

Tenorio, Pat

From: Fuoto, John, S. [jsfuoto@ees.com]
Sent: Monday, May 01, 2000 12:49 PM
To: 'O. C. Payne'; 'Sue Perez'; 'Willie Malone'; 'Vanessa Quinn'; 'Pat Tenorio'
Subject: FW: IP2 - Emergency Response Deficiencies

>For your information.

>OE10937 - Emergency Response Organization Weaknesses During an Alert
>Event Date: February 15, 2000
>Unit Name: Indian Point Unit 2 (Consolidated Edison
>Co. of New York)
>NSSF/A-E: Westinghouse/UE&C
>Docket No./LER No.: 50-247/00-01
>Year Commercial: 1974
>Rating: 1,008 MWe Gross Nameplate Rating
>EIS System Code(s):N/A
>NSSF Applicability: PWR
>Maintenance Rule Applicability: No

>Abstract:

>An Alert was declared at Indian Point No.2 on February 15, 2000 at
>7:29 PM due to a steam generator tube failure. The operators had
>tripped the plant, and had activated the Emergency Response
>Organization as required by the station Emergency Plan. (See SEN 213
>and other references for transient and operational details.)

>Following stabilization of the plant in cold shutdown approximately 23
>hours after the reactor trip, the station terminated the emergency as
>of 6:50 PM on February 16th and deactivated Emergency Response
>Facilities.

>The Emergency Plan adequately protected the health and safety of the
>public in this event, but there were several Emergency Response
>Organization deficiencies, including:

- >- Delayed completion of personnel accountability
- >- Delayed activation of Emergency Response Facilities
- >- Equipment and facilities that were not fully ready for use
- >- External communication weaknesses
- >- Emergency Response Organization procedure weaknesses
- >- Emergency Preparedness Training weaknesses

>In almost all cases, these conditions were identified in reviews of an
>August 31, 1999 event (INPO SER 3-99) and of a September 1999
>Emergency Exercise, and in station self-assessments. Actions to
>correct these conditions were identified, scheduled, and initiated
>prior to the February 15, 2000 event, but had not been fully
>implemented.

>Event Description:

>In the evening of February 15, 2000, Indian Point Unit 2 was operating
>at 99% power with an electrical load of 1,003 MWe. Primary to
>secondary leakage was approximately 3.4 gallons per day.

>At 7:17 PM the N-16 monitor alarmed and pressurizer level began
>decreasing, followed about a minute later by the R-45, steam jet air
>ejector process radiation monitor warning alarm. Operators started a
>second charging pump to maintain pressurizer level. Reactor coolant
>inventory loss exceeded the capacity of two charging pumps at 7:29 PM.
>Plant operators responded by manually tripping the reactor, entering
>Emergency Operating Procedures, and declaring an "Alert." The Shift
>Manager assumed responsibility as Emergency Director.

>Within the next four minutes, plant operators initiated "Site

>Accountability" by sounding the Site Emergency Assembly Alarm and
>mobilized the Emergency Response Organization (ERO) by notifying the
>Central Information Group (CIG, the corporate organization responsible
>for emergency pager activation) of the Alert. The Emergency Director
>(Shift Manager) appointed an "accountability officer" to establish
>personnel accountability. This individual had not been trained to
>carry out this responsibility; however, trained accountability
>officers were not consistently available outside of normal day-shift
>hours.

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>Seven minutes after the Central Control Room (CCR) directed Emergency
>Response Organization mobilization, the CIG called the Control Room
>for verification of the Alert declaration. ERO pagers actuated at
>8:00 PM, 27 minutes after the initial direction from the Central
>Control Room.

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>Initial notifications of the State of New York, local counties, and
>the New York Power Authority's (NYPA) Indian Point Unit 3 Shift
>Supervisor were completed between twelve and twenty minutes following
>Alert declaration.

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>Access to the Owner Controlled Area through the Con Edison traffic
>gate was controlled by about 8:00 PM, approximately thirty minutes
>into the event. The NYPA traffic gate that allows access to the same
>Owner Controlled Area was not controlled for an indeterminate period
>of time.

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>At 8:45 PM (76 minutes after the emergency declaration)
>"accountability" was incorrectly reported to the Control Room as
>complete. At 9:47 PM (138 minutes after emergency declaration) a
>second "accountability" determined four individuals to be missing.
>These individuals were accounted for at 10:17 PM.

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>The Technical Support Center (TSC) was declared "functional" 90
>minutes into the event (8:59 PM) and formally activated 83 minutes
>later (10:22 PM). The physical facility was not fully ready to
>support the Emergency Response Organization. Remodeling to correct
>deficiencies discovered in an earlier event (8/31/99) was incomplete.
>Furniture, reference materials, and computers were in neither the old
>nor the remodeled configuration. During the event, some of the TSC
>staff referred to procedures drafted for the remodeled configuration
>that were marked "For Training Use Only."

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>The Emergency Operations Facility (EOF) was activated at 9:15 PM, 106
>minutes following emergency declaration. Joint News Center (JNC)
>activation time is not documented in the Emergency Preparedness event
>records.

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>Emergency Response Facilities experienced a number of equipment
>deficiencies throughout the event, including insufficient telephones,
>failures of critical telephones, and repeated failures of the
>Emergency Response Data System (ERDS) and the Emergency Data Display
>System (EDDS).

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>Following plant stabilization in cold shutdown, the station terminated
>the emergency as of 6:50 PM on February 16th and deactivated the
>Emergency Response Facilities. There was no detectable increase in
>normal background levels of radioactivity as measured by off-site
>environmental sampling and monitoring equipment.

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>Causes:

>Although the Emergency Plan adequately protected the health and safety
>of the public in this event, the event revealed some aspects of
>Emergency Response Organization performance did not meet expectations,
>including:

>
>- Delayed completion of personnel accountability

- >- Delayed activation of Emergency Response Facilities
- >- Equipment and facilities that were not fully ready for use
- >- External communication weaknesses
- >- Emergency Response Organization procedure weaknesses
- >- Emergency Preparedness Training weaknesses

> In almost all cases, these conditions were identified during reviews of an August 31, 1999 event (INPO SER 3-99) and of a September 1999 Emergency Exercise, and in station self-assessments. Actions to correct these conditions had been identified, scheduled, and initiated prior to event, but had not been fully implemented.

> Analysis:

> DELAYED COMPLETION OF PERSONNEL ACCOUNTABILITY

> The Indian Point Unit 2 Emergency Plan requires personnel accountability to be established within 30 minutes following declaration of an emergency classified at or above the "Alert" level. "Accountability" is established within the Protected Area either when all individuals have been located or when those individuals who have not been located have been identified by name.

> The plant required 138 minutes to establish personnel accountability during this event. Contributing factors included:

- >- Some on-site personnel were not sure how to respond to the "accountability" alarm and were slow to take action;
- >- The accountability system was cumbersome and did not take advantage of the site access control ("keycard") system;
- >- Delayed recognition by Emergency Response Organization that the initial "accountability" had been inaccurately determined;
- >- Assignment of an untrained individual as the initial "accountability officer";
- >- Misunderstanding by some participants of the definition of "accountability";
- >- Insufficient exercises involving off-hours accountability.

> DELAYED ACTIVATION OF EMERGENCY RESPONSE FACILITIES

> With the exception of the Central Control Room (CCR), none of the Emergency

> Response Facilities activated within the required time interval following declaration of the "Alert." With the exception of the Joint News Center, the station Emergency Plan required facility activation within one hour of emergency classification at or above the "Alert" level.

> The Technical Support Center (TSC) was "functional" 90 minutes after Alert declaration and formally activated when fully staffed 173 minutes after Alert declaration. The Emergency Operations Facility (EOF) required 106 minutes to activate. Joint News Center (JNC) activation is not documented in the Emergency Preparedness event records..

> Contributing factors included:

- >- A 27 minute delay in Emergency Pager activation, due to (1) a decision to confirm "Alert" validity by phone prior to activating the pagers (~7 minutes); (2) uncertainty about which activation code to use; and (3) unfamiliarity of corporate personnel with nuclear Emergency Plan requirements;
- >- Prior to embarking in response to Alert notification, a number of Emergency Response Organization members confirmed the emergency by calling the Central Control Room;
- >- Security personnel direction to arriving Emergency Response Organization members concerning where to report was inconsistent and sometimes not in accordance with procedural requirements;
- >- Some key Emergency Pagers failed to properly activate (e.g., Nuclear Information Manager);

- >- Joint News Center staffing had significant, recent changes; training had not been completed;
- >- Off-hour Emergency Response Organization mobilization had not been exercised since 1993.

>EQUIPMENT AND FACILITIES WERE NOT FULLY READY FOR USE

- >The event revealed numerous facility and equipment weaknesses that unnecessarily challenged the Emergency Response Organization, including:

- >- Incomplete Technical Support Center remodeling to correct deficiencies from an earlier event (8/31/99), with furniture, procedures, reference materials, computers, fax machines, telephones, and supplies in neither the old nor the remodeled configuration;
- >- Non-functional Emergency Data Display System (EDDS) and Emergency Response Data System (ERDS) for the first five (5) hours of the event;
- >- Numerous telephone malfunctions;
- >- Inaccurate or missing telephone number lists;
- >- Off-site radiation monitoring equipment (Reuter-Stokes) that did not perform as anticipated (unexplained instrument "lock-up" and inability to transmit data from remote locations);
- >- Joint News Center HVAC problems that required opening of windows that allowed background noise and aircraft exhaust to impact facility operation.

>EXTERNAL COMMUNICATIONS WEAKNESSES

- >Coordination with external (non-utility) agencies was hampered by a number of communication weaknesses:

- >- The Emergency Response Organization did not include provision for a dedicated individual to continuously communicate with the NRC;
- >- The Joint News Center was unable to link to the Con Edison intranet, email service, or LAN;
- >- The Joint News Center provided a total of three press releases during the event;
- >- Technical Advisors were provided to state and local Emergency Operations Centers on an ad hoc basis to enhance communications. The responsibilities, communication interfaces, and procedural requirements for these individuals had not been established;
- >- Communications regarding event termination involved senior management outside the Emergency Operations Facility unanticipated in the Emergency Plan and Implementing Procedures.
- >- Event response was not critiqued immediately following emergency termination; when it was critiqued several hours or days later, county and state response personnel were not invited to participate in the critique. As a result, corrective actions for deficiencies identified by external agencies were not coordinated with corrective actions by the station.

>EMERGENCY RESPONSE ORGANIZATION PROCEDURE WEAKNESSES

- >- Procedures covering Joint News Center activation and operation had not been developed;
- >- Procedure revisions and Temporary Procedure Changes to Emergency Plan implementing and immediate action procedures were not distributed to all controlled copies in a timely manner;
- >- Neither sufficient procedural guidance nor training was not provided for some communications equipment.

>EMERGENCY PREPAREDNESS TRAINING WEAKNESSES

- >Post-event investigation identified a number of training weaknesses that contributed to this event:
- >- Not all personnel in Emergency Response Organization positions had completed required training;
- >- The Emergency Response Organization had insufficient number of

- >. trained personnel to support requirements of extended emergency support;
- >- TSC/OSC personnel used draft procedures (labeled "For Training Purposes Only") in conjunction with existing procedures during the event;
- >- A number of training modules and self-training modules had not been updated to reflect EP Implementing Procedure and Immediate Action Procedure changes;
- >- Formal training for Joint News Center personnel had not been identified or performed; a number of individuals assigned to the JNC were unfamiliar with facility equipment, lay-out, and activation requirements;
- >- Emergency Response Organization log-keeping practices were poor;
- >- Past EP drills and exercises did not adequately test the Emergency Response Organization in all aspects of their responsibilities:
- >- Monthly pager tests exercised the equipment only, did not test the adequacy and use of activation codes
- >- Off-hours ERO activation was last exercised in March 1993
- >- Off-hours "accountability" was insufficiently exercised.

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>Safety Significance

- >The Emergency Plan and the station response to this event adequately protected the health and safety of the public, but Emergency Response Organization performance did not meet all expectations.

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>Previous Event History

- >Similar Emergency Preparedness deficiencies were identified in reviews of an earlier event (August 31, 1999, described in SER 3-99 of December 29, 1999) and of a subsequent Emergency Exercise (September 1999).

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>Corrective Actions

- >The following list describes some of the corrective actions taken or planned by the station. This list is provided for information; it is not intended to be a comprehensive source of potential corrective actions:

>

- >1. Reassign responsibility for Emergency Response pager activation to Station Security.
- >2. Assign Emergency Response pagers to all ERO members.
- >3. Redefine the accountability process.
- >4. Revise Emergency Response Organization roster.
- >5. Complete critical TSC/OSC facility upgrades.
- >6. Evaluate and address Joint News Center facility, equipment, staffing, procedure, and training deficiencies.
- >7. Revise procedures to reflect the above changes.
- >8. Conduct ERO training covering the above changes.
- >9. Conduct exercise(s) to demonstrate ability to perform off-hours personnel accountability and off-hours ERO mobilization within required time-limits.

>

>References

- >1. OE 10729. February 29, 2000.
- >2. LER 247/2000-001-00. March 17, 2000.
- >3. SEN 213. April 12, 2000.

>

>Subject: OE10937 - Emergency Response Organization Weaknesses During an Alert

>Information Contact Michael Blatt, SEE-IN contact, (914) 734-5669
> Frank Inzirillo, Emergency

>Preparedness

>Manager, (914) 271-7418.

>

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From: Eric Bollin <ebollin@inpoan.org>
 Subject: OE11062 - Emergency Preparedness Weaknesses During an Alert
 Date: Monday, June 05, 2000 8:16 AM

Event Date: February 15, 2000
 Unit Name: Indian Point Unit 2 (Consolidated
 Edison Co. of New York)
 NSSS/A-E: Westinghouse/UE&C
 Docket No./LER No.: 50-247/00-01
 Year Commercial: 1974
 Rating: 1,008 MWe Gross Nameplate

EIIS System Code(s):
 N/A

NSSS Applicability:
 All

Maintenance Rule Applicability:
 No

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 Randy
 Wayne
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THIS IS the "consolidated Edison memo" referred to in the 6/21 Journal News Article.
Tom Anderson - Journal News

Abstract:

An Alert was declared at Indian Point No. 2 on February 15, 2000 at 7:29 PM due to a steam generator tube failure. Initial plant response was as expected and appropriate. The Emergency Response Organization was activated as required by the station Emergency Plan. Following stabilization of the plant in cold shutdown, approximately 23 hours after the reactor trip, the station terminated the emergency at 6:50 PM on February 16th and deactivated the Emergency Response Facilities.

The Emergency Plan protected the health and safety of the public in this event, but there were several Emergency Response Organization deficiencies. Emergency preparedness training weaknesses included drill artificialities that preconditioned responses of surrounding counties and cities to anticipate and expect deteriorating conditions. Event scenarios utilized during practice drills did not address actions during lengthy periods needed to bring the plant to cold shutdown. In addition, delays occurred completing personnel accountability and activating emergency response facilities. Other deficiencies included equipment and facilities, external communications and procedures.

Many of these conditions were previously identified. Actions to correct these conditions had been scheduled and initiated prior to the February 15, 2000 event, but had not been fully implemented.

Description:

On the evening of February 15, 2000, Indian Point Unit 2 was operating at 99% power with an electrical load of 1,003 MWe. At 7:15 PM, primary to secondary leakage measured by the N-16 monitor was approximately 3.4 gallons per day. Industry experience indicates the source of leakage below 10gpd from any one steam generator is not

detectable.

At 7:17 PM the N-16 monitor alarmed and pressurizer level began decreasing, followed about a minute later by the R-45, steam jet air ejector process radiation monitor warning alarm. A second charging pump was started to maintain pressurizer level. Reactor coolant inventory loss exceeded the capacity of two charging pumps at 7:29 PM. The reactor was manually tripped, Emergency Operating Procedures were entered, and an "Alert" was declared. The Shift Manager assumed responsibility as Emergency Director.

Within the next four minutes, "Site Accountability" was initiated by sounding the Emergency Assembly Alarm and the Emergency Response Organization (ERO) was mobilized by notifying the Central Information Group (CIG, the corporate organization responsible for emergency pager activation) of the Alert. The Emergency Director (Shift Manager) appointed an "accountability officer" to establish personnel accountability. This individual had not been trained to carry out this responsibility.

Seven minutes after the Central Control Room (CCR) directed Emergency Response Organization mobilization the CIG called the control room for verification of the Alert declaration. ERO pagers actuated at 8:00 PM, 27 minutes after the initial direction from the Central Control Room.

Initial notifications of the State of New York, local counties, and the New York Power Authority's (NYPA) Indian Point Unit 3 Shift Supervisor were completed between twelve and twenty minutes following Alert declaration.

Access to the Owner Controlled Area through the Con Edison traffic gate was controlled by 8:00 PM, approximately thirty minutes into the event. The NYPA traffic gate that allows access to the same Owner Controlled Area was not controlled until 4:00 AM, February 16, 2000.

At 8:45 PM (76 minutes after the emergency declaration) "accountability" was reported to the Control Room as complete. At 9:47 PM (138 minutes after emergency declaration) an "accountability" review determined four individuals to be missing. They were accounted for at 10:17 PM.

The Technical Support Center (TSC) was declared "functional" 90 minutes into the event (8:59 PM) and formally activated 83 minutes later (10:22 PM). The physical facility was not fully ready to support the Emergency Response Organization. Remodeling to correct deficiencies discovered in an earlier event (8/31/99) was 70-80 percent complete. Other furniture, reference materials, and computers were in neither the old nor the remodeled configuration.

The Emergency Operations Facility (EOF) was activated at 9:15 PM, 106 minutes following emergency declaration. Joint News Center (JNC) activation time is not documented in the Emergency Preparedness event records.

Emergency Response Facilities experienced a number of equipment deficiencies that included the telephone system, the Emergency Response Data System (ERDS) and an inability to activate it within one hour of the event declaration. Difficulties were experienced in

transmitting data from the control room to the Technical Support Center, Emergency Operations Facility and offsite.

Following plant stabilization in cold shutdown, the station terminated the emergency as of 6:50 PM on February 15th and deactivated the Emergency Response Facilities. There was no detectable increase in normal background levels of radioactivity as measured by off-site environmental sampling and monitoring equipment.

Causes:

Although the Emergency Plan protected the health and safety of the public in this event, the event revealed Emergency Response Organization weaknesses including:

- Emergency Preparedness Training weaknesses
- Delayed completion of personnel accountability
- Delayed activation of Emergency Response Facilities
- Equipment and facilities deficiencies
- External communication weaknesses
- Emergency Response Organization procedure weaknesses.

Actions to correct many of these conditions were scheduled and initiated prior to the event, but not fully implemented.

Analysis:

Emergency Preparedness Training Weaknesses

Post-event investigation identified a number of training weaknesses that contributed to this event. Past Emergency Plan drills and exercises did not adequately test the Emergency Response Organization and prepare it for the realities of an event.

- Drill artificialities preconditioned members of emergency response organizations of the surrounding counties and cities to anticipate rapidly deteriorating conditions that did not occur.
- Initial responses to the tube failure were appropriate. However, actions over many additional hours needed to stabilize the plant and place it in cold shutdown with a faulted steam generator were hesitant and difficult. Training in steam generator tube failure scenarios does not address the lengthy plant stabilization period.
- Monthly pager tests exercised the equipment only, but did not test the adequacy and use of activation codes.
- Off-hours ERO activation was last exercised in March 1993.
- Off-hours "accountability" was insufficiently exercised.
- Not all personnel in Emergency Response Organization positions had completed required training. The Emergency Response Organization had insufficient number of trained personnel to support requirements of extended emergency support.
- Formal training for Joint News Center personnel had not been identified or performed; a number of individuals assigned to the JNC were unfamiliar with facility equipment, lay-out, and activation requirements.
- Emergency Response Organization log-keeping practices were poor.

Delayed Completion of Personnel Accountability

The Indian Point Unit 2 Emergency Plan requires personnel accountability to be established within 30 minutes following

declaration of an emergency classified at or above the "Alert" level. "Accountability" is established within the Protected Area either when all individuals have been located or when those individuals who have not been located have been identified by name.

The plant required 138 minutes to establish personnel accountability during this event. Contributing factors included:

- Some on-site personnel were not sure how to respond to the "accountability" alarm and were slow to take action.
- The accountability system was cumbersome and did not take advantage of the site access control ("keycard") system.
- Delayed recognition by Emergency Response Organization that the initial "accountability" had been inaccurately determined;
- Assignment of an untrained individual as the initial "accountability officer";
- Misunderstanding by some participants of the definition of "accountability";
- Insufficient exercises involving off-hours accountability.

Delayed Activation of Emergency Response Facilities

With the exception of the Central Control Room (CCR), none of the Emergency Response Facilities activated within the required time interval following declaration of the "Alert." With the exception of the Joint News Center, the station Emergency Plan required facility activation within one hour of emergency classification at or above the "Alert" level.

The Technical Support Center (TSC) was "functional" 90 minutes after Alert declaration and formally activated when fully staffed 173 minutes after Alert declaration. The Emergency Operations Facility (EOF) required 106 minutes to activate. Joint News Center (JNC) activation was not documented in the Emergency Preparedness event records.

Contributing factors included:

- A 27 minute delay in Emergency Pager activation due to (1) a decision to confirm "Alert" validity by phone prior to activating the pagers (~7 minutes), (2) uncertainty about which activation code to use and (3) unfamiliarity with Emergency Plan requirements.
- Prior to embarking in response to Alert notification, a number of Emergency Response Organization members confirmed the emergency by calling the Central Control Room.
- Security personnel direction to arriving Emergency Response Organization members concerning where to report was inconsistent and sometimes not in accordance with procedural requirements.
- Some key emergency pagers failed to properly activate (e.g., Nuclear Information Manager).
- Joint News Center staffing had recent changes; training had not been completed.
- Off-hour Emergency Response Organization mobilization had not been exercised since 1993.

Equipment and Facilities Deficiencies

The event revealed numerous facility and equipment weaknesses that unnecessarily challenged the Emergency Response Organization,

including:

- Incomplete Technical Support Center remodeling to correct deficiencies with furniture, procedures, reference materials, computers, fax machines, telephones, and supplies in neither the old nor the remodeled configuration and compensatory actions not in place.
- Non-functional Emergency Data Display System (EDDS) and Emergency Response Data System (ERDS) for the first five (5) hours of the event.
- Numerous telephone malfunctions.
- Inaccurate or missing telephone number lists.
- Off-site radiation monitoring equipment (Reuter-Stokes) that did not perform as anticipated (unexplained instrument "lock-up" and inability to transmit data from remote locations).
- Joint News Center HVAC problems that required opening of windows allowing background noise and aircraft exhaust to impact facility operation.

External Communications Weaknesses

Coordination with external (non-utility) agencies was hampered by a number of communication weaknesses:

- The Emergency Response Organization did not include provision for a dedicated individual to continuously communicate with the NRC.
- The Joint News Center was unable to link to the Con Edison intranet, e-mail service, or LAN.
- Technical Advisors were provided to state and local Emergency Operations Centers on an ad hoc basis to enhance communications. The responsibilities, communication interfaces, and procedural requirements for these individuals had not been established.
- Communications regarding event termination involved senior management outside the Emergency Operations Facility unanticipated in the Emergency Plan and Implementing Procedures.
- Event response was not critiqued immediately following emergency termination; when it was critiqued several hours or days later, county and state response personnel were not invited to participate in the critique.

As a result, corrective actions for deficiencies identified by external agencies were not coordinated with corrective actions by the station.

Emergency Response Organization Procedure Weaknesses

- Procedures covering Joint News Center activation and operation had not been developed.
- Procedure revisions and Temporary Procedure Changes to Emergency Plan implementing and immediate action procedures were not distributed to all controlled copies in a timely manner.
- Neither sufficient procedural guidance nor training was provided for some communications equipment.

Safety Significance:

The Emergency Plan and the station response to this event protected the health and safety of the public.

Previous Event History:

Similar Emergency Preparedness deficiencies were identified in reviews of an earlier event (August 31, 1999, described in SER 3-99 of December 29, 1999) and of a subsequent Emergency Exercise (September 1999).

Corrective Actions:

The following list describes some of the corrective actions taken or planned by the station. This list is provided for information; it is not intended to be a comprehensive source of potential corrective actions:

1. Reassign responsibility for Emergency Response pager activation to Station Security.
2. Assign Emergency Response pagers to all members of the Emergency Response Organization, including the Joint News Center.
3. Redefine the accountability process.
4. Revise Emergency Response Organization roster.
5. Complete critical TSC/OSC facility upgrades.
6. Evaluate and address Joint News Center facility, equipment, staffing, procedure, and training deficiencies.
7. Revise procedures to reflect the above changes.
8. Conduct ERO training covering the above changes.
9. Conduct exercise(s) to demonstrate ability to perform off-hours personnel accountability and off-hours ERO mobilization within required time limits.
10. Modify/enhance simulator training scenarios to include cooldown/depressurization with faulted steam generator.
11. Explore mechanism to modify emergency preparedness drill scenarios to test more likely situations and de-emphasize the unrealistic escalation of drill situations.

References:

1. OE 10729. February 29, 2000.
2. LER 247/2000-001-00. March 17, 2000.
3. SEN 213. April 12, 2000.

Subject: OE11062 - Emergency Preparedness Weaknesses During an Alert

Information Contact: Michael Blatt, SEE-IN (914) 734-5669

Frank Inzirillo, Emergency Preparedness Manager, (914) 271-7418.