UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
2100 RENAISSANCE BOULEVARD, SUITE 100
KING OF PRUSSIA, PENNSYLVANIA 19406-2713

March 15, 2013

Mr. Kevin Walsh
Site Vice President
Seabrook Nuclear Power Plant
NextEra Energy Seabrook, LLC
c/o Mr. Michael O'Keefe
P.O. Box 300
Seabrook, NH 03874

SUBJECT: SEABROOK STATION, UNIT NO. 1 – NRC SUPPLEMENTAL INSPECTION REPORT 0500443/2013007 AND ASSESSMENT FOLLOW-UP LETTER

Dear Mr. Walsh:

On January 24, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection pursuant to Inspection Procedure (IP) 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," at Seabrook Station, Unit No. 1. The enclosed inspection report (IR) documents the inspection results, which were discussed on January 24, 2013, with you and members of your staff.

In accordance with the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed to followup on a White finding of low to moderate safety significance in the second quarter of 2012, that involved the failure of Seabrook Station personnel to carry out their assigned roles and responsibilities and to adequately critique the performance of the April 17, 2012, evaluated emergency preparedness exercise. NextEra responded to the finding by letter dated June 21, 2012. The NRC reviewed the additional information provided and communicated the final significance determination to you in a letter dated August 7, 2012, "Final Significance Determination for a White Finding, with Assessment Follow-up and Notice of Violation, NRC Inspection Report No. 05000443/2012504 – Seabrook Station, Unit 1" (ML12220A471). You informed the NRC on December 1, 2012, of your staff's readiness for this supplemental 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 risk significant performance issues were identified; and (3) corrective actions for risk significant performance issues are sufficient to address the root and contributing causes and prevent recurrence. The inspection consisted of examination of activities conducted under your license as they relate to safety, compliance with the Commission's rules and regulations, and the conditions of your operating license.

The NRC concluded that, overall, the inspection objectives were met and that the combined effect of NextEra's completed and planned corrective actions were reasonable to address the related performance issues.

Based on the results of this inspection, no findings were identified.

Given your acceptable performance in addressing the inadequate exercise critique process, and in accordance with the guidance in Inspection Manual Chapter (IMC) 0305, “Operating Reactor Assessment Program,” the White finding will only be considered in assessing plant performance for a total of four quarters, and Seabrook Station will transition from the Regulatory Response Column of the NRC’s Action Matrix to the Licensee Response Column on April 1, 2013.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.930 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 Publically Available Records System (PARS) component of the NRC’s Agencywide Documents Access and Management System (ADAMS), accessible from the NRC web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Anthony Dimitriadis, Chief
Plant Support Branch 1
Division of Reactor Safety

Docket No: 50-443
License No: NPF-86

Enclosure:
Inspection Report 05000443/2013007
w/Attachment: Supplementary Information

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In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.930 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 Publically Available Records System (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Anthony Dimitriadis, Chief
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ADAMS ACCESSION NUMBER: **ML13073A614**

☑ SUNSI Review		☑ Non-Sensitive ☐ Sensitive		☑ Publicly Available ☐ Non-Publicly Available	
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DATE	03/14/13	03/14/13	03/15/13		

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U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Docket No.: 50-443

License No.: NPF-86

Report No.: 05000443/2013007

Licensee: NextEra Energy Seabrook, LLC

Facility: Seabrook Station, Unit No. 1

Location: Seabrook, New Hampshire 03874

Dates: January 22, 2013, through January 24, 2013

Inspectors: Stephen Barr, Senior Emergency Preparedness Inspector
Elise Burket, Emergency Preparedness Inspector
Kenneth Hussar, Physical Security Inspector (Training)

Approved by: Anthony Dimitriadis, Chief
Plant Support Branch 1
Division of Reactor Safety

Enclosure

Summary of Findings

IR 05000443/2013007; 1/22/2013 – 1/24/2013; Seabrook Station, Unit No.1; Supplemental Inspection – Inspection Procedure (IP) 95001.

Three Region I inspectors performed this inspection. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Cornerstone: Emergency Preparedness

The NRC staff performed this supplemental inspection in accordance with IP 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess NextEra's root cause evaluation and corrective actions taken in response to their failure to adequately critique the performance of the April 17, 2012, Evaluated Emergency Preparedness Exercise. The NRC staff initially characterized this issue as low to moderate safety significance (White), in NRC Inspection Report 05000443/2012503 (ML12151A036) and finalized the significance determination in Inspection Report No. 05000443/2012504 (ML12151A036)

NextEra identified the root cause of the issue as an inadequate exercise critique process. Specifically, Emergency Preparedness Drill and Exercise Manual Chapter 6, Post Drill and Exercise Critiques, was inadequate because it lacked sufficient detail to require a listing of Drill and Exercise Performance opportunities and criteria to judge effectiveness. This resulted in an inadequate evaluation and documentation of exercise weaknesses identified by players and controllers both during the exercise and the post exercise critique.

Based on the results of this inspection, the inspectors concluded that NextEra performed an adequate root cause evaluation of the April 2012 event, and had completed and planned corrective actions that were reasonable and adequate for addressing the related performance issues.

Given NextEra's acceptable performance in addressing the performance issues associated with the inadequate exercise critique and in accordance with the guidance in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," the White finding associated with the April 2012 event will only be considered in assessing plant performance for a total of four quarters.

Other Findings

No findings were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 Supplemental Inspection (95001)

.01 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure (IP) 95001 to assess NextEra'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 causes and contributing causes of risk-significant performance issues were understood;
- To provide assurance that the extent of conditions and extent of cause of risk-significant performance issues were identified;
- To provide assurance that the licensee's corrective actions for risk-significant performance issues were sufficient to address the root and contributing causes and prevent recurrence.

On April 17, 2012, the NRC inspectors observed Seabrook's full scale emergency planning exercise. During the exercise, the Seabrook Emergency Operations Facility (EOF) Coordinator and the dose assessment staff used incorrect meteorological conditions to develop the initial protective action recommendation (PAR), which was required to be included with the off-site notification made for the declaration of a General Emergency (GE). The NextEra EOF staff's human performance error resulted in an incorrect PAR being provided to the required off-site agencies. Following the conclusion of the exercise, the licensee conducted an exercise critique on April 17-19, 2012. NRC regulations require that the licensee critique emergency exercises in order to identify ERO performance weaknesses and place those issues into their corrective action program. Although the NRC inspectors witnessed and identified the errors in the licensee's initial PAR and GE notification, the NextEra staff determined that the notification of the GE and the initial PAR had been correct per the exercise scenario. The licensee's exercise critique did not identify the errors observed by the NRC inspectors, and NextEra inaccurately counted the offsite notification associated with the initial GE declaration as a successful Drill and Exercise Performance (DEP) performance indicator (PI) opportunity.

The NRC issued a Notice of Violation (NOV) for Seabrook's exercise critique process for not properly identifying a weakness associated with a risk-significant planning standard (RSPS) during a full-scale exercise. The NOV was associated with emergency preparedness planning standards listed in Title 10 of the *Code of Federal Regulations* (10 CFR) 50.47(b)(14) and 10 CFR 50.47(b)(5) and the requirements of Section IV.F.2.g of Appendix E to 10 CFR Part 50. 10 CFR 50, Appendix E, Section IV.F.2.g, requires, in part, that all exercises provide for formal critiques in order to identify weak or deficient areas that need correction. The NOV was determined to be of low-to-moderate safety significance (White) based on the criteria contained in Inspection Manual Chapter (IMC) 0609, Appendix B, Emergency Preparedness Significance Determination Process. This issue was entered into the licensee's corrective action program under Action Report (AR) Number 1766946.

NextEra responded by letter dated June 21, 2012. After considering the statements in NextEra's response letter, the results were conveyed to NextEra in a letter dated August 7, 2012, "Final Significance Determination for a White Finding, with Assessment Follow-up and Notice of Violation, NRC Inspection Report No. 05000443/2012504 – Seabrook Station, Unit 1" (ML12220A471).

Additionally, Seabrook Station entered the Regulatory Response Column of the NRC's Action Matrix in the second quarter of 2012, as a result of one inspection finding of low to moderate (White) safety significance.

NextEra performed a readiness review from November 27, 2012, to November 29, 2012, to assess the station's readiness for a 95001 inspection for the April 17, 2012, event. The results were documented in Action Report (AR) Number 1828093, "Quick Hit Assessment on: EP White Finding 95001 Preparation." The review determined that the root cause evaluation was comprehensive and corrective actions complete. NextEra staff informed the NRC staff on December 1, 2012, that they were ready for the supplemental inspection.

The inspectors reviewed NextEra's root cause and condition report for the failure to critique the event, reviewed applicable corrective action program documents and EP procedures, and interviewed emergency preparedness personnel. The inspectors also held discussions with licensing, Emergency Response Organization, and training personnel to ensure that the root and contributing causes were understood and corrective actions taken or in progress were appropriate to address the identified causes and to prevent recurrence of the original issue.

.02 Evaluation of the 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 inspectors noted that NextEra's root cause evaluation (RCE) recognized that it was the NRC inspectors who identified the failure of the Seabrook staff to properly critique the performance error which resulted in the incorrect PAR. The RCE also recognized that the issue was identified during and immediately after the exercise critique was performed.

Overall, the inspectors determined that NextEra's root cause evaluation adequately documented that this was an NRC-identified issue.

b. *IP 95001 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.*

NextEra's RCE explicitly stated how long this event existed: the critique failure occurred on the day of the exercise (April 17), and was identified by the NRC at their exit meeting on April 19, 2012. The RCE concluded that the issue existed for 48 hours before it was identified. Since a failure to critique issue could not be identified prior to the human

performance error which occurred during the exercise, and the faulty critique was the issue, there was no prior opportunity for the licensee to identify this issue.

Overall, the inspectors determined that NextEra's root cause evaluation effectively documented that the issue existed for 2 days.

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(s).*

NextEra's RCE documented the safety consequences of this event. The licensee concluded that the event did not create any actual radiological risk, because the event took place during a drill and was not associated with actual plant operations. However, the licensee also concluded that the event did represent a potential radiological issue in that, if the same kind of failure occurred during an actual emergency, the EOF could make an incorrect PAR to the various surrounding states.

The RCE adequately identified the compliance concerns of the issue through the documentation of the specific requirements of 10 CFR Part 50.47(b)(14) and 10 CFR 50, Appendix E, that were not satisfied by the events of April 17-19, 2012.

Overall, the inspectors determined that NextEra's evaluation documented the plant specific risk consequences and compliance concerns associated with the issue and was consistent with the NRC's evaluation.

d. Findings

No findings were identified.

02.02 Root Cause, Extent of Condition, and Extent of Cause 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.*

NextEra used the following systematic methods to complete the root cause evaluation: An Event and Causal Factor Chart to identify causal factor for the event; and a Barrier Analysis to assess barriers. NextEra identified one root cause, three contributing causes, and one apparent cause. NextEra determined the root cause of the event to be:

> "The Exercise Critique Process was inadequate. Emergency Preparedness Drill and Exercise Manual Chapter 6, Post Drill and Exercise Critiques, was inadequate in that it lacked sufficient detail to require a listing of Drill and Exercise Performance opportunities and criteria to judge effectiveness. This resulted in an inadequate evaluation and documentation of exercise weaknesses identified by players and controllers both during the exercise and the post exercise critique."

When Seabrook used their site procedures to prepare the exercise package for this exercise, NextEra implemented a new fleet procedure EP-AA-101-1000, Nuclear Division Drill and Exercise Procedure. As part of the root cause determination, NextEra

compared their new procedure to the site procedure and determined that the fleet procedure, while containing better guidance, still lacked sufficient details. The fleet procedure included a critique timeline to ensure key information was captured, it did not include sufficient detail to capture items such as the start of a release or dose assessment.

NextEra additionally identified three contributing causes:

- Inadequate change management, in that the senior EP Coordinator who had been the lead for exercise conduct had left the company, and the pertinent procedures had not been bolstered in order for the remaining staff to properly compensate for that individual's departure;
- Inadequate drill scenario development process, in that, during the April 17, 2012, exercise, a presumed minor modification in simulator data caused the actual drill timeline to diverge from the expected scenario timeline, with no provision for updating the evaluators' documentation packages; and,
- The exercise critique process was not implemented appropriately, in that, while the facility critiques were appropriately conducted at the end of the exercise, the follow-on formal post-drill critique was not conducted in accordance with NextEra procedures.

The inspectors determined that NextEra had evaluated the issue using systematic methodologies to identify root, contributing, and apparent causes.

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

NextEra's root cause evaluation included the use of a combination of root cause assessment methods that were complimentary. The licensee's RCE included an extensive timeline of events and an event and causal factor tree, and their investigation of the contributing causes expanded the scope of the root cause beyond just the Emergency Planning Department. The RCE report included an event analysis and then assessed the evaluation attributes of: previous occurrences; extent of condition; extent of cause; safety culture; risk/consequence; and, operating experience. NextEra's collective review of the root and contributing causes did not result in the identification of any additional fundamental issues.

The NRC's emergency exercise evaluation process examines the licensee's ability to conduct a valid exercise that adequately challenges the ERO in implementing the site emergency plan and the licensee's ability to identify any weaknesses in ERO performance. NRC regulations require those weaknesses to be identified and adequate actions taken to correct them. NextEra's Quick Hit self-assessment identified that the original RCE did not provide a sufficient depth of analysis in the discussions of the root and contributing causes, i.e., the report did not provide the level of causal detail to appropriately match the NRC's level of significance for this issue. The inspectors determined the revised, final RCE report adequately addressed the significance of the performance issues associated with how emergency exercises are conducted and evaluated. The inspectors concluded that the final version of the RCE had properly

evaluated the causes of the human errors that occurred in the EOF during the April 17, 2012, exercise as well as the failures of the licensee's critique process.

The inspectors determined that the licensees' root cause evaluation was conducted to a level of detail commensurate with the significance of the issue.

c. *IP 95001 requires that the inspection staff determine that the licensee's root cause evaluation included a consideration of prior occurrences of the issue and knowledge of Operating Experience.*

The root cause evaluation documented a review of internal and external operating experience. The reviews were initially narrowly focused on previous notification errors and did not consider previous drill/exercise critique errors. This deficiency was identified by the licensee's Quick Hit Assessment and subsequently addressed in the RCE. The final RCE report provided a detailed discussion of any previous occurrences identified by searching the site's corrective action history data bases, using various search terms enveloping any past incidents which may have related to the issue of the RCE. The RCE also considered external operating experience by searching the Industry of Nuclear Power Operations' and the NRC's data bases for similar previous events and findings.

Overall, the inspectors determined that NextEra's root cause evaluation included a consideration of prior occurrences of the issue and knowledge of operating experience.

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

The RCE used a Same/Similar technique to assess the extent of condition and extent of cause.

Extent of condition. NextEra's root cause evaluation addressed the extent of condition for the event. The condition identified was: "E-Plan Drill failed to self-identify and properly critique a weakness with state notification during a Graded Exercise." The licensee reviewed all the evaluator data from the April 17, 2012, exercise to ensure all other critique items had properly been addressed. Also, the RCE examined Seabrook operating experience and their corrective action program history for the previous 10 years to identify any similar failures. No additional examples were found. The scope was expanded to search for failures associated with DEP opportunities during a graded exercise and during licensed operator proficiency exams. The broadened scope identified one missed DEP opportunity during a graded exercise, which had been properly identified and critiqued. The licensee also determined that there had been 11 missed DEP opportunities during operator exams in the previous two years, and an AR had been initiated to address those performance issues.

The NRC recognized the challenge in identifying missed critique opportunities from previous drills and exercises, and concluded the licensee's extent of condition was performed to an adequate level.

Extent of Cause. The root cause evaluation team considered the extent of cause associated with the root and contributing causes both within the Emergency Planning department and in other site organizations. The RCE root cause determination had

identified that the fleet exercise procedure lacked detail. The RCE team reviewed the fleet procedures for other EP functions, such as the emergency plan change process, and determined the upgraded fleet EP procedures had sufficient detail and adequately addressed any extent of cause within the Emergency Planning department. The RCE determined that the contributing cause of change management was potentially applicable to other station departments. Certain corrective actions, involving procedure enhancements, exercise evaluation team composition, and improved pre-drill preparations, addressed this concern beyond the Emergency Planning department directly involved in this event.

Overall, the inspectors determined that NextEra's root cause evaluation addressed the extent of cause of the issue.

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 0305.*

NextEra performed a safety culture evaluation of the components described in NRC IMC 305 and considered the following safety culture aspects of to be applicable to this issue:

- Complete, accurate, and up-to-date design documentation, procedures, and work packages
- Adequate training and knowledge transfer
- Change management
- Licensee appropriately plans work activities by incorporating: risk insights, job site conditions, including environmental conditions that may impact human performance; plant structures, systems, and components; human-system interface; or radiological safety
- Identify issues completely, accurately and in a timely manner commensurate with the safety significance.

Corrective actions were initiated taking into consideration the input of the safety culture aspects. These actions included procedure enhancements, improvements in drill preparation and evaluation team composition, and staff training on exercise critique expectations and the critique process.

Overall, the inspectors determined the root cause evaluation included a proper consideration of whether the root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture components.

f. Findings

No findings were identified.

02.03 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.*

The root cause evaluation documented corrective actions for the root cause, contributing causes, and an apparent cause. The inspectors reviewed all of the corrective actions to ensure that they addressed the identified causes. The corrective actions were designed to address the: root cause; contributing causes; extent of condition; extent of cause; safety culture evaluation; effectiveness review; and, other actions that were identified but outside the scope of the RCE effort. Corrective actions for the root cause focused on changes to procedure EP-AA-101-1000, Nuclear Division Drill and Exercise Procedure, specifically the processes and expectations for pre-drill verification, the evaluation of performance during the drill, and performance of the post-drill critique, including a new level of management oversight to ensure critiques are performed to the depth and broadness required, based on independent drill observation. The procedure enhancements were also designed to compensate for the contributing cause related to the lack of change management prior to the April 2012 exercise; where the experienced EP staff had been relied upon for the conduct of adequate critiques, the enhanced procedure steps now provide for a process to achieve an adequately comprehensive and complete critique. The contributing causes related to drill scenario development and to the exercise critique process were addressed by improvements in training, mentoring, and exposure to operating experience for personnel involved in drill preparation and evaluation. The procedure and training program changes were designed to improve the drill preparation and critique processes, and the performance of the critiques by those involved in exercise conduct and evaluation. The inspectors found the corrective actions to be extensive and thorough with regard to addressing the specific performance deficiencies identified with this event.

Overall, the inspectors found that NextEra specified appropriate corrective actions for the root cause, contributing causes, apparent cause, extent of condition, and extent of 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 inspectors reviewed the prioritization of the corrective actions and verified that the prioritization was based on appropriate consideration of risk significance and regulatory compliance. By the time of this inspection, the majority of the corrective actions had been implemented. The corrective actions involving drill preparation and evaluation had been implemented by the end of September 2012, so that they were in place to support the remainder of the drill schedule to be performed in that year. The only actions yet to be implemented were longer term actions, such as the periodic verification that certain on-site departments were maintaining the corrective actions involving knowledge management, and the effectiveness review of the entire set of corrective actions recommended by the RCE.

Overall, the inspectors determined that NextEra had established an appropriate prioritization of their corrective actions.

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

NextEra's corrective actions and proposed corrective action plan provided dates for completion of actions as described in the root cause evaluation. As of the issue date of this report, all corrective actions had at least been initiated, with those directly related to drill preparation and evaluation completed. As described in paragraph 02.03.b, the only open corrective actions involved longer-term reviews of the effectiveness of the more immediate corrective actions.

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 prevent recurrence.*

The inspectors determined that the root cause evaluation included an effectiveness review plan for the corrective actions to prevent recurrence. The RCE described the methodology, attributes, and success criteria of the effectiveness review plan. The success criteria included:

- All the corrective actions have been implemented as written and by the schedule due dates;
- No similar issues in EP drills or operator requalification testing have been reported since the corrective actions were implemented;
- No new unwanted/unexpected conditions have occurred due to the corrective actions implemented for this event;
- No failures in critiquing identified drill weaknesses;
- No unidentified missed DEP opportunities; and,
- Verifying drill success by the use of pre-defined criteria for DEP opportunities.

The effectiveness review was scheduled to be completed by the June 30, 2103, and was designed to provide for a review of all causal factors and corrective actions. The inspectors identified that the due date for completion of the effectiveness review was potentially not delayed enough to fully assess the adequacy of the corrective actions focused on drill/exercise critique opportunities. NextEra stated they would consider a longer assessment period for those corrective opportunities in order to develop a large enough sample to adequately determine the effectiveness of the whole set of corrective actions.

Overall, the inspectors determined that NextEra had established an appropriate effectiveness review to determine the adequacy of the corrective actions.

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.*

As required by the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was conducted because a finding of low to moderate safety significance

(White) was identified in the second quarter of 2012. This issue was documented in NRC Inspection Report 05000443/2012503, dated May 29, 2012, and involved the failure of Seabrook Nuclear Power Station personnel to carry out their assigned roles and responsibilities and to adequately critique the performance of the April 17, 2012, Evaluated Emergency Preparedness Exercise. NextEra responded by letter dated June 21, 2012. After considering the statements in NextEra's response letter, the results were conveyed to NextEra in a letter dated August 7, 2012, "Final Significance Determination for a White Finding, with Assessment Follow-up and Notice of Violation, NRC Inspection Report No. 05000443/2012504 – Seabrook Station, Unit 1" (ML12220A471). NextEra responded to that Notice of Violation on August 31, 2012, which described: their corrective actions taken and results achieved; corrective steps that would be taken; and the date when full compliance will be achieved. NextEra concluded full compliance was achieved on August 22, 2012, with the revisions to the Nuclear Division Drill and exercise procedures.

The inspectors reviewed the procedure and program changes made to restore compliance and verified that all elements of the White finding and the associated NOV had been appropriately addressed.

f. Findings

No findings were identified.

02.04 Evaluation of Inspection Manual Chapter 0305 Criteria for Treatment of Old Design Issues

This part of IP 95001 was not implemented as NextEra did not request credit for self-identification of an old design issue and the finding did not meet the requirements of IMC 0305 paragraph 04.18 for consideration as an old design issue.

4OA6 Exit Meeting

On January 24, 2013, the inspectors presented the inspection results to Mr. K. Walsh, Site Vice President, and other members of his staff, who acknowledged the results. The inspectors verified that no proprietary information was retained by the inspectors or documented in this report.

Regulatory Perofrmance Meeting

Following the January 24, 2013, exit meeting, the NRC discussed with NextEra its performance at Seabrook Station, Unit 1 in accordance with IMC 0305, Section 10.01.a. The meeting was attended by the Region I Division of Reactor Safety, Engineering Branch 1, Branch Chief, and other NRC staff and the Seabrook Station Site Vice President and other Seabrook Station staff. During this meeting, the NRC and NextEra discussed the issues related to the White finding that resulted in Seabrook Station Unit 1 being placed in the Regulatory Response Column of the Action Matrix. This discussion included the causes, corrective actions, extent of condition and extent of cause for the issues identified as a result of the April 17, 2012 Emergency Preparedness Drill and critique.

ATTACHMENT: SUPPLEMENTAL INFORMATION

ATTACHMENT

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel
K. Walsh, Site Vice President
D. Currier, Emergency Planning Manager

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Closed

05000443/2012503-001	NOV	Failure of Exercise Critique to Identify a RSPS Weakness as a DEP PI Opportunity Failure.

LIST OF DOCUMENTS REVIEWED

Procedures
EP-AA-101-1000, Nuclear Division Drill and Exercise Procedure, Revision 5
HR-AA-1000, Knowledge Transfer and Retention, Revision 0
PI-AA-100-1005, Root Cause Analysis, Revision 7

Miscellaneous
Ltr from U.S. NRC to Mr. Paul Freeman, Seabrook Station, Unit 1- NRC Evaluated Emergency Preparedness Exercise Inspection Report 05000443/2012503-Preliminary White Finding, dated 5/29/12
Ltr from NextEra Energy to U.S. NRC, Clarification of the Event Description for NRC Evaluated Emergency Preparedness Exercise, dated 6/21/12
Ltr from U.S. NRC to Mr. Kevin Walsh, Final Significance Determination for a White Finding with Assessment Follow-up and Notice of Violation [NRC Inspection Report No. 05000443/2012504] – Seabrook Station, Unit 1, dated 8/7/12
Ltr from NextEra Energy to U.S. NRC, Reply to a Notice of Violation; EA-2012-093, dated 8/31/12

Root Cause Evaluation Report
Seabrook Station Emergency Plan Exercise White Finding, AR 1766946

Self-Assessments
EP White Finding 95001 Preparation, Quick Hit Self-Assessment, AR 1828093

Other Action Reports

199215	1833427
1748851	1842026
1757270	
1794419	
1828802	

LIST OF ACRONYMS

ADAMS	Agencywide Documents Access and Management System
AR	Action Report
CFR	Code of Federal Regulations
DEP	Drill and Exercise Performance
EOF	Emergency Operations Facility
EP	Emergency Preparedness
ERO	Emergency Response Organization
GE	General Emergency
IMC	Inspection Manual Chapter
IP	Inspection Procedure
NOV	Notice of Violation
NRC	Nuclear Regulatory Commission
PAR	Protective Action Recommendation
PI	Performance Indicator
RCE	Root Cause Evaluation
RSPS	Risk-Significant Planning Standard