

Dave Morey
Vice President
Farley Project

Southern Nuclear
Operating Company
P.O. Box 1295
Birmingham, Alabama 35201
Tel 205 992.5131

February 18, 1997



Docket Nos.: 50-348
50-364

10 CFR 50, App. E

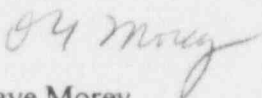
U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

Joseph M. Farley Nuclear Plant
Response to an Inspector Follow-up Item (IFI)
NRC Inspection Report Nos. 50-348/96-14 and 50-364/96-14

Ladies and Gentlemen:

As requested by your transmittal dated January 24, 1997, this letter responds to IFI 50-348, 364/96-14-01, "Exercise Weakness--Significant emergency information was not communicated to the appropriate emergency manager in a timely manner." The Southern Nuclear Operating Company (SNC) response to IFI 50-348, 364/96-14-01 is provided in Enclosure 1.

Respectfully submitted,


Dave Morey

WHL/clt:ifi96141.doc

Enclosures:

1. Response to IFI 50-348, 364/96-14-01

cc: Mr. L. A. Reyes, Region II Administrator
Mr. J. I. Zimmerman, NRR Project Manager
Mr. T. M. Ross, Plant Sr. Resident Inspector

9702260232 970218
PDR ADOCK 0500034f
G PDR

IEDI 1/1

ENCLOSURE 1

Response to IFI 50-348, 364/96-14-01

Enclosure 1
Response to IFI 50-348, 364/96-14-01

IFI-50-348,364/96-14-01, "Significant emergency information was not communicated to the appropriate emergency manager in a timely manner," noted good exchange of information between members of the Emergency Response Organization (ERO) in most instances with two noted exceptions. These two exceptions state:

"The first exception was the decision by the Unit 1 Shift Supervisor to evacuate the Unit 1 and Unit 2 Auxiliary Building. Although this was a protective action taken for onsite personnel, the interim Emergency Director (ED) was unaware of this decision until asked about it by the on call ED prior to turnover. The second exception was the failure of the Recovery Manager to be aware of the leaking containment at the time of the General Emergency (GE). This almost resulted in a incorrect follow-up notification being provided as discussed in paragraph P4.4 above. This was also important to the Recovery Manager as the lead manager in the EOF where the responsibilities for providing dose assessment information were located. A major responsibility to be provided to offsite agencies from the EOF following the GE was a dose assessment for the ongoing release. His failure to be timely informed of the release by either the TSC or his own staff was a significant oversight."

"These two instances of significant emergency information not being communicated to the appropriate emergency managers in a timely manner was identified as an exercise weakness."

Admission or Denial

The exercise weakness occurred as described in the Inspector Follow-up Item. There were several individuals involved with the two examples that were listed by the NRC in three different locations (the Control Room, Technical Support Center and Emergency Operations Facility).

Reason for Exercise Weakness

The root cause of both instances is communication error. In the first instance, where the Unit 2 Shift Supervisor(SS)/Emergency Director(ED) did not know about the evacuation, the lack of a repeat back can be directly related to the error. For the second instance, the ED and the Technical Support Center (TSC) staff forgot to relay the release information to the Emergency Operations Facility (EOF). The EOF staff did not use the information that they had available to them in the form of Emergency Response Data System (ERDS) data or the initial emergency notification form that was verbally transmitted and faxed to the EOF.

Enclosure 1
Response to IFI 50-348, 364/96-14-01

Corrective Action Taken and Results Achieved

The specific errors that were listed by the NRC were corrected at the time of the error by other members of the Emergency Response Organization (ERO) staff. The Stop, Think, Act and Review process (STAR) was effectively used by the ERO, preventing any adverse effects or improper off-site notifications to be made as a result of the communications errors.

Corrective Steps to Avoid Recurrence

A Training Advisory Notice (TAN) has been issued to all licensed individuals and the entire on-site ERO. The contents of the TAN include a description of the events based on the NRC observations and plant drill evaluators observations, information from FNP-0-ACP-1.0, Operational Communications, and some conclusions on how to prevent these types of errors in the future. The expected date when all responses to the TAN will be received is March 3, 1997. The communication errors and the TAN will be trained on during the Emergency Planning 1997 table top exercises for each of the crews and during 1997 Emergency Director Retraining. The last Table top exercise and crew drill is scheduled to be completed on September 10, 1997.

Date Corrective Actions to be Complete

September 10, 1997.