July 11, 2005

Mr. Jay K. Thayer
Site Vice President - Vermont Yankee
Entergy Nuclear Vermont Yankee, LLC
P.O. Box 0500
185 Old Ferry Road
Brattleboro, VT 05302-0500

SUBJECT: VERMONT YANKEE - NRC EMERGENCY PREPAREDNESS INSPECTION REPORT NO. 05000271/2005007

Dear Mr. Thayer:

The enclosed report documents two inspection efforts at the Vermont Yankee Nuclear Power Station during the week of May 23, 2005. A baseline inspection evaluated the performance of your emergency response organization during the May 24, 2005 full-participation exercise and post-exercise critique. A supplemental inspection was conducted to evaluate your corrective actions to ensure the proper distribution and maintenance of tone alert radios used by residents within the emergency planning zone that are outside of siren coverage. This issue was initially identified during a July 2004 inspection of your emergency preparedness program and resulted in a violation of White significance which was documented in a letter to you from Samuel Collins dated February 2, 2005. The inspectors discussed the results of these inspection activities with you and other members of your staff on May 27, 2005.

The inspectors 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 exercise evaluation inspection consisted of a selected examination of emergency plan procedures and representative records, observations of exercise activities, and interviews with emergency preparedness personnel. The supplemental inspection was conducted to determine if the root and contributing causes of the White finding were understood, to assess the extent of condition review, and to determine if the corrective actions for the risk significant performance issue were sufficient to address the causes and to prevent recurrence. To accomplish these objectives, the inspectors reviewed your root cause analysis report, condition reports and self-assessments associated with the issue.

Based on the results of this exercise evaluation inspection, no findings of significance were identified. Based on the supplemental inspection, the NRC concluded that your staff understood the root and contributing causes of the White finding, adequately addressed the extent of condition, and took adequate corrective actions for the underlying causes to prevent recurrence.

Given your acceptable performance in addressing the tone alert radio issue, the associated White finding will only be considered in assessing plant performance through the period concluding at the end of the third calendar quarter of 2005, in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program."

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/reading-rm/ADAMS.html (the Public Electronic Reading Room).

Should you have any questions regarding this report, please contact Mr. Raymond Lorson at (610) 337-5282.

Sincerely,

/RA/

Raymond K. Lorson, Chief
Plant Support Branch 1
Division of Reactor Safety

Docket No. 50-271
License No. DPR-28

Enclosures: Inspection Report No. 05000271/2005007

cc w/encl:
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U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No:	50-271
License No:	DPR-28
Report No:	050000271/2005007
Licensee:	Entergy Nuclear Vermont Yankee, LLC
Facilities:	Vermont Yankee Nuclear Power Station
Location:	Vernon, Vermont
Dates:	April 25 - May 27, 2005
Inspectors:	D. Silk, Senior Emergency Preparedness Inspector (Lead) W. Raymond, Senior Resident Inspector, Pilgrim, DRP G. Johnson, Operations Engineer, DRS S. Lavie, Senior Emergency Preparedness Specialist, NSIR
Observers:	R. Treadway, Reactor Inspector, DRS
Approved by:	Raymond K. Lorson, Chief Plant Support Branch 1 Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

IR 05000271/05-007; 05/23/2005-5/27/2005; Vermont Yankee Nuclear Power Station; Emergency Preparedness Exercise; Supplemental Inspection for the White Finding associated with the distribution and maintenance of the Tone Alert Radios; Performance Indicators.

This inspection was conducted by two regional inspectors, a resident inspector, and an emergency preparedness specialist from NSIR. No findings of significance were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Cornerstone: Emergency Preparedness

A. Inspector Identified Findings

Cornerstone: Emergency Preparedness

None.

B. Licensee Identified Findings

None

C. Supplemental Inspection

The NRC performed this supplemental inspection to assess the licensee's evaluation and corrective actions for a White finding (identified in Inspection Report 05000271/2004009) related to the distribution and maintenance of the tone alert radios (TARs) to the emergency planning zone (EPZ) population located outside of siren coverage. During this supplemental inspection, performed in accordance with Inspection Procedure 95001, the inspectors determined that Entergy performed a comprehensive evaluation of the TAR issue. Entergy's evaluation identified the primary root causes of the performance issue to be ineffective management control and oversight of the TAR program. Entergy's extent of condition and cause review was acceptable in that other EP functions were reviewed to ensure adequate formalized processes were being implemented to preclude deterioration of those functions. The primary corrective action was to develop and implement a formal process for the distribution, maintenance, and testing of the TARs. The inspectors determined that the effectiveness reviews to ensure the adequacy of the correction actions were appropriate.

Given the licensee's acceptable performance in addressing the TAR distribution and maintenance issue, the White finding associated with this issue will only be considered in assessing plant performance through the period concluding at the end of the third calendar quarter of 2005, in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program."

Report Details

1. REACTOR SAFETY

Cornerstone: Emergency Preparedness (EP)

1EP1 Exercise Evaluation (7111401 - 1 sample)

a. Inspection Scope

An in-office review was conducted of Entergy Nuclear Vermont Yankee exercise objectives submitted to the NRC on April 25, 2005 and the exercise scenario submitted on April 21, 2005 to determine if the Vermont Yankee exercise would test major elements of Entergy's emergency plan as required by 10 CFR 50.47(b)(14).

The onsite inspection consisted of the following reviews and assessments:

- The adequacy of Entergy's performance in the biennial full-participation exercise by primarily focusing on the implementation of the risk-significant planning standards (RSPS) in 10 CFR 50.47 (b) (4), (5), (9) & (10) which are emergency classification, offsite notification, radiological assessment, and protective action recommendations, respectively.

- The overall adequacy of Entergy's emergency response facilities and its implementation of NUREG-0696, "Functional Criteria for Emergency Response Facilities," and emergency plan commitments. The facilities assessed were the simulator, Technical Support Center (TSC), Operations Support Center (OSC), and Emergency Operations Facility (EOF).

- Other performance areas, such as, the emergency response organization's (ERO) recognition of abnormal plant conditions, command and control, intra- and inter-facility communications, prioritization of mitigation activities, utilization of repair and field monitoring teams, interface with offsite agencies, and the overall implementation of the emergency plan and implementing procedures.

- Past performance issues from NRC inspection reports and Entergy drill reports to determine effectiveness of corrective actions as demonstrated during this exercise to ensure compliance with 10 CFR 50.47(b)(14).

- The post-exercise critique to evaluate the Entergy's self-assessment of its ERO performance during the exercise and to ensure compliance with 10 CFR 50 Appendix E.IV.F.2.g.

Additionally, the inspectors reviewed the documents listed in Attachment 1 to this report.

b. Findings

No findings of significance were identified.

1EP4 Emergency Action Level and Emergency Plan Changes (7111404 - 1 sample)

a. Inspection Scope

During the period of May 10 to16, 2005, the NRC received and acknowledged the changes made to the Vermont Yankee emergency plan in accordance with 10 CFR 50.54(q). The licensee had determined that the changes did not decrease the effectiveness to the Plan and that the changes continue to meet the requirements of 10 CFR 50.47(b) and Appendix E to 10 CFR 50. The inspectors conducted a sampling review of the changes that could potentially result in a decrease in effectiveness. This review does not constitute an approval of the changes and, as such, the changes are subject to future NRC inspection. The inspection was conducted in accordance with NRC Inspection Procedure 71114, Attachment 4, and the applicable requirements in 10 CFR 50.54(q) were used as reference criteria.

B. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator (PI) Verification (71151 - 3 samples)

a. Inspection Scope

The inspectors reviewed data for the EP PIs which are: (1) Drill and Exercise Performance (DEP); (2) ERO Drill Participation; and (3) Alert and Notification (ANS) Reliability. The inspectors reviewed supporting documentation from drills and ANS testing in the third and fourth quarters of 2004 and the first quarter of 2005 to verify the accuracy of the reported data. The review of these PIs was conducted in accordance with NRC Inspection Procedure 71151, Performance Indicator Verification. The acceptance criteria used for the review were 10 CFR 50.9 and NEI 99-02, Revision 2, Regulatory Assessment Performance Indicator Guidelines.

b. Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems

a. Inspection Scope

The inspectors reviewed Entergy's critique findings and condition reports generated from drills/exercises conducted in 2004 and 2005 to determine if significant performance trends existed and to determine the effectiveness of licensee corrective actions based upon ERO performance during this recent exercise. The inspectors verified that issues identified during this biennial exercise were entered into Entergy's corrective action program.

b. Findings

No findings of significance were identified.

4OA5 Other

SUPPLEMENTAL INSPECTION

Summary of the Performance Issue

A finding associated with emergency planning standard 10 CFR 50.47(b)(5) was identified by the NRC during an EP program inspection conducted from July 26 through October 12, 2005. The NRC determined that a performance deficiency existed in that the licensee did not have the means to provide early notification to those in the emergency planning zone (EPZ) population who had, or desired to have, a tone alert radio (TAR) for areas lacking siren coverage. Specifically, the licensee did not have an active program in place to ensure that all residents outside of siren coverage and who needed a TAR were offered one. The method in place at the time of the inspection was passive in that it relied upon residents to take action to acquire and maintain a TAR. The licensee did not have a current data base to track those residents who had TARs. These conditions did not meet the intent of the 1996 FEMA Final Report which accepted the ANS design based upon the licensee's 1984 Final Analysis Report (FAR) of the Alert and Notification Systems for the Vermont Yankee EPZ. By not fulfilling the ANS design criteria, the licensee had failed to satisfy planning standard 10 CFR 50.47(b)(5). As a result, the NRC issued a notice of violation and made a final determination that the issue was of low to moderate significance (White).

Supplemental Inspection Scope

During the week of May 23, 2005, the NRC completed a supplemental inspection using Inspection Procedure 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess Entergy's evaluation of the issues associated with the distribution and maintenance of the TARs to the EPZ population located outside of siren coverage. This performance issue was characterized as a White finding in NRC Inspection Report (IR) 50-271/04-009 and is related to the EP cornerstone in the reactor

safety strategic performance area. The objectives of this supplemental inspection were 1) to provide assurance that the root causes and contributing causes of risk significant performance issues are understood, 2) to provide assurance that the extent of condition of risk significant issues is identified, and 3) to provide assurance that licensee's corrective actions to risk significant performance issues are sufficient to address the root causes and contributing causes, and to prevent recurrence.

02 EVALUATION OF INSPECTION REQUIREMENTS

02.01 Problem Identification

a. Determination of who (i.e., licensee, self-revealing, or NRC) identified the issue and under what conditions.

The NRC identified the issue during a routine baseline inspection of the EP program in July 2004.

b. Determination of how long the issue existed, and prior opportunities for identification.

In 1984, when the FAR was submitted to FEMA, Vermont Yankee (VY) was in compliance. The discontinuation of mailing batteries and a survey (which was replaced by the mailing of calendars) occurred sometime after 1996. Although information about the TARs (batteries, operation, replacing TARs, etc.) was placed in calendars, it was at this point that the residents became responsible for the maintenance of their TARs.

The licensee's review of the TAR issue identified that multiple opportunities existed for prior identification. The licensee's root cause mentioned a 1999 letter from the NRC that forwarded FEMA's approval of the 1984 ANS design report submittal. Specifically, due to the dated nature of the report, the letter recommended that the licensee review the report for applicability. Also, NRC Information Notice 2002-025 (Challenges to Licensees' Ability to Provide Prompt Public Notification and Information during an Emergency Preparedness Event) prompted the licensee to review the TAR program. In 2003, NRC inspection findings regarding TARs at Arkansas Nuclear One and Callaway also prompted Entergy to review the TAR program. Despite these reviews, appropriate timely actions were not implemented to address the problem.

c. Determination of the plant-specific risk consequences (as applicable) and compliance concerns associated with the issue.

Due to the nature of this issue, there are no plant-specific risk consequences (to core damage). The potential consequences were that the licensee may not have had the means to provide early notification to some individuals in the EPZ that are outside of siren coverage. In the root cause analysis (RCA) report under the *Problem Statement*, Entergy acknowledged that they had not ensured an effective implementation of a TAR program as required by the emergency plan and 10CFR50.47(b)(5). With route alerting

as an immediate compensatory measure, compliance with NRC regulations was restored. The inspectors determined that the original issue was of low to moderate significance as documented in IR 05000271/04-009.

02.02 Root Cause and Extent of Condition Evaluation

a. Evaluation of methods used to identify the root causes and contributing causes.

The licensee used two accepted methods to assess the TAR issue: 1) Event and Causal Factor and 2) Barrier Analysis. Key team members were trained in root cause methodology. Also included in their investigation was an Organization and Programmatic Weakness Evaluation which assessed program and organizational interface issues. Overall, the inspectors concluded that the methods used to review this issue were appropriate.

b. Evaluation of the level of detail of the root cause investigation.

The root causes included the lack of a formal process for the distribution and maintenance of the TARs and also ineffective management oversight. Specifically, requirements and standards for the TARs were not properly formalized, documented, or maintained. The contributing causes were a failure to act upon industry Operating Experience (OE) regarding TARS as mentioned in Section 2.01 b. above, and untimely corrective action to address potential weaknesses in VY's TAR program. Specifically, in 2002 there was a plan to survey TAR holders to update the data base however, this action was delayed. If the survey, and accompanying activities, had been completed, the RCA report stated that the TAR issue could have been prevented. The inspectors concluded that the licensee's root cause evaluation accurately identified the root and contributing causes.

c. Consideration of prior occurrences of the problem and knowledge of prior operating experience.

There had not been a previous TAR issue at VY. However, as was noted in Section 2.01 b, the licensee had several opportunities in recent years where external sources brought attention to potential TAR program issues. Also, the licensee's team identified several past condition reports at VY that were applicable to the EP program. Such CRs included management formality and standards, maintenance of EP procedures and technical bases, and untimely corrective actions. The inadequate response to these past CRs substantiated the root and contributing causes which were identified by the RCA team.

d. Consideration of potential common causes and extent of condition of the problem.

The licensee's RCA report identified several areas within the purview of EP where the same root and contributing causes could have an impact. Regarding the potential extent of condition, several areas were identified including: software associated with the new sirens, the new plant radio system, FEMA drill objectives, and personnel

accountability. The inspectors did not identify any specific problems in these areas and noted that the licensee has initiated appropriate actions to address these potential concerns. Regarding the extent of cause, the licensee took several actions. Vermont Yankee initiated action to review if other aspects of the EP program lacked formality. To enhance management oversight, an industry expert in EP was contracted was to assist the EP manager. Industry OE related to EP will be reviewed to determine applicability to VY. Progress on corrective actions will be monitored to assess priorities and backlog. Overall, the licensee's efforts in this area were thorough.

02.03 Corrective Actions

a. Evaluation of the appropriateness of the corrective actions.

The immediate short term corrective action was to notify offsite agencies of the need to automatically perform route alerting in areas dependent upon TARs for notification. Long term corrective actions addressed the specific causes. VY developed a formal process for the distribution, maintenance and testing of the TARs that satisfied the FAR. The scopes of self-assessments and audits were modified to include reviews of the TAR program to ensure management oversight. Also, roles were clarified between site and corporate management regarding oversight of the EP program. To address recent failures to learn from industry OE, the current EP manager has been assigned to review past industry OE items associated with EP to assess specific applicability to VY's EP program. To ensure that corrective actions are given the appropriate attention, EP personnel were trained on when to use CRs versus lower level tracking processes and licensee management will monitor for the proper use of the corrective action program. The licensee plans to make some enhancements to its ANS, update the ANS design report, and submit the report to FEMA.

As a result of the licensee's corrective actions, the TAR data base has been updated with the latest available information. Based upon "best effort" actions by the licensee, over 2000 additional TARs have been distributed throughout the EPZ. The licensee's corrective actions were thorough and appear sufficient to preclude recurrence.

b. Evaluation of the prioritization of the corrective actions.

As stated above, the licensee took immediate short term corrective action to address the TAR issue. Also, the licensee promptly initiated corrective actions and a root cause investigation prior to the NRC issuing the final White Determination. As of the time of this 95001 inspection, all corrective actions had been completed except for the performance of effectiveness reviews of the implemented corrective actions. The licensee demonstrated proper prioritization of corrective actions for this issue.

c. Establishment of schedule for implementing and completing the corrective actions.

As stated above, the licensee planned and implemented prompt corrective actions to address the root and contributing causes of the TAR issue. By completing the corrective actions, the licensee brought the TAR program back to compliance with the FAR by March 31, 2005.

d. Establishment of quantitative or qualitative measures of success for determining the effectiveness of the corrective actions to prevent recurrence.

A focused self-assessment has been scheduled to determine the effectiveness of the corrective actions for this issue. The assessment will be performed by internal and external emergency planning peers. The results of the effectiveness review will be presented to the site corrective action review board. Also, audit plans have been broadened to include a continual review and assessment of the overall TAR program to ensure continuing compliance.

40A6 Meetings, including Exit

The inspectors presented the inspection results to Mr. Jay Thayer and other members of the Entergy's staff at the conclusion of the inspection on May 27, 2005.

ATTACHMENT 1

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

N. Avrankatos, Manager Emergency Preparedness (JAF)
M. Wilson, Manager Emergency Preparedness (VY)
L. Tkaczyk, Sr. Emergency Preparedness Planner (VY)
M. Slobedien, Emergency Programs Director, WPO
J. McCarty, Root Cause Analysis Team Leader (JAF)
R. Felumb, Qualified Root Cause Analysis Evaluator (VY)

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Closed

AV 50-271/04-009-01	VIO	Failure to establish the means to provide early notification and clear instruction to the populace within the EPZ.

Opened/Discussed

None

LIST OF DOCUMENTS REVIEWED

Section 1EP1: Exercise Evaluation

Vermont Yankee Nuclear Emergency Plan, Rev 40
AP 3125, Emergency Plan Classification and Action Level Scheme, Rev. 19

Section 1EP4: Emergency Action Level and Emergency Plan Changes

Vermont Yankee Emergency Plan, Rev 40
OP 3504, Emergency Communications, Rev 40
OP 3507, Emergency Radiation Exposure Control, Rev 32
OP 3509, Environmental Sample Collection During an Emergency, Rev 18 LPC 1
OP 3510, Off-Site and Site Boundary Monitoring, Rev 29 & LPC 1
OP 3513, Evaluations of Off-Site Radiological Conditions, Rev 24 LPC 1 & 2
OP 3524, Emergency Actions to Ensure Initial Accountability and Security Response, Rev 21 LPC 1 & 2

OP 3525, Radiological Coordination, Rev 13 LPC 1
OP 3540, Control Room Actions During an Emergency, Rev 6 LPC 1
OP 3541, Activation of the Technical Support Center, Rev 5
OP 3542, Operation of the Technical Support Center, Rev 6
OP 3543, Activation of the Operations Support Center, Rev 3
OP 3544, Operation of the Operations Support Center, Rev 6
OP 3545, Activation of the Emergency Operations Facility/Recovery Center, Rev 5
OP 3546, Operation of the Emergency Operations Facility/Recovery Center, Rev 8
OP 3547, Security Actions During an Emergency, Rev 3 LPC 1
OP 3548, Emergency Termination and Recovery, Rev 0
OP 3550, Activation and Operation of the Joint News Center, Rev 1 & LPC 1

Section 4OA1: Performance Indicator (PI) Verification

EN-EP-201 Nuclear Management Manual, Revision 0

Section 4OA2: Identification and Resolution of Problems

NRC Inspection Report 50-271/03-003
November 8, 2004 VYNPS Drill Report
January 12, 2005 VYNPS Drill Report
March 9, 2005 VYNPS Drill Report

Condition Reports (CR-VTY-2005):
01648 RP radio's used in the OSC did not transmit properly
01671 TSC Engineer had to leave due actual home emergency
01672 Missed declaration of GE (PI hit)
01673 The transfer of State notification from the SCR to OF was mis-communicated
01674 Initial notification time on the state notification form was not recorded correctly (PI hit)
01675 Equipment failures
01698 SSS activated pagers improperly

Section 4OA5: Other

Root Cause Analysis Report (CR-VTY-2004-3471)
LO-VTYLO-2004-00260
CR-WPO-2004-00222
LO-OEN-2002-00117
LO-VTYLO-2003-00686
LO-VTYLO-2003-00679
LO-VTYLO-2003-00073
CR-VTY-2004-02419
CR-VTY-2004-03896
CR-VTY-2004-02419
NRC Inspection Report 05000271/2004009
March 3, 2005 letter from Vermont Yankee to USNRC

LIST OF ACRONYMS

ANS	Alert and Notification System
EOF	Emergency Operations Facility
EP	Emergency Preparedness
EPZ	Emergency Planning Zone
ERO	Emergency Response Organization
FAR	Final Analysis Report (of the ANS for the Vermont Yankee EPZ)
FEMA	Federal Emergency Management Agency
IR	Inspection Report
OE	Operating Experience
OSC	Operations Support Center
RCA	Root Cause Analysis
RSPS	Risk Significant Planning Standard
SDP	Significant Determination Process
TAR	Tone Alert Radio
TSC	Technical Support Center
VY	Vermont Yankee
WPO	White Plains Office