



ENTERGY

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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 95-14

Gentlemen:

Entergy Operations, Inc. hereby submits the response to the emergency preparedness weakness documented in the subject Inspection Report. This response is attached and includes analyses of the weakness, 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/tjs
Attachment

cc: L.J. Callan (NRC Region IV), C.P. Patel (NRC-NRR),
G.M. Good (NRC Region IV), 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 95-14

WEAKNESS NO. 9514-01:

Some communication problems were identified in the Technical Support Center (TSC). First, after declaring the General Emergency, the Technical Support Center supervisor recommended relocating the Primary Access Point (PAP), since the calculated plume was extremely close to the PAP location. The health physics coordinator agreed with the recommendation. The emergency coordinator instructed the Technical Support Center supervisor to have security prepare to relocate the PAP. This order was relayed to the PAP. In response to the order, security personnel prepared for the move but waited for further instructions before relocating. The Technical Support Center supervisor incorrectly understood that security was relocating the PAP (log entries indicated that the PAP was relocating at 11:55 a.m.). Within 30 minutes of the release, the health physics coordinator asked the Technical Support Center supervisor if the PAP had been relocated; he stated that it had. Security never relocated the PAP, because they were waiting for the order to move. As a result, security personnel could have been unnecessarily exposed. The failure to clearly communicate instructions and to positively followup/verify that the PAP had been relocated was identified as an exercise weakness (50-382/9514-01).

RESPONSE

(1) Analysis of the Weakness

The failure to clearly communicate instructions and to positively followup/verify that the PAP had been relocated is attributed to poor communications practices and the failure to apply proper "3 way" communications methods. These methods involve 1) the communication of information, 2) restatement of the information that is communicated to the receiver 3) confirmation by the provider of the information that the receiver's restatement is correct (or incorrect, if that is the case).

Records, logs and interviews with the personnel involved in the PAP relocation issue consistently indicate that the TSC Supervisor understood that he had directed security to evacuate the PAP, while security understood this direction to be to "standby" to evacuate the PAP and that other subsequent direction would follow. Both parties applied only the first part of proper communications practices. If the Security Superintendent had restated his understanding of the

initial message, or the TSC Supervisor had asked him to restate the message in order for the TSC Supervisor to confirm that the actions to relocate were clearly understood, Waterford 3 is confident that the misunderstanding in the directions would have been identified and corrected. In addition, once security "standby" actions were completed, a followup communication to the TSC stating the actions that had been taken would have indicated to the TSC Supervisor that the PAP was not yet evacuated. Lastly, a followup communication from the TSC Supervisor to security requesting status of PAP evacuation activities or confirmation of the evacuation should have occurred as the scenario progressed, especially since the TSC Supervisor received no feedback from security.

(2) Corrective Measures

Four specific corrective actions are planned:

1. The Waterford 3 Emergency Planning Department maintains a procedure (EP-003-060, Emergency Communications Guidelines) on which all Waterford 3 emergency response organization members are trained. This procedure outlines proper verbal and written communications practices to be used during an emergency. This procedure addresses the use of "repeat-backs", but does not specifically incorporate use of the "3 way" communications method, nor does it instruct the communicator of information to request feedback when it is not forthcoming. EP-003-060 will be revised to include use of the "3 way" communications method and other effective communications practices, such as requests for feedback.
2. Upon completion of the revision to procedure EP-003-060, training for all emergency response organization personnel will be provided in the form of supplemental reading. The supplemental reading will include not only the procedure revision but a lessons learned summary of the instances of poor communications in the 1995 annual exercise along with a discussion on how problems could have been avoided using better communications practices.
3. Lesson plans for all emergency response organization positions will be revised to incorporate a discussion of the "3 way" communications method and communications lessons learned from the 1995 annual exercise.
4. The Emergency Planning Department will incorporate the above lessons learned discussion in the annual tabletop program during 1996. 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 1995.

3. Date When Full Compliance Will Be Achieved

Corrective Measures 1, 2, and 3 will be completed by March 1, 1996.

Corrective Measure 4 will be completed by December 1, 1996 for the tabletop program and December 31, 1995 for the Operations seminars.