UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET, SW, SUITE 23T85
ATLANTA, GEORGIA 30303-8931

March 26, 2010

Mr. J. Randy Johnson
Vice President - Farley
Southern Nuclear Operating Company, Inc.
7388 North State Highway 95
Columbia, AL 36319

SUBJECT: JOSEPH M. FARLEY NUCLEAR PLANT – NRC SUPPLEMENTAL INSPECTION REPORT 05000348/2010006 AND 05000364/2010006

Dear Mr. Johnson:

On February 12, 2010, the U.S. Nuclear Regulatory Commission (NRC) staff completed a supplemental inspection pursuant to Inspection Procedure 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," at your Joseph M. Farley Nuclear Plant, Units 1 and 2. The enclosed inspection report documents the inspection results which were discussed at the exit meeting on February 12, 2009, with you and other members of your staff.

As required by the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed because a finding of low to moderate safety significance (White) safety significance was identified in the 2nd quarter of 2009. This issue was documented previously in NRC Inspection Reports (IR) 05000348/2009-503 and 05000364/2009-503. The NRC was informed on September 29, 2009, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root causes and the contributing causes for the risk-significant issues were understood; (2) the extent of condition and extent of cause of the issues were identified; and (3) corrective actions were or will be sufficient to address and preclude repetition of the root and contributing causes. The inspection consisted of examination of activities conducted under your license as they related to safety, compliance with the Commission's rules and regulations, and the conditions of your operating license.

The inspectors determined that your staff performed a comprehensive evaluation of the White finding. Your staff's evaluation identified two primary root causes. First, Farley management did not maintain an adequate knowledge of Farley Alert and Notification System (ANS) requirements to recognize the need for improved guidance and oversight. Program oversight failed to recognize the Federal Emergency Management Agency (FEMA) requirements, establish guidance to ensure regulatory commitments were met, and provide oversight that ensured satisfactory program implementation. Second, Farley did not adequately address the information provided in several NRC Inspection Notices (INs). The INs provided information that should have been used to correct deficiencies in the Farley ANS program. Based on the results of this inspection, no findings of significance were identified.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of ADAMS is accessible from the NRC Website at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Brian R. Bonser, Chief
Plant Support Branch 1
Division of Reactor Safety

Docket Nos.: 50-348 & 50-364
License Nos.: NPF-2 & NPF-8

Enclosure: Inspection Report 05000348/2010006 & 05000364/2010006
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of ADAMS is accessible from the NRC Website at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Brian R. Bonser, Chief
Plant Support Branch 1
Division of Reactor Safety

Docket Nos.: 50-348 & 50-364
License Nos.: NPF-2 & NPF-8

Enclosure: Inspection Report 05000348/2010006 & 05000364/2010006
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

X PUBLICLY AVAILABLE ☐ NON-PUBLICLY AVAILABLE ☐ SENSITIVE X NON-SENSITIVE

ADAMS: ☐ Yes ACCESSION NUMBER:_____ ☐ SUNSI REVIEW COMPLETE

OFFICE	RII/DRS	RII/DRS	RII/DRS	RII/DRP			
SIGNATURE	BRB /RA for/	BRB /RA for/	BRB /RA/	SMS /RA/			
NAME	JBEAVERS	LMILLER	BBONSER	SSHAEFFER			
DATE	03/26/2010	03/26/2010	03/26/2010	03/26/2010			
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: G:\DRSII\PSB1\EMERGENCY PREPAREDNESS\FARLEY\INSPECTION PLAN AND INPUT\FY2010\FARLEY IR 95001 REV 2.DOC

cc w/encl:
B. D. McKinney, Jr.
Regulatory Response Manager
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

N. J. Stringfellow
Licensing Manager
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

T. D. Honeycutt
Regulatory Response Supervisor
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Todd L. Youngblood
Plant Manager
Joseph M. Farley Nuclear Plant
Electronic Mail Distribution

Managing Attorney and Compliance Officer
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Jeffrey T. Gasser
Executive Vice President
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

L. Mike Stinson
Vice President
Fleet Operations Support
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Paula Marino
Vice President
Engineering
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Moanica Caston
Vice President and General Counsel
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Chris Clark
Commissioner
Georgia Department of Natural Resources
Electronic Mail Distribution

John G. Horn
Site Support Manager
Joseph M. Farley Nuclear Plant
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Ted V. Jackson
Emergency Response and Radiation
Program Manager
Environmental Protection Division
Georgia Department of Natural Resources
Electronic Mail Distribution

Tom W. Pelham
Performance Improvement Supervisor
Joseph M. Farley Nuclear Plant
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

C. Howard Mahan
Principal Licensing Engineer
Joseph M. Farley Nuclear Plant
Southern Nuclear Operating Company, Inc.
Electronic Mail Distribution

Cynthia A. Sanders
Radioactive Materials Program Manager
Environmental Protection Division
Georgia Department of Natural Resources
Electronic Mail Distribution

James C. Hardeman
Environmental Radiation Program Manager
Environmental Protection Division
Georgia Department of Natural Resources
Electronic Mail Distribution

Mr. Mark Culver
Chairman
Houston County Commission
P. O. Box 6406
Dothan, AL 36302

cc w/encl continued next page

cc w/encl continued

James A. Sommerville
Program Coordination Branch Chief
Environmental Protection Division
Georgia Department of Natural Resources
Electronic Mail Distribution

James L. McNees, CHP
Director
Office of Radiation Control
Alabama Dept. of Public Health
P. O. Box 303017
Montgomery, AL 36130-3017

State Health Officer
Alabama Dept. of Public Health
Electronic Mail Distribution

F. Allen Barnes
Director
Environmental Protection Division
Georgia Department of Natural Resources
Electronic Mail Distribution

Letter to J. Randy Johnson from Brian Bonser dated March 26, 2010

SUBJECT: JOSEPH M. FARLEY NUCLEAR PLANT – NRC SUPPLEMENTAL INSPECTION REPORT 05000348/2010006 AND 05000364/2010006

Distribution w/encl:
C. Evans, RII
L. Slack, RII
OE Mail
RIDSNRRDIRS
PUBLIC
RidsNrrPMFarley Resource

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos:	50-348, 50-364
License Nos:	NPF-2, NPF-8
Report No:	05000348/2010006, 05000364/2010006
Licensee:	Southern Nuclear Operating Company, Inc.
Facility:	Joseph M. Farley Nuclear Plant
Location:	Columbia, AL
Dates:	February 8, 2010 through February 12, 2010
Inspectors:	L. Miller, Senior Emergency Preparedness Inspector J. Beavers, Emergency Preparedness Inspector
Approved by:	B. Bonser, Chief Plant Support Branch 1 Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

Inspection Report (IR) 050000348/2010006, 050000-364/2010006; 02/08/2010 – 02/12/2010; Joseph M. Farley Nuclear Plant, Unit 1 and 2; Supplemental inspection for a White finding in the Emergency Preparedness Cornerstone.

A senior emergency preparedness inspector and an emergency preparedness inspector performed this inspection. No findings of significance were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

Cornerstone: Emergency Preparedness

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with a White inspection finding involving the failure to ensure that all residences within the 10 mile emergency planning zone (EPZ) were provided the means for receiving alert notification and instruction in the event of a radiological emergency. The NRC staff previously characterized this issue as having low to moderate safety significance (White) in NRC Inspection Reports (IR) 05000348/2009-503 and 05000364/2009-503.

During this supplemental inspection, the inspectors determined that the licensee performed a comprehensive evaluation of the inadequate distribution of tone alert radios (TAR). The licensee's evaluation identified a lack of guidance and oversight and a poor evaluation of operating experience identified in NRC inspection notices as the primary root causes. The total count of unknown local area residences without TAR living within the 10 mile EPZ was 886. The licensee has completed a 100 percent survey of the Farley 10 mile EPZ. TAR were distributed to the required residents, and those who refused the TARs were placed on a special needs list for emergency notification. Additional improvements in identifying and tracking TAR needs have been or will be in place. The licensee has budgeted complete siren coverage for the 10 mile EPZ as the final corrective action.

The licensee entered the Regulatory Response Column of the NRC's Action Matrix in the second quarter of 2009 as a result of one inspection finding of low to moderate safety significance (White). The finding was associated with the degradation of the administrative and physical means established for alerting the public and providing prompt instruction to the public via TAR. The finding was characterized as having White safety significance based on the results of the emergency preparedness significance determination performed by a region based senior emergency preparedness inspector and as discussed in NRC IR 05000348/2009503 and 05000364/2009503. The failure of the administrative and physical means established for alerting the public and to provide instruction to the public via TAR occurred over a number of years (2003-2008). In 2003 and in 2005, the licensee ceased the lone quality check of Farley's TAR distribution. An inadequate distribution program, over time, resulted in the total number of 886 unknown residences without TAR.

Given the licensee's acceptable performance in addressing the failure to establish effective means of providing early notification, the White finding associated with this issue will only be considered in assessing plant performance until the end of the first quarter 2010 in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program". Implementation of the licensee's corrective actions will be reviewed during a future inspection.

Findings

No findings of significance were identified.

Report Details

4. OTHER ACTIVITIES

4OA4 SUPPLEMENTAL INSPECTION (95001)

.1 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with IP 95001 to assess the licensee's evaluation of a (White) finding which affected the emergency preparedness cornerstone in the reactor safety strategic performance area. The inspection objectives were to provide assurance that the:

- root and contributing causes of risk significant issues were understood
- extent of condition and extent of cause of risk significant issues were identified
- licensee's corrective actions for risk-significant issues were or will be sufficient to address the root and contributing causes and to preclude repetition

The licensee entered the Regulatory Response Column of the NRC's Action Matrix in the second quarter of 2009 as a result of one inspection finding of low to moderate safety significance (White). The finding was associated with the failure to ensure that all residences within the 10 mile emergency planning zone (EPZ) were provided the means for receiving alert notification and instruction in the event of a radiological emergency.

The finding was characterized as having (White) safety significance based on the results of an emergency preparedness significance determination performed by a region based senior emergency preparedness inspector and as discussed in NRC Inspection Report (IR) 05000348/2009-503 and 05000364/2009-503. The failure to ensure that all residences within the 10 mile EPZ were provided the means for receiving alert notification and instruction in the event of a radiological emergency was attributed to: first, a lack of emergency preparedness program oversight failed to recognize FEMA requirements, establish guidance to ensure regulatory commitments were met, and provide oversight that ensures satisfactory program implementation; and second, NRC Information Notices (INs) 2002-025, 2005-06 and 2006-28 each provided information that should have been used to correct deficiencies in the Farley Alert Notification System (ANS) program for tone alert radios (TAR).

The licensee informed the NRC staff on September 29, 2009, that they were ready for the supplemental inspection. In preparation for the inspection, the licensee performed a root cause investigation, Condition Report (CR) 2009105268, revision 5, to identify weaknesses that existed in various organizations, which allowed for a risk significant finding, and to determine the organizational attributes that resulted in the (White) finding.

The inspectors reviewed the licensee's root cause investigation in addition to other evaluations conducted in support of and as a result of the root cause investigation. The inspectors reviewed corrective actions that were taken or planned to address the identified causes. The inspectors also held discussions with licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood and corrective actions taken or planned were appropriate to address the causes and preclude repetition.

.2 Evaluation of Inspection Requirements

02.01 Problem Identification

a. IP 95001 requires that the inspection staff determine that the licensee's evaluation of the issue documents who identified the issue (i.e., licensee-identified, self revealing, or NRC identified) and the conditions under which the issue was identified.

The licensee determined in early February 2008, that an unknown number of addresses were without TAR in the Georgia sector of the 10 mile EPZ outside the areas covered by the three sirens.

b. IP 950001 requires that the inspection staff determine that the licensee's evaluation of the issue documents how long the issue existed and prior opportunities for identification.

The licensee's root cause evaluation documented the following issues and prior opportunities for identification: licensee verification of required TAR possession ceased in 2003 for Georgia and 2005 for Alabama; July 29, 2005, Farley responds to IN 2005-06 regarding TARs and fails to identify Alert Notification System (ANS) design report deviations; late January 2008, the licensee noted an abnormal number of Farley Nuclear Plant (Farley) 2008 emergency preparedness (EP) information calendars were returned; February 4, 2008, the licensee determined that they had not provided TAR to approximately 171 addresses requiring radios and failed to ensure the State of Georgia had established the capability for compensatory alerting measures; and April 23, 2008, the licensee determined there were approximately 250 additional residences added to the Farley 10 mile EPZ with no budget item existing for the purchase of TAR for these individuals.

The inspectors determined that the licensee's evaluation was adequate with respect to identifying how long the issue existed and prior opportunities for identification.

c. IP 95001 requires that the inspection staff determine that the licensee's evaluation documents the plant specific risk consequences, as applicable, and compliance concerns associated with the issue.

The NRC determined this issue was a (White) finding, as documented in NRC IR 05000348/2009503 and 05000364/2009-503. The licensee's root cause investigation also documented that the finding associated with this issue had (White) safety significance. In addition, root cause investigation CR 2009105268 documented the consequences of the issue, which included the following:

- failure to ensure that all residences within the 10 mile emergency planning zone were provided the means for receiving alert notification and instruction in the event of a radiological emergency

- a (White) inspection finding from the NRC

The inspectors concluded that the licensee appropriately documented the risk consequences and compliance concerns associated with the issue.

d. Findings

No findings of significance were identified.

2.02 Root Cause and Extent of Condition Evaluation

a. IP 95001 requires that the inspection staff determine that the licensee evaluated the issue using a systematic methodology to identify the root and contributing causes.

The licensee used the following systematic methods to complete the root cause investigation CR 2009105268 and CR 2010101552:

- Event and Causal Factor Chart

- Barrier Analysis

- Fault Tree Analysis

- MORT Analysis

- Organizational and Programmatic Screening

- Assessment of Safety Culture Attributes

- Human Performance GAP Analysis

The licensee used both a failure modes analysis and barrier analysis to evaluate human performance issues. The inspectors determined that the licensee evaluated the issue using a systematic methodology to identify root and contributing causes.

b. IP 95001 requires that the inspection staff determine that the licensee's root cause investigation was conducted to a level of detail commensurate with the significance of the issue.

The licensee's root cause investigation included an extensive timeline of events and an event and causal factor tree as discussed in the previous section. Two root causes were identified. First, Farley management did not maintain an adequate knowledge of Farley

ANS requirements to recognize the need for improved guidance and oversight. Program oversight failed to recognize FEMA requirements, establish guidance to ensure regulatory commitments were met, and provide oversight that ensured satisfactory program implementation. Second, Farley did not adequately address the information provided in several NRC Inspection Notices (INs). The INs provided information that should have been used to correct deficiencies in the Farley ANS program. NRC INs 2002-025, 2005-06 and 2006-28 each provided information that could have been used to correct deficiencies in the Farley ANS program for TAR. Based on the extensive work performed for this root cause evaluation, the inspectors concluded that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.

c. IP 95001 requires that the inspection staff determine that the licensee's root cause investigation included a consideration of prior occurrences of the issue and knowledge of operational experience.

The licensee's root cause investigation included an evaluation of internal and external operational experience. As a result of this review, the licensee determined that operational experience from the NRC (IN 2002-025, IN 2005-06 and IN 2006-28) was not evaluated thoroughly, and the station's program for evaluating INs was not effective. Based on this review, and as detailed below, the licensee was able to make several conclusions regarding weaknesses in its operational experience program:

- IN 2002-025 – the lack of a process to notify Federal Emergency Management Agency (FEMA) when changes were made to the Farley ANS program was not identified

- IN 2005-06 – Farley did not address: the adequacy of the process to obtain FEMA acceptance and approval of ANS design changes prior to implementation; the lack of oversight with the local utilities' connect and disconnect processes used for identifying new residences in the EPZ; the accuracy of the EPZ maps; and the accuracy and upkeep of the EPZ database used to identify residences that should have TARs

- IN 2006-28 – Farley did not address compliance with FEMA REP-10, Guide for the Evaluation of Alert and Notification Systems for Nuclear Power Plants, or the adequacy of the process to obtain FEMA acceptance and approval of ANS design changes prior to implementation

Based on the licensee's detailed evaluation and conclusions, the inspectors determined that the licensee's root cause investigation included a consideration of prior occurrences of the problem and knowledge of prior operational experience.

d. IP 95001 requires that the inspection staff determine that the licensee's root cause investigation addresses the extent of condition and extent of cause of the issue(s).

The licensee's evaluation considered the extent of condition associated with:

- Residences in the entire 10 mile EPZ were not tracked in the TAR data base. The actual conditions were the 886 addresses that were without TAR in the 10 mile EPZ outside the areas covered by the three sirens. The licensee determined a lack of rigor in maintaining the accuracy of the EPZ database of addresses for TARs was present.

- The guidance and oversight for offsite program requirements was inadequate. The actual condition was the lack of oversight for the TAR program. The conclusion was a lack of oversight through all levels of the emergency preparedness organization with respect to the TAR program.

- Operational experience and INs with respect to offsite program requirements were not heeded. The actual condition was related to information with respect to the TARs. The conclusion was that Farley no longer met the alert and notification system design report requirements.

- Program deficiencies existed for all offsite emergency preparedness functions. The actual condition was program deficiencies existed with the TAR functions.

- The poor methodology of tracking residents and lack of sirens allowed inadequate distribution of TAR. The actual conditions were the same. The conclusion was the best methods and equipment available are not being used to ensure the residents within the EPZ have adequate notification capabilities.

The inspectors concluded that the licensee's root cause investigation addressed the extent of condition and the extent of cause of the issues.

e. IP 95001 requires that the inspection staff determine that the licensee's root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture components as described in IMC 0310.

The licensee found weaknesses in the cross-cutting areas of Human Performance (all four components unsatisfactory) and Problem Identification and Resolution (all three components unsatisfactory). Additionally, the continuing learning environment component was found unsatisfactory. Given these weaknesses, the licensee determined it would be prudent to consider and investigate weaknesses in the site and fleet safety culture. A site and fleet safety culture self-assessment was conducted from September 8 through the 22 and approved on November 2, 2009. This assessment, CR 200910067 Nuclear Safety Culture Fleet Self-Assessment, addressed all general safety culture issues and no further actions were considered necessary.

The inspectors determined that the licensee's root cause investigation included a proper consideration of whether a weakness in any safety culture component was a root cause or significant contributing cause of the issue.

f. Findings

No findings of significance were identified.

2.03 Corrective Actions

a. IP 95001 requires that the inspection staff determine that (1) the licensee specified appropriate corrective actions for each root and/or contributing cause, or (2) an evaluation that states no actions are necessary is adequate.

Root cause #1 – Lack of emergency preparedness program oversight failed to recognize FEMA requirements, establish guidance to ensure regulatory commitments were met, and provide oversight that ensure satisfactory program implementation. The licensee recommended the assembly of a document that provides requirements for Farley ANS, development of procedures to address these requirements, training on these requirements for EP personnel, development of performance indicators to report the effectiveness of the ANS program based on these requirements, and development of a procedure to inform personnel with weakness related to guidance and oversight for the ANS program.

Root cause #2 – The Farley evaluation of NRC INs did not identify the similar problems at Farley and no action was taken. The licensee recommended: review and consideration of actions to address NRC INs 2002-025, 2005-06 and 2006-28; identification and review of existing INs related to ANS functions to identify problems and weakness reported at other sites that may be applicable to Farley; and establish guidance that requires responses to industry operating experience review reports (NRC INs, INPO SERs, Vendor reports, etc).

Contributing cause #1 – Fleet oversight audits of emergency preparedness failed to identify weaknesses in the distribution of TAR. The licensee recommended that criteria be developed to identify non-compliances in the emergency ANS program for TAR distribution and maintenance.

Contributing cause #2 – Methods and technology to collect and validate data for TAR distribution and maintenance in the 10 mile EPZ were not the best available. The licensee recommended evaluation of other sources of information and new technology to improve accuracy and reliability of the EPZ database and installation of additional sirens in the EPZ.

Contributing cause #3 – Criteria for assignment of severity levels to condition reports that identify problems in the area of emergency preparedness was not adequate. The licensee recommended a review of emergency preparedness requirements and development of appropriate criteria for assignment of severity levels in the corrective action program. The inspectors determined that the proposed corrective actions were appropriate and addressed each root and contributing cause.

b. IP 95001 requires that the inspection staff determine that the licensee prioritized corrective actions with consideration of risk significance and regulatory compliance.

The licensee's immediate corrective actions distributed TAR to all residences within the 10 mile EPZ. Residents refusing TAR were placed on a special needs list for emergency notification. This ensured all residences within the 10 mile EPZ were provided the means for receiving alert notification and instruction in the event of a radiological emergency. The licensee's corrective actions to address the root and contributing causes were prioritized in accordance with NMP-GM-002, Corrective Action Program.

Based upon the guidance of NMP-GM-002, Corrective Action Program, and the prioritization of the corrective actions in accordance with this procedure, the inspectors determined that the corrective actions were prioritized with consideration of risk significance and regulatory compliance.

c. IP 95001 requires that the inspection staff determine that the licensee established a schedule for implementing and completing the corrective actions.

The licensee established due dates for the corrective actions in accordance with their corrective action program. A task list project report was reviewed identifying owners and reasonable due dates. The inspectors determined that a schedule had been established for implementing and completing the corrective actions.

d. IP 95001 requires that the inspection staff determine that the licensee developed quantitative and/or qualitative measures of success for determining the effectiveness of the corrective actions to preclude repetition.

As documented in root cause investigation CR 2009105268 and CR 2010101502, the licensee established measures for determining the effectiveness of the corrective actions. These measures include:

- comparing the results of the 2009 walk down with the connect/disconnect reports from the respective utilities
- determining the level of knowledge within the Emergency Preparedness organization with respect to the Farley ANS
- reviewing the results from the fleet oversight audits of Farley Emergency Preparedness
- verifying an ongoing database update process is routinely identifying changes in addresses in the Farley 10 mile EPZ and reflecting those changes in the TAR database
- verifying problems with the Farley alert and notification system are being identified, are assigned appropriate severity level and are being satisfactorily resolved

- reviewing the Farley EPZ alert and notification siren test results to ensure that complete and reliable coverage is provided to all residents in the Farley 10 mile EPZ

The licensee entered these measures into their corrective action program to ensure that these effectiveness reviews and enhanced monitoring were performed. The inspectors determined that quantitative and qualitative measures of success had been developed for determining the effectiveness of the corrective actions to preclude repetition.

e. IP 95001 requires that the inspection staff determine that the licensee's planned or taken corrective actions adequately address a Notice of Violation (NOV) that was the basis for the supplemental inspection, if applicable.

The NRC issued an NOV to the licensee on July 10, 2009. The licensee provided the NRC a written response to the NOV on June 15, 2009. The licensee response described: (1) corrective steps which have been taken and the results achieved; (2) corrective steps which will be taken; (3) the date when full compliance will be achieved; and (4) the reasons for the violation. During this inspection, the inspectors confirmed that the licensee's root cause investigation and planned and taken corrective actions addressed the NOV. The licensee restored full compliance on November 20, 2009 by Action Item 2009113584 with the complete distribution of all required TAR.

f. Findings

No findings of significance were identified.

4OA6 Exit Meeting

On February 12, 2010, the inspectors presented the inspection results to Mr. J. Randy Johnson and other members of your staff, who acknowledge the findings. The inspectors asked the licensee if any of the material examined during the inspection should be considered proprietary. The licensee did not identify any proprietary information.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

J. Horn, Site Support Manager
J. Hutto, Operations Manager
J. Johnson, Site Vice President
L. Smith, Maintenance Manager
C. Thornell, Engineering Director
T. Youngblood, Plant Manager

ITEMS OPENED AND CLOSED

Opened and Closed

None

List of Documents Reviewed

Plans and Procedures

NMP-GM-002, Corrective Action Program, Ver. 9.0
NMP-GM-002-001, Corrective Action Program Instructions, Ver. 15
NMP-GM-002-GL11, Root Cause Determination Guideline, Ver. 1.0
NMP-GM-002-F03, Root Cause Quality Review Sheet, Ver. 6.0
NMP-GM-002-F08, Organizational & Programmatic (O&P) Screening Tool, Ver. 4.0
FNP-0-EPP-1.1, FNP Alert and Notification System (ANS) Program, Ver. 3.0
NMP-GM-002-F30, Common Cause Analysis Report for CR 2009113617, Ver. 1.0

Corrective Action Documents

CR 2009105268 - Root Cause Investigation for Inadequate Distribution of Tone Alert Radios
CR 2009105611 - Tone alert radio database validation survey review updates
CR 2009102721 - Request for personnel to conduct walkdown
CR 2008113398 - Meetings with 5 utilities
CR 2008106217 - 250 residents not covered by tone alert radios
CR 2008104013 - Large number of 2008 calendars returned. PDF
CR 2008100241 - Fleet EP INPO Excellence Team Self Assessment
CR 2008100370 - CR initiated in Corporate Database to document 250
CR 2008100234 - AFR on VEGP and Hatch not meeting E-plan (Corp) requirements on tone alert radio annual survey
CR 2008100220 - Documents the budget Impact of needing 250 tone alert (Corp) radios for Georgia
CR 2008100206 - Documents a comment from Early Count EMA during an (Corp) Audit (Corp) residences in GA not covered by tone alert radios GA.
CR 2005105902 - CR to address NRC IN 2005-06
CR 2003001895 - NRC EP annual inspection (Corp)
CR 2002001967 - FNP response to NRC IN 2002-025, "Challenges to Licensees ability to provide prompt notification and information during an emergency preparedness event."
AI 2008204750 - Completed AI documenting the 100% walkdown survey of the 10 mi EPZ
AI 2008204750 - Final Walkdown Survey Summary listing/tabulation
AI 2008204751 - AI to revise FNP-0-TCP28.1 to (i) require a 100% walkdown of the tone alert radio coverage area every 3 years (ii) follow up review of customers refusing a tone alert radio and review annually (iii) annual review of the utility connect/disconnect program (iv) The EPA shall contact the utilities quarterly to determine program changes
AI 2008205592 - Comparison of Farley procedures to Regulatory Requirements
AI 2008200695 - FNP/SNC commit to perform an annual survey of the tone (Corp) alert radio distribution
AI 2008203072 - Action taken to Update tone alert radio list from counties in GA.
AI 2003202934 - Make new door hangers
AI 2008205592 - procedures to ensure regulatory requirements for tone alert radio distribution and maintenance are being met
AI 2008203072 - action plan for GPC and Three Notch Inaccurate lists
AI 2009203608 - Update ANS design report

Miscellaneous Documents

Supplemental Even Analysis Report, February 10, 2010

Corrective Action Documents generated as a result of this inspection

CR 2010100908 - Corporate Licensing is asked to evaluate ANS Design Report and determine if it is a licensing document
CR 2010101577 - FNP TAR database does not provide a tracking mechanism for the re-offering of TARs on an annual basis
CR 2010101578 - Several residences were noted as not being re-contacted for program participation for > 3 years
CR 2010101552 - Amended TAR root cause CR2009105268 to include a "Tone Alert Radio Supplemental Event Evaluation"

Acronyms

AI	Action Item
CRs	Condition Reports
EPZ	Emergency Planning Zone
FEMA	Federal Emergency Management Agency
IMC	Inspection Manual Chapter
IP	Inspection Procedures
IR	Inspection Report
NRC	Nuclear Regulatory Commission
PARs	Publicly Available Records
TAR	Tone Alert Radio
VIO	Violation