

U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report Nos. 50-206/93-07, 50-361/93-07, and 50-362/93-07
License Nos. DPR-13, NPF-10, and NPF-15
Licensee: Southern California Edison Company (SCE)
Irvine Operations Center
23 Parker Street
Irvine, California 92718
Facility Name: San Onofre Nuclear Generating Station (SONGS), Units 1, 2,
and 3
Inspection at: San Onofre Site, San Diego County, California
Inspection Conducted: April 19 - 28, 1993
Inspector: Arthur D. McQueen 5/6/93
A. D. McQueen, Emergency Preparedness Analyst Date Signed
Approved by: Robert J. Pate 5/11/93
Robert J. Pate, Chief Date Signed
Safeguards, Emergency Preparedness, and
Non-Power Reactor Branch

SUMMARY:

Areas Inspected: Routine inspection to address the Operational Status of the Emergency Preparedness Program and Onsite Follow-up of Events at Operating Power Reactors. Inspection procedures 82701, 92701, and 93702 were used as guidance.

Results: The results of this inspection indicated that the licensee was maintaining its emergency preparedness program. Emergency preparedness staffing remains substantively unchanged, and staff members continued to display a conscientious attitude toward the accomplishment of their assigned duties. One non-cited violation of a license condition was identified as discussed in Section 2.b.

DETAILS

1. Persons Contacted

Licensee Personnel

- *C. Anderson, Supervisor, Emergency Planning (EP)
- *D. Axline, Engineer, Onsite Nuclear Licensing (ONL)
- *K. Bellis, Manager, Nuclear Affairs and Emergency Planning (NA&EP)
 - M. Brooks, Health Physics (HP) Engineer, SONGS
 - B. Culverhouse, Emergency Planning Specialist
- *J. Dale, EP Training
- *M. Farr, Engineering Aide, ONL
- *J. Fee, Health Physics
 - T. Ford, System Engineer
 - K. Fowler, Engineering Aide
 - R. Garcia, Emergency Planning Engineer
 - G. Hammond, Supervisor, ONL
 - P. Haralson, System Engineer
 - C. Hayes, Design Engineer
- *A. Llorens, ONL
 - J. Wallace, NA&EP
- *H. Wood, Quality Assurance (QA) Engineer
- *M. Zenker, Lead Engineer, Emergency Planning
- *W. Zintl, Manager, Site Emergency Preparedness (SEP)

NRC Personnel

- *A. McQueen, Emergency Preparedness Analyst, NRC
- *J. Russell, Resident Inspector, NRC

The above individuals denoted with an asterisk were present during the April 23, 1993, exit interview. The inspector also contacted other members of the licensee's emergency preparedness, administrative, and technical staff during the course of the inspection.

2. Functional or Program Areas Inspected

The licensee appeared to be maintaining their previous level of performance in the following areas and their program seemed adequate to accomplish their objectives.

b. Operational Status of the Emergency Preparedness Program (MC 82701)

(1) Emergency Plan and Implementing Procedures

- (a) Two emergency plan changes had been submitted by the licensee since the last routine EP inspection at the site. Revision 5.2 has been reviewed and found acceptable. A revision to Appendix J to the plan is currently awaiting review.

- (b) Thirty Temporary Change Notices (TCN) and numbered revisions to emergency plan implementing procedures (EPIP) had been made since the last routine EP inspection. Changes and revisions, as identified by the licensee, were reviewed during this inspection with no indicated degradations to site emergency preparedness. Review of these changes was conducted in the Region V office following completion of the onsite inspection activity.
- (c) By letter dated April 12, 1993, the licensee transmitted planned changes to the San Onofre Nuclear Generating Station (SONGS) Emergency Plan. The licensee indicated the changes are associated with the permanent shutdown and defueling of Unit 1. A copy of the letter and attachments were provided to the inspector for discussion with site EP staff members during this inspection. The licensee indicated that the plan changes include deletions of SONGS 1 instrumentation no longer needed for emergency response and changes to SONGS 1 operator positions and titles. The licensee submitted a licensing Amendment Application 210 to the NRC on January 15, 1993, for approval of the changes to operator positions and titles. They anticipate receiving the approval of the amendment by about mid-May 1993. They also briefed the inspector on the deletions of instrumentation. The instrumentation was part of a planning study and 10 CFR 50.59 evaluation by the licensee. A copy of the planning document, including the instrument study, was submitted to NRC Headquarters. The licensee also made a copy of the study available for Region V review, but cautioned that it is a planning document only and has not been submitted as final. The licensee indicated the April 12 submission was for NRC information; but the licensee is not requesting a formal licensing review or response. Once finalized, the emergency plan change will be submitted for formal review and acceptability by the NRC.

(2) Emergency Facilities, Equipment, Instrumentation, and Supplies

- (a) An inspection tour was made of each of the emergency response facilities (ERFs), which included spot checking of items of equipment, instrumentation, and supplies. ERFs appeared well maintained and ready for emergency use. Spot checks were made at random of radiation monitoring and respiratory equipment at each ERF, and all selected items were verified as being in calibration or had been appropriately inspected on a scheduled basis.

- (b) By letter, Subject: Docket No. 50-362 Emergency Operations Facility (EOF) Ventilation System, dated September 11, 1992, the licensee notified the NRC that

Pursuant to the San Onofre Nuclear Generating Station, Unit 3 Facility Operating License NPF-15, License Condition 2.G, this letter constitutes the 14 day follow-up written report of an apparent violation of Unit 3 Full Power License Condition 2.C(24). Specifically we have determined that exhaust isolation dampers in the Emergency Operations Facility (EOF) ventilation system were not installed as required. This condition was reported to Region V by phone on August 28, 1992, by... (the) Assistant Manager, Nuclear Regulatory Affairs. Due to an administrative oversight during the preparation of this report, the 24 hour written follow-up to the telephone notification was not submitted.

The letter further indicated corrective actions being initiated, as follows

SCE will install isolation dampers on the exhaust side of the EOF HVAC system and make any other appropriate changes. These physical modifications will be completed by December 15, 1992. SCE maintains an alternate EOF which will be utilized in the event the primary EOF is rendered uninhabitable. Emergency Plan Implementing Procedures (EPIP) contain guidance for relocating to the alternate EOF. Training on this process was provided to EOF emergency response personnel.

Although we believe that this was an isolated installation error, we are conducting a special review of our commitments regarding the EOF. After we have compiled our EOF commitment listing, we will reverify completion of the commitments. If any additional discrepancies are discovered, we will provide supplemental reports as appropriate.

A review of licensee actions during this inspection indicated that corrective actions had been completed. Inspection of the exhaust ducts verified that an electro-mechanical damper mechanism had been installed on each of the four exhaust ducts. Procedures for activation of the system were added to Emergency Plan Implementing Procedure (EPIP) S0123-VIII-30.1, Attachment 1, by Temporary Change Notice (TCN) 9.3.

The inspector reviewed the licensee Root Cause Evaluation Report 92-037 and the Emergency Operations Facility (EOF) Commitment Review. These documents appeared to appropriately address original causes of the violation and insured that all other commitments pertaining to the EOF had been completed, in order to assure no recurrence of this type event.

The licensee-identified violation is not being cited because the criteria specified in Section V.G of the Enforcement Policy were satisfied. (Non-Cited Violation, 93-07-01)

(3) Organization and Management Control

A discussion with the Manager, Site Emergency Preparedness, indicated that no substantive reorganizations or organizational changes have occurred since the last Systematic Analysis of Licensee Performance (SALP). Nor have there been changes to management control systems. Organization appears consistent with that described in the emergency plan.

(4) Independent and Internal Reviews and Audits

(a) Annual Emergency Preparedness Audit

The 1993 Annual Emergency Preparedness Audit, Audit Report number SCES-556-92, dated December 1992, was reviewed during the inspection. The "Synopsis of Audit Results" indicated:

The SONGS Emergency Preparedness program was found to be adequately implemented with the exception of (one) minor Field Corrected Error... The requirements of 10 CFR 50.54(t) - i.e., interfaces with State and local governments as well as drills, exercises, capabilities and procedures - were found adequately described and implemented in the SONGS Emergency Preparedness program. Recommendations for improvement are documented and have been

reported to appropriate levels of management.

The "minor administrative item" identified during the audit for correction involved a needed change to an Emergency Plan Implementing Procedure (EPIP). It was concluded that a reference to a Technical Specification (TS) was no longer correct due to changes in the TS. Corrective action was to change the reference with Revision 11 to both S01-VIII-1 and S023-VIII-1. Changes to these EIPs, since they involve Emergency Action Levels (EALs) are required to be submitted to NRC for approval; therefore, the corrective action will be reviewed by NRC Region V upon submission by the licensee.

(b) Quality Assurance (QA) Surveillance Reports

Six QA Surveillance Reports for 1992 and 1993 were reviewed.

SOS-214-92, EOF Emergency Ventilation System. Eight deficiencies were found in reviewing Maintenance Orders (MOs) and five deficiencies were identified in the Emergency Plan Equipment Surveillance Program Manual. Corrective Action Request (CAR) P-1406 was issued for correction of items identified in this surveillance.

SOS-247-92, Community Alert Notification Systems. Deficiencies noted during the surveillance were discussed with responsible individuals and documented on CAR P-1411. This surveillance item had also been identified by NRC as a non-cited violation (NCV), Inspection Followup Item (IFI) 92-25-01, which is discussed in Section 5 below.

SOS-346-92, Off-Site Community Alert Siren System. The surveillance identified four areas of programmatic deficiencies and indicated root causes as:

- lack of approved program and procedures to address trouble shooting methods and or guidelines for QA Program affecting Non-Safety Related Community Alert Sirens; and
- lack of an approved program and procedures to address the calibration, tracking and use of test equipment for testing and trouble-shooting QA Program affecting Non-Safety Related Community Alert Sirens.

See also the discussion of CAR-002-93 and P-1411 below.

SOS-086-93, Emergency Plan Drill Site Evacuation. Surveillance of this drill evacuation indicated that in three items observed, deficiencies in the participation of evacuees are being addressed and tracked by Site Emergency Preparedness with Generic tracking System Number (GENTS) 93-00015. All other items were indicated as having been performed satisfactorily in accordance with pertinent documented objectives and requirements.

SOS-093-93, 1st Quarter Drill Emergency News Center. This surveillance verified the Emergency News Center was adequately activated during the first quarter EP Drill.

SOS-107-93, Emergency Drill Operational Support Center (OSC). This Performance Based Observation (PBO) during the first quarter EP Drill verified that the emergency response teams were dispatched from the OSC and the OSC was activated, staffed, managed and controlled in accordance with applicable EIPs.

(c) Corrective Action Requests (CAR)

Three CARs were reviewed, which result from or refer to QA surveillances discussed above.

CAR P-1406, Site Emergency Preparedness Program - EOF. Six deficiencies pertaining to testing and maintenance of EOF related equipment were identified and responded to by Site Emergency Preparedness. CAR P-1406 indicated which actions have been taken and actions still in progress.

CAR P-1411, Site Emergency Preparedness Program - Offsite Sirens. This CAR indicated that it specifically identified "an inadequate program for offsite Siren operability as required by the Emergency Plan." A QA affecting procedure is being developed to adequately define and establish organizational responsibility and interface requirements for the Community Alert Siren System. In that this CAR and CAR-002-93 below address what was concluded to be an inadequate program required by the Emergency Plan, completed actions will be reviewed in a future EP inspection (93-07-02).

CAR-002-93, Off-site Community Alert Siren System. Reference is made in the CAR to QA Surveillance Report SOS-346-92, and indicates that the site Nuclear

Regulatory Affairs (NRA) had verified that the QA requirements of TQAM (Topical Quality Assurance Manual) Chapter 8-b do apply to Off-site Community Alert Siren System testing and maintenance. This CAR was prepared and approved on April 5, 1993, and response is pending.

4. Onsite Follow-up of Events at Operating Power Reactors (Inspection Procedure 93702)

Five licensee events pertaining to emergency alert sirens, which had occurred since the last routine inspection and had been reported to the NRC Headquarters Operations Officer (HOO), were reviewed during this inspection. None were identified or classified as emergency events.

- a. On October 16, 1992, the HOO documented a telephonic report from the licensee as follows:

The licensee is required to report when greater than five emergency notification sirens are inoperable for greater than one hour. At approximately 0903 PDT, six sirens were declared inoperable due to loss of power. Power was restored to five of the six sirens at 1040 PDT. Work is in progress on restoring power to the last siren. (HOO Event Number 24441)

- b. On October 26, 1992, the NRC HOO documented a telephonic report from the licensee as follows:

The licensee reported five emergency sirens inoperable. The licensee received four area annunciator alarms for emergency sirens on an annunciator panel near the Technical Support Facility at 0800 PST. The licensee contacted the local phone company to investigate the reason for the alarms. The phone company reported that construction was being conducted in the area of emergency siren telephone cables and that the cables had been accidentally cut. A fifth emergency siren had already been declared inoperable by the licensee..... The telephone company has repaired the cables. The licensee declared the four sirens operable at 1225 PST. (HOO Event Number 24501)

- c. On November 23, 1992, the NRC HOO documented a telephonic report from the licensee as follows:

Five emergency offsite sirens were discovered to be inoperable. The five emergency offsite sirens are in the San Juan area, north of the site. The licensee is investigating the cause of the problem. The problem with the sirens was identified by a trouble light

indication for each individual siren. The first trouble light indication was noticed at 1349 PST following trouble light indications were noticed at 1533, 1547, 1558 and 1603.

An update to the HOO from the licensee at 2011 PST indicated that

The licensee is retracting this report. In accordance with NUREG 1022 Rev 1 the licensee will notify the NRC if more than 5 sirens are inoperable for greater than one hour. One of the five sirens was verified operable at 1629, which was prior to the one hour time limit expiring. (HOO Event Number 24646)

- d. On January 15, 1993, the NRC HOO documented a telephonic report from the licensee as follows:

Licensee was notified by the San Clemente Police Department of an emergency siren that inadvertently actuated for 5 - 10 seconds. The siren is located in San Juan Capistrano. No emergency exists at the plant. Personnel have been dispatch to investigate the actuation.... The licensee is making this notification as an information only call. (HOO Event Number 24887)

- e. On January 19, 1993, the NRC HOO documented a telephonic report from the licensee as follows:

Offsite emergency sirens inoperable due to adverse weather. This notification is for San Onofre units 1, 2 and 3 and is being made pursuant to 10 CFR 50.72(b)(1)(v) for a loss of offsite response capability. This is a non-emergency one hour report.

At 19:30 hours, PDT, on January 17, 1993, the SONGS Telecommunications Department determined that 10 community alert sirens located on Camp Pendleton were inoperable. SCE has defined a significant portion of the offsite notification system to be either 16 community alert sirens inoperable for greater than one hour, or five (5) community alert sirens inoperable for greater than 48 hours. The sirens are not expected to be placed back in service prior to expiration of the 48 hour limit at 19:30 this evening. Thus, this report is an early one-hour telephone notification.

The cause has been attributed to adverse weather conditions (rain). Repairs are expected to be completed within one week and is dependent on Camp Pendleton (USMC) telephone system storm damage repair

capabilities. Camp Pendleton retains emergency response capability through the use of their chain of command system.... A courtesy notification was made to FEMA...at 14:55 hours today.

In each of the above events, the NRC Resident Inspector was notified at the time of the incident. The events were apparently independent of each other and did not appear to indicate generic type problems with the emergency siren system. A review of the events indicated reporting and actions by the licensee appeared in accordance with regulatory requirements.

5. Action on Previous Inspection Findings

(Closed) Follow-up Item (91-27-01) Health Physics Exercise Weaknesses

During the 1991 annual emergency exercise, an inspector observing activities in the Operations Support Center (OSC) documented weaknesses in health physics response activities during the exercise. Specifically, seven observations for improvement were documented and indicated in the inspection report for follow-up. Review of this item during the 1992 annual exercise indicated this item could be closed.

(Closed) Follow-Up Item (92-24-03) Emergency Operations Facility (EOF) Notifications Deficiencies

During the 1992 annual emergency exercise, the NRC inspector at the EOF observed a discussion between a local agency liaison representative and the EOF Communicators which identified a problem with the way information was presented in backup communication methods. Wind direction was provided in compass bearings and speed in meters per second and not the sector format and miles per hour used in primary communication methods. This caused confusion at the local Emergency Operations Centers (EOCs) and the licensee was requested to report future information in the format offsite officials were familiar with. The licensee exercise players agreed to make these changes. No further communications were observed using the backup communication method so the inspector was unable to determine if these changes were made.

Event Notification Forms (ENFs) # 3 and 4 indicated there was not a need for protective action beyond the site boundary while at the same time recommending evacuation of the State Beach. This communication inconsistency could lead to confusion and should be resolved by the licensee.

The inconsistency noted with the communication of PARs on ENFs and problems concerning the reporting of meteorological information to offsite agencies with backup communication methods were identified as an Inspection Followup Item (IFI). The licensee indicated during this inspection that their review following the exercise found that both instances involved human failures. In one case, it was failure to not properly follow procedures and to properly complete the form. The other

was a case of incorrectly entering data on a form and failure to check appropriate check boxes on the form. The licensee implemented and is still conducting a training program to emphasize following procedures and proper execution of documentation in quarterly training drills.

(Closed) Follow-up Item (92-25-01) Delayed One-Hour Report (Emergency Notification Sirens)

At 10:52 p.m. (PDT) on July 30, 1992, the licensee's Telecommunications Control Center (TCC) received a loss of power alarm for three community alert sirens. Power was restored to the sirens by 2:20 a.m. (PDT) on July 31, 1992. Two other sirens were out of service at the time due to unrelated repair activities. The total of five inoperable sirens for a period of three hours and eighteen minutes met the licensee's reporting criteria of five inoperable sirens for greater than one hour. The condition was not reported to operations personnel until after the power had been restored to the three de-energized sirens. At that time, the licensee determined that the event was reportable. (HOO Event Number 23980)

Section 6.2 (Events Requiring Immediate One-Hour Telephone Notification) of licensee Operations Division Procedure SO123-0-14 (Notification and Reporting of Significant Events) requires that the NRC be notified of "Any event that results in a MAJOR LOSS OF: Offsite response capability (e.g., EMERGENCY NOTIFICATION SYSTEM): ...Five or more community alert sirens inoperable; i.e., loss of power or loss of remote activation capability, for greater than one hour (Ref. NUREG-1022, Supplement No. 1)"

Licensee notification of this five inoperable siren event was made to the NRC at 2:16 p.m. on July 31. It was indicated that it was a delayed one-hour notification.

During the exit interview, the SEP manager indicated actions already taken to preclude recurrence of this type event. The licensee promulgated requirements for reporting of inoperable sirens to the TCC and from the TCC to the Unit 1 Shift Superintendent, or if not reachable, to the Unit 1 Control Room Supervisor or the Unit 1 superintendent backup (San Onofre Siren Procedures, Procedure #5000). The licensee further indicated "The TCC has begun a new Siren Log sheet that will effectively capture status of siren problems. Communication between the TCC and the Shift Superintendent have been clearly defined as a change in siren status notification. ...we will be going to the TCC on August 31 to ensure the above corrective actions are being implemented as intended." It was also indicated that the Nuclear Oversight Division (Site Quality Assurance (QA)) is conducting a QA surveillance of this event and will initiate appropriate Corrective Action Requests (CAR) upon completion of the surveillance to insure additional appropriate corrective action to preclude recurrence. The licensee-identified violation was not cited because the criteria specified in Section V.G of the Enforcement Policy were satisfied.

Licensee corrective actions, root cause analysis, verification of EOF commitments fulfillment, and the QA surveillance were reviewed in this inspection. It was verified that actions committed to by the licensee have been accomplished, therefore this item is closed. Also, as indicated in section 2.b(4) above, actions to improve the siren testing and maintenance program are still being pursued.

(Open) Follow-up Item (92-24-02) Health Physics Shortcomings in the 1992 Annual Emergency Exercise

During the 1992 annual emergency exercise, a repair team dispatched by the OSC was accompanied by the NRC inspector at that facility due to its involvement in activities requiring entry into ultra high radiation fields (1,000 R per hour or more) and performing tasks to mitigate plant damage or radioactive releases to the environment. This team (No. 19) had to access the Auxiliary Feed Water Pump Building (AFW Building) which had an unshieldable radiography source exposed that created dose rates of 1,000 R/hr at 6 inches from the source. Planning for tasks within the building assumed workers would not get within 2 feet of the source (64.5 R/hr). The task to be accomplished within the AFW Building was to establish the valve line for returning the steam turbine powered AFW pump (P140) to service. Approximately 4 valves near the radiography source had to be positioned. The radiography source was located directly on top of the discharge piping of the pump. Approximately 2 hours were spent in planning for the AFW Building entry. The inspector noted that senior HP engineers and operational HP supervisors were involved in the planning, and even though they were planning for success the extremely conservative radiation exposure controls and limits placed on the repair team would have only led to failure. The inspector noted the following shortcomings in the licensee's planning and execution of this repair task:

- Limiting operators and HPTs to 2.5 and 0.5 rem whole body exposures, respectively. These controls limited one of the three operators to less than two minutes of work and prevented the HPTs from entering the AFW Building with the operators to monitor their performance.
- Establishing stay times for the operators (one at a time entering the AFW Building to position selected valves) when they were outfitted with state of the art alarming/digital readout dosimeters.
- Not taking advantage of Unit 3's AFW Building as a mockup for operator familiarization with valve locations and determining worker body positions for dosimeter placement.
- Not anticipating need for valve manipulating tools or keys to unlock valve hand wheels.
- HPTs remained outside of the AFW building even though radiation

exposure rates just inside the entrance were less than 0.5 R/hr.

- Unknown to the HPTs, two of the three operators became detached from the team on the way to the AFW Building. The operators separated from the team for several minutes to obtain work gloves. No determination of the dose rates to be encountered by the operators on their quest to find gloves was made prior to their leaving the team.
- The use of multiple whole body and extremity dosimeters were rejected during task planning.
- Of the two operators used at the AFW Building, one (a senior operator) could not find one of the valves and bent directly over the radiography source twice looking for it. Getting within 6 inches of the source would have surely depleted the operator's remaining dose, causing the dosimeter to alarm. This would have required the backup operator (less experienced) to enter the building and find the valve and position it.

Due to the failure to ensure workers knew exactly where the valves were located, using extremely conservative dose limits, and not using multiple dosimeters; the licensee would have, more than likely, failed to accomplish the mission in one try and one operator would have received a significant amount of unmonitored exposure and would have also exceeded the licensee's administrative dose limits (not the 25 REM allowed under emergency conditions).

The inspector further noted that EIPs S0123-VIII-10, "Emergency Coordinator Duties," S0123-VIII-10.1, "Station Emergency Director Duties," S0123-VIII-40.1, "OSC Health Physics Coordinator Duties," S0123-VIII-80, "Emergency Group Leader Duties," and other EIPs, limit the Rapid Deployment Teams from the OSC to 0.3 R per person for performing the following:

- Plant-saving actions,
- Lifesaving actions,
- Protection of the public health and safety, and
- Restoration of critical plant functions.

The 0.3 R per person limit appeared extremely restrictive considering the nationally recognized limits of 25 R or higher per person for plant and life saving activities respectively. The inspector further noted that the licensee frequently evaluated personnel exposure extensions to the potential for exceeding 10 CFR Part 20 exposure limits, when the NRC has previously established (NUREG-0654 FEMA-REP-1, Revision 1) that emergency worker exposure limits should follow the guidance provided by the Environmental Protection Agency's (EPA) Emergency Worker and

Lifesaving Activity Protective Actions Guides (EPA Documents 520/1-75/001 or more current, with the new Revision to 10 CFR Part 20, EPA 520/1-75-001-A).

Furthermore, the inspector noted the following at the licensee's OSC Controllers critique after the drill:

- The controllers failed to note that the two operators left the AFW pump team during their travel to the AFW Building.
- The controller failed to note that one operator could not find one of the valves, wandered around looking for it, and bending over the radiography source twice.
- The controllers failed to note that the operators body position during the valve line up and location of his dosimeters did not ensure monitoring of the significant exposure being received by his right hip/thigh area from the radiography source. However, a possible overexposure (the 2.5 rem assigned limit) was alluded to at the Corporate debriefing on the drill.

The inspector concluded that the above noted observations concerning extremely conservative radiological exposure controls could have prevented the licensee from implementing timely and effective plant saving and release mitigating actions. The above noted concerns were identified as elements of an Inspection Followup Item. A review of licensee activities in response to the above findings during this inspection indicated several actions were taken to improve health physics response activities.

- Each quarterly drill includes responses to high radiation areas.
- Each drill is being preceded with high radiation protection training.
- Health Physics (HP) is being brought into exercise/drill scenario development early in the planning process.
- All operational HP technicians and supervisors have been given four hours of high radiation protective measures training plus follow-up training prior to each emergency exercise.
- HP guidance has been developed for each type of postulated accident at the site.
- HP mini-drills are conducted monthly to review and practice radiation protection.

This item will be reviewed for closure during the 1993 annual emergency exercise.

6. Exit Interview

On April 23, 1993, at the conclusion of the site visit, the inspector met with the licensee representatives identified in paragraph 1 above to summarize the scope and the preliminary results of this inspection. The licensee was informed that one apparent violation of a license condition was identified (Section 2.b(2)(b) above). It was indicated that prior to closing the inspection, review of EPIP changes since the last routine inspection would be accomplished at Region V.