

Public Citizen

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Ralph Nader, Founder


October 23, 1992

James Taylor
Executive Director for Operations
U.S. Nuclear Regulatory Commission
Washington, DC 20555

Dear Mr. Taylor:

Enclosed you'll find a 2.206 petition submitted by Public Citizen, Greenpeace, Nuclear Information & Resource Service and the Safe Energy Communication Council.

Sincerely,


James P. Riccio
Energy Campaigner

Public Citizen's Critical Mass Energy Project

9211240294

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Buyers Up • Congress Watch • Critical Mass • Health Research Group • Litigation Group

Ralph Nader, Founder

UNITED STATES OF AMERICA
BEFORE THE NUCLEAR REGULATORY COMMISSION
PETITION FOR SHOW CAUSE CONCERNING
TURKEY POINT NUCLEAR PLANT UNITS 3 & 4

JURISDICTION AND INTRODUCTION

This petition is filed pursuant to 10 CFR 2.206 and 10 CFR 2.202. The action requested is that an order be issued to the Florida Power and Light company (FPL) to show cause as to why the Turkey Point nuclear plant, units 3 & 4 should not remain closed and or have its operating license suspended by the U.S. Nuclear Regulatory Commission unless and until that time at which the licensee demonstrates conclusively to the commission and the public that the radiological emergency response plan fully complies with 10 CFR 50.47 and 10 CFR Part 50, Appendix E.

The following material demonstrates that there is not reasonable assurance that the Turkey Point nuclear plant can be operated safely due to the numerous deficiencies in the radiological emergency response plan.

DESCRIPTION OF PETITIONERS

Public Citizen is a non-profit, public interest organization whose objectives include safeguarding the public health and welfare and educating the public about issues that effect their health and safety. Public Citizen has over 110,000 members nation wide. Public Citizen brings this petition on behalf of our members living within the 50 mile ingestion pathway emergency planning zone as well as those of our members that reside within the 10 mile plume exposure pathway emergency planning zone for the Turkey Point nuclear plant.

Greenpeace is an international nonprofit organization dedicated to protecting the environment through non-violent direct action. Greenpeace has over 4 million members nationwide. Greenpeace brings this petition on behalf of our members living within the 50 mile ingestion pathway emergency planning zone as well as those of our members that reside within the 10 mile plume exposure pathway emergency planning zone for the Turkey Point nuclear plant.

The Nuclear Information & Resource Service is a nonprofit organization dedicated to providing the public and its members with accurate and intelligible information on nuclear issues. NIRS has been a participant in nuclear regulatory affairs including rulemakings, enforcement actions and adjudications involving individual plants since 1978. NIRS brings this petition on behalf of our members living within the 50 mile ingestion pathway emergency planning zone as well as those of our members that reside within the 10 mile plume exposure pathway emergency planning zone for the Turkey Point nuclear plant.

The Safe Energy Communication Council (SECC) is an environmental coalition of national energy, environmental and public interest media groups working to increase public awareness of the ability of energy efficiency and renewable energy sources to meet an increasing share of our nation's energy needs, and of the serious economic and environmental liabilities of nuclear power. Members of the 11 national organizations that comprise SECC reside in the area effected by the Turkey Point nuclear plant. SECC brings this petition on behalf of our coalitions members living within the 50 mile ingestion pathway emergency planning zone as well as those of our members that reside within the 10 mile plume exposure pathway emergency planning zone for the Turkey Point nuclear plant.

I. RADIOLOGICAL EMERGENCY RESPONSE PLAN

Nuclear Regulatory Commission (NRC) regulations provide that no full power operating license shall be issued by the NRC unless the NRC finds "that there is reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency." (10 CFR 50.47 (a)(1)). The NRC lists sixteen particular standards which must be met by the emergency response plans. (10 CFR 50.47 (b)). A more detailed presentation of the minimum requirements for emergency plans are set out in "Emergency Planning and Preparedness for Production and Utilization Facilities" (10 CFR part 50, Appendix E). The NRC bases its finding of adequacy of the emergency plan upon a review by the Federal Emergency Management Agency (FEMA) of state and local emergency plans (10 CFR 50.47 (a)(2)). Evaluation criteria relied upon by state and federal agencies to set up and evaluate emergency plans is set out in "Criteria for Preparation and Evaluation of Radiological Emergency Response Plans and Preparedness In Support of Nuclear Power Plants," NUREG-0654 /FEMA-REP-1, Rev. 1, November, 1980 & Supplement 1988.

Both the NRC and FEMA are empowered to withdraw their approval of plans that do not adequately protect the public (10 CFR 50.100, 50.54 (e); 44 CFR 350.13). The NRC can revoke, suspend or modify a license to operate a nuclear power plant (10 CFR 50.100).

Serious deficiencies exist in the radiological emergency response plan for the Turkey Point nuclear plant, warranting the suspension of Florida Power and Light Company's operating license by the NRC. The effect of these deficiencies are such that there is NOT "reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency" as required by 10 CFR 50.47 (a)(1). A specific delineation of the deficiencies in the licensee's radiological emergency response plan is set out below.

II. DEFICIENCIES IN NOTIFICATION DURING AN ACCIDENT

Federal Regulations require notification of "all segments" of the population (10 CFR Part 50, Appendix E, IV. D. 3). The licensee's offsite emergency plan fails to meet this requirement in several regards. In the preliminary report on the status of the radiological emergency preparedness capabilities in the 10 mile EPZ surrounding the Turkey Point nuclear plant, FEMA states that:

Due to extensive electric power disruption, it must be assumed that a number of EPZ residents do not have access to the EBS messages which provide specific instructions relative to the emergency. There is also good reason to believe that most of those residents are living in structures which are or will be condemned and that these structures are spread throughout the EPZ with no identifiable concentrations. Also, as a result of Hurricane Andrew there are residents living in Life Support Centers (tent cities) who may not have access to radio or television.

(Letter from Grant Peterson, Associate Director, State and Local Programs and Support, Federal Emergency Management Agency; to James M. Taylor, Executive Director for Operations, U.S. Nuclear Regulatory Commission, October 16, 1992, p. 4. hereinafter referred to as FEMA preliminary report).

To compensate, FP&L plans to use the siren system in the public address mode. However, FEMA acknowledges that the audibility of such a system has not been verified and will not be verified until full cycle tests of the system are conducted in November.

Restart of the Turkey Point nuclear plant absent verification of this system constitutes a violation of NRC regulations requiring that "means to provide early notification and clear instruction to the populace within the plume exposure pathway Emergency Planning Zone have been established" (10 CFR 50.47 (b)(5)).

Petitioners ask that the NRC suspend FP&L's license to operate the Turkey point nuclear plant Units 3 & 4 until "there is reasonable assurance that adequate protective measures can and will

be taken in the event of a radiological emergency." (10 CFR 50.47 (a)(1)).

III. DEFICIENCIES IN NOTIFICATION OF PERSONS WITH SPECIAL NEEDS

As noted above, federal regulations require notification of "all segments" of the population (10 CFR Part 50, Appendix E, IV. D. 3). However, FEMA's preliminary report shows that the special needs community within the Turkey point EPZ is on the whole unreachable. The preliminary report states that:

FEMA attempted to call 42 special facilities; 14 calls were successfully completed, 13 yielded no answer after 10 rings, 7 yielded constant busy signals, 6 were intercepted by a phone company message that the call could not be completed, and 2 yielded only static on the line. FPL attempted to call 134 PSN's (persons with special needs); only 6 calls were successfully completed.

(FEMA Preliminary report, p. 3)

FEMA acknowledges that these results warrant a reassessment of the special needs population and alternative means of notification. However, acknowledging a problem is not the same as solving it.

FEMA's recommended compensatory measures do not address the problem of notifying the special needs population. FEMA's recommended compensatory measure of using patrol cars to notify the population fails to meet the NRC regulations requiring "prompt notification of the public within the plume exposure pathway EPZ within about 15 minutes." (10 CFR Part 50, Appendix E, IV. D. 3.) Nor can any credit be given to sheltering of the special needs population given the wide spread devastation of southern Dade County. As acknowledged by FEMA, "residents are living in structures which are or will be condemned and that these structures are spread throughout the EPZ with no identifiable concentrations." (FEMA Preliminary Report, p. 4)

Restart of the Turkey Point nuclear plant prior to addressing the problems of notifying the special needs community constitutes a violation of 10 CFR part 50, appendix E and NRC regulations requiring that "means to provide early notification and clear instruction to the populace within the plume exposure pathway Emergency Planning Zone have been established" (10 CFR 50.47 (b)(5)).

Again, petitioners request that the NRC suspend FP&L's license to operate the Turkey point nuclear plant Units 3 & 4 until "there is reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency" (10 CFR 50.47 (a)(1)).

IV. DEFICIENCIES IN EVACUATION PLANS

The original evacuation plans for the Turkey point plume exposure pathway EPZ and the ingestion pathway EPZ are based upon assumptions which are no longer valid.

The original plan calls for residents within the EPZ to use their own vehicles to evacuate. However, as stated by FEMA, "it is evident that there was considerable loss of personal vehicles caused by Hurricane Andrew. Those residents suffering vehicle loss may have difficulty evacuating the EPZ after being notified." (FEMA Preliminary Report, p.2)

The original plan calls for the sheltering of those populations which are unable to evacuate. However, as noted by FEMA "... residents are living in structures which are or will be condemned and that these structures are spread throughout the EPZ with no identifiable concentrations. Also, as a result of Hurricane Andrew there are residents living in Life Support Centers (tent cities)..." (Id at p.4)

The original plan assumes that residents have electricity and telephone service and thus can be notified of a radiological emergency in a timely manner. However, FEMA acknowledges that "due to extensive electric power disruption, it must be assumed that a number of EPZ residents do not have access to the EBS messages which provide specific instructions relative to the emergency." (Id at p. 4)

FEMA has failed to address the disruption of traffic patterns caused by Hurricane Andrew. In fact the press has done a better analysis of this problem than has FEMA. Data is readily available from the Florida Department of Transportation (DOT) yet FEMA does not even address this issue in its preliminary report to the NRC. DOT's director of operations for Dade County has stated that "its going to be anywhere from six months to a year before we begin to see normal traffic patterns." (Holly, Dan "Traffic up, road ratings down following storm" Miami Herald, Oct. 19, 1992 p. 2B). Failure to address this issue will result in unrealistically low evacuation time estimates. Petitioners argue that the disruption in traffic patterns within the plume exposure pathway EPZ constitutes such a change in the licensee's emergency plan that FP&L's analysis of evacuations time required under 10 CFR Part 50, Appendix E, IV, is essentially meaningless.

FEMA's recommended compensatory measures on these and other issues fail to meet the NRC requirement "that there is reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency." (10 CFR 50.47 (a)(1)). FEMA's recommended compensatory measures are not "adequate"; they are ad hoc and as such constitute a new and as yet untested emergency evacuation plan.

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*Current version sent to OGC
 approx 2/1/93. In late February
 we insisted on getting at least
 part of their comments which we did
 (unofficially). We addressed them all
 and sent the corrected version back up on 2/26.
 Still awaiting the rest of their comments.*

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~~FOR~~
 PLANNING

In view of the confusion surrounding the aborted restart of the Turkey point nuclear plant, serious questions have been raised as to the ability and commitment of the Florida Power & Light Company and the U.S. Nuclear Regulatory Commission to abide by regulations requiring "that there is reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency." (10 CFR 50.47 (a)(1)).

There is, as yet, no explanation as to why the licensee was allowed to attempt a restart of Turkey Point nuclear plant, Unit 4; nor any indication from the Nuclear Regulatory Commission as to why it failed to enforce its own regulations. Petitioners argue that this is yet another instance where the agency has "failed to maintain a proper regulatory relationship with the nuclear industry." (Subcommittee on General Oversight and Investigations, Committee on General Oversight and Insular Affairs, U.S. House of Representatives, 100th Congress, First Session, NRC COZINESS WITH INDUSTRY: Nuclear Regulatory Commission Fails to Maintain Arms Length Relationship with the Nuclear Industry, December 1987, p. 5.)

As indicated in correspondence attached to this petition, neither Dade county nor FEMA were informed of the licensee's decision to restart unit 4 until the reactor was in power ascension. (See Letter to Joette Lorion, President, Floridians for Safe Energy, from Joaquin G. Avino, County Manager, Metropolitan Dade County, October 15, 1992.)

In fact, NRC indicated to FEMA that "no restart of the reactors was contemplated prior to mid-November at the earliest." (Letter to The Honorable Robert Graham, United States Senate; from Grant C. Peterson Associate Director, State and Local Programs and Support, Federal Emergency Management Agency, October 15, 1992, p.1). Mr. Peterson further states that the NRC

allowed the FP&L to restart the reactor "(w)ithout any coordination, advance notice, or request that FEMA confirm offsite capabilities..." as required by the April 1985 FEMA/NRC Memorandum of Understanding (MOU). (Id at p.1).

Until this issue is addressed, any finding by the NRC that "there is reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency" is meaningless. (10 CFR 50.47 (a)(1)). The NRC and the licensee have already evinced their disregard for the public health and safety by the aborted restart of Turkey Point nuclear plant, unit 4. Any attempt to restart the nuclear plant absent a fully revised and tested radiological emergency response plan will constitute a violation of NRC regulations as well as an abrogation of the Commission's duty to ensure the public health and safety under the Atomic Energy Act of 1954.

Petitioners again request that the NRC suspend FP&L's license to operate the Turkey point nuclear plant Units 3 & 4 until "there is reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency" (10 CFR 50.47 (a)(1)).

CONCLUSION

The petitioners have demonstrated that the inadequacy of the radiological emergency response plan for the Turkey Point nuclear plant, as well as the inattentiveness of the licensee and the Commission combine to preclude any "reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency" (10 CFR 50.47 (a)(1)).

Consequently, the petitioners request that the NRC issue an order to the Florida Power and Light Company to show cause as to why the Turkey Point nuclear plant should not remain closed, and initiate proceedings to suspend FP&L's operating license for Turkey Point nuclear plant units 3 & 4, unless and until that time at which the licensee demonstrates conclusively to the NRC and the public that the radiological emergency response plan is in full compliance with the provisions of 10 CFR 50.47 and 10 CFR part 50 Appendix E; and that coordination between the licensee, NRC, FEMA, state and county agencies is such that the NRC ensure the public health and safety. Any attempt to restart the nuclear plant absent a fully revised and tested radiological emergency response plan will constitute a violation of NRC regulations as well as an abrogation of the Commission's duty to ensure the public health and safety under the Atomic Energy Act of 1954. The petitioners also request that, subsequent to the suspension of FP&L's operating license, the NRC provide to the public a full accounting of the factual basis for any determination it makes pursuant to the lifting or revision of the operating license suspension.

Furthermore, the petitioners request that the NRC, prior to allowing restart of the Turkey Point nuclear plant schedule a

comprehensive public hearing to address the issues raised in this petition. Such a hearing should address the confusion evident in the aborted restart of Turkey Point Unit 4 and other related issues, including but not limited to Turkey Point nuclear plant's relationship to present and future regional energy needs.

Petitioners reserve their right to amend this petition as new information becomes available from the Federal Emergency Management Agency, state and local emergency planning agencies.

Respectfully Submitted October 23, 1992:

James P. Riccio
Energy Campaigner
Public Citizen's Critical Mass Energy Project.
215 Pennsylvania Ave. SE
Washington DC 20003

Harvey Wasserman
Energy Campaigner
Greenpeace
1436 U street NW
Washington DC 20009

Michael Marriotte
Director
Nuclear Information & Resource Service
1424 16th Street NW
Washington, DC 20036

Scott Denman
Director
Safe Energy Communication Council
1717 Massachusetts Ave. NW
Washington, DC 20036

Docket Nos. 50- and 50-
(10 CFR § 2.206)

Mr. James P. Riccio
Energy Campaigner
Public Citizen
215 Pennsylvania Ave., S.E.
Washington, DC 20003

Dear Mr. Riccio:

This letter is to acknowledge receipt of a Petition dated October 23, 1992, submitted by you on behalf of Public Citizen, Greenpeace, Nuclear Information & Resource Service and the Safe Energy Communication Council (Petitioners) to the Executive Director for Operations of the U. S. Nuclear Regulatory Commission (NRC) pursuant to 10 CFR § 2.206. The Petition has been referred to my office for preparation of a response.

In the Petition, you requested that the NRC issue an order to show cause to the Florida Power & Light Company (FP&L or Licensee) as to why the Turkey Point Nuclear Units should not remain closed or have its operating license suspended by the NRC unless and until such time as the Licensee demonstrates full compliance with the NRC's emergency planning regulations.

The Petition alleged a number of deficiencies regarding emergency planning at the Turkey Point Units as a result of the effects of Hurricane Andrew. Deficiencies are alleged in the following areas: notification during an accident and notification of persons with special needs and evacuation plans. In alleging these deficiencies, Petitioners rely in part on a preliminary report prepared by the Federal Emergency Management Agency (FEMA) and forwarded to the NRC on October 16, 1992. The petitioners also allege deficiencies in the coordination between the Licensee, and federal, state and local agencies responsible for radiological emergency response planning based on the circumstances surrounding the initial restart of the Turkey Point Unit 4 following Hurricane Andrew. It is alleged that the NRC allowed the Licensee to restart the reactor without any coordination, advance notice, or request that FEMA confirm offsite capabilities.

With regard to your request in the Petition that the Turkey Point Units not resume operation or that the operating license be suspended until your concerns have been addressed, (NRR to provide a response. Response to note that the Turkey Point units have been restarted).

Accordingly, your request that the operating licenses for the Turkey Point Units be suspended until your concerns are addressed is (granted/denied). As provided by § 2.206, the NRC will take

-2-

action with regard to the specific issues raised in your Petition within a reasonable time. For your information, I have enclosed a copy of the Notice that is being filed with the Office of the Federal Register for publication.

Sincerely,

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation

Enclosure: As stated

cc w/enclosure: Turkey Point Licensee

U.S. NUCLEAR REGULATORY COMMISSION

Docket Nos. 50- and 50-

FLORIDA POWER & LIGHT COMPANY

Turkey Point Nuclear Units

RECEIPT OF PETITION UNDER 10 C.F.R. SECTION 2.206

Notice is hereby given that, on October 23, 1992, Mr. James P. Riccio submitted a Petition to the U.S. Nuclear Regulatory Commission (NRC) pursuant to 10 CFR § 2.206 regarding the Turkey Point Nuclear Units of the Florida Power & Light Company (FP&L or Licensee). The Petition was submitted on behalf of Public Citizen, Greenpeace, Nuclear Information & Resource Service and the Safe Energy Communication Council (Petitioners). The Petition has been referred to the Office of Nuclear Reactor Regulation for preparation of a response.

The Petitioners alleged a number of deficiencies regarding emergency planning at the Turkey Point Units as a result of the effects of Hurricane Andrew. Deficiencies are alleged in the following areas: notification during an accident and notification of persons with special needs and evacuation plans. In alleging these deficiencies, Petitioners rely in part on a preliminary report prepared by the Federal Emergency Management Agency (FEMA) and forwarded to the NRC on October 16, 1992. The Petitioners also allege deficiencies in the coordination between the Licensee, and federal, state and local agencies responsible for radiological emergency response planning based on the circumstances surrounding the initial restart of the Turkey Point Unit 4 following Hurricane Andrew. It is alleged that the NRC allowed the Licensee to restart the reactor without any coordination, advance notice, or request that FEMA confirm offsite capabilities.

Based on these allegations, Petitioners requested that the NRC issue an order to show cause to the Florida Power & Light Company (FP&L or Licensee) as to why the Turkey Point Nuclear Units should not remain closed or have its operating license suspended by the NRC unless and until such time as the Licensee demonstrates full compliance with the NRC's emergency planning regulations. In a letter dated _____, the Petitioners' request that the Turkey Point Nuclear Units not be permitted to restart was denied.

As provided by § 2.206, appropriate action with regard to the specific issues raised in the Petition will be taken within a reasonable time.

A copy of the Petition is available for inspection at the Commission's Public Document Room at 2120 L Street, NW, Washington, DC 20555 and at the Local Public Document Room for the Turkey Point plant located at _____.

FOR THE NUCLEAR REGULATORY COMMISSION

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland
this ____ day of _____, 1992

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RECIP. NAME RECIPIENT AFFILIATION
MURLEY, T.E. Office of Nuclear Reactor Regulation, Director (Post 870411) R

SUBJECT: Forwards 921023 petition submitted by JP Riccio on behalf of
Public Citizen, Greenpeace, NIRS & SECC alleging numerous
deficiencies re emergency planning at plant as result of
effects of hurricane Andrew. I
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UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

OGC
Concurrence
Version
5/27/93

Docket Nos. 50-250
and 50-251
(10 CFR § 2.206)

@ 5⁰⁰ pm

L. Laghara

~~Fete~~

Mr. Regino R. Diaz-Robainas
5932 SE Riverboat Drive
Stuart, Florida 34997

Dear Mr. Diaz-Robainas:

I am responding to your Petition of October 15, 1992, that you submitted to my office pursuant to Section 2.206 of Title 10 of the Code of Federal Regulations (10 CFR § 2.206). In a letter of October 21, 1992 you filed an addendum to your October 15, 1992 Petition.

In the Petition and its addendum, you alleged deficiencies with the Turkey Point units and requested the U.S. Nuclear Regulatory Commission (NRC) to not permit the Florida Power and Light Company (FPL or the Licensee) to resume operation of the units until your concerns were addressed. I acknowledged receipt of your Petition in a letter of October 23, 1992, and denied your request because the issues raised in your Petition were not of sufficient safety significance to warrant action by the NRC to preclude restart of Turkey Point nuclear units. In my October 23, 1992 letter, I indicated that the NRC staff would issue a detailed response to the specific issues raised in your Petition. The NRC staff has completed its review of the issues and reached final conclusions which are discussed in the enclosed Director's Decision. I am also enclosing copies of inspection reports referenced in the Decision.

For the reasons discussed in the Director's Decision, we conclude that the Turkey Point facilities are being operated in accordance with NRC regulations and do not endanger the health and safety of the public. Therefore, any further action on the issues you have raised in your Petition is denied.

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Mr. Regino R. Diaz-Robainas

- 2 -

As required in 10 CFR 2.206(c), a copy of this Director's Decision will be filed with the Secretary for the Commission for review. I have also enclosed a copy of the notice that is being filed with the Office of the Federal Register for publication.

Sincerely,

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation

Enclosures:

1. Director's Decision (DD-93-)
2. Federal Register Notice
3. Inspection Reports

cc w/enclosures and incoming:
See next page

As required in 10 CFR 2.206(c), a copy of this Director's Decision will be filed with the Secretary for the Commission to review. I have also enclosed a copy of the notice that is being filed with the Office of the Federal Register for publication.

Sincerely,

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation

Enclosures:

1. Director's Decision (DD-93-)
2. Federal Register Notice
3. Inspection Reports

cc w/enclosures and incoming:
See next page

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* By telephone K.Landis on April 1, 1993

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U.S. NUCLEAR REGULATORY COMMISSIONDOCKET NOS. 50-250 AND 50-251FLORIDA POWER AND LIGHT COMPANYTURKEY POINT NUCLEAR GENERATING UNITS 3 AND 4ISSUANCE OF DIRECTOR'S DECISION UNDER 10 CFR 2.206

Notice is hereby given that the Director, Office of Nuclear Reactor Regulation, has taken action on a Petition of October 15, 1992, and an addendum to the October 15 Petition dated October 21, 1992 (Petition) for action under 10 CFR § 2.206, filed by Mr. Regino R. Diaz-Robainas (Petitioner) concerning the Turkey Point Nuclear Generating Units of the Florida Power and Light Company (FPL or Licensee).

The Petitioner alleged a number of deficiencies with the Turkey Point units during and after Hurricane Andrew. The Petitioner requested that the Turkey Point units, which were shut down, not be permitted to restart until the Petitioner's concerns were addressed. The Notice of Receipt of Petition Under 10 CFR 2.206 was published in the FEDERAL REGISTER on December 9, 1992 (57 FR 58263).

The Director of the Office of Nuclear Reactor Regulation has determined that the Petition should be denied for the reasons explained in the "Director's Decision under 10 CFR 2.206" (DD-93-), which is available for public inspection at the Commission's Public Document Room at 2120 L Street, NW., Washington, DC 20555 and at the Local Public Document Room for the Turkey Point plant located at Florida International University, University Park, Miami, Florida 33199.

A copy of this Director's Decision will be filed with the Secretary for the Commission to review in accordance with 10 CFR 2.206(c). As provided in this regulation, this decision will constitute the final action of the

Commission 25 days after the date of issuance of this decision, unless the Commission on its own motion institutes a review of the decision within that time.

Dated at Rockville, Maryland, this day of June, 1993

FOR THE NUCLEAR REGULATORY COMMISSION

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

OFFICE OF NUCLEAR REACTOR REGULATION
Dr. Thomas E. Murley, Director

In the Matter of)	
)	
FLORIDA POWER AND LIGHT, ET AL.)	Docket Nos. 50-250,
)	50-251
(Turkey Point Nuclear Generating)	
Plant, Units 3 and 4))	10 CFR 2.206

DIRECTOR'S DECISION UNDER 10 CFR 2.206

I. INTRODUCTION

On October 15, 1992, Mr. Regino R. Diaz-Robainas (Petitioner) filed a Petition, pursuant to Section 2.206 of Title 10 of the Code of Federal Regulations (10 CFR 2.206), and alleged a number of deficiencies with the restart of the Turkey Point nuclear units after Hurricane Andrew. On October 21, 1992, the Petitioner filed an addendum to the Petition. The Petitioner requested that the U.S. Nuclear Regulatory Commission (NRC or the staff) not permit the Florida Power and Light Company (FPL or licensee) to resume operating Turkey Point Nuclear Generating Plant units 3 and 4 until the concerns raised in the Petition were addressed. The Petition and its addendum (hereinafter referred to as the Petition) were referred to the Office of Nuclear Reactor Regulation (NRR) for action in accordance with 10 CFR 2.206.

In a letter of October 23, 1992, to the Petitioner, the Director acknowledged receiving the Petition and informed the Petitioner that the issues raised in the Petition were not of sufficient safety significance to warrant action by the NRC to preclude restart of Turkey Point nuclear units. The Director based this determination on NRC inspections and evaluations of

the licensee's restart activities. In its October 23, 1992 letter, the staff indicated that it was documenting NRC inspection activities at the Turkey Point facility in inspection reports which, upon completion, would be made available to the Petitioner and that it would issue detailed responses to the specific issues raised in the Petition within a reasonable time. The staff has completed its review of the issues and has reached final conclusions which are discussed herein.

II. BACKGROUND

Turkey Point, situated on the shore of Biscayne Bay approximately 25 miles south of Miami, Florida, is the site of four electric generation units that are owned and operated by FPL. Turkey Point Units 1 and 2 are fired by oil or gas, and Units 3 and 4 are pressurized water nuclear units. Tropical storms pass through the area about once every 2 years, and hurricane force winds are experienced about once every 7 years.

On August 24, 1992, Class 4 Hurricane Andrew hit south Florida. The eye of the storm passed slightly north of the Turkey Point site and caused damage at the site and throughout the 10-mile emergency planning zone (EPZ) around the plant. The storm damage included loss of offsite power, loss of communications, loss of access by road, and damage to the fire protection and security systems, the material warehouse, and the smoke stacks for the fossil fuel units. When the hurricane warning was issued for southern Florida, FPL declared an "Unusual Event" and brought the units to "hot shutdown" in accordance with its Emergency Plan Implementing Procedures (EPIPs). On August 24, 1992^{at} 9:16 a.m., the licensee upgraded the event classification to an "Alert"^{2A} because of degradation of the fire protection system after the hurricane hit the site. The licensee remained in the Alert status until

August 30, 1992. Upon completing storm damage repairs, FPL restarted Unit 4 on September 28, 1992. On October 1, 1992, FPL voluntarily shut down Unit 4 after being informed by the NRC that the Federal Emergency Management Agency (FEMA) had not completed the post-hurricane reverification of the adequacy of the offsite emergency planning facilities and equipment located within the 10-mile EPZ around the site. FPL suspended operation of the unit until FEMA completed the re-assessment. After FEMA reaffirmed the adequacy of offsite emergency preparedness, on October 25, 1992, FPL resumed operating Unit 4. Upon restarting Unit 4, FPL began its previously scheduled Cycle 13 refueling outage for Unit 3 and repaired the storm damage to this unit. On December 1, 1992, FPL brought Unit 3 to power operation.

The Petitioner alleged deficiencies with the restart of Turkey Point Unit 4 after Hurricane Andrew. The alleged deficiencies are related to the following broad areas: emergency procedures; evacuation mechanisms and offsite power and communications systems; reliability and margin of safety of emergency diesel generators; radiation monitoring; security; interim fire protection; violation of plant Technical Specification (TS) requirements and missed surveillances; TS and design basis adequacy; licensee staffing and economics of reconstruction; and co-existence of nuclear and fossil units.

The staff has reviewed the Petition and the review results are discussed below. On the basis of its review, the staff has concluded that the issues raised in the Petition are not of sufficient safety significance to warrant action by the NRC to preclude continued operation of the nuclear units.

III DISCUSSION

Emergency Procedures

The Petitioner alleged that the licensee violated its emergency procedure, EPIP-20106, which requires plant shutdown to Mode 4 within 2 hours of the projected onset of sustained hurricane force winds (over 73 mph) at the site. The Petitioner expressed concern that Unit 4 did not reach Mode 4 until 4:05 a.m. on August 24, 1992, and should have been shut down before 3:50 a.m. based on the 5:50 a.m. storm arrival time recorded at the National Hurricane Center in Coral Gables.

The licensee's procedures require the units to be in at least Mode 4 (hot shutdown) 2 hours before the projected arrival of hurricane force winds. The hurricane was projected to arrive at early to mid-day on August 24, 1992. The licensee could not accurately determine the exact time that hurricane force winds arrived at the site because the meteorological towers which measure wind speed were damaged. The last credible wind speed measured was approximately 70 mph at 4:50 a.m. on August 24. Estimating 8 hours to achieve hot shutdown, the licensee began shutting down the Unit 3 reactor at 6:00 p.m. on August 23, and began shutting down the Unit 4 reactor at 8:05 p.m. on August 23, 1992 to comply with its procedural requirements. On August 24, Unit 3 entered Mode 4 at 3:12 a.m. and Unit 4 entered Mode 4 at 4:05 a.m. The reactors were in hot shutdown when hurricane force winds arrived at Turkey Point, although the hurricane winds arrived earlier than had been projected when the licensee began the shutdown. This early arrival had no safety consequence since the licensee had elected to maintain both units in the hot shutdown mode to ensure that two methods of cooling were always available: use of the residual heat removal (RHR) system or, on loss of all alternating

current (AC), use of the steam-powered auxiliary feedwater pumps with steam from the steam generators.

Although, in the final hours, immediately before landfall, the hurricane intensified and accelerated and hurricane force winds arrived earlier than projected, the licensee complied with its procedures by shutting down the plant 2 hours before the projected arrival of the storm.

Evacuation Mechanisms and Off-site Power and Communication Systems

As a result of storm damage the Petitioner expressed concern about the design adequacy of critical communication and off-site power systems. The Petitioner stated:

Critical communication and evacuation mechanisms were completely unavailable during hurricane Andrew for a significant period of time during which the units were still in hot shutdown or requiring the operation of critical cooling equipment without offsite power. The burden of proof lies in demonstrating that this absence of safety will no longer occur during future events.

Recognizing that communication and evacuation capabilities could be severely limited or interrupted immediately after the hurricane, the licensee took extensive precautionary measures and, before the arrival of the hurricane, brought the nuclear plants to Mode 4 (hot shutdown) in accordance with its EIPs. Also, before the hurricane, Dade and Monroe Counties issued an evacuation order to the population in the area, including the 10-mile EPZ. During the hurricane, the nuclear units were in hot shutdown and the nuclear safety-related portions of the units were not damaged. The staff finds these emergency preparedness measures to be adequate.

Before Hurricane Andrew, the licensee's communication capabilities included telephone or telephone line-controlled systems, cellular telephone and radio communication systems. The telephone systems either used Southern Bell Company's overhead copper wire or the licensee's corporate fiber-optic

system. Radio communication and cellular telephone systems used antennas that were installed on top of the plant support buildings. Sustained hurricane force winds damaged Southern Bell Company's overhead communication transmission lines, antennas, and transmitters. These offsite communication systems were not designed to withstand the event. The communication systems that used the Southern Bell aerial copper wire along Palm Drive, the main road to and from the plant, failed as a result of fallen trees and missiles generated by high velocity winds.

To improve the reliability of the communication systems, Southern Bell aerial copper wire lines have been replaced by a buried fiber optic cable along Palm Drive. The licensee has installed two new high frequency radio systems for communications between the plant and offsite locations and procured new antennas designed to withstand winds in excess of 322 kilometers per hour (200 mph). Spare portable antennas also are available on site to ensure prompt replacement, if needed. These improvements should adequately reduce the potential for a loss of the offsite communications capability in the future.

The storm also damaged power transmission lines and switchyard equipment, which resulted in loss of offsite power. The nuclear safety systems at the Turkey Point plant are designed to operate without offsite power. Four emergency diesel generators (EDGs) (two for each unit) are designed to receive an automatic start signal immediately on sensing a loss of load from the offsite power supply buses. Only one EDG is required to supply emergency power for each unit. If necessary, the four EDGs can be cross-tied to supply emergency power to either unit. The EDGs are designated as seismic Class/Category I and designed so their integrity is not impaired by the safe

shutdown earthquake, or by the design basis wind storm or floods. None of the safety-related EDGs were damaged by the storm because they are housed in seismic Category 1 steel-reinforced concrete structures. The EDGs and their safety-related electrical buses remained operable throughout the hurricane and recovery and functioned reliably to supply power for adequate cooling functions when the off-site power was unavailable.

Reliability and Margin of Safety for the Emergency Diesel Generators

The Petitioner alleged that the margin of safety for the EDGs was reduced because of clogging of the intake canal cooling water that supplied cooling water to the EDGs and the unavailability of the black start diesel generators (BSDG) as a backup to the EDGs due to oil surrounding the BSDGs. As the basis for his allegation, the Petitioner quoted from the August 24, 1992 NRC transcript of events at Turkey Point following the hurricane:

Licensee noted that this Black Start Diesel which can be used as backup if EDG's fail is inoperable at this time due to a lot of oil surrounding the Diesel following an oil tank rupture...A lot of grass is in the intake structure and licensee has to clean the strains every hour to prevent them from clogging up (supplies cooling water to EDG's)...

The Petitioner further stated that the abolition of EDG component cooling functions is non-conservative and reduces the margin of safety for EDGs and BSDGs which are required during loss of offsite power.

The statement in the August 24, 1992 NRC transcript of events that the intake structure canal "supplies cooling water to EDG's..." is incorrect and may be due to a transcription error or misstatement. The safety-related EDGs, as well as the non-safety-related BSDGs, have closed cooling water radiator systems and do not depend on any outside water source for cooling. Therefore, clogging of the intake canal cooling water by debris did not affect the ability of the EDGs to function.

The hurricane ruptured a fossil unit oil tank and, as a result, the BSDG control and relay panels were covered with fuel oil. This condition did not render the BSDGs inoperable. After the hurricane, moisture intrusion in the non-safety-related breaker cabinets prompted FPL to declare the BSDGs inoperable. The BSDGs are non-safety-related diesel generators and are provided as an additional defense-in-depth to supply AC power through non-safety-related buses to various non-safety-related loads. Thus, inoperability of the non-safety-related BSDGs did not reduce the margin of safety for the EDGs. On August 27, 1992, FPL restored the BSDGs to service.

Expressing his concern regarding reliability of diesels, the Petitioner asserted that failures in both units' redundant diesels "calls into doubt not just the overall reliability of the diesels, but also specific aspects of system[ati]c vulnerability such as weaknesses of the ground detection and isolation mechanisms..." The EDGs at Turkey Point are designed to receive an automatic start signal immediately on sensing a loss of load from the offsite power supply buses. Once the diesel motor and generator are running at the proper speed, the load sequencer automatically sequences the various safety-related loads to the generator. The EDGs and sequencers worked as designed. In preparing for the storm, the licensee tested the EDGs and verified that all fuel tanks were full before the storm arrived. Fuel oil can be transferred between fuel oil storage tanks as required. The available fuel exceeded TS requirements. On August 26, 1992, shipments of diesel fuel began arriving by tanker once the road to the plant was open.

At 11:57 a.m. on August 24, 1992, the 4A EDG power to the 4KV bus was lost for approximately 3 minutes because the output breaker inadvertently opened when operators were attempting to isolate an electrical system ground.

Upon opening breaker 4D23-5, emergency load sequencer 4C23A, power to the 4A sequencer was interrupted, resulting in the 4A EDG output breaker opening. This event was due to a procedural problem. Procedure O-ONOP-003.10, "125 VDC System - Location of Grounds", assumes normal AC and DC power is available. As a corrective action, a cautionary note was added to the procedure reminding personnel that there may be off-normal plant conditions (i.e., EDG operating and supplying power) when certain equipment should not be de-energized. At 7:05 a.m. on August 27, 1992, the 3A EDG tripped because of a lockout which occurred while the 3B EDG remained in operation. Loads were transferred to the 3B EDG. At 9:38 a.m., the 3A EDG was restored to its safety bus. The cause of the 3A EDG lockout could not be determined and did not recur. A single EDG can supply power to all the nuclear safety-related equipment necessary for a single unit during such an event. None of the safety-related EDGs suffered any damage from either the storm or the resultant fossil unit oil spill. Except as noted above, the EDGs and their safety-related electrical buses remained operable throughout the hurricane and recovery.

Radiation Monitoring

The Petitioner alleged that sufficient information regarding monitored radiation/contamination/exposure from August 24, 1992 does not exist. The Petitioner questioned whether there was any radioactive release, or any kind of venting that may have resulted in such release and whether the NRC had enough reliably recorded data to determine radioactive releases to the environment. Referring to an NRC summary of a September 10, 1992 meeting between the licensee and the NRC, which includes a discussion of "Radiation Monitoring Stack-Instrumentation and Minor Stack Foundation Damage", the Petitioner is concerned that radiological assessment teams were not sent out

until 8:01 a.m. on August 24, 1992 and that radiological exposure may have been either not monitorable, or inadequately monitorable for a significant time period.

The licensee maintains a program to monitor radiation, both onsite and in the environs. In accordance with the TS, the licensee monitors radiation offsite using direct radiation monitors: thermoluminescent dosimeters (TLDs) and air samplers. Onsite radiation is also monitored by TLDs and area radiation monitors (ARM). The storm destroyed four air sampling stations and several TLDs surrounding the plant. During and immediately after the storm, 18 of the 30 environmental TLDs remained available to monitor direct radiation levels and detected no abnormal radiation levels. The NRC also had 37 co-located environmental TLDs, of which 18 were damaged. The remaining 19 TLDs were functional. Approximately 52 of 76 TLDs located within the licensee's radiologically controlled area (RCA) and protected area boundaries also continued monitoring for any releases from the plant. All results were within normal levels for TLDs, and the licensee noted no changes to radiation dose rates either inside or outside the RCA. The licensee conducted special surveillances immediately after the storm and continued routine contamination surveillance programs. These surveillances did not show any abnormal contaminations.

Within a few days after the storm, the NRC staff performed radiation surveys (on and off the site) with a portable meter and found no readings above background levels. About a month after the storm, the NRC staff reviewed the licensee's special and routine radiation protection surveillances conducted during the storm and during recovery efforts. During an onsite inspection conducted from September 26, to October 1, 1992, the staff compiled

details of the licensee's Radiation Protection (RP) program activities and analyzed data on the monitored radiation, contamination and exposures. The staff documented this information in Inspection Report (IR) 50-250,251/92-21, dated November 9, 1992. The inspection results are summarized below.

The licensee analyzed the data from the ARMs and those TLDs recovered after the storm. The data did not indicate any unexpected exposures. The licensee reviewed the dose rates for selected ARMs for the period from 0:00 hours on August 23 through 12:00 noon on August 24, 1992. The licensee's records of dose rates for ARMs located in selected areas were as follows: U-3/4 containment refueling floor, approximately 5 millirem per hour (mrem/hr); U-3 containment personnel hatch, 1 - 1.5 mrem/hr; U-3/4 spent fuel pit buildings and transfer canals, 0.5 - 8 mrem/hr; and Auxiliary Building, 0.1 - 0.5 mrem/hr. The licensee compared the ARM data collected during or immediately after the storm with data collected before the storm and found no significant changes in the measured radiation values. The TLDs maintained at selected locations in the RCA and protected area perimeter reported exposure rate values from 8 to 37 microrem per hour (μ rem/hr), which was similar to data for TLDs positioned at each monitoring location during the second quarter of 1992. The licensee collected and processed at least one TLD from each directional sector except for the NNW directional sector. Preliminary results were similar to previous values, with a maximum exposure rate of 7.9 μ rem/hr. The licensee reestablished all required and supplemental TLDs by September 14, 1992. During tours of the environmental monitoring stations on September 26-29, 1992, the inspector verified, by direct observation, the location of the Radiological Environmental Monitoring Program direct radiation monitors (TLDs) as described in the licensee's records for approximately 30 percent of the

licensee's current TLD network. The licensee established all sample stations within several hundred feet of the original locations of these stations. The inspector also verified the location of licensee and NRC TLDs at two separate sample locations.

NRC inspectors reviewed selected chemistry records and held discussions with cognizant licensee representatives. The inspectors found that, before declaring the monitors operable, the licensee established continuous sampling of the main stack effluents with grab samples collected and analyzed every 12 hours. Each week, the licensee analyzed samples for particulates, iodine, and tritium in accordance with the operability requirements of TS 3.3.3.6 and found no abnormal or elevated gaseous effluent concentrations. The licensee's records for selected noble gas, iodine, and particulate analyses of main stack grab samples collected before August 24, 1992, indicated that the only noble gas and iodine species found were xenon-133 (Xe-133) and iodine-131 (I-131), with concentrations ranging from 7 E-8 to 1.1 E-6 microcuries per cubic centimeter ($\mu\text{Ci/cc}$) and 7.8 E-14 to 1.5 E-13 $\mu\text{Ci/cc}$, respectively. The licensee found no radionuclides in the particulate sample analyses.

The hurricane damaged the main stack radiation monitor and the duct from the Radioactive Waste Building to the main stack. During the inspection, NRC representatives verified that before and immediately after the hurricane arrived, the Radioactive Waste Building fan was secured, thus preventing any exhaust from entering the damaged ductwork leading to the main plant stack. To verify the absence of releases from the Radioactive Waste Building, the licensee began continuously sampling the Radioactive Waste Building gaseous effluent pathway on September 5, 1992. The licensee collected and analyzed grab samples every 12 hours. Each week, the licensee also collected and

analyzed samples for iodine, particulates, and tritium. The iodine and tritium concentrations were less than the licensee's analytical detection limits, and the concentrations of total isotopes in the grab samples ranged from $1.6 \text{ E-}7$ to $2.5 \text{ E-}6 \text{ } \mu\text{Ci/cc}$. On September 19, 1992, the licensee discontinued this supplemental sampling after repairing the ductwork leading to the main plant vent.

The inspection team reviewed the analyses conducted for both the main stack and Radioactive Waste Building gaseous effluent samples and found that all radionuclide concentrations were less than the detection limits specified in TS Table 4.11.2. Further, the worst case minimum dispersion value at the site boundary, $5.8 \text{ E-}7 \text{ } \mu\text{Ci/cc}$ as listed in the licensee's Offsite Dose Calculation Manual of June 25, 1991, indicated that the radionuclide concentrations would be significantly below the limits in 10 CFR Part 20, Appendix B, Table 2, Column 1 of $3 \text{ E-}7 \text{ } \mu\text{Ci/cc}$ for Xe-133 and $1 \text{ E-}10 \text{ } \mu\text{Ci/cc}$ for I-131, as required by 10 CFR Part 20.106.

The storm rendered inoperable four of the five air sampling stations required by TS. As allowed by TS Table 3.12.-1, Notation 1, the initial hazardous environmental conditions and the lack of an electrical power source for the sampling equipment required the licensee to delay resuming routine airborne pathway monitoring until September 9, 1992, when limited monitoring was established using three sampling stations that were returned to service. By September 19, 1992, the licensee had reestablished five air sampling stations and returned them to operation. The licensee reestablished three of the four damaged air sampling stations within several hundred feet of their original locations. Each remained in its original directional sector. However, sample location T-57 in the NW directional sector was not usable.

Therefore, the licensee selected an alternate location, west-8. The licensee previously established a supplemental air sampler at this location.

The NRC noted no abnormal radionuclide concentrations in gaseous effluents while reviewing selected chemistry records and discussing radiation levels with the licensee's cognizant representatives. The inspection findings indicated that (1) the sampling frequency for compensatory gaseous effluent samples collected and analyzed for both the main stack and radwaste building effluents met the TS requirements and (2) all radionuclide concentrations were less than the detection limits specified in TS Table 4.11.2.

The inspectors also reviewed the licensee's actions for other sampling matrices. During tours of the environs surrounding the Turkey Point site, NRC inspectors verified access to all sampling locations. The licensee's records indicated that on September 9, 1992, it had also collected both broadleaf and water samples to meet the surveillance requirements of the TS radiological environmental monitoring program (REMP). The licensee has contracts with the State of Florida to conduct the REMP. All results were within expected ranges, and the staff found no other concerns with the implementation of the REMP program.

Security

The Petitioner expressed concern that during the storm, automatic security systems were compromised and inquired concerning alleged criminal or negligent security infringements at Turkey Point. Specifically, on the basis of a newspaper article in the Palm Beach Post reporting stolen cables from an FPL compound that was damaged by the storm and the sale of 1544 pounds of wire to a metal recycling center (scrap metal yard) and a complaint along the same lines to the NRC by a former crane operator, the Petitioner questioned whether

the health or safety of his community was compromised by selling possible contaminated or radioactive materials to scrap yards so that they may eventually be recycled into consumer products.

The licensee's security systems consist of an initial protected area barrier with associated intrusion detection and assessment equipment. Additional barriers and associated alarms protect the vital equipment. Security officers assess each contingency and respond accordingly. This equipment is not required to withstand hurricane force winds because the licensee has provided for compensatory measures in the event of equipment failure. At the perimeter, the hurricane caused damage to several barriers, microwaves, cameras, and the site access building. Some vital area alarms also briefly failed, but the vital area barriers remained intact.

In anticipation of severe weather conditions, on August 24, 1992, before the storm, the licensee suspended certain security safeguards in accordance with its Physical Security Plan. After locking and securing all access control points, the licensee evacuated all security personnel to shelters in Class I buildings, which are constructed to withstand hurricane force winds. The security systems, however, were not de-activated. After the storm, upon determination by a damage and safety evaluation team that other personnel could depart shelters, the licensee deployed security officers to assess damage, to conduct checks of the protected and vital areas, and to secure the site. During these searches of the protected and vital areas, the licensee found no indications that outsiders had penetrated the site during the storm. On August 24, 1992, after the storm, the security department deployed personnel and reestablished material access controls along with alarm response

and implemented compensatory measures for the failed equipment in the protected area.

On September 22, 1992, the licensee restored the regular security program with some compensatory measures still in place. On September 23-25, 1992, Region II safeguards inspectors reviewed the security measures and found them acceptable.

Expressing concern regarding removal of contaminated/radioactive material from the site, the Petitioner refers to an earlier complaint made in 1991 by a former crane operator, Mr. Gene Hutchinson. NRC Region II inspectors performed an onsite inspection during July 8-12, 1991 and reviewed the licensee's Radiation Protection (RP) program for removing material from the RCA. The inspection determined that the scrap material was removed from non-contaminated systems and that, at that time the material was surveyed, the material was free of measurable contamination. The licensee took corrective actions relating to removal of material from RCA. The staff documented its findings and acceptance of the licensee corrective actions in Inspection Report (IR) 50-250,-251/91-26, dated August 16, 1991. This report is available in the local public document room. By letter dated January 29, 1992, the NRC staff forwarded Inspection Report (IR) 50-250,-251/91-26 to Mr. Gene Hutchinson and informed him that his allegation was not substantiated.

With respect to the Palm Beach Post report on the stolen material, the alleged stolen cable material was the backup material for transmission lines. This material was not located at the Turkey Point site and was not under the plant security jurisdiction.

Interim Fire Protection

The Petitioner alleged several deficiencies in the interim fire protection system. The Petitioner alleged that the interim fire protection system violated plant TS section 3.7.8.1, "Fire Water Supply and Distribution System," requirements. Additionally, the Petitioner alleged that the design of the Unit 4 interim fire protection system reduced the margin of safety for fire protection due to several design deficiencies. The alleged design deficiencies include: lack of automatic level control for the fire water supply tank, procurement of electric fire pumps by an unclear specification and procurement process, use of a non-safety-related fire water source due to clogging of intake canal, use of unreliable screen wash pumps and vulnerable temporary diesel pumps due to its location with unassured power supplies and breaker coordination problems, and reduction of fire water flow due to a 6 inch hose connection. The Petitioner also claimed that the location of the temporary diesel pumps in buildings that were destroyed by the hurricane demonstrated the vulnerability of the pumps.

The hurricane winds caused the service water system high water storage tank to collapse, which caused damage to the fire protection system. Specifically, the raw water tank (RWT) I and its appurtenances, the county water supply line to RWT II, the casing and controller for the electric-powered fire pump, the jockey system pressure pumps and portions of the fire protection system piping and piping supports, and certain power cables associated with the pumps, were damaged.

After the hurricane, the licensee fully restored the fire protection system to its design configuration by November 8, 1992. Until the fire protection system was restored, the licensee implemented an interim fire

valves, the last valve ahead of the water flow alarm device on each sprinkler or hose standpipe, and the last valve ahead of the deluge valve on each deluge or spray system required to be OPERABLE according to TS 3.7.8.2, 3.7.8.3, and 3.7.8.4.

Action statement (a), associated with TS 3.7.8.1, requires that, with one pump and/or one water supply inoperable, the inoperable equipment must be restored to OPERABLE status within 7 days or an alternate backup pump or supply must be provided. Action statement (b), associated with TS 3.7.8.1, requires that with the fire water supply and distribution system otherwise inoperable, a backup fire water capability should be established within 24 hours. These action statements apply to both units simultaneously.

Only one of the required two water supplies was available in the interim fire protection water supply system configuration. To be consistent with the action statement (a), the licensee used the screen wash system as the alternate backup supply for the fire protection water supply. The licensee, by hydraulic calculations, verified in its safety evaluation that the worst case system demand with adequate hose stream could be supplied. The staff found the screen wash system acceptable as an alternate water supply system for the fire protection water supply system. In addition, to meet the requirements of Section III.A in Appendix R to 10 CFR 50.48, the licensee previously used the screen wash pump system as an alternate fire protection water supply, use of which was approved by the staff in a letter of March 21, 1984.

Use of the screen wash system for fire protection reduced the volume of water available for manual hose streams from 2839 liters per minute (750 gpm)

to 1893 liters per minute (500 gpm) with the largest fixed fire water suppression system in operation. The volume of 1893 liters per minute (500 gpm) met the NRC's minimum guidelines for manual hose stream volume and was more than an adequate flow for manual hose streams for use by the fire brigade if a fire activated the largest fixed fire water suppression system. Reducing from 2839 liters per minute (750 gpm) to 1893 liters per minute (500 gpm) for manual hose stream capacity when the screen wash system was used as the primary fire protection water supply did not significantly reduce the effectiveness of the manual hose stream at the Turkey Point Nuclear Plant. This flow reduction is within the current NRC guidelines.

Manual level control, used in the interim fire protection configuration instead of automatic level control for controlling level in the fire water tank, did not reduce the margin of safety for fire protection. RWT II was the existing water supply for the electric- and diesel-driven fire pumps in the interim configuration. The volume of the tank was 2,839,059 liters (750,000 gallons). The tank automatically maintained a minimum level of 1,135,623 liters (300,000 gallons) of water dedicated for fire protection. The service water system, which also drew off the RWT, had its intake nozzles high on the tank wall in a manner equivalent to standpipes to prevent service water draw from the dedicated inventory of the fire suppression system. The minimum volume of water required by NRC guidelines for fire protection water supply at nuclear power plants is 1,135,623 liters (300,000 gallons). This amount of water is the largest expected design demand of any fire suppression system, with 1893 liters (500 gallons) per minute for manual hose streams for a minimum of 2 hours. The licensee maintained the RWT level by visual inspections, as required by the Turkey Point administrative controls.

The interim fire protection water supply configuration following the hurricane included a new electrically-driven fire pump with flow and pressure characteristics similar to the electrically-driven fire pump damaged in the hurricane. The licensee stated that it installed the new pump in accordance with National Fire Protection Association (NFPA) Standard 20, "Standard for the Installation of Centrifugal Fire Pumps." This is a nationally recognized standard for installing fire pumps and is the minimum acceptance standard for installing fire pumps allowed by NRC Fire Protection Guidelines.

To ensure that a fire protection water supply was readily available after the loss of offsite power and the failure of both the electric and diesel driven fire pumps, the licensee evaluated the power supplies to the screen wash pumps. The licensee modified the interim configuration to correct the breaker fuse coordination to ensure all power paths to the screen wash pumps were maintained for normal and emergency conditions and demonstrated that these pumps had a reliable source of power under all conditions.

The interim configuration also included a backup supply from three temporary diesel pumps. The hurricane damaged the central receiving and health physics buildings, as alleged. However, the onsite temporary diesel pumps were not located in the central receiving or the health physics buildings but were tied down near the auxiliary building. They were not damaged and were available for fire fighting immediately after the storm. Therefore, the Petitioner's concern as to the vulnerability of the pumps is unfounded.

The licensee also brought portable diesel pumps to the site to improve its fire fighting capability. The fire fighting capability after the hurricane was as follows:

- First 83 hours: portable fire extinguishers and portable diesel fire pumps with hoses
- August 27, 1992: screen wash pump and fire header meeting TS 3.7.8.1 placed in service in addition to the above
- August 28, 1992: diesel fire pump and RWT II in service in addition to the above
- September 26, 1992: electric fire pump in service in addition to the above before Unit 4 restart
- November 8, 1992: fire protection system restored to original design basis

The Petitioner also stated that the interim fire protection configuration represents a significant change to the plant and, as a result, alleged that the licensee's implementation of the change by a safety evaluation rather than a license amendment process violates the requirements of 10 CFR 50.59. Additionally, the Petitioner alleged that the licensee's safety evaluation is inadequate in that it did not include specific surveillance and other testing requirements.

The licensee did not violate 10 CFR 50.59 requirements. 10 CFR 50.59 requires all licensees to first obtain the Commission's approval whenever a proposed change, test or experiment involves a change in the TS incorporated in the license or an unreviewed safety question. Licensees must determine, and document in safety evaluations, whether a proposed change can be made without prior NRC approval or must be made by license amendment. Accordingly, the licensee's safety evaluations were not a circumvention of the process, but were a necessary and essential part of the process to satisfy the regulation.

To verify the changes to the fire protection system, as discussed in the responses to other issues, FPL prepared a safety evaluation report pursuant to 10 CFR 50.59 in which it documented its evaluation of the interim fire protection system configuration for compliance with the licensing and design basis requirements. The licensee determined which system configuration requirements, including surveillance and functional testing requirements, were needed before it could restart Unit 4. The licensee's safety evaluation did not identify any change to the TS or the presence of any unreviewed safety question. Therefore, the plant changes did not require prior NRC approval. In addition, the staff reviewed the licensee's safety evaluation and found the changes to be consistent with the plant TS and to not involve an unreviewed safety question and, therefore, acceptable.

TS Violations and Missed Surveillances

The Petitioner alleged several operational deficiencies during and after the hurricane. The alleged deficiencies include certain TS violations, failure to perform required surveillances and start-up tests, and erroneous actuation of the overpressure mitigation system (OMS). Specifically, the Petitioner alleged: the licensee "used 'lack of lighting in Containment & support personnel on site' as excuses" and did not depressurize and vent the reactor coolant system as required by TS 3.4.9.3, missed two tests relating to venting of the emergency core cooling system (ECCS) and did not run the standby feedwater pumps on September 29, 1992, and erroneously actuated the overpressure mitigation system (OMS). The Petitioner questioned the reliability of the OMS and contended that these deficiencies constitute serious reduction in the margin of safety for the reactor coolant system. The Petitioner also stated that it is not clear what the NRC position is with

regard to the licensee's implementation of required technical specifications and LCO's during crises and alleged that failure to follow TS resulted in a dangerous reduction in the margin of safety.

Turkey Point TS 3.4.9.3, "Overpressure Mitigating Systems", "Limiting Condition of Operation", specifies that, when the reactor coolant system (RCS) average temperature falls below 135°C (275°F), the high pressure safety injection (HPSI) flow paths are to be isolated and require two operable power-operated relief valves (PORVs) or provision for adequate depressurizing and venting of the RCS. These requirements reduce the possibility for a low temperature overpressurization (LTOP) condition of the RCS when it is in a cold and water-solid condition by isolating HPSI to prevent injection into a water-solid RCS, by preventing the start of an idle reactor coolant pump when the difference between the RCS and steam generator temperatures is more than 10°C (50°F) and by providing an adequate vent path. The Turkey Point units and many other pressurized water reactor (PWR) plants also rely on automatic venting through PORVs to protect against an LTOP. The TS for these plants specify setpoints for the PORVs and also specify the minimum RCS vent size. These requirements are designed to prevent mass and heat input transients more severe than those assumed in the LTOP protection analyses.

To verify that the PORVs are operable, the licensee should perform surveillance procedure, 3/4-OSP-041.4, "OMS Nitrogen Backup Leak and Functional Test" and check the pressure in the nitrogen bottle to verify that the PORV will open on a test signal. The nitrogen bottle is a backup supply to the instrument air system which normally operates the PORV.

During August 24 - 25, 1992, after the Turkey Point units were brought to a hot shutdown, the licensee, under the provisions of 10 CFR 50.54(x), decided

not to enter the containment and not to hook up the equipment required to perform the necessary OMS surveillance test procedure. The licensee took this action because the normal lighting in the containment was not available due to loss of offsite power and portable lighting would have been required to perform this surveillance. Entry into containment without the normal lighting carried too high a risk of potential human error and injuries which could result in an undesirable plant transient. At the time, the safety importance of the OMS was substantially reduced from its design basis because the unit was not in a water-solid condition during or following the hurricane. Also, the HPSI flow path to the RCS was isolated, as required by the TS under such conditions. The licensee successfully accomplished the control room portion of testing the OMS (i.e., cycling of the PORVs within 24 hours of the shutdown of the units) using normal instrument air. The nitrogen portion of the OMS was tested and declared operational by September 7, 1992, when stable offsite power was restored and normal lighting was available inside containment. The instrument air system remained operational throughout the entire event.

Regarding the Petitioner's allegation that the licensee used "lack of lighting in Containment & support personnel on site as excuses" and its "subjective" implementation of required technical specifications and LCO's during crises, the NRC requires each licensee to conduct TS surveillances during normal operation. However, when a plant is in an Unusual Event or other emergency condition, 10 CFR 50.54(x) allows a licensee to

take reasonable action that departs from a license condition or a technical specification (contained in a license issued under this part) in an emergency when this action is immediately needed to protect the public health and safety and no action consistent with the license conditions and technical specifications that can provide adequate or equivalent protection is immediately apparent.

The licensee is expected to exercise good judgment and minimize possible upset situations where feasible. Further, 10 CFR 50.54(y) requires that the "licensee's action permitted by paragraph (x) of this [10 CFR 50.54] section shall be approved, as a minimum, by a licensed senior operator prior to taking the action. The licensee actions to depart from the TS-required surveillance tests were not a failure, but rather conscious emergency decision and actions consistent with the provisions of 10 CFR 50.54(x). The NRC staff reviewed the licensee's actions taken during the emergency condition to depart from the TS surveillance noted above and determined that they were immediately needed to protect the public health and safety and no other adequate or equivalent action consistent with license conditions or TS was immediately apparent. The NRC staff also found the licensee's actions appropriate on the basis that, as required by 10 CFR 50.54(y), the departure from TS was approved by a licensed senior reactor operator prior to implementation, the licensee provided notifications to the NRC as required by 10 CFR 50.72, and the licensee took necessary actions to recover from the departure from TS as soon as practicable following the hurricane (i.e., departed from TS only to the extent necessary). The NRC staff evaluation of this event is documented in Inspection Report 50-250,251/92-20 dated November 20, 1992.

On October 5, 1992, with Unit 4 in cold shutdown, the licensee was performing the OMS nitrogen backup leak and functional test. The test requires preparation of the primary coolant loop such as to allow opening of the PORVs without depressurization of the RCS. The test is accomplished by introducing a simulated high pressure signal to the primary coolant loop instrumentation being tested and verifying that the loop instrumentation operates as designed. In performing the test, licensee personnel erroneously

proceeded to apply the simulated high pressure signal to a backup instrumentation loop instead of the primary loop under test. The backup is a parallel loop which is identical in operation and configuration to the primary loop. Since the backup loop was not prepared for the test, application of the test pressure resulted in a brief opening of the PORV and a slight depressurization of the RCS, approximately 82.74 KiloPascal (12 psig). The incorrect simulated high RCS pressure signal also inadvertently caused a suction valve in the RHR system to close. This resulted in a brief loss of RHR cooling and a less than 1 degree C (1 degree F) increase in the RCS temperature. After the event, the PORV was closed. Additionally, the RHR system was returned to normal operation in a timely manner. No high system pressure actually occurred as a result of the inadvertent actuation of the PORV and the OMS and RHR system functioned as expected. With the plant in cold shutdown at approximately 2413 KiloPascal (350 psig), a spurious safety injection (SI) would not have occurred because, by procedure, the HPSI flow path was isolated. The licensee successfully completed the test and has implemented appropriate corrective actions to prevent recurrence of inadvertent actuation of OMS. The NRC staff evaluated the deficiencies discussed above and documented its evaluations in Inspection Report 50-250,251/92-24. As noted in the inspection report, this resulted in a non-cited violation, in accordance with NRC enforcement policy, for the licensee's failure to follow procedures, which resulted in the inadvertent opening of a PORV.

The tests which the Petitioner contends were not completed are related to the venting of the emergency core cooling system (ECCS) and the running of the non-safety-related standby feedwater pumps in the recirculation mode. The

Turkey Point TS require that each ECCS component and flow path and the standby feedwater pumps be demonstrated to be operable at least monthly while the units are in Modes 1, 2 or 3. On September 29, 1992, with Unit 4 in Mode 2, the licensee discovered that, contrary to these TS requirements, ECCS pump and piping venting and the standby feedwater pump operability demonstration had not been performed prior to entry into Mode 3. ECCS venting had been last performed on August 7, 1992 and standby feedwater pump operability had been last demonstrated on August 5, 1992.

In response to the discovery of these missed surveillances, the licensee satisfactorily completed them promptly and demonstrated that both the ECCS and the non-safety-related standby feedwater pumps were operable. Further, the licensee returned Unit 4 to Mode 3 and satisfactorily verified that all other required surveillances had been performed. During this time the normal feedwater and safety-related auxiliary feedwater remained available. In addition, ECCS pump and piping venting (high head safety injection pump readiness test) showed no evidence of air when venting the piping or pump casing. The licensee also walked down the RHR and safety injection systems to verify valve alignment. Prior to entry into Mode 4, cooling of the RCS was provided by an RHR pump which ran normally. It is important to note that there was no reactor trip, nor was there an inability to cool the primary system under any required condition as a result of these missed surveillances, as alleged.

The licensee attributed the cause of this event to personnel error, in that the surveillance due dates were improperly changed in the computer, and has implemented corrective measures to require supervisory review and approval of all changes to surveillance dates in the computer. The NRC staff reviewed

the licensee's event analyses and actions and determined that the missed surveillances did not result in any health and safety concern and that the licensee's corrective actions were satisfactory. In accordance with NRC enforcement policy, however, this resulted in a non-cited violation for the licensee's failure to perform TS-required surveillances within the specified time frames. The NRC staff evaluation is documented in Inspection Report 50-250, 251/92-20.

TS and Design Basis Adequacy

The Petitioner has raised several issues regarding plant TS adequacy and design bases. Specifically, the Petitioner claimed that the Turkey Point nuclear units performed poorly during the storm, and that there were post-hurricane operational deficiencies including certain violations of technical specifications, and questioned the adequacy of the Turkey Point design bases and technical specifications and whether they should be re-evaluated to assure maintenance of an adequate margin of safety.

As discussed in detail in this Director's Decision, the Turkey Point nuclear units functioned well and withstood the hurricane wind forces. Although the storm caused significant onsite and offsite damage, it did not damage the nuclear safety-related portions of Units 3 and 4, which could pose a radiological hazard to the public if they failed. These safety-related systems were designed to withstand hurricane force winds. All emergency systems functioned as designed and the EDGs operated in a reliable manner and supplied adequate power to critical cooling functions throughout the period when the offsite power was not available. Before the storm arrived, the licensee, in accordance with its emergency planning procedures, brought the

units to the hot shutdown mode, and the units remained in a stable condition throughout.

During the storm, the licensee departed from TS requirements relating to OMS surveillances, fire watch and AC electrical power sources. These departures from TS surveillances were not a failure, but rather conscious and prudent emergency licensee actions consistent with the provisions of 10 CFR 50.54(x). For a full discussion of this issue, see "TS Violations and Missed Surveillances", supra. Further, the startup problems identified by the Petitioner were related to human errors that have subsequently been evaluated and corrective actions taken. However, these problems did not reduce any margins of safety.

To minimize any future damage of the types experienced during Hurricane Andrew, the licensee has implemented several design enhancements. Specifically, the design enhancements include: 1) elimination of the service water high water storage tank which caused damage to the fire protection system, 2) attachment of TLDs to the warning siren poles, which will better withstand hurricane force winds and enable recovery of the TLDs after a hurricane, 3) replacement of the communications systems that relied on the Southern Bell aerial copper wire with a buried fiber optic cable along Palm Drive, and 4) installation of two new high frequency radio systems for communications between the plant and offsite locations. In addition, the licensee has procured new antennas, designed to withstand winds above 200 mph, to improve system reliability. Spare portable antennas also are available on site to ensure prompt replacement, if needed.

The staff's inspection of the licensee's emergency preparations and actions before, during, and after the storm revealed that they were prudent

and consistent with the regulations and did not identify any reduction in the margin of safety in the design of safety-related systems. Therefore, the staff concludes that the plant design bases and TS, and licensee's design enhancements, are adequate.

Licensee Staffing and Economics of Reconstruction

The Petitioner questioned whether the licensee had adequate staffing to perform necessary onsite and offsite support activities during the storm. The Petitioner also asserted that "insufficient workers under overworked and rushed conditions led to the accident of a worker, operating a crane, falling inside radioactive water in the Reactor cavity". In addition, the Petitioner contended that economics of reconstruction of the nuclear units to "reliably prevent or mitigate an accident of unpredictable magnitude" and need for development of alternate energy sources must be evaluated.

The conditions in the area after the storm required the licensee to limit support personnel at the site. The licensee limited the number of onsite personnel (volunteers) to approximately 150. The licensee considered this staffing level, which included two complete operating crews, adequate to shut down both units and to maintain them in a safe shutdown condition. After the hurricane, licensee personnel were available in sufficient numbers to accomplish the cleanup and repair efforts which made it possible for Unit 4 to be ready for startup by September 28, 1992.

On October 9, 1992, a maintenance technician was giving directional assistance to a crane operator when he lost his footing and slipped into the Unit 3 reactor cavity approximately up to his waist. This event resulted from human error and was reviewed for preventive corrective action. The event

occurred after the licensee had voluntarily shut down Unit 4 on October 1, 1992, and no rush or haste was involved.

The Petitioner's contention regarding economics of reconstruction is not within the scope of the NRC's responsibilities.

Coexistence of Nuclear and Fossil Units

On the basis of the Hurricane Andrew experience, including damage to the fossil unit stacks and the rupture of oil tanks, the Petitioner questioned whether such events on the fossil side, or the non-safety side of the nuclear units, could adversely affect the containment structures or any nuclear safety-related systems and whether they have been evaluated.

Class I structures, systems, and equipment, which could pose radiological hazards if they failed, are designed to withstand earthquake, and other severe natural phenomena, and failure as a result of interaction with other non-safety structures, systems and components without any loss of function.

If the fossil unit stacks had failed, potential existed for debris from these stacks impacting certain safety-related systems such as the EDG buildings, the EDG oil tank, and the switchgear building. However, due to redundancies and physical separation of these safety-related equipment and structures, it is not expected that the falling of fossil stacks could adversely affect the safe operation of the plant. The hurricane caused severe damage to the Unit 1 stack, which posed a personnel safety concern. The licensee responded by removing the stack, using controlled demolition techniques. Before the stack was demolished, the staff reviewed the licensee's evaluation and safety precautions and found them to be acceptable. The Unit 2 stack sustained only minor damage. The licensee performed a detailed inspection and analysis of the stack to verify its structural

integrity. The licensee concluded that the stack, in its existing condition, has adequate margin to failure and, therefore, can withstand its original design wind load without adversely interacting with the nuclear units. The staff reviewed the licensee's analyses and found them acceptable for restart of the nuclear units. The licensee agreed to the staff's recommendation to periodically perform surveillance on the Unit 2 stack until it is reinforced, to ensure that it has not degraded. By April 1993, the licensee completed the modifications and reinforcements to the Unit 2 stack and erected new Unit 1 stack.

Failure of sections of fossil units did not endanger the nuclear units. The puncture of the oil tank created a cleanup problem for both the fossil and nuclear units but did not create a safety problem.

IV. CONCLUSION

For the reasons discussed above, the NRC concludes that Turkey Point Units 3 and 4 are being operated in accordance with applicable regulations and do not endanger the health and safety of the public. The institution of proceedings pursuant to 10 CFR § 2.202 is appropriate only if substantial health and safety issues have been raised (see Consolidated Edison Company of New York (Indian Point Units 1, 2, and 3), CLI-75-8, 2 NRC 173, 175 (1975); Washington Public Power Supply System (WPPSS Nuclear Project No. 2), DD-84-7, 19 NRC 899, 924 (1984)). This is the standard that has been applied to the concerns raised by petitioner to determine if enforcement action is warranted.

Therefore, any further action on the issues addressed in this Director's Decision and the Petitioner's request for action pursuant to 10 CFR 2.206 is denied. As provided in 10 CFR 2.206(c), a copy of this Director's Decision will be filed with the Secretary for the Commission to review.

FOR THE NUCLEAR REGULATORY COMMISSION

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation

Dated at Rockville, Maryland,
this day of