention and oversight (29%), and corrective actions (19%).

### Cooper Station - 78 Items

The major categories contributing to these items were management and supervision (45%) and procedures (35%). In these categories, departments contributing the most were operations (38%) and mechanical (11%). The primary issues in the management and supervision category were work control (37%), corrective actions (31%), and attention and oversight (23%). The primary issues in

the procedure category were failure to follow procedures (48%) and inadequate procedures (37%).

#### Palo Verde - 89 Items

The major categories contributing to these items were management and supervision (37%) and procedures (37%). In these categories, departments contributing the most were operations (38%) and mechanical (18%). The primary issues in the management and supervision category were work control (33%), corrective actions (27%), and attention and oversight (24%). The primary issues in the procedure category were failure to follow procedures (57%) and inadequate procedures (33%).

#### River Bend - 96 Items

The major categories contributing to these items were procedures (44%), management and supervision (32%), and communications (19%). In these categories, departments contributing the most were operations (44%) and engineering (31%). The primary issues in the procedure category were inadequate procedures (55%) and failure to follow procedures (40%). The primary issues in the management and supervision category were corrective actions (35%), work control (26%), self-evaluation (23%), and attention and oversight (16%). The primary issues in the communication category were communication less than adequate (66%), and misunderstood information (28%).

#### WNP-2 - 75 Items

The major categories contributing to these items were procedures (33%), communications (28%), and management and supervision (24%). In these categories, the department contributing the most was operations (57%). The primary issues in the procedure category were inadequate procedures (56%) and failure to follow procedures (36%). The primary issues in the communication category were communication less than adequate (71%), and misunderstood information (24%). The primary issues in the management and supervision category were attention and oversight (33%), self-evaluation (28%), corrective actions (22%), and work control (17%).

#### OTHER COMMENTS

None.



# LER DATA ENTRY SHEET

Plant name: (as marked on LER and selected from  
HFIS pick list)

Docket number: (as marked on LER)

Event date: (as marked on LER)

LER number: (as marked on LER)

Event time:

Issue date: (leave blank)

Power level:

Micro fiche: (leave blank)

System involved: (leave blank)

Personnel category:

- licensed operator
- non-licensed operator
- instrument and control
- electrical
- mechanical
- engineer
- radiological protection
- chemistry
- security
- other

Work type:

- operating
- testing
- calibration
- troubleshooting
- maintenance
- engineering
- procedure development
- refueling
- modification
- other

Task behavior:

- skill
- rule
- knowledge

Action error:

- unavailable
- untimely action
- omission
- out of sequence
- wrong action
- extraneous action

Contributing factors:

- information unavailable
- inadequate training
- improper training
- no training
- procedure not followed
- procedure inadequate
- lack of procedure
- procedure wrong
- human system interface
- work environment
- verbal communication
- written communication
- work schedule
- work load
- management and planning
- shift turnover

Plant identified root cause:

(as marked on LER by coder)

Alternative root cause: (coder must specify here.)

Corrective Actions:

(as marked by coder)

Type of event:

(leave blank)

Cognitive error:

- attention deficit
- misinterpreting information
- forgetting
- false assumption
- poor judgement
- boredom
- other

Personnel effect code:

(leave blank)

Reportability codes:

(as marked on LER)

Personnel activity codes:

(leave blank)

DEPARTMENT	CATEGORY	AREA	DETAILS
A Instrument & Control B Electrical C Mechanical D Chemistry E Radiation Protection F Engineering G Contractor H Training J QA/QC	A Training	A Initial B Continuing/requal C OJT D Simulator	01 No training 02 Inadequate training 03 Training process problem 04 Task qualification
	B Procedures	E Normal F Off-normal G Emergency H Surveillance and test I Administrative J Special	05 No procedure 06 Inadequate procedure 07 Failure to follow procedure 08 Procedure development/procedure maintenance program LTA
	C Organizational Issues	K Staffing	09 Inadequate staffing 10 Poor task allocation
		L Overtime	11 Inadequate controls 12 Excessive number of hours worked 13 Frequent use of overtime
	D Management and Supervision	M Attention and oversight	14 No supervision 15 Inadequate supervision
		N Work Control	16 Scheduling and planning 17 Worker Selection (unqualified worker) 18 Tag outs 19 Pre-brief quality 20 Work package quality
		O Corrective actions	21 Individual actions LTA 22 Action not yet started 23 No action planned 24 Corrective action program LTA
		P Self-evaluation	25 Root cause LTA
	E Communication	Q Verbal R Written	26 Misunderstood information 27 Communication not timely 28 Communication LTA 29 No communication
	F Human - System Interface	S Equipment	30 Labels LTA 31 Controls LTA 32 Alertness LTA
		T Instrumentation and controls	33 Instrument/displays LTA 34 Controls LTA 35 Mirror image 36 Lack of consistency with other like items 37 Non-fault tolerant system of control
		U Work Environment	38 Temperature 39 Light 40 Noise 41 Radiation 42 Cramped quarters

## COMMISSION BRIEFING PAPER

VISITING OFFICIAL: Thomas F. Plunkett, President, Nuclear Division  
Florida Power and Light Company

DATE OF VISIT: November 21, 1996

PLANTS: St. Lucie Units 1 and 2, Turkey Point Units 3 and 4

ENCLOSURES: 1. Mr. Plunkett's Biography  
2. Corporate Organization Chart also showing plant management

### Background Information for St. Lucie

The St. Lucie Nuclear plant is located on an 1110 acre site on Hutchinson Island, which is a natural barrier island. The plant is comprised of two nearly identical units designed by Combustion Engineering. The non-nuclear, or steam plants, were designed by Ebasco Services. Each unit is capable of generating approximately 900 megawatts of electric power. Cooling is provided by seawater, drawn from and returned to the Atlantic Ocean.

Unit 1 was placed in commercial operation in December 1976, and Unit 2 began commercial operation in August 1983. The reactors are refueled at approximately eighteen month intervals. The next refueling (Unit 2) is scheduled for April 1997.

St. Lucie Unit 1 currently has a lifetime capacity factor of 75%. Over the years, the unit has achieved many world and U.S. records associated with plant availability and capacity factor. In 1992, Unit 1 set a world record for pressurized water reactors for consecutive days on line. The unit had operated 502 days non-stop before being removed from service for refueling. St. Lucie Unit 2 also had an outstanding performance record. In 1987-1988, Unit 2 set a FPL record for continuous operation of 427 days and had the number one capacity factor of any nuclear plant in the world. However, declining performance at the St. Lucie Plants was noted in the last SALP period which ended January 6, 1996, particularly in the areas of Operations and Maintenance. The reason for this decline is discussed below under "Current Concerns".

There have been a large number of management changes at St. Lucie in the last year. Since December 1, 1995, 8 managers have been changed (Services Manager, Licensing Manager, Outage Manager, Training Manager, Nuclear Material Management Superintendent, Steam Generator Replacement Project Manager, Operations Manager, and System & Component Engineering Manager), and in addition a new site vice president, Art Stall, reported in May of this year.

### SALP Ratings

<u>Functional Area</u>	<u>Rating This Period</u>	<u>Rating Last Period</u>
Operations	2	1
Maintenance	2	1
Engineering	1	1
Plant Support	1	1

### CURRENT STATUS

Both St. Lucie Units are currently operating at 100% of rated power.

### CURRENT CONCERNS

Since July 1995, there have been a series of events that lead to questions about the plant's overall performance. These events and several other recent deficiencies involving weak procedures, a general lack of procedural compliance, equipment failures, and personnel errors clearly indicated that the plant's past high level of performance has declined. These deficiencies highlighted weak management involvement in day to day operation of the plant; weak operator performance during routine evolutions; procedure inadequacies; weak corrective actions; lack of attention to detail; decline in equipment performance; and poor maintenance. As a result of this declining performance, the NRC has held bi-monthly meetings with FPL management to review the status of the licensee's performance improvement initiatives. The licensee undertook a number of efforts to reverse this declining performance. A number of management changes were also made in response to the declining performance. The NRC continues to closely monitor the plant's performance to determine the effect of these corrective activities.

There has been a significant increase in the number of allegations at St. Lucie. There were a total of 43 allegations in FY96, compared to 16 in FY95. This increase could be related to the FPL downsizing (13% in the last year), although there has not been a corresponding increase at Turkey Point. A significant allegation was made recently relating to the St. Lucie Emergency Preparedness program. The allegor also provided a copy of his concerns to the licensee and to the local press. The NRC performed a special inspection in response to this allegation. Violations of NRC requirements identified during this inspection will be discussed at an Enforcement Conference currently scheduled for December 10, 1996.

There has also been a large number of violations at St. Lucie, with three Level III violations since August 1995 involving: Inoperable Power Operated Relief Valves (PORVs) due to inadequate Post Maintenance Testing (8/4/95); Boron Overdilution Event (1/22/96); and Inadequate 50.59 Evaluation (7/12/96).

Due to a large number of steam generator tubes being removed from service as a result of tube degradation, the licensee is scheduled to replace the Unit 1

steam generators beginning in October 1997. The replacement SGs are already completed and are due to arrive on site in June 1997. The SGs were built by Babcock & Wilcox Industries. Unit 2 SGs have not experienced the same level of degradation as Unit 1 and there are currently no plans to replace these SGs. A 2.206 Petition from Mr. Thomas Saporito was submitted on June 12, 1996, as a result of the large number of plugged tubes in St. Lucie Unit 1. The Petition requested, among other actions, that St. Lucie Unit 1 be restricted to 50% power. The Director's Decision is scheduled to be issued by November 29, 1996. As currently drafted, the Petitioner's request would be denied.

On two occasions in July and August, the licensee discovered instances of tampering. The tampering consisted of placing a glue-like substance in a number of padlocks, doorlocks, and keylock switches. No safety systems were disabled as a result of the tampering, but the equipment was located inside vital areas of the plant. The licensee implemented augmented security measures and conducted an intense investigation, but was unable to identify the individual(s) responsible. The NRC dispatched a special inspection team to the site to review the licensee's actions. The team determined that the licensee's actions were appropriate, although some deficiencies were noted.



# **NUCLEAR DIVISION PRESIDENT MEETING WITH USNRC**

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## **AGENDA**

- **Introduction - About Florida Power & Light**
- **Turkey Point Performance**
- **St. Lucie Performance**
- **Economics**
- **Issues**
- **Future**

## Biographical Information



### **Thomas F. Plunkett**

**President, Nuclear Division**

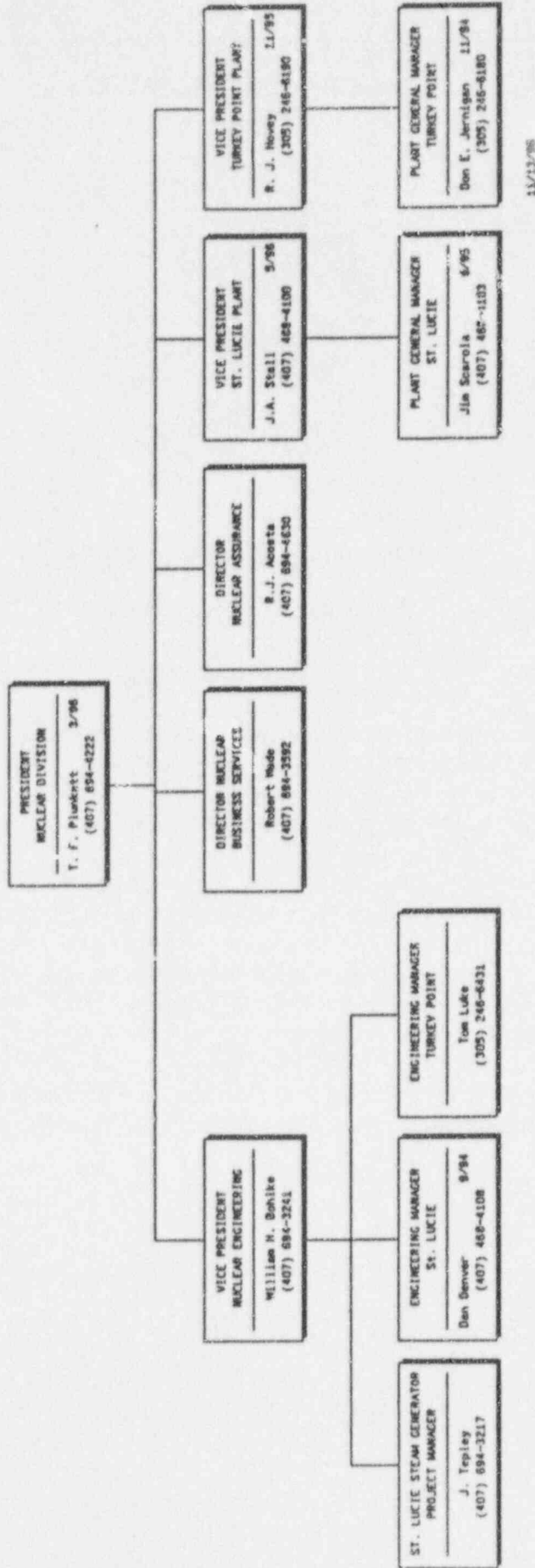
Tom Plunkett is President, Nuclear Division at Florida Power & Light Company. In this function, Mr. Plunkett oversees the operation of FPL's four nuclear units, two at Turkey Point in south Dade County and two at St. Lucie on Hutchinson Island in St. Lucie County as well as the technical support activities at corporate headquarters in Juno Beach.

Mr. Plunkett joined Florida Power and Light Company in 1990 as Vice President, Turkey Point Nuclear Plant. Prior to that he worked for Gulf States Utilities Company as General Manager of the River Bend Nuclear Plant and for Illinois Power Company as General Manager of the Clinton Nuclear Plant. Earlier he was Technical Manager at the D. C. Cook Nuclear Station for the Indiana Michigan Power Company. Mr. Plunkett began his career with the Douglas Aircraft as a nuclear engineer.

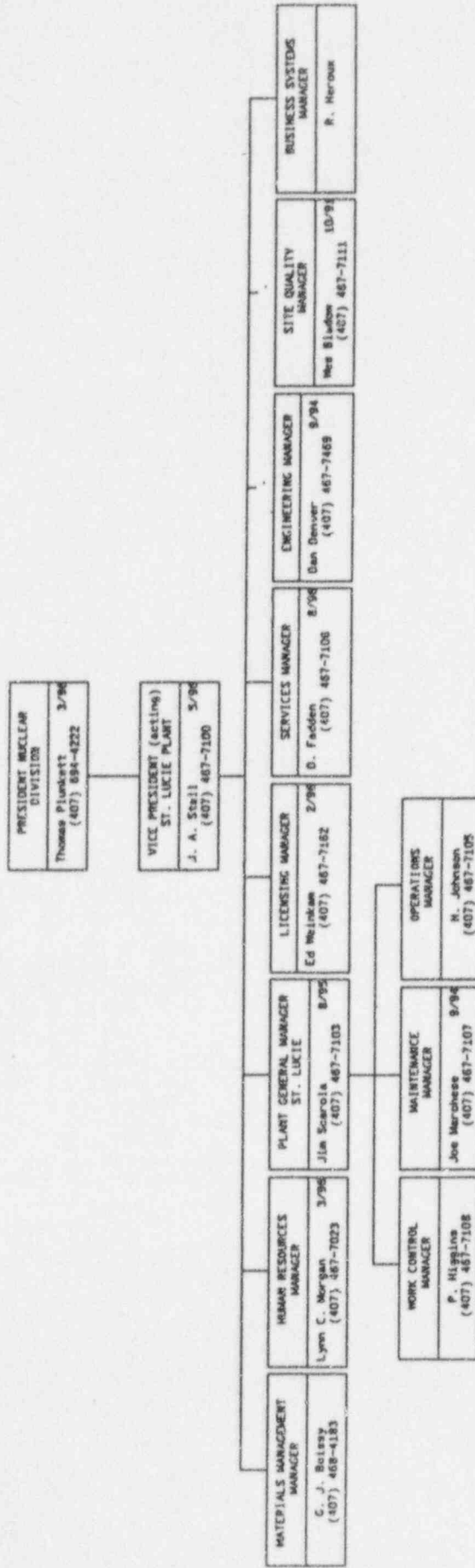
Mr. Plunkett holds both a Bachelor of Science in Mechanical Engineering and a Master of Science in Nuclear Engineering from the University of Wisconsin.

Effective 3/1/96

FLORIDA POWER AND LIGHT  
MANAGEMENT OVERVIEW



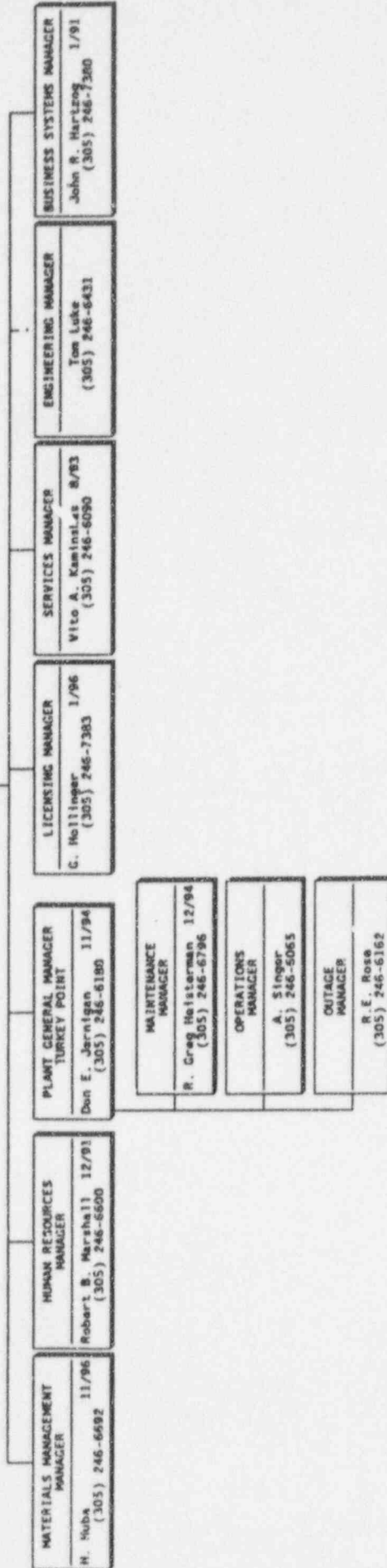
FLORIDA POWER AND LIGHT COMPANY  
ST. LUCIE UNITS 1 & 2



FLORIDA POWER AND LIGHT COMPANY  
TURKEY POINT UNITS 3 & 4

PRESIDENT NUCLEAR  
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VICE PRESIDENT  
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11/13/96