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Docket No. 50-443

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U.S. NRC Region I
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Seabrook Station

Clarification of the Event Description for NRC Evaluated Emergency Preparedness Exercise

Reference: NRC letter "Seabrook Station, Unit 1 – NRC Evaluated Emergency Preparedness Exercise Inspection Report 05000443/2012503 – Preliminary White Finding,"
May 29, 2012

The referenced letter discusses a preliminary white finding related to a failure to identify a weakness associated with a risk significant planning standard during the April 17, 2012 emergency preparedness (EP) exercise critique. In describing the preliminary finding, the inspection report represents that the station staff did not recognize that a release was in progress, and that, as a result, the radiological release condition was inaccurately reported on the state notification form as "A radiological release has not occurred." While NextEra Energy Seabrook, LLC (NextEra) is not contesting the finding or the associated cross-cutting aspect, the purpose of this letter is to clarify the event description related to the preliminary white finding with regard to the status of the radiological release.

NextEra is performing a root cause evaluation on the events surrounding the preliminary white finding. Although the evaluation has not been finally completed, the root cause team has evaluated the conditions that immediately preceded the offsite notification made at 11:28. While the inspection report represents that the station staff did not recognize that a release was in

progress when developing the protective action recommendations (PAR) and determining the release status for the 11:28 offsite notification, the root cause team has determined that no radiological release was in progress at 11:28.

During the April 17, 2012 EP drill, NextEra declared a General Emergency (GE) due to a simulated large break loss of coolant accident. The NRC inspection report describes the following sequence of events upon declaration of the GE:

The Emergency Offsite Facility (EOF) Coordinator initiated action to develop the required PAR and associated offsite notification form. This included verification of the status of any radiological release that might be occurring from the site. As part of that process, he requested the meteorological tower lower elevation wind direction from the dose assessment team. Station procedures required that the lower elevation wind direction be used for no-release conditions, which the EOF Coordinator believed was the case. If the licensee had been aware that a release was in progress, the procedure would have directed the EOF Coordinator to use the upper elevation wind direction to develop the PAR. In response to the EOF Coordinator request, the EOF dose assessment staff, which also did not recognize a release was in progress, incorrectly provided the upper elevation wind direction (81-degrees) instead of the lower elevation wind direction (146-degrees). The EOF Coordinator used the upper elevation wind direction to develop the PAR, thinking he was using the lower wind direction. At 1128, the EOF Coordinator notified the State Emergency Operation Centers of the GE and the PAR. The EOF Coordinator believed he was notifying the States of a PAR for no release in progress, but because of the EOF dose assessment error of providing the wind direction used for release conditions, the PAR was actually correct per the exercise scenario (i.e., a release was occurring). The radiological release condition was, however, inaccurately reported on the notification form as "A radiological release has not occurred."

The on-going root cause evaluation has determined that a radiological release was not in progress at the time of declaration of the GE. Station procedures define a release in progress, in part, by actuation of an Alert or High alarm on the wide range gas monitor (WRGM). The WRGM did not initiate an Alert alarm until 11:29; therefore, no release was in progress prior to the offsite notification made at 11:28. As a result, the EOF Coordinator's intention to develop the PAR based on lower elevation wind direction for a no-release condition and the report that a radiological release had not occurred were appropriate for the existing conditions.

During development of the PAR, the EOF Coordinator requested both the upper and lower wind directions from the EOF dose assessment staff. He then incorrectly used the upper wind direction rather than the lower wind direction to develop the PAR. A peer check of the documents prepared by the EOF Coordinator failed to identify the incorrect use of upper wind

direction in developing the PAR for a no-release condition. Consequently, use of the wrong wind direction resulted in an offsite notification containing an incorrect PAR.

At 11:30, the EOF staff confirmed a release was in progress following actuation of an Alert alarm on the WRGM. The EOF Coordinator recognized the need to make another state notification due to the change in radiological conditions. During preparation of the documents for this notification, the EOF Coordinator recognized his error in the 11:28 offsite notification.

The EOF Coordinator held a meeting with the EOF dose assessment staff to inform them that he had used the incorrect wind direction in the first notification. However, the critique of the exercise failed to identify the errors associated with offsite notification of an incorrect PAR.

Should you have any questions regarding this letter, please contact Mr. Michael O'Keefe, Licensing Manager, at (603) 773-7745.

Sincerely,

NextEra Energy Seabrook, LLC



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