UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-4005

December 3, 2003

R. T. Ridenoure
Division Manager - Nuclear Operations
Omaha Public Power District
Fort Calhoun Station FC-2-4 Adm.
P.O. Box 550
Fort Calhoun, NE 68023-0550

SUBJECT: FEDERAL EMERGENCY MANAGEMENT AGENCY DEFICIENCY IDENTIFIED DURING THE NOVEMBER 18, 2003, EXERCISE

Dear Mr. Ridenoure:

Enclosed is a copy of the Federal Emergency Management Agency's (FEMA) Region VII's letter to the Nebraska Emergency Management Agency, dated November 25, 2003. This letter discusses two deficiencies identified during evaluation of the November 18, 2003, emergency preparedness exercise of state and local response plans for the Fort Calhoun Nuclear Station. Both of the deficiencies were assessed against the Washington County Emergency Operations Center. FEMA defines a deficiency as, "an observed or identified inadequacy of organizational performance in an exercise that could cause a finding that offsite emergency preparedness is not adequate to provide reasonable assurance that appropriate measures can be taken in the event of a radiological emergency to protect the health and safety of the public living in the vicinity of a nuclear power plant." The first deficiency related to the effectiveness of direction and control provided by the Emergency Management Director at the Washington County Emergency Operations Center. The second deficiency related to decision-making and communication of protective action decisions for special population groups in Washington County.

The purpose of this letter is to communicate FEMA's official notification of the deficiency in accordance with the NRC-FEMA Memorandum of Understanding. No response to the Nuclear Regulatory Commission is required.

The NRC encourages Fort Calhoun Nuclear Station to work with the appropriate off-site governmental agencies to ensure a timely resolution of this issue. The NRC will continue to monitor the status of this issue. In accordance with the Memorandum of Understanding, the NRC and FEMA Region VI will assess the progress made towards resolution of this issue by approximately February 2, 2004, and will decide at that time if additional measures are necessary.

If this issue is not resolved by March 25, 2004, the Federal Emergency Management Agency may withdraw the finding of reasonable assurance according to the requirements of 44 CFR 350.13(a). At that time the NRC would take appropriate action according to the requirements of 10 CFR 50.54(s)(2) and 50.54(s)(3).

If you have any further questions, please contact Ryan E. Lantz at (817) 860-8158, or Paul J. Elkmann at (817) 276-6539.

Sincerely,

Troy W. Pruett, Chief
Plant Support Branch
Division of Reactor Safety

Docket: 50-285
License: DPR-40

Attachment:
FEMA Region VII Letter to Nebraska Emergency Management Agency, dated November 25, 2003

cc w/attachment:
John B. Herman, Manager
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FEMA Region VII
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Kansas City, MO 64108-2654

FEMA

November 25, 2003

Al Berndt, Assistant Director
Nebraska Emergency Management Agency
1300 Military Road
Lincoln, NE 68508-1090

Dear Mr. Berndt:

The purpose of this letter is to officially inform your office of the two Deficiencies identified during the November 18, 2003, full-scale/relocation, re-entry, and return exercise of the state and local radiological emergency response plans for the Fort Calhoun Nuclear Station. These issues were discussed at the post exercise participants briefing on November 20, 2003. The Deficiencies were assessed against the Washington County Emergency Operations Center.

Washington County Emergency Operations Center (EOC)

1. Criterion 1c1, activities associated with direction and control, was not adequately demonstrated, resulting in a Deficiency. The following specific concern was identified:

   Direction and control was never fully established within the Washington County EOC. The Emergency Management Director never fully assumed his leadership and coordination role within the EOC structure. The EOC staff worked independently without coordinating their activities or informing other staff of their actions. Regular briefings by all EOC staff, by functional area, did not occur until evaluators indicated to the Emergency Management Director (at approximately 10:15 a.m.) that this should be done in order to effectively coordinate activities and insure that no necessary actions were missed. Even after receiving this advice from the evaluators, this process was never fully engaged and information exchanged within the EOC about activities was incomplete. Examples of problems related to this direction and control failure include:

   - Accurate information concerning protective actions for schools was never provided to the public. The Blair and Fort Calhoun Schools were notified at the Alert (7:15 a.m.) in accordance with an automatic procedure that is implemented by the Sheriff's Office dispatch center. When asked what action was taken for the schools, the Emergency Management Director was initially uncertain about this. After consultation with the State Liaison and others, the Emergency Management Director stated that the schools would use their normal evacuation procedures. Later in the exercise, information was circulated that the schools had been notified and closed prior to their normal start time and that buses enroute to school would have been turned around. However, no message went out to the public to

address school closures and to notify parents that their children were being returned home. No information was provided to the public concerning schools or daycare facilities until an Emergency Public Information (EPI) message was released following the General Emergency (10:14 a.m.). That message incorrectly indicated that the schools had been relocated to Fremont High School. There was a great deal of uncertainty about the action taken for the schools and the status of the school children. It is possible that school children could have been returned to their homes without parental supervision. This could have posed a serious threat to their health and safety during the evacuation of sub areas 1, 2, and 3.

- The Sheriff's Office personnel conducted back-up route alerting for areas affected by a siren outage (sirens 41 and 42) following the Site Area Emergency at 8:59 a.m. A controller message about the siren failure at 8:43 a.m. led to much discussion by the Sheriff's Office on this issue. However, information about the actual initiation and completion of route alerting was not communicated to anyone else within the EOC. The Emergency Management Director never directed his staff to initiate this action and was not aware that they had done this. There was also confusion among Sheriff's Office personnel about whether this action had been initiated and completed.

- The Sheriff's Office made a decision to evacuate the village of Washington, which lies outside the 10 mile EPZ and the sub areas evacuated (1, 2, and 3). Other EOC staff and the State were unaware of this action until it was mentioned at the beginning of the post-plume phase of the exercise. No public information or EAS/EPI message was released that addressed this action.

The Emergency Management Director failed to take on a leadership and coordination role with the EOC staff. In addition, the EOC staff did not know what other functional areas of the EOC were accomplishing until the evaluators asked them to provide EOC briefings. A failure to establish direction and control resulted in miscommunication within the Washington County EOC and between the EOC and the State on important issues concerning public safety and public information. Communication and coordination in general was insufficient to insure that all necessary activities were accomplished, verified, and communicated to affected parties in a timely manner. **(NUREG-0654, A.1.d., 2.a., b.)**

Remedial Actions Required: A remedial exercise must be conducted by the Washington County Emergency Operations Center. This should occur subsequent to the Emergency Management Director receiving training in EOC direction and control. In addition, the dedicated hotline and fax machine should be moved to a location within the EOC to eliminate the Emergency Management Director from having to leave the EOC frequently.

2. Criterion 2c1, activities associated with protective action decision-making for special population groups, was not adequately demonstrated, resulting in a Deficiency. The following specific concern was identified:

   The Washington County plan states that nursing homes and hospitals will be evacuated. During the exercise, there were conflicting discussions within the EOC about what actions should be taken for the nursing homes and the hospital located within the sub areas to be evacuated. The Health and Human Services representative stated that these facilities would shelter-in-place. However, fire department personnel were standing by to assist with evacuation of these facilities and there was discussion within the EOC about providing transportation resources to assist with the evacuation of the nursing homes and the

hospital. There is no evidence that either of these protective action decisions was made for the special populations or that these facilities were ever notified (either actually or simulated) about any protective actions to take.

The plans and procedures for making decisions regarding the protection of special populations and facilities were not followed. There was a lack of effective communication within the EOC and between the EOC and the state of Nebraska's facilities. The ineffective communication and coordination of the county's actions resulted in critical actions not being accomplished. As the result of the failure to make and communicate decisions concerning special facilities, these populations were not adequately protected and the health and safety of these persons was compromised. **(NUREG-0654, J.9., 10.c.d.e.g.)**

Remedial Actions Required: A remedial exercise must be conducted by the Washington County Emergency Operations Center. All EOC staff should review plans and procedures and additional training must be provided concerning the plans and procedures for the protection of special populations. The Emergency Management Coordinator needs to ensure that plans and procedures are followed and must closely monitor staff activities within the EOC to ensure that critical actions are accomplished. In addition, careful logging of EOC activities and regular communications, both internally and externally, are required to effectively coordinate activities and provide quality control.

In accordance with 44 CFR 350,9(d) and the FEMA Radiological Emergency Preparedness Exercise Manual (FEMA-REP-14), September 1991, we have thoroughly reviewed and discussed these issues with FEMA Headquarters, the U.S. Nuclear Regulatory Commission, and appropriate FEMA Region VII Regional Assistance Committee members. FEMA-REP-14, page C.16-1, defines a Deficiency as "...an observed or identified inadequacy of organizational performance in an exercise that could cause a finding that offsite emergency preparedness is not adequate to provide reasonable assurance that appropriate protective measures can be taken in the event of a radiological emergency to protect the health and safety of the public living in the vicinity of a nuclear power plant." Because of the potential impact of a Deficiency on the public health and safety, they are required to be corrected within 120 days after the exercise through appropriate remedial actions, including remedial exercises, drills, plan changes or other actions.

Please provide a response to the proposed remedial actions listed above by December 5, 2003. My Radiological Emergency Preparedness staff is available to provide assistance in achieving resolution to this issue. Should you have any questions, please contact Mr. Joe Schulte at (816) 283-7016.

Sincerely,

Richard Hainje
Regional Director

cc: Vanessa Quinn & Kenneth Wierman, NP-TH-RP
Bill Maier, NRC IV
Carl Simmons, OPPD