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Mr. G. L. Madsen, Chief
Reactor Operations & Nuclear Support
Office of Inspection & Enforcement
U. S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76011

Subject: Arkansas Nuclear One - Units 1 & 2
Docket Nos. 50-313 and 50-368
License Nos. DPR-51 and NPF-6
Response to IE Inspection Report
50-313/81-13 and 50-368/81-11
(File: 0232, 2-0232)

Gentlemen:

After reviewing your inspection report on the ANO March 24-25, 1981 Emergency Plan Exercise, Report Nos. 50-313/81-13 and 50-368/81-11, we feel responses are warranted on several of your observations even though no violations or deviations were listed. For this purpose, the following is provided. Please note that we have no comments on items 1 thru 4, 6 and 9a.

5. Control Room (CR)

The control room personnel upon notification of the different changes in simulated operating condition responded in a very efficient manner. Plant personnel consulted their procedures and noise level was kept at a minimum. The control room observer kept the NRC inspector appraised of the staff's activities.

a. Communications - There are not an adequate number of telephones for incoming and outgoing calls. The following problems were identified:

(1) The Shift Administrative Assistant had to make three unsuccessful attempts to get an outside line to call the appropriate emergency teams and make notifications. There was no call back procedure for verification, nor a telephone available for call back. The SAA needs all call numbers on one list rather than have numbers referenced in another procedure.

(2) Persons contacted were told that this was a drill, there was considerable time spent dialing numbers. If many people request information, one SAA is not sufficient.

RESPONSE:

(1) Additional telephones are being added to the Shift Supervisor's offices in each control room. The Shift Administrative Assistant (SAA) will utilize these additional phones to aid him in responding to both incoming and outgoing calls. The only notification made by AP&L which requires verification is our call to the Arkansas Department of Health. Verification for this call is made through a matrix authentication procedure which does not require a call back. All applicable emergency call lists are being incorporated into one notification procedure. This procedure will be utilized by the SAA during emergencies.

(2) Procedures are being developed through which additional personnel will be assigned to assist the SAA in making initial emergency notifications as needed.

7. Technical Support Center (TSC)

a. Although the observers were briefed on the temporary status of the TSC, it should also be recognized that the TSC should be functional. The TSC is a normal working office space and required office furniture to be rearranged. The Emergency Plans are located in a file cabinet outside of the TSC and the Implementing Procedures are located in a bookcase labeled "Emergency Plan".

(1) Noise level in the TSC was kept at a minimum and the Duty Emergency Coordinator had control over the TSC.

(2) Upon activation of the TSC it was evident that several people were aware of their duties, however, outside people had to be called in to assist in answering the telephone and assist in various functions.

(3) Visual aids were present, however, the status board indicated that the plant was in an alert condition throughout the exercise. The NRC was notified around 0630 of the alert and the board did not reflect any more calls. Persons coming into the TSC could not get any indication of previous releases, dose assessments, etc.

(4) The public address system could not be heard in the TSC (or other parts of the building).

(5) Dose assessment was slow and due to two people attempting to do calculations on one small hand calculator.

(6) The radio operator did not have any previous training and required on-the-spot training. There was difficulty in conversing with the corporate office in Little Rock.

(7) No radiation monitoring in the TSC was observed during the exercise.

(8) The present TSC will not meet the habitability requirements of NUREG 0696. If the control room is to be the back-up, there is not sufficient space nor communications to accommodate personnel from the TSC. The area of TSC habitability will be reviewed during subsequent inspections (50-313/81-13; 50-368/81-11).

RESPONSE:

(3) Status boards are presently being redesigned to incorporate lessons learned from our March 24-25 Emergency Exercise. Procedures are being changed to incorporate the assigning of an individual as a status board keeper in the TSC. This individual will be responsible for keeping the status boards up-to-date and maintaining a history of important parameters.

(4) The public address system has been functionally tested and necessary repairs and adjustments are being made.

(5) Pre-programable hand held computers are now being purchased to assist in offsite dose assessment calculation. These computers will significantly reduce the time required to do offsite calculations.

(6) The radio system used for the March 24-25 Emergency Exercise was installed the week before the exercise. This did not allow time for formal training on the system. Training is now being conducted or is scheduled for each applicable member of the emergency response organization.

(7) Procedures are in effect at ANO which require air sampling of the administration building following a plant evacuation. During the March exercise, simulated samples were taken in the administration building (TSC is in the administration building).

(8) The primary TSC for ANO is not designed to be radiologically habitable during an accident condition. The primary TSC is backed by a habitable (designed to same radiologically habitable requirements as control rooms) secondary TSC. This concept was proposed to the NRC in our letter of January 17, 1980, and was approved by the NRC in a letter dated April 15, 1980.

8. Radiation Monitoring Teams

The onsite radiological monitoring team was observed putting on their anti-contamination clothing. They were dispatched into the plant and conducted in plant surveys.

The offsite monitoring teams were dispatched to the field. It was noted that the monitoring teams did not have adequate equipment especially to detect radioiodine. The teams did not have any capability of determining radioiodine in the field, however, the data for radioiodine levels were supposed to be coming from the field in some cases.

There appeared to be a lack of training for the plant offsite monitoring teams. There was a great deal of confusion as to where they were supposed to go for monitoring and they did not have an official observer with them to feed artificial data to them.

Personal vehicles were used and there is doubt that the teams could travel off of the main roads during bad weather conditions.

The area of capability to adequately detect radioiodine in the field will be reviewed during subsequent inspections (50-313/81-13; 50-368/81-11).

RESPONSE:

Additional offsite monitoring equipment for emergency responses is presently, and was at the time of the exercise, on order. Due to the backlog of orders at the manufacturers, this equipment was not available for the exercise. The equipment on order will have the capability to detect low levels of radioiodine in the field.

Field monitoring teams are presently being training in offsite monitoring. This training will continue on a periodic basis.

Only company vehicles were used during the exercise for offsite monitoring. A four-wheel drive, company-owned Bronco was present for the exercise and used for offsite monitoring. This vehicle was specifically purchased to accommodate off-road and bad weather condition surveying.

9. Fire and Personnel Emergency

a. There was no simulated fire for this exercise, however, the fire team did assemble.

b. There was a person who was simulated to be injured and contaminated. This person was sent to the St. Mary's Hospital for evaluation and treatment. The emergency van was not protected inside to prevent possible spread of contamination. The station person who went with the van did not check and release the rescue squad or the van. There appears to have been a break down of communications between the hospital and AP&L. The emergency equipment has been neglected. The radiation detectors would not operate and the cosimeters had drifted. A training session was held two weeks prior to the drill by the State. Some Hospital personnel used plastic for foot coverings, and had the plastic held on by tape. Some effort should be made to procure proper anti-contamination clothing. There was no AP&L observer for the ambulance

or at the hospital. Once the patient arrived at the hospital, the AP&L Health Physics technician left and did not coordinate with the hospital staff.

In a post-accident interview with the ambulance rescue team, it was stated by the team that they had requested training and equipment for emergency response Arkansas Power & Light sent them a film for plant people, which they consider inadequate. The hospital can only accept three contaminated victims, if this is the same hospital that the State will use, there is some doubt that this facility will be sufficient to accommodate over three to five people at one time. The area of hospital staff and doctors training will be reviewed during subsequent inspections (50-313/81-13; 50-368/81-11).

RESPONSE:

(b) The emergency equipment located at St. Mary's Hospital is checked monthly. Any defective equipment is repaired or replaced during this check.

Representatives of AP&L and the Arkansas Department of Health have met with St. Mary's Hospital personnel to discuss training needs. From these meetings, a training program was developed and will be conducted for St. Mary's personnel on July 29 and 30, 1981.

Meetings on training needs have also taken place between AP&L and Pope County Ambulance personnel. AP&L has scheduled training for this summer for these individuals with retraining taking place annually.

10. Emergency Control Center

The Emergency Control Center is located in a temporary house trailer. Presently there is sufficient room to accommodate a very limited response team. This refers to the fact that the Nuclear Regulatory Commission, Federal Emergency Management Agency, reporters, state, and local agencies did not go to the ECC. Visual aids were not kept up to date and it was difficult to have a historical picture due to limited information. AP&L did not make any recommendations to the state for offsite public action. There was a lack of State and AP&L interaction especially in getting offsite monitoring activities. Offsite monitoring was controlled by the Little Rock staff and there did not appear to be a coordinated effort with the plant offsite teams.

RESPONSE:

The new Emergency Control Center (ECC), which was still under construction during the March exercise, is now complete. This new facility will alleviate overcrowded conditions during an emergency. Status boards for the ECC are being redesigned at this time to accommodate updating and accumulating historical information. A status board keeper will be assigned to the ECC to maintain the board during an emergency.

AP&L's procedure for making offsite protective action recommendations was followed during the March exercise. Conditions simulated during the exercise never required AP&L to make any offsite recommendations.

During the March exercise, two State liaison personnel were located in the ECC. Information from AP&L was passed through these individuals to the State Technical Operation Control Center. The State noted in subsequent reviews of the exercise a lack of information flowing back to AP&L through these liaison personnel. The State has taken action to correct this situation.

Once the Little Rock corporate offsite monitoring teams arrive at the site, they assume the responsibility from plant personnel for offsite monitoring. There is no need for continual interface between these two groups once the transition is made.

Scenario

The scenario was not written to fully exercise the response capabilities of the plant staff. The full scenario was delivered to the NRC five days prior to the exercise which, according to AP&L, could not be changed. There were changes to the scenario by AP&L without consulting with the NRC team inspector on the day of the exercise. There appeared to be a lack of site/corporate coordination for the exercise.

The exercise started off with the plant being in an "Unusual Event" for 11 hours and then compressed the "Alert" and "General Emergency" into a very short time frame. It was apparent that most of the plant staff was very well aware of the drill and what was expected of certain people to do prior to the exercise. There were areas which were not covered by observers from AP&L.

There should be more effort expended and more time available for the State, FEMA, and NRC to review the proposed scenario. The final scenario should be available to the appropriate agencies no less than 30 days prior to the exercise.

RESPONSE:

The March 24-25, 1981 ANO Emergency Plan Exercise was not initially planned to be carried out for formal review and approval by the NRC. It was not until a phone call with the NRC on February 23, 1981, that we began planning for a full NRC review.

The same day of the February 23, 1981 phone call, a telecopy of the complete narrative summary of the scenario was sent to Mr. Tom Kevern of the NRC for his review. Also that day, the narrative summary of the scenario was sent by letter to Mr. K. V. Seyfrit of Region IV. This narrative summary contained all of the details of the scenario including times and events. The exercise evaluation book, which was nothing more than a breakdown of the narrative summary and a set of check sheets for AP&L observers, was not completely developed until mid-March. This book, which you refer to as the full scenario, was Federal Expressed to the NRC on March 19, 1981.

The scenario for the March 24-25, 1981 exercise was developed around times that the Arkansas Nuclear Planning & Response Program office, the Arkansas Office of Emergency Services, and the Arkansas Department of Health had requested, and were agreed upon in a meeting between these agencies and AP&L on January 6, 1981. In several phone calls to AP&L during the month of February, Mr. Hackney of the NRC asked that we modify our scenario to either begin the morning of the 25th or to carry out activities the night of the 24th. We explained to Mr. Hackney that the scenario had been developed around the State's schedule and that it could not be changed at this late date without disrupting the State. The NRC then sent a letter to AP&L on March 12, 1981 suggesting that the time between 11:00 p.m., March 24, and 6:00 a.m., March 25, be used to exercise offsite response agencies. Mr. Martin Tull of the Arkansas Department of Health, after reading a copy of this letter, phoned Mr. Collins of NRC Region IV and informed him that it would be impossible for the State to react to any changes in the scenario at this late date. Mr. Collins relayed to Mr. Tull that he understood the circumstances and that the scenario as written was acceptable. In phone conversations between NRC's Mr. Tom Kevern and our Mr. Dale James, Mr. Kevern explained that he thought that by starting the exercise in the evening that AP&L was going to take credit for a night exercise. After explaining this was certainly not the case and that these times were to fit the State's schedule, Mr. Kevern stated that he had no problems with the times in the scenario.

Some modifications were made to the scenario at the "last minute" on March 23, and marked up copies of the scenario including the changes were given to the inspectors. However, these modifications were only slight changes and did not effect the overall sequence of events.

The medical emergency for the exercise was moved up because it could not have been realistic to injure an individual at the time initially planned in the narrative summary. The initial notifications to the State were advanced slightly so that the State would be notified at approximately the time shown in the narrative summary for the event. This was done because the State had not planned for any variance from the schedule while AP&L had planned to act out the scenario and notify the State once the emergency had been analyzed and classified.

The above information is provided as meaningful feedback on several of your comments. We at AP&L take emergency planning very seriously and are striving to have one of the best emergency response capabilities in the country. Your constructive criticism and reviews are aiding us in this effort. We look forward to further interfaces with you on this topic.

Very truly yours,

David C. Trimble

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