U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 50-244/87-24

Docket No. 50-244

License No. DPR-18 Priority _____ Category B

Licensee: Rochester Gas and Electric Corporation
49 East Avenue
Rochester, New York 14649

Facility Name: R. E. Ginna Nuclear Power Plant

Inspection At: Ontario, New York

Inspection Conducted: October 26-29, 1987

Inspectors: _____ 11/2/87
C. Conklin, Team Leader, EPS, EP&RPB, DRSS date

_____ 11/2/87
J. Fox, Senior EP Specialist, EPS, EP&RPB, DRSS date

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Approved By: _____ 11/2/87
W. J. Lazarus, Chief, EPS, EP&RPB, DRSS date

Inspection Summary: Inspection on October 26-29, 1987 (Report No. 50-244/87-24)

Areas Inspected: Routine announced emergency preparedness inspection and observation of the licensee's annual emergency exercise performed on October 27, 1987. The inspection was performed by a team of four NRC Region I and Headquarters personnel.

Results: No violations were identified. Emergency response actions were adequate to provide protective measures for the health and safety of the public.

DETAILS

1. Persons Contacted

The following licensee representatives attended the exit meeting held on October 29, 1987.

D. Burke, Corporate Emergency Planner
W. Schraude, Facilities and Personnel Manager
W. Backus, Technical Assistant to Operations Manager
B. Snow, Superintendent Nuclear Production
J. Oberlies, Corporate Technical Spokesperson
H. Saddlock, Executive Vice President
R. Smith, Chief Engineer
R. Kober, Vice President Electric Production
S. Spector, Superintendent Ginna Production
D. Filkins, Manager Health Physics and Chemistry
P. Wilkens, Nuclear Licensing and Assessment
R. McCredy, Director Engineering Services
R. Marchionda, Training Manager

The team observed and interviewed several licensee emergency response personnel, controllers and observers as they performed their assigned functions during the exercise.

2. Emergency Exercise

The R. E. Ginna Plant full-participation exercise was conducted on October 27, 1987 from 1:00 AM to 10:00 AM. Subsequently, New York State field monitoring activities and an ingestion pathway exercise was conducted on October 28-29,1987. These activities were observed by the Federal Emergency Management Agency.

2.1 Pre-exercise Activities

Prior to the emergency exercise, NRC Region I representatives held meetings and had telephone discussions with licensee representatives to discuss objectives, scope and content of the exercise scenario. As a result, changes were made in order to clarify certain objectives, revise certain portions of the scenario and ensure that the scenario provided the opportunity for the licensee to demonstrate those areas previously identified by NRC as in need of corrective action.

NRC observers attended a licensee briefing on October 26, 1987, and participated in the discussion of emergency response actions expected during the various phases of the scenario. The licensee stated that controllers would intercede in exercise activities to

prevent scenario deviation or disruption of normal plant operations.

The exercise scenario included the following events:

- An unidentified RCS leak;
- An earthquake and subsequent after shocks;
- A fire that affected safety systems;
- A steam line break resulting in an interfacing LOCA in the RHR system;
- An offsite release;
- Declaration of Unusual Event, Alert, Site Area Emergency and General Emergency Classifications;
- Calculation of offsite dose consequences; and
- Recommendation of protective actions to state officials.

2.2 Activities Observed

During the conduct of the licensee's exercise, four NRC team members made detailed observations of the activation and augmentation of the emergency organization, activation of emergency response facilities, and actions of emergency response personnel during the operation of the emergency response facilities. The following activities were observed:

1. Detection, classification and assessment of scenario events;
2. Direction and coordination of the emergency response;
3. Augmentation of the emergency organization and response facility activation;
4. Notification of licensee personnel and offsite agencies of pertinent plant status information:
5. Communications/information flow, and recordkeeping;
6. Assessment and projection of offsite radiological dose and consideration of protective actions;
7. Provisions for inplant radiation protection;

8. Performance of offsite and inplant radiological surveys;

9. Maintenance of site security and access control;

10. Performance of technical support, repair and corrective actions;

11. Assembly, accountability and evacuation of personnel;

12. Fire fighting practices;

13. Preparation of information for dissemination at the Emergency News Center; and

14. Management of recovery operations.

3.0 Exercise Observations

The NRC team noted that the licensee's activation and augmentation of the emergency organization, activation of the emergency response facilities, and use of the facilities were generally consistent with their emergency response plan and implementing procedures. The team also noted the following actions that were indicative of their ability to cope with abnormal plant conditions:

- Positive command and control of all emergency response facilities (ERF's) was demonstrated by the respective managers;
- Classifications made by the Control Room, Technical Support Center (TSC) and Emergency Operations Facility (EOF) staff were prompt and correct, and subsequent notifications were timely;
- Protective Action Recommendations (PAR's) were made based upon both plant conditions and actual conditions and were timely and conservative;
- Offsite dose projections were performed often and differences between Licensee and state calculations were quickly resolved;
- All ERF's were staffed and augmented in a timely manner;
- Staff members in each ERF demonstrated a through knowledge of the plant and coordinated effectively with their respective counterparts; and
- Recovery discussions conducted with the TSC, EOF, counties and State were thorough and complete.

3.1 Areas Requiring Follow-up

The NRC team identified the following area which could have degraded the response and needs to be evaluated by the licensee for corrective action. This item is tracked as an Inspector Follow-up Item (IFI).

- 50-244/87-24-01; Several press releases contained inaccurate or incorrect information. Specifically;

  1. Message 2 lacked the date and time;
  2. The RCS leak was reported to be detected coincident with the earthquake in messages 3,5,6,8,10 and 11;
  3. Message 9 and 10 identified the earthquake as the cause of the RCS leak; and
  4. The RHR failure due to a steam generator rupture and earthquake reported in message 9 and 10 was conjecture.

4.0 Licensee Actions on Previously Identified Items

The following items were identified during the previous inspections (Inspection Report Nos. 50-244/81-22, 50-244/83-17, 50-244/85-20, 50-244/86-12 and 50-244/86-13). Based upon observations made by the NRC team during the exercise the following Open Items were not repeated and are closed:

(CLOSED) 50-244/81-22-42: Provide for early assessment of plume pathway so that instructions about the location of the plume will be given to offsite survey teams.

(CLOSED) 50-244/83-17-03: Improve communications between control room and TSC.

(CLOSED) 50-244/85-20-05: Improve the effectiveness of the EOF Dose Assessment function.

(CLOSED) 50-244/86-12-04: Establish onsite maintenance responsibilities in the plan and evaluate methods to ensure corporate emergency planner is cognizant of onsite actions.

The inspector reviewed the changes to the emergency plan and determined that adequate measures have been taken to ensure the EPC responsibilities are delineated and provisions have been made to ensure that the EPC has involvement and/or review of all applicable portions of the emergency program.

(CLOSED) 86-13-01: Poor communication from the scene of fire. Messages were garbled. Equipment status not received in a timely manner.

(CLOSED) 86-13-02: Several plant operators were observed in the process of making logic errors while following the EOP's.

(CLOSED) 86-13-03: The initial and update notification messages contained errors, omissions and illegible entries.

(CLOSED) 86-13-04: The TSC dose assessment team did not use expected release duration to determine integrated doses.

(CLOSED) 86-13-05: Off-site monitoring team did not take a representative sample. Sampler was under car hood.

(CLOSED) 86-13-06: Licensee should evaluate methods to ensure ALARA practices are maintained for all teams while in the plume.

(CLOSED) 86-13-07: A containment atmosphere sample was requested by EOF but never obtained by the plant staff.

(CLOSED) 86-13-08: Repair teams did not receive updates concerning plant status while in the field.

5.0 Licensee Critique

The NRC team attended the licensee's post-exercise critique on October 29, 1987, during which the key licensee controllers discussed observations of the exercise. The licensee indicated these observations would be evaluated and appropriate corrective actions taken.

6.0 Exit Meeting and NRC Critique

The NRC team met with the licensee representatives listed in Section 1 of this report at the end of the inspection. The team leader summarized the observations made during the exercise.

The licensee was informed that previously identified items were adequately addressed and no violations were observed. Although there were areas identified for corrective action, the NRC team determined that within the scope and limitations of the scenario, the licensee's performance demonstrated that they could implement their Emergency Plan and Emergency Plan Implementing Procedures in a manner which would adequately provide protective measures for the health and safety of the public.

Licensee management acknowledged the findings and indicated that appropriate action would be taken regarding the identified open item.

At no time during this inspection did the inspectors provide any written information to the licensee.