

U.S. NUCLEAR REGULATORY COMMISSION
OFFICE OF INSPECTION AND ENFORCEMENT

REGION I

Report No. 50-244/82-01

Docket No. 50-244

License No. DPR-18 Priority _____ Category _____

Licensee: Rochester Gas and Electric Corporation

Facility Name: R E Ginna Nuclear Power Plant

Inspection at: Ontario, New York

Inspection conducted: January 20-22, 1982

Inspectors: Nemen M. Terc
Nemen M. Terc
Nemen M. Terc, Exercise Team Leader

1/27/82

date signed

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Summary

Inspection on January 20-22, 1982 (Report Number 50-244/82-01)

Area Inspected: Annual Emergency Preparedness Exercise observation and inspection.
The inspection involved 360 inspection hours by a team of 10 NRC Region I, NRC Headquarters, and contractors.

Results: No items of noncompliance were identified.

DETAILS

1. Persons Contacted

<u>Name</u>	<u>Title</u>
B. A. Snow	Superintendent
J. E. Maier	V. P. Electric & Steam Production
R. Morrill	Training Coordinator
J. Arthur	V. P. Engineering
E. DeMervitt	Emergency Planning Coordinator
W. H. Bachus	Technical Assistant
L. S. Lang	Superintendent, Nuclear Operations
J. C. Noon	Assistant Superintendent
D. L. Filkins	Supervisor, Health Physics & Chemistry
B. R. Quinn	Health Physicist
R. Watts	Corp. Health Physicist
W. Goodman	H. P. Foreman
C. R. Anderson	Manager, QA
R. Sullivan	Manager, Public Relations

The team also observed and interviewed other licensee emergency response personnel.

2. Emergency Exercise

The R. E. Ginna Nuclear Power Plant emergency exercise was conducted on January 21, 1982 from about 0500 to 1800.

a. Pre-exercise Activities

Prior to the exercise the NRC Team Leader had telephone discussions with licensee representatives to review the nature and scope of the exercise scenario and to correct some discrepancies found in the submitted package, which contained control (cue) cards and other pertinent information to be used during the exercise.

In addition, NRC observers attended a licensee briefing for all observers and participated in the discussion of the emergency response actions expected during the various phases of the scenario. The licensee stated that certain functional areas of emergency response would be simulated based on the fact that these were exercised during other in-plant drills (e.g., contaminated-injured person; search and rescue). Additionally, in order to prevent disturbing normal plant operations, relocation of evacuees, loss of access to the Health Physics checkpoint and extended play of operator actions to bring plant to cold shutdown, were not carried out. The latter being exercised during special simulator training and walkthroughs.

The licensee scenario involved significant fuel deterioration and a large release of radioactivity to the environment with the intent of exercising: the onsite emergency organization, the Emergency Operations Facility Support Group, and the response of state and counties. For this reason, the scenario was developed in coordination with participating agencies.

Based on the above findings, this portion of the licensee's exercise program appears to be acceptable.

b. Exercise Observation

During the exercise, 10 NRC inspectors and contractors made detailed observations of the following activities:

- (1) Operational staff actions concerning detection, classification and operational assessment of the accident;
- (2) Notification of licensee's personnel and offsite agencies;
- (3) Radiological (dose) assessment and protective action recommendations;
- (4) Assembly and accountability;
- (5) Security and access control;
- (6) In-plant, onsite and offsite radiological surveys;
- (7) Post-accident sampling and analysis;
- (8) Radiation protection of emergency workers;
- (9) Communications and information flow;
- (10) Coordination and direction;
- (11) Technical support; and
- (12) Public information.

The NRC team noted that the licensee's organizational response was, for the most part, in accordance with procedures and that facilities and equipment were consistent with these procedures. The NRC team determined, however, that there were procedural and equipment shortcomings identified by NRC and licensee observers that needed to be evaluated and resolved. An evaluation of these shortcomings showed that they were consistent with the findings of the emergency preparedness implementation appraisal, performed during November 2 - 13, 1981.

It was noted that the licensee had taken action to correct deficiencies noted during the appraisal and which were covered in a Confirmatory Action Letter (CAL) issued on December 15, 1981. The upgrading of the Technical Support Center (Item 5 of the CAL) and the establishment of an onsite emergency organization (Item 1), for example, contributed to the overall adequacy of the licensee's emergency response.

The inspectors noted that during the exercise, the licensee had a sufficient number of observers and controllers which provided independent assessment; and who gave necessary control cards and contingency messages to participants during the scenario.

The NRC observers noted that functional areas of emergency response were exercised with enough depth and free play; and that within the scope and limitations inherent in the scenario, the licensee's response was effective.

c. Exercise Critique

The NRC team attended a post-exercise critique, on January 22, 1982, during which licensee observers discussed their findings. During the critique, licensee-observer presentations highlighted areas needing improvement. The licensee documented all observers' comments for subsequent evaluation and appropriate corrective action.

The NRC team compared its findings with those of the licensee observers and determined that many coincided. In addition, the following findings were identified by NRC observers and found to exhibit a potential for a degraded response:

Coordination/Direction

- After the activation of the onsite emergency organization a one man repair team was sent out from the control room, without going through the proper command hierarchy. As a consequence, radiological controls and communications were lacking.
- Delegation of responsibilities by one supervisory element of the onsite organization was neglected while he took a lunch-break. As a consequence, offsite teams were left without proper directions for that period of time.

Training

- Control room personnel were found lacking adequate training on the operation of the high range effluent monitor/analyizer (i.e. SPING).
- The decision-making emergency organization managers require more practice on how to de-escalate emergency classifications, and on the criteria needed to base such decisions.
- Public spokesmen, addressing the media and the public need to increase their intelligibility level so that technical information can be readily understood by laymen.

Procedures

- The procedure used to operate the high-range-effluent monitor/analyzer was found too long and cumbersome.
- The protocol for maintaining communications between the Control Room (CR) and the Technical Support group in the Technical Support Center (TSC) needs to be revised so that flow of information is orderly.
- Procedures for maintaining records and for the proper disposition of samples and data sheets need improvement.

EQUIPMENT

- The high range effluent monitor/analyzer (i.e. SPING) is limited to one radioiodine sampling cartridge that would accumulate high levels of radioactivity. As a result, a sequence of effluent concentration determinations, necessary to measure the radioiodine component of the effluents as a function of time will be lacking.
- Emergency Facilities (e.g., TSC, CR and Operational Support Center) need instruments to detect radiation levels and high airborne contamination on a continuous basis. Such instruments should have visual and audible alarms to warn personnel when habitability is in question.

The use of LAPEL air samples in lieu of the above instruments is inadequate to ascertain continuous and reliable habitability conditions in the Emergency Facilities.

- Instrumentation used by offsite teams for monitoring radiological conditions offsite were found below current standards.
- Radio communications using one channel was inadequate to maintain the proper information flow between offsite monitoring teams, and the Emergency Facilities.
- Self Contained Breathing Apparatus needs to include microphones to facilitate communications.

- The intercom between the CR and the TSC was not operating properly.

Based on the above findings, the licensee's emergency response was found to be adequate, but improvements are required as noted above to ensure that these deficiencies do not result in a degraded response capability.

3. Exit Meeting and NRC Critique

Following the critique by licensee's observers, the NRC inspectors met with licensee representatives listed in Section 1 above. The Exercise Team Leader summarized the purpose and scope of the NRC inspection and major findings. The Team Leader discussed the findings and informed the licensee that the number of observers and controllers were adequate; the amount of simulation was minimal and that enough free play allowed exercising the various functional areas of emergency response.

The Team Leader concluded that within the scope and limitations of the scenario, the licensee's actions were found to be adequate to protect the health and safety of the public; and that such actions were consistent with their Emergency Plans and Emergency Implementing Procedures.