From: James Kreh NRC:R2
To: ATB Anne Boland; NRC:R2
Date: 11/6/96 8:24am
Subject: ST. LUCIE VIOLATIONS

Anne,

Violations 1 and 2 are the ones that we're looking at for escalated enforcement (either together or separately). Feedback, please.

Jim

RKK/10

EMERGENCY PREPAREDNESS PROGRAM INSPECTION

Facility: St. Lucie Nuclear Plant

Inspection Period: October 7-18 and October 28-November 1, 1996

Inspection Report Nos.: 50-335, 50-389/96-18

Inspectors: J. L. Kreh, D. M. Barss

Violations

1. Failure to implement the requirements of the Radiological Emergency Plan with respect to arrangements to staff and activate emergency response facilities (TSC, OSC, EOF) in a timely manner, as evidenced by:

   - lack of appropriate administrative controls and functional testing for the Emergency Recall System (Autodialer) to ensure system operability (Autodialer was determined by your own investigation to have been inoperable from July 22 to October 3, 1996); in addition, this represents a repeat of a failure of Autodialer controls that occurred during the June 1993 exercise

   - failure to adequately provide for the implementation of Emergency Plan Implementing Procedure (EPIP)-3100023E, "On-Site Emergency Organization and Call Directory", in that the subject procedure was not distributed to all designated call-tree personnel required to maintain the procedure for use during off-hours, and appropriate training and drills to ensure proficiency in the use of the procedure were not conducted

2. Failure to implement the training program for Emergency Response Organization personnel as specified in the Radiological Emergency Plan, as evidenced by the following examples:

   a. failure to provide training for 17 positions in 1994 and 8 positions in 1995

   b. failure to provide initial training, periodic retraining, or information on revisions with respect to three implementing procedures for multiple Emergency Response Organization positions. The procedures in question were EPIPs 3100026E, "Criteria for and Conduct of Evacuations"; 3100027E, "Re-entry"; and 3100035E, "Offsite Radiological Monitoring".

   c. failure to ensure completion of required retraining for 2 individuals designated as OSC Supervisors and 2 individuals designated as TSC Security Supervisors during 1994, without removal of these individuals from the Emergency Response Organization roster during all of 1995 when their training had expired

   d. failure to ensure maintenance of respirator qualifications for 6 individuals listed on the 10-9-96 Emergency Response Organization roster (database for ERS)

3. Failure to establish an EPIP, or to have an adequate EPIP, with appropriate implementing details to address certain aspects of the Radiological Emergency Plan in the following instances:

   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}

   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 Emergency Response Organization 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 as follows:

   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)

   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)

POSITIVE OBSERVATIONS

1. Good progress has been made in the last two months to develop and implement corrective actions to address the large number of open concerns in the St. Lucie emergency preparedness program.

2. Significant improvements in the emergency preparedness training program have been initiated.