UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA ST., N.W.
ATLANTA, GEORGIA 30323

Report Nos.: 50-250/89-02 and 50-251/89-02

Licensee: Florida Power and Light Company
9250 West Flager Street
Miami, FL 33102

Docket Nos.: 50-250 and 50-251 License Nos.: DPR-31 and DPR-41

Facility Name: Turkey Point Plant, Units 3 and 4

Inspection Conducted: January 17-20, 1989

Inspector: James L. Kreh 2-14-89
J. L. Kreh Date Signed

Approved by: W H Rankin 2-13-89
W. H. Rankin, Acting Chief Date Signed
Emergency Preparedness Section
Emergency Preparedness and Radiation
Protection Branch
Division of Radiation Safety and Safeguards

SUMMARY

Scope: This special, unannounced inspection was conducted to review the licensee's actions with respect to the requirements of the Radiological Emergency Plan and its Implementing Procedures during an incident on January 7, 1989, involving a Reactor Coolant System leak on Unit 3. In addition, a routine inspection was conducted in the area of emergency preparedness which included reviews of the following programmatic elements: (1) Radiological Emergency Plan and Emergency Plan Implementing Procedures; (2) emergency facilities, equipment, instrumentation, and supplies; and (3) organization and management control.

Results: In the areas inspected, one violation was identified involving failure on January 7, 1989 to promptly declare an Alert and provide required notifications to the State of Florida, Dade and Monroe Counties, and the NRC (Paragraph 2). The licensee's deficient response to this event indicated a lack of understanding of the regulatory requirements for declaring and reporting an emergency condition, no matter how briefly it existed, so that local, state, and Federal authorities are made aware of unusual or significant events at the facility. Notwithstanding the licensee's poor performance during the subject event, which appeared to represent an isolated breakdown, the overall findings of this inspection indicated that the licensee was adequately prepared to respond to a radiological emergency at the Turkey Point Plant.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*J. Cross, Plant Manager
*G. LaGarde, Emergency Planning Coordinator (Site)
*J. Maisler, Emergency Planning Manager (Corporate)
R. Mende, Operations Supervisor
*D. Miller, Emergency Planning Senior Engineer (Corporate)
*J. Odom, Site Vice President
*L. Pearce, Operations Superintendent
*F. Southworth, Technical Department Supervisor
A. Taylor, Emergency Planning Technician
T. Wogan, Plant Supervisor-Nuclear

Other licensee employees contacted during this inspection included operators, security force members, technicians, and administrative personnel.

Nuclear Regulatory Commission

*R. Butcher
T. McElhinney

*Attended exit interview

2. Onsite Follow-up of January 7, 1989 Event (93702)

This special inspection was conducted to review the licensee's actions relative to an abnormal event on January 7, 1989, and to determine whether those actions were in accordance with NRC regulations and licensee requirements contained in the Radiological Emergency Plan and the Emergency Plan Implementing Procedures. The inspector interviewed persons who were directly involved in the event response and reviewed supporting documentation, including Control Room logs and licensee summaries and analyses of the event.

On January 7, 1989, at 8:10 a.m., a Control Room operator observed on a data display that the Unit 3 pressurizer level was decreasing. The level ultimately decreased from the original value of 24% to approximately 16% over a period of about seven minutes. The pressurizer level decrease occurred as a result of an operator opening the wrong valve (viz., discharge line drain isolation valve 3-767B) during the process of valving in the 3B RHR [Residual Heat Removal] pump. (The operational aspects of this event are detailed in NRC Report Nos. 50-250, 50-251/88-40.) Leakage of Reactor Coolant System (RCS) inventory occurred for about 20 minutes until the error was detected and the valve in question was closed. Based

on the rate of decrease in the pressurizer level, operators were able to quickly approximate the RCS leak rate as having been 50-70 gpm for a period of several minutes at the outset of the event, although the leak was stopped by the time the aforementioned rate was established. One of the Emergency Action Levels (EALs) in Section 4 of Table 1 (Emergency Classification Table) of Emergency Procedure (EP) 20101 (Duties of the Emergency Coordinator) specified an Alert classification in the event that "RCS water inventory balance indicates leakage _50 GPM by ... [d]ecreasing pressurizer level with all charging pumps running." The Plant Supervisor-Nuclear (PSN) recognized that this EAL had been exceeded, but did not promptly declare the emergency because the leak had already been stopped. Plant management concluded that no emergency declaration was necessary since the event was terminated and the plant was under control. It was further decided that the event was not reportable to the NRC.

The Plant Manager was consulted much later in the day, and he directed the staff to notify the NRC of the event. At 1:28 a.m. on January 8, 1989, the NRC was informed that criteria for an Alert declaration had been met briefly, but that licensee management had decided not to declare an Alert so as to avoid unnecessarily activating their own emergency response facilities as well as those of the State and counties. Cognizant officials of the State of Florida and Dade and Monroe Counties were informed by the licensee of the event in question on January 9, 1989.

The licensee's response to this event indicated a poor understanding of both the letter and intent of NRC guidance and regulatory requirements regarding declaration and reporting of an emergency condition. Such a condition, no matter how briefly it existed, must be promptly declared at the appropriate emergency class and reported in a timely manner to local, State, and Federal authorities so that they are informed of unusual or significant events at the facility. Such information is crucial in order that those authorities are continuously prepared to discharge their responsibility to protect the public health and safety. Moreover, the licensee failed to follow the straightforward requirements of EP 20101. Proper implementation of this procedure would have resulted in simultaneous declaration and termination of the emergency, thus keeping cognizant authorities informed while obviating the need to activate any emergency response facilities.

Failure to follow the requirements of EP 20101 is a violation. Although the NRC recognizes that the licensee identified this violation and took prompt short-term corrective action to preclude a repetition of this type of response, a Notice of Violation is nevertheless being issued to emphasize that the NRC views this as a serious matter which must not be allowed to recur.

Violation 50-250/89-02-01: Failure on January 7, 1989 to promptly declare an Alert and provide required notifications to the State of Florida, Dade and Monroe Counties, and the NRC, in accordance with EP 20101.

3. Emergency Plan and Implementing Procedures (82701)

Pursuant to 10 CFR 50.47(b)(16), 10 CFR 50.54 (q), Appendix E to 10 CFR Part 50, and Section 7 of the licensee's Radiological Emergency Plan, this area was inspected to determine whether significant changes were made to the emergency preparedness program since the inspection of June 1988, and to assess the impact of any such changes on the overall state of emergency preparedness at the facility.

The inspector reviewed the licensee's system for making changes to the Radiological Emergency Plan (REP) and the Emergency Plan Implementing Procedures (EPIPs). The inspector verified that licensee management approved all revisions to the EPIPs issued since June 1988 (no revisions to the REP were issued during this period), and that these revisions were submitted to the NRC within 30 days of the effective date, as required.

The inspector reviewed documentation related to the one emergency declaration which had occurred since June 1, 1988. On August 16, 1988, an incident involving leakage of approximately 3000 gallons of water from the Spent Fuel Pool was classified as a Notification of Unusual Event. Notifications to the State, counties, and NRC were accomplished within the required time limits following the declaration. The licensee conducted a detailed critique of this event which identified numerous minor problems, most of which were related to a finding that internal information was not always accurate or consistent with the REP/EPIPs, nor was the flow of such information uniformly efficient. Some changes in EPIPs were made to address the shortcomings.

No violations or deviations were identified.

4. Emergency Facilities, Equipment, Instrumentation, and Supplies (82701)

Pursuant to 10 CFR 50.47(b)(8) and (9), 10 CFR 50.54(q), and Section IV.E of Appendix E to 10 CFR Part 50, this area was inspected to determine whether the licensee's emergency response facilities and other essential emergency equipment, instrumentation, and supplies were maintained in a state of operational readiness.

The inspector toured the onsite emergency response facilities (ERFs) including the Control Room, Technical Support Center (TSC), and Operations Support Center (OSC). The licensee had completed (in November 1988) the process of moving the OSC from the I&C Building to the Health Physics Building. The space assigned to the Health Physics and Chemistry groups in the TSC was relocated to the NRC Conference Room, with the designated NRC space moved to the opposite side of the TSC. These changes appeared to have enhanced the licensee's operation, and were reflected in Figure 2 of EP 20105. The computer software for the Emergency Response Data Acquisition and Display System (ERDADS) was recently upgraded to provide the capability for dose assessment. This change will be reviewed during a forthcoming ERF appraisal follow-up inspection. According to observations

by the inspector and statements by licensee representatives, no other significant ERF changes were made since the last inspection.

The inspector conducted a detailed review of licensee records dated May to December 1988 to determine compliance with the requirement in REP Section 7.4 that all emergency equipment and instrumentation (maintained in the Control Room, TSC, and OSC, as well as field monitoring equipment at the Florida City Substation) be inventoried, operationally checked, and inspected at least once each calendar quarter and following each use. The records disclosed that this requirement was being met on a monthly (rather than quarterly) basis in accordance with Health Physics procedure HP-90. In addition, emergency equipment and supplies were selectively examined during the inspector's plant tour and found to be maintained in an appropriate state of readiness.

No violations or deviations were identified.

5. Organization and Management Control (82701)

Pursuant to 10 CFR 50.47(b)(1) and (16), Section IV.A of Appendix E to 10 CFR Part 50, and REP Sections 2 and 7, this area was inspected to determine the effects of any changes in the licensee's emergency organization and/or management control systems on the emergency preparedness program and to verify that such changes had been properly incorporated into the REP and EPIPs.

The organization and management of the emergency preparedness program were reviewed. The inspector determined that no significant changes had occurred in this area since the last inspection. Similarly, no changes in management of, or methods of coordination with, key offsite support agencies had occurred since June 1988, according to licensee representatives.

Personnel changes in certain plant management positions resulted in the reassignment of several key positions involving primaries as well as alternates in the emergency response organization. Review of training records of 9 such persons confirmed that training requirements for their new positions in the emergency organization were completed prior to assignment to those positions.

Discussions with licensee representatives indicated that no program was in place to periodically demonstrate that the capability for emergency staff augmentation, as claimed in Table 2-2a of the REP, actually existed during nonregular working hours. The licensee had already begun to review various possible approaches to verifying the required capability, and agreed to expedite corrective action for this finding.

Inspector Follow-up Item (IFI) 50-250, 251/89-02-02: Implementing a program for periodically testing the capability to augment the emergency response organization during off-hours.

6. Action on Previous Inspection Findings (92701)

(Closed) IFI 50-250, 251/87-03-03: Eliminating use of uncontrolled procedures in the Emergency Operations Facility (EOF).

The licensee provided documentation that six controlled copies (nos. 34-39) of the EPIPs were permanently assigned to the EOF effective March 30, 1987. In a related action, two controlled versions of the Plant Operating Diagrams and one of the Piping and Instrumentation Drawings were placed in the EOF in July 1988 in response to an exercise finding by the licensee.

7. Exit Interview

The inspection scope and results were summarized on January 20, 1989, with those persons indicated in Paragraph 1. The inspector described the areas inspected and discussed in detail the inspection results listed below. Although proprietary information was reviewed during this inspection, none is contained in this report. Dissenting comments were not received from the licensee.

Item No.	Description
50-250/89-02-01	Violation: Failure on January 7, 1989 to promptly declare an Alert and make required notifications to State and local authorities and the NRC (Paragraph 2).
50-250, 251/89-02-02	Inspector Follow-up Item: Implementing a program for periodically verifying the capability to augment the emergency response organization during off-hours (Paragraph 5).