ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket No.:	50-458
License No.:	NPF-47
Report No.:	50-458/98-14
Licensee:	Entergy Operations, Inc.
Facility:	River Bend Station
Location:	5485 U.S. Highway 61 St. Francisville, Louisiana
Dates:	September 28 - October 2, 1998
Inspector:	Thomas H. Andrews Jr., Emergency Preparedness Specialist
Approved By:	Blaine Murray, Chief, Plant Support Branch
Attachment:	Supplemental Information

EXECUTIVE SUMMARY

River Bend Station
NRC Inspection Report 50-458/98-14

A routine, announced inspection of the operational status of the licensee's emergency preparedness program was conducted. The inspection included the following areas: events, emergency facilities and equipment, emergency plan and implementing procedures, training, organization and management control, audits, effectiveness of licensee controls, and followup on open items. Emphasis was placed on changes that had occurred since the last routine emergency preparedness inspection.

Plant Support

- The emergency preparedness program was properly implemented. With one exception, involving the failure to declare a notification of an unusual event, all events reported to the NRC operations center since June 1996 were properly evaluated and classified. Changes made to the emergency plan were implemented in accordance with 10 CFR 50.54(q). Procedure changes accurately reflected changes in the emergency plan. The emergency preparedness staff was well trained and maintained good awareness of industry issues. The emergency response organization training program was implemented satisfactorily. Annual reviews of the emergency plan, implementing procedures, emergency action levels, and letters of agreement were properly performed and documented. Emergency response facilities were properly equipped and maintained in a state of proper operational readiness. The corrective action request process effectively tracked resolution of emergency preparedness issues, and these issues were resolved in a timely manner. Quality assurance audits of the emergency preparedness program were performed by technically qualified personnel and were of proper scope and depth.

- Emergency response facilities were tidy and contained appropriate communications equipment, emergency implementing procedures, portable survey instruments, dosimeters, and emergency supplies. Siren availability results were properly trended (Section P2).

- During walkthroughs with two crews using the training simulator, one performance weakness was identified related to the failure of one crew to properly assess plant conditions, which led to declaration of a general emergency instead of a site area emergency. Other than this one example, all of the other events were properly assessed and characterized. Notifications to offsite agencies were timely. Internal communications were very good (Section P4).

- A sufficient number of personnel was respiratory protection qualified for emergency response to events. Corrective actions for radiation worker training requirements were properly implemented. The documented schedule for drills and exercise objectives was comprehensive and accurate (Section P5).

Report Details

IV. Plant Support

P1 Conduct of Emergency Preparedness Activities (93702)

The inspector reviewed licensee events and assessed the appropriateness of the emergency action levels used to classify events, timeliness of notifications, and effectiveness of action item identification and resolution.

The inspector reviewed Event 32286, May 7, 1997, "Notification of Unusual Event - Unisolable Leak Found on Reactor Recirculation System." This event was discussed in detail in NRC Inspection Report 50-458/97-08, which included a violation for failure to properly classify and declare a notification of an unusual event.

The licensee conducted a thorough investigation of the event, including a root cause determination, and identified appropriate corrective actions. The corrective actions were tracked and closed appropriately. The inspector determined that the licensee's review of this event was conducted properly.

With this one exception, all events reported to the NRC operations center since June 1996 were properly evaluated and classified.

P2 Status of Emergency Preparedness Facilities, Equipment, and Resources

a. Inspection Scope (82701-02.02)

The inspector toured the emergency response facilities and reviewed equipment inventories to determine if they were adequately maintained, technically adequate, met NRC requirements, licensee commitments, and were appropriately incorporated into the emergency plan and implementing procedures. The licensee's offsite communication capabilities were included in this review.

b. Observations and Findings

The inspector observed that the emergency response facilities were tidy and contained appropriate communications equipment, emergency implementing procedures, portable survey instruments, dosimeters, and emergency supplies. The inspector noted that the licensee had procured a satellite telephone, purchased an inventory of emergency meals, water, and air mattresses to support emergency response following events, such as hurricanes. The inspector concluded that the emergency response facilities were maintained in a state of operational readiness.

The licensee had revised the charcoal, air-purifying respirator cartridges shelf life to be indefinite. However, the cartridges were delivered from the vendor with a shelf life expiration date. The evaluation as to the basis to extend the shelf life to indefinite was incomplete; therefore, the inspector could not assess if the extension was appropriate. The licensee initiated Condition Report 98-1276 to track efforts to obtain supporting

documentation for this extension. Because these cartridges may not provide the expected level of protection if extending the shelf life was inappropriate, this issue is identified as an inspection followup item pending the licensee obtaining supporting documentation for the extension (50-458/98014-01).

The inspector observed that a sufficient quantity of large and small face pieces was available in a supply cabinet in the control room. However, these were stored across the control room from the self-contained breathing apparatuses. According to Updated Safety Analysis Report, Revision 10, Section 6.4.2.6 stated, "Operator training is provided in donning and operating this equipment such that a trained operator can be breathing air supplied by these devices within 30 seconds." Section 6.4.4.2 stated, "Each operator is taught to distinguish the odor of chlorine and ammonia, and practice drills are conducted to ensure that each operator can don breathing apparatus within 2 minutes." Given the distance between the cabinet where the large and small face pieces were stored and the location of the self-contained breathing apparatuses, the inspector questioned if the 2 minute time frame was achievable. The licensee stated that drills had not revealed any problems in this area.

The inspector conducted telephone calls on selected offsite telephone circuits within the response facilities to test these circuits. The tests were successful and demonstrated that communication circuits were operational. Review of corrective action documents and test results did not indicate maintenance problems with these circuits.

The inspector reviewed siren availability from scheduled tests for 1997 and the first two quarters of 1998. The availability for 1997 was 95 percent, and the availability for the first half of 1998 was 93 percent. The 1998 results were adversely affected by the loss of sirens caused by an improper software upgrade. However, the results remained above the 90 percent annual evaluation criteria used by the Federal Emergency Management Agency. The inspector noted that there were periods where siren availability was less than 90 percent. The licensee was trending the siren performance information appropriately.

The licensee stated that they were planning upgrades to the sirens. The licensee discussed replacement of the computer hardware as well as siren hardware. Because the siren system capabilities were reviewed by the Federal Emergency Management Agency, the licensee was encouraged to contact them and discuss the changes, as well as the possible need for siren performance evaluation.

c. Conclusions

Emergency response facilities were properly equipped and maintained in a state of proper operational readiness. Facilities were tidy and contained appropriate communications equipment, emergency implementing procedures, portable survey instruments, dosimeters, and emergency supplies. Communication circuits were maintained operational, and siren availability results were properly trended.

P3 Emergency Preparedness Procedures and Documentation

a. Inspection Scope (82701-02.01)

The inspector reviewed the emergency plan and implementing procedures. Specifically, the inspector evaluated the following areas:

- Verified that emergency implementing procedures were reviewed annually and that changes were submitted in accordance with 10 CFR 50.54(q) and 10 CFR Part 50, Appendix E.V,
- Verified annual review of emergency action levels with offsite authorities, and
- Verified annual reconfirmation of offsite organization letters of agreement.

b. Observations and Findings

The inspector verified that emergency implementing procedures were reviewed annually and that changes were submitted in accordance with 10 CFR 50.54(q) and 10 CFR Part 50, Appendix E.V. As part of the process, the licensee listed all procedures that did not require modification along with the justification. Procedures that required modification, as a result of the review, were revised in accordance with the licensee's procedure revision process. Procedure changes were properly reviewed before they were implemented. Procedures were transmitted to the NRC within 30 days of implementation as required by 10 CFR Part 50, Appendix E.

The inspector determined the licensee had complied with the regulatory requirement for annual review of emergency action levels with offsite authorities were conducted during meetings with offsite emergency managers. The review was documented in meeting minutes.

The inspector verified annual reconfirmation of offsite organization letters of agreement. During review of changes, the inspector observed that one change associated with the local hospital appeared to be inconsistent with regulatory guidance. According to NUREG-0654/FEMA-REP-1, "Criteria for Preparation and Evaluation of Radiological Emergency Response Plans and Preparedness in Support of Nuclear Power Plants," Revision 1, Planning Standard L.1 stated that, ". . . each organization shall arrange for local and backup hospital having the capability for evaluation of radiation exposure and uptake. . . ." The letter of agreement with the local hospital did not provide for evaluation of exposure and uptake. According to the licensee, a contract had been arranged for a specialist to provide these support services when needed to augment the licensee's local hospital capabilities. The inspector determined that this action was appropriate.

The inspector reviewed the process used to identify changes to documents and plant components that may impact the effectiveness of the implementation of the emergency plan. The licensee stated that they have multiple reviews of changes that have the opportunity to identify the need for review by emergency preparedness personnel.

Changes to the emergency plan were implemented in accordance with 10 CFR 50.54(q).

c. Conclusions

Changes made to the emergency plan were implemented in accordance with 10 CFR 50.54(q). Procedure changes accurately reflected changes in the emergency plan. Annual reviews of the emergency plan, implementing procedures, emergency action levels, and letters of agreement were properly performed and documented.

P4 Staff Knowledge and Performance in Emergency Preparedness

a. Inspection Scope (82701-02.04)

The inspector conducted walkthroughs with two operating crews using a dynamic simulation on the plant-specific control room simulator. The inspector assessed the ability of the control room teams to classify events accurately, perform the required notifications in a timely manner, perform offsite dose assessments, and make adequate protective action recommendations.

b. Observations and Findings

The licensee developed the following scenario for use in the simulator walkthroughs:

- A fire alarm was received for smoke detection in the 4160-volt switchgear building at the circulating water pump house.
- NNS-SWG2A and 2B tripped causing the loss of normal service water and circulating water systems. An automatic start of the standby service water system occurred on low header pressure; however, the pump tripped after 5 minutes.
- A manual reactor scram was initiated following loss of all normal service water. The reactor protection system failed to initiate the scram; however, alternate rod injection successfully inserted all the control rods. This satisfied the conditions for an alert classification.
- When the reactor scrammed, a reactor coolant leak occurred in the drywell.
- A thunderstorm caused the trip of the RSS-2 line causing the loss of NPS-B, NNS-B, NNS-C, and ENS-b. The Division 2 diesel failed to energize the bus.
- The loss of circulating water and RSS-2 resulted in a loss of condenser vacuum and resulted in a main steam isolation valve/main steam line drain isolation. The safety relief valves functioned for pressure control.
- The reactor core isolation cooling pump tripped on overspeed, and a steam leak occurred in the reactor core isolation cooling room. This satisfied the conditions

for a site area emergency. The standby gas treatment system filtered the effluent such that no release requiring a protective action recommendation occurred.

- The loss of high pressure feed and a steam leak caused the reactor pressure vessel level to lower. When the reactor water level reached the top of active fuel, conditions were satisfied for declaring a general emergency.

The inspector observed good use of three-part communications during the walkthroughs. Three-part communication was where the first person initiated a statement, request, or observation. The receiver of the message repeated the statement, request, or observation, and the first person confirmed that the information was correct. Briefings of the control room crew were conducted on a frequent basis. Both crews demonstrated very good awareness of the need to protect personnel in the plant and made plant announcements when major changes or events occurred. Both crews used the emergency operations procedures properly.

Notifications to offsite agencies were timely in that they were made within 15 minutes. The inspector and the licensee's evaluators observed that neither crew initiated any notifications other than when the event was classified or upgraded. The licensee's procedures call for frequent updates to offsite agencies using a followup notification form. The inspector observed that the individual that was making the offsite notifications was also the emergency notification system communicator. The inspector noted that communications with the NRC were simulated. Therefore, communications with the NRC did not represent an additional challenge for the communicator.

Dose assessment calculations were correctly performed using appropriate input assumptions. Protective actions were properly formulated based upon dose projections.

With one exception, all events were properly assessed and classified. During the scenarios, one crew failed to properly assess plant conditions, which led to declaration of a general emergency instead of a site area emergency. After the scenario, the inspector discussed this with the shift manager who stated that the basis for the general emergency was the loss of two fission product barriers (containment and reactor pressure vessel), and the potential loss was the fuel clad barrier. The basis for the potential loss was from the anticipated transient without a scram. There were no indications of fuel damage such as coolant activity, containment radiation, etc. When the manual reactor scram failed to occur, there were no unusual core parameters present that would have damaged fuel. The alternate rod injection occurred in a matter of seconds after failure of the manual scram to occur. Based on these factors, the inspector determined that the basis for declaring the general emergency was incorrect given the conditions present at the time of the declaration. The inspector determined that the improper assessment of plant conditions, which led to the improper classification of an emergency was a performance weakness (50-548/98014-02).

The performance weakness was also identified by the licensee's evaluators. The licensee discussed this error with the personnel involved and conducted remedial training on indications of fuel damage. Specifically, the crew was told that an anticipated transient without a scram did not imply that fuel damage had occurred. The

licensee also informed other shift crews of this issue. According to 10 CFR Part 50, Appendix E, Section IV.F.2.g, any weaknesses or deficiencies that are identified shall be corrected. The inspector reviewed the licensee's corrective actions and determined that the licensee's actions were appropriate to address the issue.

After the walkthroughs, both crews conducted a routine critique in the format used for operating crew training. The critiques were thorough and complete.

c. Conclusions

During walkthroughs with two crews using the training simulator, one performance weakness was identified related to the failure of one crew to properly assess plant conditions, which led to declaration of a general emergency instead of a site area emergency. Other than this one example, all of the other events were properly assessed and characterized. Notifications to offsite agencies were timely. Internal communications were very good.

P5 Staff Training and Qualification in Emergency Preparedness

a. Inspection Scope (82701-02.04)

The inspector: (1) reviewed changes to the emergency preparedness department organization, (2) reviewed program changes for respiratory protection qualifications, (3) reviewed training records for key emergency response personnel, and (4) reviewed records and documents associated with emergency drills/exercises.

b. Observations and Findings

Since the last inspection, two notable changes were made to the emergency preparedness staff. They were:

- One emergency planner was added to the staff to fill a vacancy created by a retired employee. The licensee had developed a task qualification process for emergency planners that was used to qualify the new emergency planner.

- A new emergency preparedness manager had been appointed. The individual appointed had a strong management background. The inspector interviewed several licensee personnel and determined that the change in managers had yielded positive results.

The inspector discussed recent industry events with emergency preparedness staff. The staff was aware of events and issues identified at other facilities and was prepared to discuss actions taken to review and resolve the issues at the licensee's facility.

Occupational Safety and Health Administration regulations for respiratory protection (29 CFR 1910.134) changed as of April 1998 with a "grandfather" period for existing programs through October 5, 1998. Prior to this change, positive pressure respiratory protection devices did not require fit testing. The revised regulations required fit testing

of self-contained breathing apparatuses. The inspector reviewed the respiratory protection qualifications of personnel assigned to the emergency response organization and the process used to qualify these people.

The purpose of the licensee's corporate policy and a site policy for respiratory protection requirements was to specify quotas for departments for respiratory protection qualified personnel to address a variety of plant conditions. The inspector determined that a sufficient number of personnel was qualified to deal with a short-term event; however, the licensee-specified quotas were not satisfied in all departments. The licensee initiated accelerated fit testing to ensure an adequate number of personnel was respiratory protection qualified in areas, which were considered to be vulnerable.

The inspector observed that the licensee used a different configuration for the self-contained breathing apparatus face piece used to perform fit testing compared to the configuration found in the plant. The fit test face piece used a 5-point contact/5 point adjustment harness, while the units in the plant used a 5-point contact/2-point adjustment harness. The licensee was using this process to qualify personnel to use self-contained breathing apparatuses after October 5, 1998 (effective date for revised OSHA regulations).

According to the new OSHA regulations, before an employee may be required to use any respirator with a negative or positive pressure tight-fitting face piece, the employee must be fit tested with the same make, model, style, and size of respirator that will be used. The licensee previously identified the differences between the harnesses and determined that this practice did not negatively impact the results of the quantitative mask fit, however, there was no documentation to support this practice. According to the vendor, a preliminary evaluation did not indicate a problem with this practice but that a thorough evaluation would be performed. The inspector observed that the fit testing process being used may not be acceptable; therefore, the respiratory qualifications of the entire organization for use of self-contained breathing apparatus may be at risk. This practice could affect the qualification of personnel wearing self-contained breathing apparatuses. Condition Report 98-1277 was initiated to track and document the licensee's evaluation of this practice. This issue is identified as an inspection followup item pending further NRC review of the licensee's actions (50-548/98014-03).

The inspector reviewed the procedure used to determine qualification requirements for emergency response personnel. The procedure specified initial qualification and requalification requirements for emergency response positions. The requalification requirement matrix was an enhancement added by the licensee that clearly identified the training required for each emergency response position. The tracking of training was done through use of the emergency response organization database. Previously, this was performed manually. The inspector reviewed the method used to track emergency response organization member qualifications and found it to be a workable process.

The licensee conducted training of personnel who were assigned to the emergency response organization but who had not taken radiation worker training. During a review of their emergency plan, the licensee discovered that the plan stated that emergency response personnel will be trained in plant access training and radiation worker training.

Because certain personnel do not routinely require entry into the plant radiological control area, the requirement for radiation worker training was dropped. As a short-term corrective action, a special training course was conducted for emergency response personnel who had not recently taken radiation worker training. This course covered the basic radiation worker information required by emergency response personnel. As the long-term corrective action, the licensee stated that all emergency response personnel would be required to attend radiation worker training starting in calendar year 1999. The inspector determined that the licensee's corrective actions were adequate and appropriate.

The inspector reviewed schedules for drills and exercises as well as the schedule for satisfying various objectives. The method was automated using a database program. The inspector found the system to be comprehensive. A sample of drills/objectives was reviewed and found to be scheduled within the proper frequency requirements.

The licensee made several changes to the emergency response program, including use of the simulator for drills and exercises and expanding the number of response teams to four teams. The licensee conducted several drills with each team to ensure that they were familiar with using data from routine sources fed by the simulator instead of using controller provided information. The licensee recognized that because the team that participated in the evaluated exercise participated in multiple dress rehearsals as well as the exercise, this team may have received more training than others. To ensure that lessons learned were passed on to other teams, the team that participated in the exercise performed evaluation/coaching of other teams during drills. The inspector determined that the changes served to enhance the licensee's emergency preparedness program.

c. Conclusions

The emergency preparedness staff was well trained and maintained good awareness of industry issues. The emergency response organization training program was implemented satisfactorily. A sufficient number of personnel was respiratory protection qualified for emergency response to short-duration events. Corrective actions for radiation worker training requirements were properly implemented. The schedule for drills and exercise objectives were comprehensive and accurate.

P7 Quality Assurance in Emergency Preparedness Activities

Independent and Internal Reviews and Audits

a. Inspection Scope (82701-02.05)

The inspector examined the latest audits of the emergency preparedness program and reviewed the licensee's action item tracking system and other methods used to identify areas in need of corrective action.

b. Observations and Findings

The licensee's emergency plan stated that independent reviews of the program would be conducted annually. The inspector pointed out that 10 CFR 50.54(t) required that the review be performed at least every 12 months. As a result, there was potential for misinterpreting the emergency plan that would result in a violation of regulatory requirements. The licensee stated that the emergency plan would be reviewed to determine if changes were needed.

The licensee used the quality assurance audits as the independent reviews of the emergency preparedness program. The inspector reviewed the frequency of the audits to determine if they satisfied the frequency requirements. No issues were identified, but the trend appeared to show that the end date for the report was continually moving outside of the 12-month review period. The licensee considered the assessment period to be from the date of the entrance meeting for the audit until the date the report was issued. The due date for the start of the next audit was set to the 1-year anniversary of the report date. Therefore, there could be a period of 12 months where no review was performed. This concern was discussed with the licensee and the licensee stated they would review the quality assurance audit report schedule process for the annual emergency preparedness audit.

The inspector noted that a noncited violation was issued during the previous inspection of the emergency preparedness program because the audit scope was incomplete. The inspector reviewed the audit scope for the 1996, 1997, and 1998 audits and determined that they were much broader in scope and addressed the concerns identified in the previous inspection. The inspector determined that the scope and depth of the audits had significantly improved.

The inspector reviewed the technical expertise contained on the audit teams. The inspector observed that the licensee used emergency preparedness personnel from other facilities to provide the technical expertise in the audits, and assigned the more challenging audit topics to these people. The inspector determined that the audits were conducted by personnel who were independent of the licensee's emergency preparedness organization and contained sufficient technical expertise to support the audit.

The licensee made the audit available as part of the routine meeting with offsite emergency managers. This was documented in meeting minutes.

The inspector noted that the licensee was using the corrective action program more aggressively. The past practice was to resolve issues internally through the emergency preparedness organization. The licensee's use of the corrective action program provided resources for trending and tracking that previously were difficult to manage. The inspector considered this to be an improvement.

Corrective actions identified during audits were properly addressed. The inspector reviewed the due dates for open corrective action items and noted that the trend had improved since the last inspection. Most corrective actions had due dates shorter than

1-2 months. The inspector determined that corrective actions were being addressed in a timely manner.

c. Conclusions

Quality assurance audits of the emergency preparedness program were performed by technically qualified personnel and were of proper scope and depth. The corrective action request process effectively tracked resolution of emergency preparedness issues and these issues were resolved in a timely manner.

P8 Miscellaneous EP Issues (92904)

P8.1 (Closed) Inspection Followup Item 50-458/96007-05: Control Room Habitability Assessment

Review of emergency plan implementing procedures revealed that if both the operations support center and the technical support center were uninhabitable, personnel from both facilities would relocate to the control room. The inspectors determined that: (1) there were no procedures/guidance for relocating to the backup facilities (relocation criteria, specific positions/personnel to be relocated, and equipment/items to be relocated), and (2) the functional capabilities of the backup facilities had never been tested in a drill. Moreover, when the inspectors asked about the capabilities of the control room ventilation system, the licensee indicated that there may be a question about the ability of the system to support the additional personnel.

The licensee performed a control room habitability assessment to determine the number of people that could be accommodated within the control room during an accident. Using the results of this assessment, the licensee added guidance to emergency plan implementing procedures to specify the emergency response positions that would relocate to the control room, thereby limiting the number of people in the control room within the capabilities of the control room ventilation system. The inspector determined that the licensee had appropriately addressed the identified concerns.

P8.2 (Closed) Violation 50-458/97008-05: Failure to Properly Classify and Declare a Notification of Unusual Event

On May 7, 1998, during review of the previous day's events, the inspector noted that the licensee had determined that pressure boundary leakage existed but did not declare a notification of unusual event and take the actions prescribed in the emergency plan. The licensee conducted a root cause investigation and identified appropriate corrective actions. The inspector reviewed the corrective actions taken and determined that the licensee had appropriately addressed the problem.

P8.3 (Closed) Inspection Followup Item 50-458/97013-08: Followup on Pager Test Augmentation Drills

During an emergency preparedness program audit, the quality assurance department observed that an after-hours augmentation drill had not been performed in several

years. The licensee configured the automated call-out system such that it would only address the on-call team. Normally, if there was not a response from an on-call team member, the system would telephone a member from one of the other duty teams. The intent of the drill was to determine what percentage of the team would actually respond and to determine how quickly the emergency response facilities could be staffed. Using this modified process, the drill was conducted on August 12, 1997, at 7 p.m. Only 27 of the 74 on-call emergency team reported to their assigned facilities.

The inspector reviewed pager test results for 1998 to determine the effectiveness of the licensee's corrective actions. Results for the overall emergency response organization ranged from 93 to 100 percent, and yielded an average of 98 percent. The licensee issued a letter to the emergency response organization (Letter No. EP-M-98-037 dated May 14, 1998) specifying the actions that would be taken if an individual's pager was operable, but they fail to respond. Since this date, the results of pager tests have yielded 100 percent response. The inspector determined that the licensee's corrective actions were adequate to address the identified concerns.

P8.4 (Closed) Inspection Followup Item 50-458/98001-02: Part 19.12 Training for Emergency Response Organization Members

The inspector noted that Procedure EIP-2-012, "Radiation Exposure Controls," Revision 13, stated that 10 CFR Part 20 occupational exposure limits applied to all members of the emergency response organization, even if they had not received radiation worker training. Although the licensee required all personnel to attend plant access training, which included a brief discussion of radiation, the training did not include a discussion of regulatory limits, instructions for frisking, protection of the embryo/fetus per the declared pregnant female program, etc. Since these topics were only discussed in radiation worker training, the inspector questioned whether emergency response organization members received training consistent with 10 CFR 19.12.

While it was not clear if 10 CFR 19.12 applied to emergency response organization personnel, the licensee determined that the topics identified were valid and should be taught to emergency response personnel training who had not taken radiation worker training. The licensee developed a temporary training course discussing these topics and conducted training of emergency response organization personnel. The licensee stated that starting in 1999, annual training requirements for all emergency response organization personnel will include completion of radiation worker training. The inspector determined that the licensee's actions were appropriate to address the identified concerns.

P8.5 (Closed) Unresolved Item 50-458/98001-03: Regulatory Guide 8.13 Training per Updated Safety Analysis Report

The licensee's emergency plan stated that all personnel would receive emergency plan/procedure training in plant access and radiation worker training as described in the Updated Safety Analysis Report. The inspectors reviewed the Updated Safety Analysis Report description of the general employee training and compared it to the plant access training content. The Updated Safety Analysis Report stated that the training would include a discussion of Regulatory Guide 8.13, which discussed the effects of radiation

on the embryo/fetus. This subject was included as part of the licensee's declared pregnant female program but was not discussed in the plant access training.

The licensee stated that discussion of topics, such as effects of radiation on the embryo/fetus, was inappropriate for plant access training because students had not been provided sufficient information regarding the concepts of radiation to be able to interpret the information adequately. Therefore, this was taught in radiation worker training. The inspector confirmed that this was taught as part of emergency response organization training either in supplemental training or radiation worker training.

The licensee had initiated a change to the Updated Final Safety Analysis Report to reflect their current training program. The inspector reviewed the change and determined that the issue was appropriately resolved.

V. Management Meetings

X1 Exit Meeting Summary

The inspector presented the inspection results to members of licensee management at the conclusion of the inspection on October 2, 1998. The licensee acknowledged the findings presented. No proprietary information was identified.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

M. Bakerich, Manager, Emergency Preparedness
R. Edington, Vice President-Operations
K. Huffstatler, Emergency Planner
J. Hurst, Senior Emergency Planner
R. Jobe, Senior Emergency Planner
M. Jones, Senior Operations Instructor
D. Mims, General Manager, Plant Operations
D. Myers, Senior Licensing Specialist
W. O'Malley, Manager, Operations
N. Tison, Emergency Planner

INSPECTION PROCEDURES USED

82701 Operational Status of the Emergency Preparedness Program

92904 Followup - Plant Support

93702 Prompt Onsite Response to Events at Operating Reactors

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

458/98014-01 IFI	Extension of charcoal respirator canister shelf life to indefinite (Section P2)
458/98014-02 IFI	Performance weakness -- General emergency declared based upon improper assessment of plant conditions (Section P4)
458/98014-03 IFI	Use of a different configuration face piece harness to perform fit testing from the type used in the plant (Section P5)

Closed

458/96007-05 IFI	Control Room Habitability Assessment (Section P8.1)
458/97008-05 VIO	Failure to Properly Classify and Declare a Notification of Unusual Event (Section P8.2)
458/97013-08 IFI	Followup on Pager Test Augmentation Drills (Section P8.3)

458/98001-02 IFI	Part 19.12 Training for Emergency Response Organization Members (Section P8.4)
458/98001-03 URI	Regulatory Guide 8.13 Training per USAR (Section P8.5)
458/98014-02 IFI	Performance weakness -- General emergency declared based upon improper assessment of plant conditions (Section P4)

DOCUMENTS REVIEWED

Condition Reports

96-0818, "Control Room Habitability Assessment," April 18, 1996

97-0644, "Declaration of Notification of Unusual Event," May 7, 1997

97-1159, "Emergency Planning has no formal training requirements for staff, " August, 27, 1997

97-1160, "Emergency Planning's training and qualification requirements were not specified for personnel performing 10 CFR 50.54(q) evaluations," August 27, 1997

97-1166, "Emergency Planning pager test not performed for May 1997," August 6, 1997

98-0182, "General Employee Training," February 18, 1998

98-0722, "Discrepancies between River Bend and corporate policy guide," June 9, 1998

98-1276, "Documentation of evaluation of charcoal canister shelf life," October 1, 1998

98-1277, "Documentation of fit test practice assessment," October 1, 1998

Letters

EP-M-97-053, "TSC Relocation to Control Room Due to Habitability," March 6, 1997

EP-M-97-070, "Notification of Unusual Event," April 8, 1997

EP-M-97-071, "Notification of Unusual Event - Lessons Learned," April 12, 1997

EP-M-97-083, "DEM Meeting Minutes," June 18, 1997

EP-M-97-197, "Response to RBS QA Audit of Emergency Planning," October 7, 1997

EP-M-97-236, "Emergency Implementing Procedures," December 18, 1997

EP-M-98-015, "EAL Training," January 27, 1998

EP-M-98-037, "Responses to ERO Paging"

EP-M-98-072, "DEM Meeting Minutes," September 4, 1998

RBF4-96-0078, "RBS Audit Notification," June 17, 1996

RBF5-96-0104, "RBS QA Audit of Emergency Response and Emergency Planning Organization," September 9, 1996

RBF5-97-0072, "RBS QA Auditof Emergency Planning," September 8, 1997

RPG-M-96-053, "MSA Charcoal Canister Shelf-life Requirements," March 27, 1996

Procedures

EIP-2-016, "Operations Support Center," Revision 15

EIP-2-018, "Technical Support Center," Revision 17

EIP-2-020, "Emergency Operations Facility," Revision 19

EIP-2-022, "Alternate EOF-Activation and Transfer of Functions," Revision 11

EIP-2-102, "Training, Drills, and Exercises," Revision 16

EIP-2-201, "River Bend Station Emergency Preparedness Organization and Responsibilities," Revision 10

Other Documents

Updated Safety Analysis Report, Revision 10
Policy R-PL-026, "Respiratory Protection," Revision 0
Quality Assurance Audit Plan - Audit 96-07-I-FEPL
Quality Assurance Audit Plan - Audit 97-08-I-FEPL
Quality Assurance Audit Plan - Audit 98-08-I-FEPL