

April 19, 2001

EA-00-214

Mr. Mark Reddemann  
Site Vice President  
Kewaunee and Point Beach Nuclear Plants  
Nuclear Management Company, LLC  
6610 Nuclear Road  
Two Rivers, WI 54241

SUBJECT: KEWAUNEE NUCLEAR POWER PLANT - NRC SUPPLEMENTAL  
INSPECTION REPORT 50-305/01-07(DRS)

Dear Mr. Reddemann:

On March 30, 2001, the NRC completed a supplemental inspection at your Kewaunee Nuclear Power Plant. The enclosed report presents the results of that inspection, which were discussed on March 30, 2001, with you and other members of your staff.

During a baseline NRC inspection conducted on August 14 through September 21, 2000, the NRC identified a White issue concerning your unannounced, off-hours, emergency response augmentation drills. The issue involved the failure to correct self-identified deficiencies disclosed through emergency response staffing drills during the second, third, and fourth quarters of 1999 and the second quarter of 2000. In 16 of those 18 drills, you failed to demonstrate that sufficient staff would respond to the site in a timely fashion, as required for emergency response. In accordance with the NRC's significance determination process, the NRC characterized this issue as a preliminary White finding.

On January 30, 2001, you and members of your staff participated in a regulatory conference that was held in the NRC Region III office to discuss the preliminary White finding. During this meeting, you and your staff described your root cause evaluation and planned corrective actions. Following that conference, the NRC transmitted the final results of our significance determination of the finding in a letter dated February 28, 2001. As described in this correspondence, the emergency response augmentation finding was determined to be a finding having low to moderate safety significance. The failure to timely augment on-shift staff during an emergency could delay necessary emergency actions and decisions and could result in on-shift staff being distracted by multiple and possibly competing responsibilities. Consequently, the NRC issued a White finding and associated Notice of Violation concerning this performance issue.

The NRC conducted this supplemental inspection to assess your completed evaluation of the emergency response augmentation White finding. The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspector reviewed selected

procedures and records, observed activities, and interviewed personnel. Specifically, the inspector reviewed your root cause evaluation for the White emergency response augmentation finding and your planned corrective actions to address this performance problem.

We found that your staff performed a comprehensive evaluation of the augmentation drills and identified two root causes and a number of contributing causes. In general, these root causes identified weaknesses in management attention to the emergency preparedness program and weaknesses in the corrective action program. We concluded that this root cause evaluation was systematic and conducted at the appropriate depth.

We also concluded that your long-term corrective actions were appropriate to address the root causes identified in your evaluation and to prevent recurrence. These actions focused on providing additional depth and flexibility within your emergency response organization to ensure that key response positions could be augmented in a timely manner. In addition, your ongoing efforts in improving your corrective action program performance appear adequate to address the corrective action deficiencies that your staff also identified. We plan to review the implementation of these long term actions during future NRC baseline inspections.

During our review of your immediate corrective actions, we identified deficiencies in your staff's initial actions to achieve success in your augmentation drills. Specifically, we found that your actions to address concerns with the timely response of a key Technical Support Center position resulted in an additional violation of NRC requirements. To obtain the required 30-minute augmentation response for that position, your staff instructed and trained personnel to respond to a location other than the Technical Support Center, which is contrary to your current implementing procedures. In effect, your emergency preparedness staff changed your emergency response plan without revising the necessary procedures and without formally assessing the impact of that change. We acknowledge that this change enabled you to augment your staff in a timely manner and to meet your response criteria for key emergency response positions; however, we are concerned that your actions were not performed in accordance with your procedures nor with the requirements of your emergency plan.

Based on the results of this inspection, the inspector identified one issue of very low safety significance (Green). The issue was determined to involve a violation of NRC requirements. However, because of its very low safety significance and because it has been entered into your corrective action program, the NRC is treating this issue as a Non-Cited Violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this Non-Cited Violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Kewaunee facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

Sincerely,

***/RA by Roy Caniano Acting For/***

John A. Grobe, Director  
Division of Reactor Safety

Docket No. 50-305  
License No. DPR-43

Enclosure: Inspection Report 50-305/01-07(DRS)

cc w/encl: K. Hoops, Manager, Kewaunee Plant  
D. Graham, Director, Bureau of Field Operations  
Chairman, Wisconsin Public Service Commission  
State Liaison Officer

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 50-305  
License No: DPR-43

Report No: 50-305/01-07(DRS)

Licensee: Nuclear Management Company, LLC

Facility: Kewaunee Nuclear Power Plant

Location: N 490 Highway 42  
Kewaunee, WI 54216

Dates: March 27 through March 30, 2001

Inspector: Steven K. Orth, Senior Radiation Specialist

Approved by: Gary L. Shear, Chief  
Plant Support Branch  
Division of Reactor Safety

## SUMMARY OF FINDINGS

IR 05000305-01-07, on 03/27 - 03/30/2001, Nuclear Management Company, Kewaunee Nuclear Power Plant, Unit 1. Supplemental Inspection - Degraded Cornerstone.

The inspection identified one Green finding, which was a Non-Cited Violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609 "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

### **Cornerstone: Emergency Preparedness**

This supplemental inspection was performed by the NRC to evaluate the licensee's evaluation associated with the failure to conduct successful quarterly, off-hours, unannounced staff augmentation drills during the second, third, and fourth quarters of 1999 and the second quarter of 2000. This performance issue was previously characterized as having low to moderate risk significance ("White") in NRC Inspection Report No. 50-305/2000015(DRS).

During this supplemental inspection, performed in accordance with Inspection Procedure 95002, the inspector concluded that the licensee performed a comprehensive evaluation of the unsuccessful staff augmentation drills. The licensee's evaluation identified two root causes which resulted in the unsuccessful drills and in the staff's inability to correct the deficiencies:

- (1) Management has not effectively acted to provide increased depth and flexibility in the emergency response organization following a reduction in staffing several years ago; and
- (2) Management has accepted an adverse trend of test failures without requiring investigation into the root causes.

The inspector reviewed the licensee's corrective actions, both completed and planned, and concluded that the programmatic corrective actions appeared to address the identified root causes. In particular, the licensee assigned certain positions to an on-call rotation to ensure personnel were capable of augmenting in a timely manner, and the licensee was progressing in training additional staff to increase the depth of personnel assigned to key emergency response positions. In addition, the licensee was continuing its efforts in improving its corrective action program.

The inspector reviewed the licensee's immediate response to the issue and identified that one of the licensee's initial corrective actions resulted in a Non-Cited Violation of regulatory requirements. To obtain a timely response of a key emergency response position (severe accident management - core hydraulics), the emergency preparedness staff effectively changed the emergency plan without revising the necessary procedures and without formally assessing the impact of that change. The staff instructed and trained personnel to respond to a location other than the Technical Support Center, which was contrary to the licensee's current implementing procedures. While this change enabled the licensee to augment its staff in a timely manner, the change was not performed in accordance with NRC requirements. In order

to make such a change, the licensee's emergency plan required that the change be formally assessed to ensure that it did not reduce the effectiveness of the plan or any other implementing procedure. Since the issue did not result in a failure to meet an emergency preparedness planning standard, the failure to adequately implement the emergency plan was determined to be a violation of very low safety significance (Green) (Section 02.3(a)).

Due to the licensee's acceptable performance in assessing the emergency response augmentation drill deficiencies, the White finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program." Implementation of the licensee's corrective actions will be reviewed during a future inspection.

## Report Details

### 01 Inspection Scope

This supplemental inspection was performed by the NRC in accordance with Inspection Procedure (IP) 95002 to assess the licensee's evaluation of repetitive deficiencies in its unannounced, off-hours, emergency response augmentation drill performance. During a baseline inspection of the emergency preparedness program (NRC Inspection Report No. 50-305/00-15(DRS)), the NRC identified repetitive failures of the licensee's emergency response augmentation drills conducted in 1999 and 2000. At the time of that inspection, the licensee had not successfully completed the drills in the second, third, and fourth quarters of 1999 and in the second quarter of 2000. In all, the licensee had failed 16 of the previous 18 drills reviewed by the inspector. Based on the issues identified, the NRC issued a White finding (i.e., finding of low to moderate safety significance) and associated Notice of Violation for the failure of the licensee to correct the self-identified deficiencies disclosed through the emergency response augmentation drills.

During this supplemental inspection, the NRC evaluated the licensee's root cause evaluation and corrective actions for the emergency response augmentation drill performance issue. Since this supplemental inspection was conducted using the requirements of NRC IP 95002, the following details are organized by the specific inspection requirements of IP 95002 which are noted in italics in the following sections.

### 02 Evaluation of Inspection Requirements

#### 02.1 *Problem Identification*

- a. *Determine that the evaluation identifies who (i.e., licensee, self-revealing, or NRC) and under what conditions the issue was identified.*

The licensee's root cause evaluation of the deficiencies in its staff augmentation drills was completed in January 2001 and documented as RCE No. 01-002. Based on its review, the licensee's root cause team verified that the licensee had self-identified failures in the monthly augmentation drills during 1999 and 2000. During this period, the licensee had initiated seven Kewaunee Assessment Process (KAP) forms documenting drill failures. The team also found that licensee self-assessments (1998 and 1999) had identified weaknesses in emergency response organization staffing but did not include any corrective actions. The team concluded that the condition did not receive adequate management attention until an NRC baseline inspection was performed in August 2000.

- b. *Determine that the evaluation documents, how long the issue existed, and prior opportunities for identification.*

The licensee's root cause evaluation team reviewed the history of the licensee's augmentation drill performance deficiencies during calendar years 1999 and 2000. During this period, the team concluded that the licensee had identified



and documented a number of the failures and a decline in drill results -- KAP forms and self-assessments. However, the team concluded that the licensee did not effectively use these opportunities to adequately investigate the occurrences and to determine the apparent causes for the continuing drill failures. The team also found that these issues were similar to problems identified in other areas of the emergency preparedness program (i.e., siren performance) and in other licensee programs. Therefore, the inspector concluded that the licensee had performed an adequate assessment of the licensee's previous opportunities to correct this issue and of the common causes.

- c. *Determine that the evaluation documents, the plant specific risk consequences (as applicable), and compliance concerns associated with the issue.*

The licensee's root cause evaluation included an assessment of the risk consequences of the repetitive augmentation drill failures. Overall, the licensee concluded that the risk significance of a "test failure where several key positions fail to respond for staff augmentation during an actual event is considered low." Specifically, the licensee based its assessment on the following:

- **Each augmentation drill conducted in calendar years 1999 and 2000 resulted in the response of over 150 plant personnel. In the case of an actual event, the licensee indicated that these persons could be used to fill open (non-responding) emergency response positions.** However, the inspector asked the licensee if it had evaluated the previous drill failures to determine if the responding personnel would have been capable of filling absent key positions. The licensee indicated that it had not formally evaluated the absences but assumed that there would be extra personnel who could have substituted for the absent responders.
- **Personnel who did not respond to their pagers could be contacted via telephone, and personnel with similar qualifications from Point Beach could be contacted for support.** Until recently (January 2001), the licensee did not have a designated back-up system for contacting emergency responders and had not practiced/demonstrated the described alternate actions. In addition, the licensee did not have any predetermined arrangements with the Point Beach facility for specific emergency response augmentation. Until only recently (Fall 2000), the Kewaunee and Point Beach facilities were operated as independent entities, which may have previously limited the licensee's ability to augment its emergency response organization with Point Beach personnel.
- **The licensee has an excellent history of operating with very few emergency events.**

Based on the inspector's discussions with the licensee, the inspector concluded that the licensee's risk assessment was not based on a thorough assessment of the events. In the case of the failed monthly augmentation drills, the licensee did

not evaluate the specific events to determine what effect the non-responsive or late personnel may have had on an event response. In terms of the licensee's operating history, the absence of an actual emergency event minimized the specific risks associated with the licensee's history of failed augmentation drills. However, the licensee appeared to minimize the future risk associated with emergency preparedness based on its operating history. The licensee acknowledged the inspector's issues and indicated that it had applied its routine risk determination to the issue, which considered the frequency of initiating events. In the emergency preparedness cornerstone, the licensee indicated that it would more critically consider this factor in the future.

## 02.2 Root Cause and Extent of Condition Evaluation

- a. *Determine that the problem was evaluated using a systematic method(s) to identify root cause(s) and contributing cause(s).*

The licensee formed a root cause evaluation team consisting of a contractor (industry recognized root cause evaluator) and recently trained members of the licensee's staff. The team performed the root cause evaluation using the licensee's draft "Root Cause Evaluation Guideline." The inspector reviewed the root cause evaluation report (RCE No. 01-002) and discussed the results with members of the root cause team. The team employed the following techniques: records review, personnel interviews, events and causal factors charting, failure mode analysis, and stream analysis. The inspector concluded that the evaluation was performed in a systematic manner to determine the root causes and contributing causes.

- b. *Determine that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.*

The licensee's root cause evaluation was thorough and determined that the repetitive failures of monthly emergency response augmentation drills resulted from two root causes and a number of contributing causes:

### Root Causes

- (1) **Management has not effectively acted to provide increased depth and flexibility in the emergency response organization following a reduction in staffing several years ago.**

The licensee also identified contributing causes including: the lack of specific assignment in responsibility to personnel, the limited number of personnel assigned to key emergency response positions, weaknesses in the licensee's notification system, and weaknesses in the application of drill criteria and the licensee's verification process.

**(2) Management has accepted an adverse trend of drill failures without requiring investigation into the root causes.**

In addition to the root cause, the licensee identified the following contributing causes: the inconsistent use of the corrective action program in documenting drill failures, the failure to initiate a root cause evaluation when a declining trend in drill results was identified, and the failure to implement effective corrective actions for prior self-identified occurrences.

The inspector associated this root cause and its contributing causes to weaknesses in the licensee's corrective action program, which had been documented in NRC Inspection Reports Nos. 50-305/00-12(DRS), 50-305/00-17(DRS), 50-305/00-19(DRP), and 50-305/01-05(DRS).

Based on the above causes identified by the licensee, the inspector concluded that the licensee's evaluation was conducted to an adequate level of detail.

- c. Determine that the root cause evaluation included a consideration of prior occurrences of the problem and knowledge of prior operating experience.*

The root cause evaluation team effectively reviewed augmentation drill failures which occurred in calendar years 1999 and 2000 and a similar drill failure which occurred in 1996. Based on this evaluation, the team identified corrective action weaknesses including the inconsistent use of the licensee's corrective action program. The team also evaluated the effectiveness of the licensee's self assessments and audits. Based on the weaknesses in the licensee's prior responses to the issues, the team developed its second root cause documented in Section 02.2.b (above).

- d. Determine that the root cause evaluation included consideration of potential common cause(s) and extent of condition of the problem.*

The licensee performed a programmatic assessment of the emergency preparedness program. The NRC reviewed this assessment during a previous supplemental inspection (NRC Inspection Report No. 50-305/01-05(DRS)). In this assessment, the licensee effectively determined the extent of condition of the problem and identified common causes.

**02.3 Corrective Actions**

- a. Determine that appropriate corrective action(s) are specified for each root/contributing cause or that there is an evaluation that no actions are necessary.*

During November of 2000, the licensee implemented the following corrective actions to achieve timely staff augmentation:

- (1) A letter was sent from the Site Vice President to the emergency response organization restating the responsibility of individuals to ensure an acceptable response to their pagers for drills and actual events.
- (2) The licensee instituted an on-call organization. For each of the key emergency response positions, personnel were specifically assigned the responsibility to be able to respond to their assigned emergency response facilities within the times specified by the emergency preparedness program. During the on-call rotations, designated personnel were required to be in the area (i.e., within the required response times) and to be fit for duty.
- (3) Due to a problem in the location of residences of personnel responsible for the 30 minute reactor engineering response (severe accident management - core hydraulics (SAMCH) position), the licensee instructed those persons to report to either the Emergency Operations Facility (Green Bay, WI) or the Technical Support Center (Kewaunee Site) to accomplish the 30 minute response goal. The licensee indicated that the Emergency Operations Facility was much closer to the individuals' residences, that adequate information was available in either response facility, and that the individuals could relocate to the Technical Support Center as more personnel became available.

Based on these corrective actions, the licensee documented successful augmentation drills since November 2000. However, the inspector identified a problem concerning the licensee's corrective actions. Specifically, the licensee's Emergency Preparedness Implementing Procedure (EPIP) EPIP No. EP-TSC-1 (Revision 0), "Technical Support Center Organization and Responsibilities," directed the SAMCH position to respond to the Technical Support Center when notified that an emergency had been declared. The procedure also instructed the individual to provide assistance in activating that facility. In addition to the EPIP, Section 6.2.5 of the emergency plan states that severe accident assessment would be performed in the Technical Support Center by a team which included the SAMCH position. This section of the emergency plan provided further instructions for the SAMCH to respond to the Technical Support Center. Consequently, the inspector concluded that the licensee had effectively changed the requirements of the plan and procedure by training/instructing the personnel responsible for the SAMCH position to respond to a location other than the Technical Support Center. The inspector also identified that the licensee had not formally assessed the change and had not formally revised the EPIP. During the licensee's extent of condition review, the licensee had also identified a more generic issue related to the review and revision to EPIPs.

The inspector identified that the licensee's instructions to personnel filling the SAMCH position effectively resulted in a change to the emergency plan and EPIPs that was not conducted in accordance with the requirements of the emergency plan. This issue, if uncorrected, would become a more significant safety issue because the failure to properly assess the consequences of emergency plan or EPIP changes could inadvertently reduce the effectiveness of the licensee's emergency plan and response to an actual emergency. Therefore, the issue was reviewed using the NRC Significance Determination Process (SDP) for the emergency preparedness cornerstone. Although the finding involved a failure to implement a regulatory requirement, the finding did not represent an actual event implementation problem, a drill or exercise critique problem,

or a failure to meet a planning standard. Therefore, in accordance with the SDP, this issue is a Green finding.

10 CFR 50.54(q) requires that licensees follow and maintain in effect emergency plans which meet the standards in 10 CFR 50.47(b) and the requirements in Appendix E to 10 CFR Part 50. Section IV.G of Appendix E to 10 CFR Part 50 requires that emergency plans contain provisions to ensure that the emergency plan, its implementing procedures, and emergency equipment and supplies are maintained up to date. Section 8.3.1 of the Kewaunee emergency plan states that all proposed EPIP changes will be reviewed prior to issue to ensure that the change would not compromise the effectiveness of any other EPIP or degrade the effectiveness of the plan. Contrary to the above, the licensee made an effective change to EPPIP No. EP-TSC-1 without performing the required review and without formally revising the EPIP. However, because of the very low safety significance of the item and because the licensee has included this item in its corrective action program (KAP Work Request No. 01-002110), this violation is being treated as a Non-Cited Violation (NCV 50-305/01-07-01).

The inspector reviewed the licensee's November 2000 through March 2001 augmentation drill records, which the licensee determined to be successful demonstrations of its augmentation capabilities. Based on the change to the response location of the SAMCH position, the inspector verified that the licensee could augment the emergency response staff within the times specified in its procedures. In addition, the inspector found that problems identified through the augmentation drills were properly entered into the KAP.

The licensee had also developed plans for long-term corrective actions. The inspector reviewed these planned corrective actions and determined that they adequately addressed the root causes identified in the licensee's assessment. For example, the licensee planned to perform the following:

- (1) Develop emergency response candidates to achieve a minimum depth of four or five qualified personnel for most emergency response positions.
- (2) Perform cross-training to improve organizational flexibility for multiple responders to fill key emergency response positions.
- (3) Develop administrative controls to ensure that specific responsibilities for key positions are assigned and accepted by the required number of responders.
- (4) Use the KAP to document any significant test failures or drill deficiencies and perform investigations of these events at least at the apparent cause level.

Overall, the inspector concluded that the long-term corrective actions were appropriate to address the root causes and to prevent recurrence.

- b. Determine that the corrective actions have been prioritized with consideration of the risk significance and regulatory compliance.*

The licensee implemented the immediate corrective actions described in Section 02.3.a in November of 2000. The inspector noted that these actions occurred approximately three months after the NRC identified the issue to licensee management, which did not appear timely considering the risk significance of the issue. The licensee indicated that its response to the issue was delayed due to competing issues with its corrective action program and the time needed to develop an adequate, interim solution.

The licensee entered the long-term corrective actions into the KAP (KAP Forms Nos. 00-002907-01 and 00-002907-02). The inspector observed that the priority assigned to the actions was consistent with the instructions contained in procedure GNP 11.08.07 (Revision A), "Action Prioritization," and was commensurate with the risk significance of the issue.

- c. *Determine that a schedule has been established for implementing and completing the corrective actions.*

The licensee developed a schedule for the implementation of the long-term corrective actions in accordance with procedure GNP 11.08.07. Each of the corrective actions was assigned an owner and was scheduled to be completed by April 30, 2001. Overall, the inspector observed progress in the licensee's efforts to complete the corrective actions. However, the licensee indicated that certain actions would probably be extended due to the resources necessary to accomplish the tasks.

During the inspection, the inspector observed a training drill that was performed to develop additional personnel for key emergency response positions. Two personnel failed to be present for the drill, which challenged the other participants and the drill controllers and which further increased the artificialities of the drill environment. Nonetheless, the controllers effectively covered the vacant positions and provided an appropriate training experience for the trainees.

- d. *Determine that quantitative or qualitative measures of success have been developed for determining the effectiveness of the corrective actions to prevent recurrence.*

The licensee determined that an audit would be performed by the quality assurance staff to assess the effectiveness of the corrective actions. At the time of this inspection, the licensee had not defined the quantitative or qualitative measures of success. However, the inspector noted that the assigned audit was entered into the licensee's corrective action program to administratively track the review (KAP work order No. 00-002907-02). Licensee management indicated that the audit was planned for January 2002 and that the performance measures would be determined prior to the audit.

#### 02.4 Independent Assessment of Extent of Condition

The inspector reviewed the licensee's extent of condition review (Section 02.2.d) and compared the licensee's results to the NRC's inspection of the emergency preparedness cornerstone (NRC Inspection Report No. 50-305/00-15(DRS)) and the results of the previous NRC supplemental inspections. Based on this evaluation, the

inspector determined that the licensee had performed an adequate review of the extent of condition.

03 Miscellaneous Issues

.1 Preliminary White Finding (Unresolved Item No. 50-305/00-15-01)

During a baseline inspection of the emergency preparedness program conducted on August 14 - September 21, 2000, the NRC identified a preliminary White issue and potential violation for the licensee's failure to successfully correct deficiencies identified during staff augmentation drills and to demonstrate timely staff augmentation in 1999 and 2000. The issue was unresolved pending the outcome of the NRC's final significance determination. On January 30, 2001, the NRC conducted a regulatory conference with the licensee and subsequently issued the licensee a White finding and Notice of Violation (Enforcement Action No. 00-214) associated with the performance issue. Consequently, the unresolved item is closed, and the White finding and associated Notice of Violation will be tracked as VIO No. 50-305/01-07-02.

On March 30, 2001, the licensee provided the NRC with its response to the above Notice of Violation, which contained its immediate and long term corrective actions for the finding. Based on the inspector's review, the licensee's immediate corrective actions resulted in the licensee's ability to demonstrate timely augmentation of its staff. The remaining corrective actions will be reviewed as a routine aspect of future NRC inspections. This violation is closed.

04 Exit Meeting Summary

On March 30, 2001, the inspector presented the inspection results to Mr. Reddemann and other members of the Kewaunee staff. The licensee acknowledged the findings presented. The inspector asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

## KEY POINTS OF CONTACT

### Nuclear Management Company

R. Farrell, Manager, Radiation Protection  
G. Harrington, Licensing Leader  
K. Hoops, Plant Manager, Kewaunee Plant  
B. Koehler, Manager, Quality Programs  
R. Mende, Director, Engineering  
R. Nicolai, KAP Process Leader  
R. Pulec, Assessment Manger  
M. Reddemann, Site Vice President  
R. Repshas, Manager, Site Services  
J. Riste, Licensing Leader  
D. Seebart, Process Leader, Emergency Preparedness

### U.S. Nuclear Regulatory Commission

Z. Dunham, Kewaunee Resident Inspector  
J. Lara, Kewaunee Senior Resident Inspector  
S. Orth, Senior Radiation Specialist  
G. Shear, Chief, Plant Support Branch

## LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

### Opened

50-305/01-07-01	NCV	Failure to implement the emergency plan in accordance with 10 CFR 50.54(q) (Section 02.3(a)).
50-305/01-07-02	VIO	Failure to conduct successful quarterly, off-hours, unannounced staff augmentation drills during second, third, and fourth quarters of 1999 and second quarter of 2000 (Section 03.1).

### Closed

50-305/00-15-01	URI	Failure to conduct successful quarterly, off-hours, unannounced staff augmentation drills during second, third, and fourth quarters of 1999 and second quarter of 2000 (Section 03.1).
50-305/01-07-01	NCV	Failure to implement the emergency plan in accordance with 10 CFR 50.54(q) (Section 02.3(a)).
50-305/01-07-02	VIO	Failure to conduct successful quarterly, off-hours, unannounced staff augmentation drills during second, third, and fourth quarters of 1999 and second quarter of 2000 (Section 03.1).



## LIST OF DOCUMENTS REVIEWED

### KAP Forms

(WO No.)	(Subject/Title)
00-002907	A "White" Program Finding in Emergency Preparedness Program
00-004114	October 2000 Pager Response Drill Fails to Meet Planning Standard
01-000171	GNP 2.9, Rad. Tech. Priority of Tasks
01-000197	Responsibilities and On-Shift Staffing
01-000198	Independent Assessment of Planning Standard 10 CFR 50.47(b)(6)
01-000628	Unfilled ERO Positions in Draft Results of January Pager Response Test

(WR No.)	(Subject/Title)
01-002110	50.54(q) Process Not Followed

### Miscellaneous

"Emergency Response Organization On-Call (ERO) Expectations," dated February 21, 2001  
"Emergency Response Organization (ERO) On-Call Policy," dated February 21, 2001  
EPMP Form 2.6-2 (Revision B), "ERO Response Data," completed for September 2000, October 2000, November 2000, December 2000, January 2001, and February 2001  
Memorandum from KH Weinhauser to all emergency response organization members, dated November 20, 2000  
Root Cause Evaluation No. 01-002, dated January 26, 2001  
"Root Cause Evaluation Guideline," approved January 9, 2001

### Procedures

EPIP AD-07 (Revision AM), "Initial Emergency Notifications"  
EPIP APPX-A-02 (Revision BI), "Response Personnel Call List"  
EPIP EP-TSC-1 (Revision O), "Technical Support Center Organization and Responsibilities"  
GNP 11.08.07 (Revision A), "Action Prioritization"  
NAD 11.08 (Revision E), "Kewaunee Assessment Process"

## LIST OF ACRONYMS USED

EPIP	Emergency Plan Implementing Procedure
GNP	General Nuclear Procedure
IP	Inspection Procedure
KAP	Kewaunee Assessment Process
NCV	Non-Cited Violation
RCE	Root Cause Evaluation
SAMCH	Severe Accident Management -- Core Hydraulics
URI	Unresolved Item
VIO	Violation