From: Anne Boland, RII
To: jlk1, RII J Kran, RII
Date: 11/12/96 3:14pm
Subject: St. Lucie EAW -Forwarded

NOTICE OF VIOLATION

Saint Lucie Nuclear Plant
Inspection Report No. 50-335, 50-389/96-18

10 CFR 50.54(q) requires that nuclear power plant licensees follow and maintain in effect emergency plans which meet the planning standards of 10 CFR 50.47(b), and the requirements in 10 CFR 50 Appendix E.

Section 7.2.2 Training of On-site Emergency Response Organization Personnel, of the licensee's REP, Revision 31 states that the training program for members of the on-site emergency response organization will include practical drills, as appropriate, and participation in exercises, in which each individual demonstrates an ability to perform assigned emergency functions. Section 7.2.2 of the licensee's Emergency Plan further states that for employees with specific assignments or authorities as members of emergency teams, initial training and annual retraining programs will be provided. Training must be current to be maintained on the site Emergency Team Roster." Section 7.3.2 of the licensee's Emergency Plan states, "The Plant Training Manager will ensure that on-site Emergency Response Organization personnel are informed of relevant changes in the Emergency Plan and Emergency Plan Implementing Procedures."

Contrary to the licensees Emergency Plan requirements stated above, the licensee failed to provide a program which included an opportunity for each individual, assigned to the on-site emergency response organization, to participate in a drill or exercise. In the year 1994 the licensee failed to provide training for 17 positions, approximately 92 individuals, identified as part of the on-site response organization. In the year 1995 the licensee failed to provide training for 8 positions, approximately 54 individuals, identified as part of the on-site response organization. The licensees training program failed to include initial or periodic retraining on all procedures required to be implemented by several identified positions. The licensees failed to inform individuals of significant changes to procedures required to be implemented by several identified positions. In the year 1995 the license failed to remove from the emergency response organization 4 individuals who had not completed retraining as required. The licensee failed to remove 6 individuals from the emergency response organization effective October 6, 1996, who had not remained qualified to fill response team requirements by allowing respirator qualification to lapse.

This is a Severity Level __ violation (Supplement VIII).

5. **Identification Credit?** [Enter Yes or No]: YES

Consider following and discuss if applicable below:
☐ Licensee-identified ☐ Revealed through event ☐ NRC-identified
☐ Mixed identification ☐ Missed opportunities

Enter date Licensee was aware of issues requiring corrective action:

The licensee was aware of most of the items in January 1996.
[ ]

#

Explain application of identified credit, who and how identified and
consideration of missed opportunities:

Many of the identified failures in the licensees program were self identified in a self assessment that was performed in January 1996. However, some of the identified failures were not self identified, but should have been through existing licensee program controls.

6. **Corrective Action Credit?** [Enter Yes or No]: NO

Brief summary of corrective actions:

The licensee has initiated action items to evaluate and determine corrective actions for self identified issues. The licensee is currently completing a mass training effort for all ERO positions necessitated by recent changes in responsibilities from Corporate staff assignments to Plant staff assignments.

Explain application of corrective action credit:

The licensee has not yet fully determined nor implemented programmatic changes to resolve identified issues.

ENFORCEMENT ACTION WORKSHEET

BREAKDOWN IN MANAGEMENT CONTROL OF THE
ST. LUCIE EMERGENCY PREPAREDNESS PROGRAM

PREPARED BY: James L. Kreh DATE: November 7, 1996

This Notice has been reviewed by the Branch Chief or Division Director and each violation includes the appropriate level of specificity as to how and when the requirement was violated.

_____
Signature

Facility: St. Lucie Plant
Units: 1 & 2
Docket Nos.: 50-335, 50-389
License Nos.: DPR-67, NPF-16
Inspection Report No.: 96-18
Inspection Dates: October 7-18 and October 28-November 1, 1996
Lead Inspector: J. L. Kreh

1. Brief Summary of Inspection Findings:

Violation A

On the evening of October 3, 1996, the licensee conducted a test of its automated system known as the FPL Emergency Recall System (informally called "autodialer") for notifying the emergency response organization (ERO) in the event of an off-hour emergency requiring augmentation of the on-shift crew for staffing and activation of emergency response facilities (viz., Technical Support Center [TSC], Operational Support Center [OSC], and Emergency Operations Facility [EOF]). The autodialer did not operate, and no individuals received notifications during the test. A failure assessment by the licensee disclosed that the autodialer had been in an inoperable configuration for a period which apparently began on July 22, 1996. In addition, the inspection identified the licensee's failure to adequately maintain the manual backup system (a "call tree") for ERO call-out over an indeterminate period (at least the last several years). These concurrent deficiencies represent a failure (during the period July 22-October 3, 1996 at minimum) to maintain the capability to execute the provisions of the REP and its implementing procedures in a timely manner with respect to mobilization of the ERO during off-hours.

Violation B

The licensee's training program for ERO personnel has not been adequately implemented since at least 1994. This violation includes failure to provide opportunities for most personnel to participate in exercises and/or drills, failure to provide annual retraining to certain designated personnel in 1994 and 1995, failure to provide any training for certain ERO positions with respect to selected implementing procedures, and failure to remove individuals from the ERO roster when their respirator qualifications had lapsed.

2. **Analysis of Root Cause:**

The root cause of both violations is failure of licensee management to (a) provide an appropriate level of oversight of the emergency preparedness program as required by the REP, and (b) ensure the implementation of timely and effective corrective actions for identified findings and deficiencies in emergency preparedness.

3. **Basis for Severity Level (Safety Significance):**

For both violations: Supplement VIII - Emergency Preparedness, SL III

Section C.3 of Supplement VIII presents as an example, "Violations involving ... a breakdown in the control of licensed activities involving a number of violations that are related ... that collectively represent a potentially significant lack of attention or carelessness toward licensed responsibilities."

Section IV.A of the Enforcement Policy states that "a group of Severity Level IV violations may be evaluated in the aggregate and assigned a single, increased severity level, thereby resulting in a Severity Level III problem, if the violations have the same underlying cause or programmatic deficiencies, or the violations contributed to or were unavoidable consequences of the underlying problem."

4. **Identify All Previous Escalated Actions Within 2 Years or 2 Inspections**

- 95-180: PORVs Inoperable Due To Personnel Error; SL III
- 96-040: Dilution Event; SL III
- 96-249: Multiple Examples of Inadequate 50.59 Reviews; SL III

5. **Identification Credit?** Yes

Violation A

Date licensee was aware of issues requiring corrective action: October 3, 1996. This identification credit/date applies only to the autodialer inoperability portion of the violation. The problem with the manual call-out system was NRC/CI-identified.

Explain application of identified credit, who and how identified and consideration of missed opportunities:

The inoperability of the autodialer was identified by the licensee on 10/3/96, but could have been identified much earlier if periodic functional tests (e.g., weekly) had been performed. With appropriate administrative controls in place (as had been recommended by an EP Coordinator as early as April 1996), autodialer inoperability would have almost certainly have been precluded. An autodialer problem (limited in scope--not a complete system failure) also occurred during the NRC-evaluated June 1993 exercise, but corrective action for that problem was clearly not sufficiently comprehensive.

Violation B

Date when the licensee was aware of issues requiring corrective action: January 1996.

Explain application of identification credit, who and how identified and consideration of missed opportunities:

Many of the identified failures in the licensees training program were self-identified in a self-assessment that was performed in January 1996. However, some of the identified failures were not self-identified, but should have been through existing licensee program controls.

6. **Corrective Action Credit?** No

Violation A

Administrative controls have been implemented for the autodialer under Protective Services Department Guideline No. PSG-015, "Maintenance and Testing of the Emergency Recall System", Revision 0, dated 10/29/96. For the manual call-out system, individuals required to maintain a copy of the procedure were added to the controlled distribution list, and a drill was conducted on October 10, 1996 with reasonably successful results.

Application of corrective action credit: (1) No credit for autodialer issue because identified by licensee EP Coordinator in early 1996 and no action taken; (2) Credit for correction of manual call-out problem after identification to licensee on 10/7/96.

Violation B

The licensee has initiated action items to evaluate and determine corrective actions for self-identified issues. The licensee is currently completing a mass training effort for all emergency response organization positions necessitated by recent changes in responsibilities from Corporate staff assignments to Plant staff assignments.

Application of corrective action credit: No credit because the licensee has not yet fully determined or implemented programmatic changes to resolve identified issues.

7. **Candidate For Discretion?** No

Licensee's performance in emergency preparedness is now recognized to have been particularly poor during the past several years.

8. **Is A Predecisional Enforcement Conference Necessary?** Yes

Why? To determine whether the subject violations represent a programmatic breakdown in emergency preparedness.

If yes, should OE or OGC attend? Yes
Should conference be closed? No

9. **Non-Routine Issues/Additional Information:**

OTHER FINDINGS FROM THE OCTOBER 1996 EP PROGRAM INSPECTION

Violation

Failure to establish an Emergency Plan Implementing Procedure (EPIP), or to have an adequate EPIP, with appropriate implementing details to address certain aspects of the Radiological Emergency Plan as follows:

a. the transfer of OSC functions to an alternate location in the event that evacuation of the primary OSC is required (EPIP-3100032E, "On-site Support Centers", contains no implementing details for the statement in Radiological Emergency Plan Section 2.4.4 that "In the event that the OSC becomes untenable, the Emergency Coordinator will designate an alternate location.") {inadequate procedure}, and

b. recovery activities upon reaching a stable plant condition following an emergency (Radiological Emergency Plan Section 5.4) {no procedure}.

Emergency Preparedness Program Weaknesses

1. Inadequate program of drills to ensure availability of sufficient ERO personnel and timeliness of ERF staffing

2. Management failure to ensure the implementation of timely corrective actions for certain emergency preparedness deficiencies and weaknesses. Examples are:

   a. failure to address concerns regarding the audibility of the Gaitronics (or plant public-address system) formally identified in late 1994 and still being tracked as an open item by the licensee's corrective action system,

   b. failure to provide adequate corrective action to address a questionable capability for notification of the State of Florida within 15 minutes of an emergency declaration (identified by an NRC inspection in February 1995), and

c. failure to implement timely corrective actions for deficiencies and recommendations identified by the critique of the Hurricane Erin response in August 1995 (examples of issues: identify hurricane-safe structures onsite and a plan for positioning personnel in those structures; designate an onsite individual to monitor the hurricane path; establish consistent staffing policies)

10. **This Action is Consistent With the Following Action (or Enforcement Guidance) Previously Issued:**

Supplement VIII, Section C.3

11. Regulatory Message:

Management must provide strong and consistent oversight and support for emergency preparedness activities in order to ensure a viable emergency response capability at all times.

12. Recommended Enforcement Action:

Two SL IV violations evaluated in the aggregate as a SL III problem

13. Should This Action Be Sent to OE For Full Review? No

14. Exempt from Timeliness: No
Basis for Exemption: N/A

Enforcement Coordinator:
DATE:

DRAFT NOTICE OF VIOLATION

St. Lucie Plant
Inspection Report Nos. 50-335, 50-389/96-18

A. 10 CFR 50.54(q) requires that nuclear power plant licensees follow and maintain in effect emergency plans which meet the planning standards of 10 CFR 50.47(b) and the requirements in Appendix E to 10 CFR Part 50.

Section 2.4 of the licensee's Radiological Emergency Plan (REP), Revision 31, states that activation of the Technical Support Center (TSC) and the Operational Support Center (OSC) will be initiated by the Emergency Coordinator in the event of an Alert, Site Area Emergency, or General Emergency, and that arrangements have been made to staff the TSC and OSC in a timely manner. Also specified is that activation of the Emergency Operations Facility (EOF) is required for a Site Area Emergency or General Emergency, and that arrangements have been made to activate the EOF in a timely manner.

The REP requirements delineated above are implemented by procedure EPIP-3100023E, "On-Site Emergency Organization and Call Directory", Revision 72. The instruction in Section 8.2 of that procedure states that, upon the declaration of an emergency classification, "the Duty Call Supervisor will initiate staff augmentation" using the "Emergency Recall System or Appendix A, Duty Call Supervisor Call Directory to notify persons..."

Contrary to the above, from approximately July 22 to October 3, 1996, arrangements were not available to staff or activate the TSC, OSC, or EOF in a timely manner because the licensee did not have the capability to implement either the primary method (using the Emergency Recall System) or the backup method (using the Duty Call Supervisor Call Directory) for notifying its personnel to report to the plant during off-hours to staff and activate the TSC, OSC, and EOF.

B. 10 CFR 50.54(q) requires that nuclear power plant licensees follow and maintain in effect emergency plans which meet the planning standards of 10 CFR 50.47(b) and the requirements in Appendix E to 10 CFR Part 50.

REP Section 7.2.2, "Training of On-Site Emergency Response Organization Personnel", states, "The training program for members of the on-site emergency response organization will include practical drills as appropriate and participation in exercises, in which each individual demonstrates an ability to perform assigned emergency functions." The licensee's Plan further states, "For employees with specific assignments or authorities as members of emergency teams, initial training and annual retraining programs will be provided. Training must be current to be maintained on the site Emergency Team Roster."

Contrary to the above, the licensee failed to provide a program which included an opportunity for each individual assigned to the on-site emergency response organization to participate in a drill or exercise, as follows:

1. In 1994, the licensee failed to provide training for 17 positions (approximately 92 individuals) identified as part of the on-site response organization. In 1995, the licensee failed to provide training for 8 positions (approximately 54 individuals) identified as part of the on-site response organization.

2. The licensee's training program failed to include initial, periodic retraining, or information on revisions with respect to certain procedures required to be implemented by several identified positions. These procedures included EPIP 3100026E, Criteria for Conduct of Evacuation; EPIP 3100027E, Re-entry; and EPIP 3100035E, Offsite Radiological Monitoring.

3. For the calendar year 1995, the licensee failed to remove from the emergency response organization 4 individuals who had not completed retraining as required, and their training qualifications had expire in 1994. The licensee failed to remove 6 individuals from the emergency response organization effective October 6, 1996, who had not remained qualified to fill response team requirements as a result of allowing their respirator qualifications to lapse.