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

OCT 26 1984

Report No.: 50-302/84-28

Licensee: Florida Power Corporation
3201 34th Street, South
St. Petersburg, FL 33733

Docket No.: 50-302 License No.: DPR-72

Facility Name: Crystal River Unit 3

Inspection Conducted: September 24 - 27, 1984

Inspector: J. L. Kreh 10-12-84
J. L. Kreh Date Signed

Approved by: J. R. Dicker for 10-12-84
W. E. Cline, Chief Date Signed
Emergency Preparedness Section
Division of Radiation Safety and Safeguards

SUMMARY

Scope: This routine, unannounced inspection involved 33 inspector-hours on site in the area of emergency preparedness.

Results: Violation - failure to adequately maintain emergency implementing procedures. No deviations.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*P. F. McKee, Nuclear Plant Manager
*G. L. Boldt, Nuclear Plant Operations Manager
*M. E. Collins, Nuclear Safety and Reliability Superintendent
*P. J. Skramstad, Nuclear Chemistry & Radiation Protection Superintendent
*A. H. Gelston, Nuclear Electrical/I&C Engineering Supervisor
*P. G. Hughes, Licensing Engineer
*D. E. Spires, Nuclear Compliance Specialist
*S. D. Mansfield, Administrative Assistant to Nuclear Plant Manager
*W. M. Marshall, Nuclear Shift Supervisor
D. B. Eggleston, Nuclear Shift Supervisor
G. P. Hebs, Nuclear Shift Supervisor
T. A. Miller, Nuclear Shift Supervisor
D. P. Jones, Assistant Nuclear Shift Supervisor
G. L. Sutter, Nuclear Operator
*E. K. Neuschaefer, Supervisor, Radiological Emergency Planning

Other Organizations

G. Guthrie, Chief, Division of Emergency Management, Department of Health and Rehabilitative Services, State of Florida

NRC Resident Inspector

T. F. Stetka

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized on September 27, 1984, with those persons indicated in paragraph 1 above. A violation described in paragraph 5 (failure to adequately maintain emergency implementing procedures) was discussed in detail. The licensee took no exception to this finding.

3. Licensee Action on Previous Enforcement Matters

(Closed) Violation (50-302/84-13-03): Failure to specify use of the child thyroid dose in the computerized radioiodine dose assessment procedure. Revision 3 (dated 8-24-84) to EM-204(B) was found to address conversion of the calculated adult thyroid dose rate to the child thyroid dose rate. In addition, the inspector reviewed the letter that was sent to all Dose Assessment Team members on this subject.

4. Emergency Detection and Classification (82201)

Pursuant to 10 CFR 50.47(b)(4) and 10 CFR 50, Appendix E, Parts IV.B and IV.C, this program area was inspected to determine whether the licensee used and understood a standard emergency classification and action level scheme.

The inspector reviewed the licensee's classification procedures. The event classifications in the procedures were consistent with those required by regulation. The classification procedures did not appear to contain impediments or errors which could lead to incorrect or untimely classification, except as noted below.

Selected emergency action levels (EALs) specified in the classification procedures were reviewed. The reviewed EALs appeared to be consistent with the initiating events specified in Appendix 1 of NUREG-0654. The inspector noted that some of the EALs were based on parameters obtainable from Control Room instrumentation. However, the EALs for earthquakes were found to be based on seismic monitoring data which was not readily obtainable, even though the seismic recorder was located in the Control Room. During the three walk-throughs in the Control Room, the Shift Supervisor and his staff were variously either not knowledgeable of how to obtain seismic data from the recorder, or stated that at least 20 minutes were required to obtain the data. In addition, the inspector noted that because of these problems procedure AP-961 ("Earthquake") could not be implemented in a timely manner. The licensee was aware of these inadequacies and had (approximately one month earlier) assigned a Nuclear Operator the collateral responsibility for rectifying this matter. The inspector interviewed the assigned individual to obtain information on potential corrective action. The inspector stated during the exit meeting that NRC considered this matter to be a licensee-identified violation of 10 CFR 50.47(b)(8). Further discussion of this matter during telephone conversations with licensee corporate staff on October 2 and 4 elicited a commitment to complete corrective action for the above-described inadequacy by January 1, 1985.

Inspector Follow-up Item (302/84-28-01): EALs for prompt classification of seismic events.

The inspector verified that the licensee's notification procedures included criteria for initiation of offsite notifications and for development of protective action recommendations. The notification procedures required that offsite notifications be made promptly after declaration of an emergency.

The inspector discussed with licensee representatives the coordination of EALs with State and local officials. On April 18 and August 22, 1984, the licensee conducted special training sessions on plant systems and EALs, to which appropriate State officials, as well as emergency preparedness officials for all counties in the 50-mile EPZ, were invited. A total of 44 persons attended this training. In a telephone conversation with a State

official who had received the training, the inspector inquired about the suitability of this approach to fulfilling the requirement for an annual review of EALs with State and local authorities. The State official commended the licensee's efforts in this area and said that he agreed with the EALs.

Interviews were held with three Shift Supervisors to verify that they understood the relationship between core status and such core damage indicators as containment dome monitor, high-range effluent monitor, and post-accident primary coolant analysis. All interviewees appeared knowledgeable of the various core damage indications and their relationship to core status.

The responsibility and authority for classification of emergency events and initiation of emergency action are prescribed in licensee procedures and in the emergency plan. Interviews with selected key members of the licensee's emergency organization revealed that all except one of these personnel understood their responsibilities and authorities in relation to accident classification, notification, and protective action recommendations. One of the Shift Supervisors did not appear to be aware that he was not allowed to delegate decision-making responsibilities in these three areas (see paragraph 6).

Walk-through evaluations involving accident classification problems were conducted with three Shift Supervisors. Except as noted below, all personnel interviewed promptly and properly classified the hypothetical accident situations presented to them, and appeared to be familiar with appropriate classification procedures. One of the Shift Supervisors experienced considerable difficulty in using the classification matrix in EM-202 ("Duties of the Emergency Coordinator"). This matter is discussed further in paragraph 6.

No violations or deviations were identified in this program area.

5. Protective Action Decision-Making (82202)

Pursuant to 10 CFR 50.47(b)(9) and (10) and 10 CFR 50, Appendix E, Part IV.D.3, this area was inspected to determine whether the licensee had 24-hour-per-day capability to assess and analyze emergency conditions and make recommendations to protect the public and onsite workers, and whether offsite officials had the authority and capability to initiate prompt protective action for the public.

The inspector discussed responsibility and authority for protective action decision-making with licensee representatives and reviewed pertinent portions of the licensee's emergency plan and procedures. The plan and procedures clearly assign responsibility and authority for accident assessment and protective action decision-making. Interviews with members of the licensee's emergency organization revealed that these personnel understand their authorities and responsibilities (except as noted in paragraph 4) with respect to accident assessment and protective action decision-making.

Walk-through evaluations involving protective action decision-making were conducted with three Shift Supervisors. Personnel interviewed appeared to be cognizant of appropriate onsite protective measures and aware of the range of protective action recommendations appropriate to offsite protection. Interviewees demonstrated adequate understanding of the requirement that protective action recommendations be based on core condition and containment status even if no release is in progress.

During one of the walk-throughs, the inspector noted that the Shift Supervisor was using EM-203 ("Recommended Protective Actions for Gaseous Plume Exposure"), which, according to previous discussions with licensee representatives, had been superseded, along with EM-207 ("Reporting Requirements on Emergencies"), by the August 1984 issuance of Revision 23 (dated 7-25-84) to EM-202. The latter procedure consolidated the information that was formerly found in EM-202, EM-203, and EM-207. The inspector determined that two copies of the Emergency Coordinator's Manual and one copy of the Plant Operating Quality Assurance Manual (all are controlled copies kept in the Control Room) contained superseded procedures EM-203 and EM-207.

Violation (302/84-28-02): Failure to maintain emergency implementing procedures as required by Technical Specification 6.8.1.

Licensee procedures make provisions for contacting responsible offsite authorities on a 24-hour basis. Backup communications links with offsite authorities are available. The inspector independently confirmed that offsite decision-makers with authority for emergency response activities could be contacted by making a telephone call to the State Warning Point, Tallahassee, from the Control Room.

One violation and no deviations were identified in this program area.

6. Knowledge and Performance of Duties (Training) (82206)

Pursuant to 10 CFR 50.47(b)(15) and 10 CFR 50, Appendix E, Part IV.F, this area was inspected to determine whether emergency response personnel understood their emergency response roles and could perform their assigned functions.

The inspector reviewed the description (in the emergency plan) of the training program, training procedures, and selected lesson plans, and interviewed members of the instructional staff. Based on these reviews and interviews, the inspector determined that the licensee had established a formal emergency training program.

Records of training for key members of the emergency organization for the period January 1983 to August 1984 were reviewed. According to these records, the type, amount, and frequency of training were consistent with approved procedures.

The inspector conducted walk-through evaluations with selected key members of the emergency organization. During these walk-throughs, individuals were given various hypothetical sets of emergency conditions and data and asked to respond as if an emergency actually existed. Two of the three Shift Supervisors who were interviewed demonstrated familiarity with emergency procedures and equipment, and no problems were observed in the areas of emergency detection/classification and protective action decision-making. As mentioned in paragraph 4, one of the Shift Supervisors was not readily aware of his decision-making responsibilities as interim Emergency Coordinator; he stated that there were no responsibilities which he was not allowed to delegate. That individual also stated that he had one hour (rather than 15 minutes, as required by procedure) to notify offsite governmental authorities upon declaration of an emergency. Furthermore, that same Shift Supervisor had trouble classifying a detailed scenario involving a large-break loss-of-coolant accident (LOCA). His classifications of the first two stages of this scenario were incorrect due to the use of an inappropriate accident category in the classification matrix; he used the proper category for the third stage only after prompting by the inspector. During a meeting on September 27 (prior to the exit interview), the inspector discussed these findings with the Plant Manager and several members of his staff. The licensee agreed to provide prompt remedial training, within a time frame of several weeks from that date, for the Shift Supervisor in question. Further discussion of this matter during telephone conversations with licensee corporate staff on October 2 and 4 elicited a commitment to provide training and to certify the successful completion of said training by November 2, 1984.

Inspector Follow-up Item (302/84-28-03): Remedial training for one of the Shift Supervisors.

No violations or deviations were identified in this program area.

7. Licensee Audits (82210)

Pursuant to 10 CFR 50.47(b)(14) and (16) and 10 CFR 50.54(t), this area was inspected to determine whether the licensee had performed an independent review or audit of the emegency preparedness program.

Records of audits of the program were reviewed. The records showed that an independent audit of the program was conducted by the Quality Programs Department (corporate) on January 9 - February 3, 1984. This audit (documented in Audit Report QP-249, dated March 2, 1984) fulfilled the 12-month frequency requirement for such audits. The audit records showed that the State and local government interfaces were evaluated, and that findings concerning the interfaces were made available to State and local government authorities. Audit findings and recommendations were presented to plant and corporate management. A review of past audit reports indicated that the licensee complied with the five-year retention requirement for such reports.

Licensee emergency plans and procedures required critiques following exercises and drills. Licensee documentation dated June 20, 1984 showed that a critique was held following the annual exercise. The records showed that deficiencies were discussed in the critiques and recommendations for corrective actions were made.

The licensee's program for follow-up action on audit, drill, and exercise findings was reviewed. Licensee procedures required follow-up on deficient areas identified during audits, drills, and exercises. The inspector reviewed licensee records which indicated that corrective action was taken on identified problems, as appropriate. The licensee had established a tracking system as a management tool in following up on actions taken in deficient areas.

No violations or deviations were identified in this program area.

8. Inspector Follow-up (92701)

a. (Closed) Inspector Follow-up Item (IFI) 302/83-13-02: Revision of EM-202 and EM-207. See paragraph 8d below.

b. (Closed) IFI 302/83-13-08: Procedurally providing for acquisition of the dose assessment computer at the TSC. This is now covered in EM-204(B), Revision 3, dated 8-24-84.

c. (Closed) IFI 302/83-13-12: Establishing either 75 rem or 100 rem as the plant lifesaving standard. RP-101 has been revised to eliminate the remaining inconsistency that was noted in IE Report No. 50-302/84-18, paragraph 11.

d. (Closed) IFI 302/84-13-02: Revision of EM-202 and training in its use for potential Emergency Coordinators. The inspector reviewed EM-202, Rev. 23, and found it to be an improvement over the former arrangement, which scattered the same types of information among EM-202, EM-203 and EM-207. Training on the new version of EM-202 was provided to potential Emergency Coordinators through issuance on 8-14-84 of a self-study package from the Nuclear Emergency Training Instructor which highlighted the changes and provided hints for practical use of the procedure.

e. (Closed) IFI 302/84-18-01: Instruction of Shift Supervisors on use of meteorological instrumentation. A short-term instruction was in effect which specified use of the "old" meteorological instrumentation if meteorological data are needed for the implementation of manual dose assessment procedure EM-204(A).

f. (Closed) IFI 302/84-18-03: Revision of dose assessment model to compensate for source-term decay prior to release. A licensee representative said that the State's dose assessment model did not provide for source-term decay. The State indicated in discussions with the licensee that it did not wish to revise its dose assessment model to compensate for source-term decay. The licensee has decided to retain assessment consistency with the State. The inspector had no further questions on this matter.