UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

April 12, 2000

Randal K. Edington, Vice President - Operations
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Entergy Operations, Inc.
P.O. Box 220
St. Francisville, Louisiana 70775

SUBJECT: RIVER BEND STATION 1998 EXERCISE, FEDERAL EMERGENCY MANAGEMENT AGENCY'S REPORT

Enclosed are copies of five pages from the Federal Emergency Management Agency's (FEMA) exercise evaluation report of the February 11, 1998, emergency preparedness exercise at the River Bend Station. These pages were inadvertently deleted from the final report. The enclosed pages are listed in numerical order and correspond to pages 58, 63, 78, 99, and 102 of the final report.

No response to this letter is required. If you have any further questions, please contact Mr. William A. Maier at (817) 860-8126.

Sincerely,

Gail M. Good, Chief
Plant Support Branch
Division of Reactor Safety

Enclosure: As stated

Docket No.: 50-458
License No.: NPF-47

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NRR-093

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within the EPZ to shelter-in-place, were agreed upon by the Deputy DEM in conference with the other risk parishes and the State at 10:31 a.m. The sirens were activated at 10:40 a.m., with a followup EAS message broadcast from the radio stations beginning at 10:40 a.m. The second alert and notification sequence began at 11:27 a.m. when the parishes made a decision to implement the PADs in Scenario #16, which calls for evacuation of PAS-13 and shelter-in-place for PAS-14, and concluded when the sirens were sounded at 11:36 a.m. with a followup EAS message broadcast from the radio stations beginning at 11:36 a.m. The parish specially notified by telephone the three special facilities identified in the Scenario #16 Summary; Georgia Pacific Paper Mill (PAS-14), Amoco Production (PAS-14) and the Port Hudson Head Start (PAS-13). This special notification is reported on the Emergency Notification Form for Special/Transient Facilities in the East Baton Rouge Parish.

Under Scenario #16, the PAR is to evacuate PAS-13 and to shelter-in-place in PAS-14, except for institutions and recreation areas that are to be evacuated. As discussed above, those special facilities requiring special notification of evacuation, as designated in the Scenario Summary, Rev. 3, were notified by telephone by the Communicator. None of these Special Facilities required transportation assistance. There are no nursing homes or hospitals located in PAS-13 or 14. The Scenario Summary indicates, however, that four people located within PAS-13 require evacuation assistance with a wheelchair-equipped bus or van. Key EOC staff, including the DEM and Communicator, did not appear to be aware of a special needs population within the area affected by Scenario #16. No special notification or arrangements were made for these four people.

The EOC Public Works representative requested assistance from the State Department of Transportation to help in the removal of debris. Winds from the simulated tornado left the streets and roads littered with broken tree limbs and other debris.

A shift change was initiated at 10:19 a.m. The Deputy DEM was already present at the EOC, since it was her normal duty station at the Emergency Preparedness Office at the time of the shift-change initiation. Within a reasonable time, second-shift personnel reported to the EOC to replace the Communicator, Sheriff's Department representatives, Police Department representative, RO and PIO. A replacement Mayor's Office representative also arrived at the EOC. Each new arrival was briefed on the situation, and operations continued uninterrupted. The incoming shift was knowledgeable and capable.

In summary, the status of FEMA exercise objectives for this location is as follows:

a. **MET:** Objectives 1, 2, 3, 4, 5, 9, 10, 14, 23, and 30

b. **DEFICIENCIES:** NONE

Red Cross assigned evacuees to shelters. All staff members were knowledgeable in their duties and performed them as directed by their procedures. It is suggested that a procedure be developed to assure the registration desk that each individual is free from contamination before being registered. Presently, the procedure states that a person found clean be directed to registration with no proof that he has been monitored. A simple system of providing a slip of paper or a mark by a rubber stamp would enhance this function.
The American Red Cross opened a shelter at the Baton Rouge High School. The capacity of the school is 200 evacuees. Procedures are in place to open a second and third shelter when each of the preceeding shelters reaches 80 percent capacity.

The Red Cross had two vehicles, a storage van and a canteen, to support the sheltering and feeding of evacuees. Communications were provided through land lines belonging to the school, Red Cross cellular telephones and RACES.

Fast food vendors provide feeding during the first 24 hours. The St. Vincent de Paul Catholic Charities would provide hot meals for several days until the local Masonic Lodges took over.

Sheltering by the Red Cross is done within the school system. Three schools were available to house a total of 600 persons. They had 1,000 cots and blankets available for shelter use. Red Cross volunteers and staff provided the manpower to operate sheltering. There were 10 persons available for the first shift. They also had three persons doing shelter assignments at the Centroplex and personnel at the East Baton Rouge and State EOCs. The Red Cross unit can easily support any evacuation and sheltering needed in response to an incident at RBS.

In summary, the status of FEMA exercise objectives for this location is as follows:

a. **MET:** Objectives 1, 4, and 19

b. **DEFICIENCY:** NONE

c. **AREAS REQUIRING CORRECTIVE ACTION:** Objectives 5 and 18

**Issue Id:** 53-98-05-A-06

**Description:** Several Baton Rouge Fire Department members performing evacuee monitoring and decontamination at the Centroplex Reception Center were not familiar with their exposure limit of 1R. (NUREG-0654, K.,3., 4.)

**Recommendation:** Additional training on exposure control should be provided to emergency workers.

along side the hospital gurney, which stayed in the clean area. This process limited the potential for spread of contamination in the emergency room unloading area and inside the hospital. It also significantly reduced the amount of floor space that needed to be protected (radiologically), cordoned off and cleaned up/decontaminated while causing no reduction in patient care.

The ambulance crew and plant HP conveyed information concerning the patient vitals, contamination, accident details and other pertinent data to the attending hospital staff. The patient was wheeled into the treatment area and medical attention was immediately given.

The REA was divided into a buffer zone and a treatment area. Known and suspect radiologically contaminated materials were allowed only in the treatment area. A rope partitioned the room and different colored herculite floor coverings were used for each area to provide additional visual separation. The room had all the required supplies, instruments, and amenities to handle radiologically contaminated injuries.

Primary patient treatment was provided by a well-trained and experienced RN who was assisted in the hot zone by another RN. The attending doctor remained in the buffer zone to assist and direct the nursing staff. This process worked well while allowing the doctor to remain radiologically clean and immediately available for other emergencies and duties. The effectiveness of this procedure was due, in large part, to the competency of the attending nurses and their familiarity with medical treatment and radiological contamination.

The treatment team worked quickly to determine the extent of the injuries at the same time they conducted a thorough interview of the patient. The proper medical treatment was determined and executed to stabilize the patient before the radiological issues were addressed. Clothing was cut away to expose injuries and minimize cross contamination. Sample wipes of uncontaminated and known contaminated areas on the patient and other materials were taken, bagged, labeled and properly handled.

The patient went through several decontamination attempts before she was determined to be free of contamination. The wash materials were collected and disposed of according to procedures. The decontamination process was very thorough as conducted by the RNs, the plant HP and with assistance from the buffer zone staff. Upon completion of the decontamination process an x-ray was taken of the patient by a hospital technician. Care was taken to keep the x-ray equipment and operator from picking up any contamination.

After the x-ray was complete, the patient's clothing, that was earlier cut away, was removed. This allowed the HP to thoroughly monitor the patient's backside. At this point, the patient was determined to be completely decontaminated and was transferred out of the REA. The REA staff demonstrated proper step-off and removal of protective

| TIME . | EVENT |
|---|---|
| 12:55 p.m. | Adequate core cooling is established and the RPV depressurized resulting in a lowering radiological release rate. |
| 13:00 p.m. | The work team will complete relay repairs and bus inspection and restore power to the bus. Div. II components are restored. The crew will be successful in closing the valve from the control room terminating the release path. RBS and the State of Louisiana continue to track the plume until it clears the EPZ. |
| 15:20 p.m. | Off-site airborne radioactivity returns to background level. |
| 15:30 p.m. | RBS and LRPD confer on terminating the emergency. |
| 16:00 p.m. | The emergency is terminated, and the LRPD Accident Assessment staff at the RBS EOF will participate in the recovery tabletop discussion. At the conclusion of the tabletop, the day one of the exercise will be concluded. |
| 16:30 p.m. | At the conclusion of the tabletop, the plume phase of the 1998 RBS exercise will be concluded. |
| **Exercise Day Two** | |
| 07:30 a.m. | Activities for the second day of the exercise will begin at LRPD Headquarters (HQ) in Baton Rouge LRPD Technical Assessment Team leader(s) will provide to the entire response team a summary of the plume phase events.<br><br>State Field Monitoring Teams (FMT) will be dispatched from LRPD HQ to designated sampling locations along the plume footprint to collect various environmental media samples (e.g., soil, water, milk and vegetation), and to confirm isotopic deposition. These samples will be sent to appropriate laboratories for analysis. |
| 08:30 a.m. | Initial coordination between the Laboratory, Technical Assessment Team and FMTs will begin at LRPD HQ. LRPD Radiological Laboratory, located at 4845 Jamestown Avenue in Baton Rouge, will begin activation (**Field sampling by the FMTs, Laboratory activities and Dose Assessment based on field sample analysis results will be conducted out-of-sequence from the State Table-top**). |

# APPENDIX 5

## AREAS RECOMMENDED FOR IMPROVEMENT

### JOINT INFORMATION CENTER

**Description:** The Logistics team leader could benefit from the addition of a headset to rapidly respond to the JIC staff needs.

**Recommendation:** Provide a headset to the Logistics team leader.

**Description:** The State of Mississippi PIO spokespersons need a large 50-mile IRZ map to include Mississippi risk counties. This would be most helpful during the ingestion phase.

**Recommendation:** Provide a map to meet the needs of Mississippi PIO spokespersons.

### EAST FELICIANA PARISH EOC

**Description:** The administrative staff person performed multiple tasks in an admirable manner. She set up the security area for sign-in and badging, couriered messages from the communications room to the Director, posted the status boards in a timely manner, and then was tasked to serve as security officer in addition to delivering lunches. She accomplished all in a competent manner, but due to too many tasks, her primary function of posting the status boards could not remain her priority.

**Recommendation:** Ensure that the administrative support staff workload is evenly distributed among available workers as the activity escalates.

### EAST FELICIANA PARISH T/ACP

**Description:** The Deputy Sheriff demonstrated only a limited knowledge of KI and its intended use, side effects and dosage. In addition, the Deputy was not issued a complete dosimetry kit including instructions on the use of the direct reading dosimeters and KI.

**Recommendation:** Provide East Feliciana Parish Sheriff's personnel more training on emergency worker exposure control emphasizing the use of KI. Sheriff's personnel at the EOC should be trained to insure that complete dosimetry kits, including instructions on use of the DRDs and KI are issued to all personnel deployed to the field.

### Pointe coupee parish eoc

**Description**: The EOC size is inadequate. Once all the EOC staff were in their assigned EOC locations, it became apparent the EOC was too small to accommodate

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