

September 27, 2000

The Honorable Sue W. Kelly
United States House of Representatives
Washington, D.C. 20515

Dear Congresswoman Kelly:

I am responding to your letter of June 16, 2000, discussing concerns raised by officials at the Federal Emergency Management Agency (FEMA) with regard to the Emergency Preparedness plan for communities surrounding Indian Point Unit 2 (IP2). In particular, you expressed concern about a FEMA internal memorandum regarding the adequacy of the Emergency Preparedness plan. You also requested that the U.S. Nuclear Regulatory Commission (NRC) review all issues related to emergency preparedness, including an examination of the NRC's handling of this matter before, during, and after the February 15, 2000, event at IP2.

The NRC and FEMA are the two Federal agencies with the responsibility for evaluating emergency preparedness at and around nuclear power plants, as described in the memorandum of understanding between FEMA and the NRC. FEMA has the lead responsibility for assessing offsite radiological emergency response plans and preparedness. The NRC assesses onsite emergency planning and reviews FEMA's assessment of offsite plans to evaluate the overall state of emergency preparedness. Enclosed is a summary of pertinent evaluations focused on emergency preparedness at IP2 that occurred before, during, and after the February 15 event. NRC Inspection Report numbers are provided for your reference should you desire additional details on a specific inspection.

As you may be aware, the NRC received a request from the Union of Concerned Scientists and other petitioners on June 29, 2000, that IP2 be required to conduct a full participation exercise of the onsite and offsite emergency plans prior to restart of IP2 to be in compliance with NRC regulations. NRC regulations state that the offsite emergency plans for each site will be exercised biennially with the full (or partial) participation of each offsite authority having a role under the plans. NRC regulations also require that each licensee at each site conduct an exercise of its onsite emergency plan every 2 years, and state that the onsite exercise may be included in the biennial full participation offsite exercise. Both licensees are in compliance with the requirement for a biennial exercise of their onsite plans. However, because there are two licensees at the Indian Point site, i.e., Consolidated Edison (Unit 2) and the New York Power Authority (Unit 3), the practice has been to alternate the onsite participation in the biennial offsite exercise evaluated by FEMA between the two licensees. While no concerns regarding this practice have been raised by the State of New York, the local authorities, or FEMA, the NRC is considering the petitioners' request. I will keep you informed of our decision in this matter.

The question of exercise participation by licensees co-located at a common site does not change the existing determination the NRC has made concerning the adequacy of emergency preparedness at Indian Point. Based on the NRC assessment of the licensee's onsite emergency preparedness program and on the FEMA assessment of the adequacy of the offsite radiological emergency response plans for IP2, the NRC continues to find that there is reasonable assurance that the licensee will take appropriate measures to protect the health and safety of the public in the event of a radiological emergency at the site. Notwithstanding this overall determination, our inspection efforts have identified several areas in the onsite emergency preparedness program which were in need of improvement. We have observed that the licensee is making progress on corrective actions to improve those areas that have been identified. We will continue to monitor the licensee's completion of appropriate corrective actions.

Finally, you requested an examination of NRC's handling of the licensee's emergency preparedness before, during and after the February 15, 2000, event. As you are aware, the NRC Office of the Inspector General (OIG) recently issued a report of its event inquiry "NRC's Response to the February 15, 2000, Steam Generator Tube Rupture at Indian Point Unit 2 Power Plant." That report identified issues with NRC's handling of both steam generator and emergency preparedness issues. I have directed that the NRC staff conduct a detailed review and analysis of the issues raised in the OIG report and provide any recommendations for improving NRC processes that may be warranted. I have instructed the staff to provide the results of its review to the Commission by November 1, 2000.

I trust that this letter addresses your concerns.

Sincerely,

/RA/

Richard A. Meserve

Enclosure: Summary of IP2 Emergency
Preparedness Evaluations

SUMMARY OF EMERGENCY PREPAREDNESS EVALUATIONS

Nuclear Regulatory Commission Evaluations

The NRC evaluated the licensee's performance in the full-participation plume exposure pathway exercise at IP2 that was conducted on June 24, 1998. The results of this evaluation are documented in NRC Inspection Report Number 05000247/1998-007. Overall exercise performance was good. Off-normal conditions were quickly recognized and appropriately classified. Offsite notifications were timely and there was good interfacing communication with offsite officials. Protective action recommendations were appropriate and timely based on plant conditions, and dose projections were consistent with exercise scenario conditions. As a result of this evaluation, the onsite emergency preparedness (EP) program was determined to be adequate. However, during this evaluation some concerns were identified that required licensee corrective actions. For example, there was a lack of consistent information flow and weak command and control demonstrated by the Technical Support Center (TSC) manager during the exercise which resulted in an exercise weakness. A number of procedural inconsistencies were identified that indicated a lack of attention to detail and a weak review process. Also, examples of weak or non-existent programmatic controls were identified, though no specific programmatic lapses were identified by the inspectors. It was also determined that the licensee's self-critique process was not sufficiently self-critical.

On August 31, 1999, IP2 experienced a reactor trip event with complications. The NRC conducted an Augmented Inspection Team (AIT) inspection at IP2 to review the cause, safety implications, and IP2 staff's actions following the event. Inspection Report Number 05000247/1999-008 documents the findings of the AIT inspection. During this event, the licensee failed to declare an "Unusual Event" (the first level of emergency action in the NRC required emergency action level scheme) for a loss-of-offsite power. IP2's emergency plan implementing procedure was found to lack certain information for classifying this type of event.

To verify the adequacy of the licensee's corrective actions for the findings from the June 24, 1998, exercise, and the event on August 31, 1999, the NRC evaluated an IP2 annual onsite exercise conducted on September 22, 1999. This evaluation was documented in NRC Inspection Report Number 05000247/1999-012. The evaluation identified continued concerns with performance issues in the TSC, the Operations Support Center, and with the licensee's critique process. Some of these concerns were repeat findings from previous NRC-evaluated exercises. The NRC concluded that the licensee did not adequately identify and correct weak or deficient conditions and issued a non-cited violation. Additionally, the NRC met with the licensee on October 7, 1999, to discuss NRC's concerns and the short- and long-term corrective actions proposed by the licensee. The NRC determined that the proposed short-term corrective actions were acceptable and verified with the licensee that the long-term corrective actions would be completed by March 2000.

On February 15, 2000, IP2 experienced a steam generator tube failure which required an "Alert" declaration (the second level of emergency action in the NRC-required emergency action level scheme). After receiving a notification concerning the situation from the licensee, the NRC entered Standby Mode (the first level of formal NRC response to an ongoing event). While in Standby Mode, NRC staff at the Headquarters Operations Center in Rockville, Maryland, and the Region I Incident Response Center in King of Prussia, Pennsylvania,

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evaluated the situation through dedicated communication lines with IP2 and was in continuous communication with the licensee and the NRC's onsite resident inspectors. NRC also supported State responders with information and assistance. In addition, the NRC coordinated with the Federal Emergency Management Administration (FEMA), Environmental Protection Agency (EPA), Department of Energy, Department of Transportation, Health and Human Services, United States Department of Agriculture, the Canadian Nuclear Safety Commission, and the International Atomic Energy Agency. The NRC exited Standby Mode several hours later after determining that conditions were improving and unlikely to degrade in the future, and did not result in any significant offsite implications. The NRC continued to monitor the event with a smaller number of staff until after the licensee exited the Alert condition on February 16, 2000.

Following the February 15 event the NRC conducted another Augmented Inspection Team (AIT) inspection at IP2 to review the cause, safety implications, and IP2 staff's actions for this event. Inspection Report Number 05000247/2000-002 documents the findings of the AIT inspection. Problems with emergency preparedness, along with other areas, were identified during the inspection. The NRC also determined that when the February event occurred, the licensee had not yet completed implementation of some of the long-term corrective actions that had previously been proposed following the August 1999 event. A follow-up inspection of the EP program was conducted on April 17, 2000, and between May 15 and June 2, 2000, and is documented in NRC Inspection Report Number 05000247/2000-006. This inspection was performed after initial recovery efforts and focused on the adequacy of short-term corrective actions. The inspection included an evaluation of a June 1, 2000, exercise of the licensee's onsite emergency plan.

The follow-up inspection resulted in three findings that were determined to be of low to moderate safety significance in accordance with the Significance Determination Process (SDP) because the licensee failed to meet certain NRC emergency planning standards during the February event. These findings included (1) an untimely augmentation by the emergency response organization, (2) an untimely accountability of onsite radiation emergency workers, and (3) inconsistent dissemination of information to the media and a local official during the course of the event. These findings were also determined to be violations of NRC requirements, and the violations were cited in a Notice of Violation issued on August 9, 2000. Additionally, the NRC identified six other EP findings involving failures to implement regulatory requirements. These findings were determined to be of very low safety significance. These findings also involved violations of NRC requirements, but because they had been entered into the licensee's corrective action program and because of their very low safety significance the violations were not cited. Although several problems with the EP program have been identified with the response to the February event, the NRC has determined that the licensee's staff successfully acted to protect the health and safety of the public during the event. The safety significant tasks of properly classifying the event and making timely notification to offsite officials responsible for taking protective actions for the public were accomplished in accordance with established EP requirements.

The evaluation of the licensee's corrective actions indicated that the short-term corrective actions taken in response to the problems identified from the February event were adequate. The NRC concluded that the IP2 emergency response organization demonstrated its ability to implement the onsite emergency plan during the June 1, 2000, exercise.

FEMA Evaluations

By letter dated February 19, 1999, FEMA informed the NRC that based on the results of the June 24, 1998, full-participation plume exposure pathway exercise, FEMA had determined that the offsite radiological emergency response plans for the State of New York, and the affected local jurisdictions specific to the IP2 site could be implemented and were adequate to provide reasonable assurance that appropriate measures could be taken offsite to protect the health and safety of the public in the event of a radiological emergency at the site. By letter dated February 28, 2000, FEMA provided a similar determination that the plans could be implemented and were adequate to provide reasonable assurance that appropriate measures could be taken offsite to protect the health and safety of the public in the event of a radiological emergency at the site based on an evaluation of the May 25-27, 1999, ingestion exposure pathway exercise of the plans specific to the IP2 site. In letters dated June 19, and July 6, 2000, to Mr. Edward F. Jacoby, Jr., Director of the New York State Emergency Management Office, FEMA expressed its confidence in the EP programs in the State of New York and the counties around the Indian Point Nuclear Power Plant and reconfirmed FEMA's official position regarding the adequacy of EP at Indian Point.