



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

JAN 25 1994

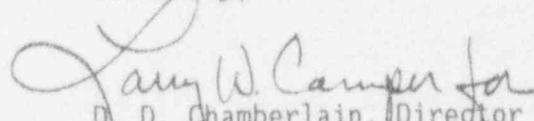
Docket: 50-382
License: NPF-38

Entergy Operations, Inc.
ATTN: Ross P. Barkhurst, Vice President
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P.O. Box B
Killona, Louisiana 70066

SUBJECT: NRC INSPECTION REPORT 50-382/93-28

Thank you for your letter dated December 29, 1993, in response to the two emergency preparedness weaknesses identified in NRC Inspection Report 50-382/93-28 dated November 24, 1993. We have examined your reply and find it responsive to the concerns raised in our inspection report. We will review the implementation of your corrective actions during a future inspection.

Sincerely,


D. D. Chamberlain, Director
Division of Radiation Safety
and Safeguards

cc:
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Entergy Operations, Inc.

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Denton, Texas 76201-3698

Entergy Operations, Inc.

-3-

bcc to DMB (IE06)

bcc w/copy of licensee's letter dated December 29, 1993:

L. J. Callan, RA

WAT Resident Inspector

Section Chief (DRP/D)

Section Chief (DRP/TSS)

Project Engineer (DRP/D)

Lisa Shea, RM/ALF (MS MNBB 4503)

MIS System

RIV File

DRSS-FIPS Files

RIV:FIPS <i>nr</i>	C:FIPS <i>D</i>	ADD:DRSS <i>nr</i>	AD:DRSS <i>nr</i>	
WLHolley:nh	BMurray	LWCamber	DDChamberlain	
1/21/93	1/21/93	1/24/93	1/24/93	

Entergy Operations, Inc.

-3-

bcc to DMB (IE06)

IE35 1/1

bcc w/copy of licensee's letter dated December 29, 1993:

L. J. Callan, RA

WAT Resident Inspector

Section Chief (DRP/D)

Section Chief (DRP/TSS)

Project Engineer (DRP/D)

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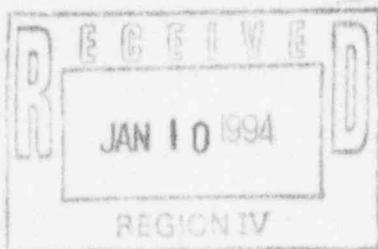
DRSS-FIPS Files

RIV:FIPSA <i>NT</i>	C:FIPS <i>D</i>	ADD: <i>[Signature]</i>	AD: <i>[Signature]</i>	
WLHolley:nh	BMurray	LMCamber	DOChamberlain	
1/21/93	1/21/93	1/21/93	1/21/93	

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R. F. Burski



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December 29, 1993

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

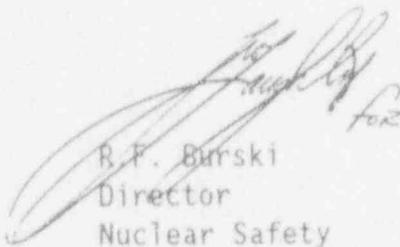
Subject: Waterford 3 SES
Docket No. 50-382
License No. NPF-38
NRC Inspection Report 93-28

Gentlemen:

Entergy Operations, Inc. hereby submits in Attachment 1 the response to the emergency preparedness weaknesses documented in the subject Inspection Report. These responses are attached and include analysis of the weaknesses, description of corrective measures and schedules for completing these actions as requested.

If you have any questions concerning this response, please contact F.J Englebracht, Emergency Planning & Administration Manager, at (504) 739-6607.

Very truly yours,


R.F. Burski
Director
Nuclear Safety

RFB/GCS/ssf
Attachment

94-0395

cc: J.L. Milhoan (NRC Region IV), D.L. Wigginton (NRC-NRR),
R.B. McGehee, N.S. Reynolds, NRC Resident Inspectors Office

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ATTACHMENT 1

ENERGY OPERATIONS, INC. RESPONSE TO THE EMERGENCY EXERCISE
WEAKNESSES DOCUMENTED IN INSPECTION REPORT 93-28

WEAKNESS NO. 9328-01

The Technical Support Center staff did not aggressively pursue the identification of the source of the penetration leakage through the shield building ventilation system to the plant stack or its termination. At 1:41 p.m., identification of the release path was established as a priority for the Technical Support Center and the Emergency Operations Facility. While there was much discussion as to possible sources of the release, it was not until 2:51 p.m. that a team was dispatched to determine if leakage was occurring at suspected penetrations. Throughout the decision process, the Technical Support Center staff considered the possibility of overpressurizing the ventilation system plenum but did not attempt in parallel to dispatch a leak search team or attempt to determine the maximum plenum pressure should it become necessary to shutdown the shield building exhaust system. At 3:44 p.m., immediately prior to terminating the scenario, attempts had not been made to isolate the release nor had a decisive mitigation strategy been determined.

It was not clear from discussions in the Technical Support Center that any assessment of core damage was being performed during the event. Discussions between the Operations Coordinator and the Health Physics Coordinator indicated a concern that some core damage had occurred, but neither indicated that any assessment was being performed to confirm their opinions. It was not observed that this concern was communicated to the Emergency Coordinator, who might have been able to dedicate resources to initiate an assessment. The Operations/Engineering Coordinator in the Emergency Operations Facility discussed with the Operations Communicator in the Technical Support Center the need for an assessment of core damage, but there were no follow-up communications regarding the assessment. For example, no one requested a Post Accident Sampling System sample during the exercise to help perform a core damage assessment.

The above examples of nonaggressive assessment of plant conditions and mitigation strategies were identified as an exercise weakness.

RESPONSE

(1) Analysis of the Weakness

The lack of timely assessment of plant conditions and identification of the release pathway is attributed to poor communications among emergency response facilities, lack of clearly defined task assignments and responsibilities for completing task assignments and timely follow-up.

With regard to communications, it appeared to the Entergy Operations, Inc. Drill Control Team that the Control Room staff was aware of the release pathway, but that this information was not clearly communicated, or understood, throughout the emergency response organization. In addition, the EOF engineering staff generated numerous ideas regarding the source of the release and ways to secure it, but feedback from the TSC on these ideas was not provided to the EOF staff, and not actively pursued by the EOF staff.

Although many ideas were discussed in the TSC and EOF, it would have been more effective if specific task assignments were generated with a specific lead engineer and a report back time assigned to each. This would have provided better trending and ownership of mitigation strategies and assisted in providing overall direction of response actions.

Several examples of lacking a follow-up of good ideas were observed. When Reactor Auxiliary Building increased air activity was suspected, a team of Health Physics personnel could have been assigned to look for leaks and take air samples in the suspected areas. The EOF staff requested the status of containment isolation several times, but follow-up to provide this information back to the EOF was not observed.

(2) Corrective Measures

Two specific corrective actions are planned:

1. Lesson plans for Control Room staff, TSC Health Physics Support personnel, TSC Operations Coordinator, TSC Operations Communicator, TSC Engineering staff, TSC Supervisor, TSC Emergency Coordinator, EOF Health Physics Support personnel, EOF Operations/Engineering Coordinator, EOF Operations/Engineering Coordinator Assistant, EOF Engineering staff, EOF Director and Deputy EOF Director will be revised to incorporate a discussion of the accident assessment problems in the 1993 annual exercise as lessons learned. This discussion will

include emphasis on clear communications among facilities and clear and timely feedback, assignment and tracking of tasks, development of corrective action strategies and thorough follow-up of ideas.

2. The Emergency Planning Department will incorporate the above lessons learned discussion in the annual tabletop program during 1994. The department conducts a minimum of 4 tabletops a year for TSC, OSC, and EOF positions. In addition, the Emergency Planning Department will address the lessons learned discussion in seminars with all Operations shifts in 1994.

(3) Date When Full Compliance Will Be Achieved

Corrective Measure 1 will be completed by April 1, 1994.

Corrective Measure 2 will be completed by December 14, 1994.

WEAKNESS NO. 9328-02

The following problems with the approval and issuance of Protective Action Recommendations were observed by the inspectors in the Technical Support Center:

The initial General Emergency notification made an erroneous Protective Action Recommendation of sheltering the 2-mile radius and evacuating 2 to 5 miles downwind. This Protective Action Recommendation was telephonically communicated to the state and parishes via the Operational Hot Line at 11:52 a.m. The correct Protective Action Recommendation should have been to shelter the 2-mile radius and 2 to 5 miles downwind. This erroneous Protective Action Recommendation was corrected on the message form at 11:55 a.m. by the Technical Support Center Lead Communicator without acquiring the approval of the Emergency Coordinator or the review of the Health Physics Coordinator. The corrected Protective Action Recommendations were subsequently communicated to the state and parishes several minutes later.

Emergency Preparedness Implementing Procedure EP-002-010, Revision 20, "Notifications and Communications," Section 5.2, Note I., specifies that the Health Physics Coordinator in the Technical Support Center is responsible for completing the notification message forms. Contrary to this procedure, the short notification form for the initial General Emergency notification was completed by the Technical Support Center Lead Communicator and was reviewed and approved by the Emergency Coordinator prior to issuance. The Health Physics Coordinator did not complete or review this message form.

Incorre Protective Action Recommendations were issued on a second occasion when the wrong procedure attachment was used to determine the recommendations. Emergency Preparedness Implementing Procedure EP-002-052, "Protective Action Guidelines," Section 5.2.1, requires that "if dose projection information is available, a release is occurring and the duration of the release is unknown, use Attachment 7.1 and proceed to Step 5.3." These enabling conditions existed at about 12:20 p.m. Step 5.3 specifies that a Protective Action Recommendation of evacuation from 0 to 2 miles in all sectors and 2 to 5 miles in the affected sectors, and shelter 5 to 10 miles in the affected sectors should be issued. Contrary to this procedure, notification message No. F-11 was issued at 12:23 p.m. which incorrectly recommended that all affected sectors be sheltered.

The issuance of incorrect Protective Action Recommendations, the failure to follow applicable procedures for completing notification messages containing Protective Action Recommendations, and the failure to receive the Emergency Coordinator's approval to modify previously approved Protective Action Recommendations were identified as an exercise weakness.

RESPONSE

(1) Reason for the Weakness

The failure to identify appropriate protective action recommendations in a timely manner, ensure modifications to protective actions are authorized and follow procedures to complete notification message forms is attributed to two root causes: 1) difficult procedures, 2) need for additional training.

The protective action guidelines procedure is difficult to implement because it includes three different methods of arriving at protective actions (no release, release with duration known, release with duration unknown). In addition, the procedure requires consideration of evacuation time estimates, plume travel times, CET temperatures, saturation margins and containment integrity conditions. In attempting to consider the various conditions addressed in the procedure, the user might erroneously allow an initial recommendation of sheltering to stay in place for some time, even though dose assessment information indicates evacuation should be the recommendation.

Regarding completion of notification forms, it is Waterford 3's position that a Lead Communicator (TSC) or Communications Coordinator (EOF) should have the ability (by procedure) to complete a message form, either partially or in its entirety, as directed by the facility Health Physics personnel. The notifications and communications procedure does not clearly specify that the communicators have the authority to perform this function.

Given the complicated nature of the protective action guidelines procedure, and the many variables involved in arriving at protective action recommendations, additional training on the determination of protective actions is necessary. This need for additional training was evident in the 1993 exercise. Several individuals were observed working to arrive at the recommendations, and all had difficulty in determining the appropriate attachment of the procedure to use. Because the same problem was experienced by at least three individuals in the TSC, the cause of the problem is attributed to an additional training need and not personnel error.

(2) Corrective Measures

1. EP-002-052, Protective Action Guidelines, has been revised with an effective date of January 1, 1994. This revision not only implements revised 10CFR20 and EPA 400 concepts and philosophy, but eliminates many of the variables and complicated logic contained in the old procedure.
2. EP-002-010, Notifications and Communications, will be revised to allow the partial, or full completion of offsite messages by communications personnel as directed by Health Physics personnel.
3. Special training seminars have been conducted by Emergency Planning for each Operations Shift and the following emergency response organization positions: Health Physics Coordinator, Health Physics Coordinator Assistant, Dose Assessment Coordinator, Dose Assessment Coordinator Assistant, Radiological Assessment Coordinator, Radiological Assessment Coordinator Assistant, Field Team Controller, Dose Projection Coordinator. A portion of these seminars was devoted to a discussion of the problems with protective action recommendations in the 1993 annual exercise as lessons learned. Training on the generation of protective action recommendations using the revised procedure was also included in the seminars.
4. In addition to the above seminars, the Emergency Planning Department will incorporate special training on the generation of protective action recommendations and a discussion of 1993 exercise problems associated with protective action recommendations as lessons learned in the annual tabletop programs during 1994. The department conducts a minimum of 4 tabletops a year for TSC, OSC, and EOF positions. The 1994 tabletops will include problems that require the participants to develop the appropriate protective actions for at least three different scenarios.
5. A discussion of the 1993 annual exercise problems associated with protective action recommendations as lessons learned will be incorporated in lesson plans for TSC Health Physics Support personnel, EOF Health Physics Support personnel, TSC Emergency Coordinators, EOF Directors, Shift Supervisors, Control Room Supervisors, TSC Communicators and EOF Communicators.

(4) Date When Full Compliance Will Be Achieved

Corrective Measures 1 and 3 have been completed.

Corrective Measures 2 and 5 will be completed by April 1, 1994.

Corrective Measure 4 will be completed by December 14, 1994.