U.S. NUCLEAR REGULATORY COMMISSION

REGION I

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REPORT NO:	50-271/94-02
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FACILITY NAME:	Vermont Yankee Nuclear Power Station RD 5, Box 169 Ferry Road Brattleboro, Vermont 05301
INSPECTION AT:	Vernon, Vermont
INSPECTION CONDUCTED:	February 14 - March 2, 1994
INSPECTORS:	Donald J. Florek, Sr. Operations Engineer A. Burritt, Operations Engineer

REPORTING INSPECTOR: D. J. Florek 3/17/94

Donald J. Florek, Sr. Operations Engineer — Date
BWR Section, Operations Branch
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BWR Section, Operations Branch
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INSPECTION SUMMARY

INSPECTION FROM FEBRUARY 14-MARCH 2, 1994 (REPORT NO. 50-271/94-02)

Areas Inspected:

An announced safety inspection of the licensed operator requalification training program was performed to ascertain whether the Vermont Yankee Nuclear Power Corporation was effectively performing those activities necessary to evaluate and ensure an adequate level of competency for licensed operators who operate Vermont Yankee.

Results:

The Vermont Yankee requalification training program is being implemented in accordance with the requirements of 10 CFR 55.59 and the other sections of 10 CFR 55 in the areas reviewed. No violations or specific program strengths were identified. However, several programmatic weaknesses were noted: (1) recurrent crew performance deficiencies in the area of crew command and control, communications, and adherence to Emergency Operating Procedures (EOPs); (2) relatively low knowledge level tested in the development of written and simulator tests; and (3) poor documentation of details related to performance deficiencies and remediation training (271/94-02-01, section 3).

Remedial training for failures from facility-administered examinations was implemented in an thorough manner, was well received, and was appropriate to the circumstances, despite weak records of such activity (section 4).

A number of EOP procedures may complicate recovery efforts by placing undue burden on the operators to implement additional procedure paths and decision steps, with no apparant significant safety gain (section 5).

The scheduling and separation methods used by the licensee were adequate to ensure examination integrity during the week observed. Even though there is no evidence to suggest actual examination compromise, the administrative controls in place for examination development were not sufficient to avoid such compromise during the entire six week examination cycle (section 6).

Medical records and the process for activation of operators' licenses were acceptable (sections 7 and 8).

DETAILS

1.0 BACKGROUND AND SCOPE

During the weeks of February 14 and 28, 1994, the NRC conducted an inspection of the Vermont Yankee requalification training program activities using NRC Temporary Instruction (TI) 2515/117, "Licensed Operator Requalification Program Evaluation." This Temporary Instruction was developed because of rulemaking that deleted the requirement that the NRC staff examine each licensed operator for the purpose of license renewal. The purpose of this inspection was to evaluate the acceptability of the Vermont Yankee licensed operator requalification training program through a performance-based inspection in the area of facility licensee evaluation process and, to some extent, the area of licensee program revision as a result of the evaluation process. This was done in lieu of an NRC staff requalification examination of licensed operators, the results of which were used in the past to perform a program evaluation.

The inspection involved many of the aspects normally associated with NRC staff-administered requalification examinations. This included a review of the written examination and operating tests from the facility licensee's licensed operator requalification examination and observation of crew/individual performance during the conduct of simulator scenarios and job performance measures. Interviews with licensed operators, training instructors, and supervisory personnel were conducted. Associated documents involved with the ongoing training program and licensed operator medical records were also reviewed.

The inspectors used NUREG-1021, "Operator Licensing Examiner Standards," Revision 7, as the basis for determining the adequacy of the facility licensee examination process. The licensee requalification program procedure stated that the facility would adhere to NUREG-1021 for this examination.

The inspectors conducted an assessment of examination material and observed examination activities during the week of February 14, 1994, and observed the simulator portion of the examination administered the week of February 28, 1994.

2.0 SUMMARY OF MAJOR FINDINGS AND CONCLUSIONS

Based upon the results of this inspection, it was determined that the Vermont Yankee requalification training program was implemented in accordance with the requirements of 10 CFR 55.59 in the areas reviewed. No violations or specific program strengths were identified. Several weaknesses were noted, which are described below.

The facility licensee requalification program description states that the program will, "strictly adhere to the requirements of NUREG-1021." Some areas were identified that did not strictly adhere to NUREG-1021.

- Written examinations contain questions that test at the memory level of knowledge (Section 3.3).

- In some instances, the cues identified for in-plant JPMs provide the conclusion that the operator needs to make rather than allowing the operator to determine that the step was performed satisfactorily (i.e., the operator is told that a valve is closed rather than telling the operator that the stem is lowering and the valve operator comes to a hard stop) (section 3.4).

- The standards for simulator crew critical tasks were not objectively worded for the specific scenario conditions (section 3.5).

- The facility licensee did not test the crew in the same configuration in the simulator as the crew normally operates in the plant (section 3.5).

- Individual operator performance assessments during the simulator portion of the operating test were not formally performed and documented (section 3.6).

The facility licensee had an appropriate threshold for identification of performance deficiencies; however, the documentation and follow-up on generic problems are weak (section 3.6).

Remedial training was implemented in a thorough manner, was well received by the licensed operators, and was appropriate to the circumstances. The documentation of the process was minimal and did not completely represent the level of effort of the instructor and the crew being remediated (section 4).

A number of EOP procedures may complicate recovery efforts by placing undue burden on the operators to implement additional procedure paths and decision steps for no apparent significant safety gain (section 5).

Even though there was no evidence of improper access provided to examination materials, the administrative controls in place for examination development were not sufficient to avoid such compromise during the entire six week examination cycle (section 6).

Medical records and the process for the activation of operators licenses were acceptable (sections 7 and 8).

3.0 REQUALIFICATION EXAMINATION

3.1 Examination Summary and Scope

During the week of February 14, 1994, the facility licensee administered the comprehensive, open-reference, written requalification examination and the annual operating test to one operating crew. The sample of operators included three senior reactor operators (SRO) and

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two reactor operators (RO). The examinations administered the week of February 14, 1994, were the first of six weeks of requalification examinations administered by the facility licensee.

During the week of February 28, 1994, examinations were administered to an operating crew and a staff crew. The inspector observed the simulator portion of the operating crew. The basis for this review was 10 CFR 55.59, 55.41, and 43.

3.2 Sample Plan

The facility had developed a sample plan for the examination. The sample plan was adequate and, as indicated in NUREG-1021, included testing in areas not specifically covered during the two-year requalification cycle. The examination product was representative of the sample plan.

3.3 Written Examination

The inspectors determined that approximately 20 percent of written examination questions were at the memory level of knowledge. Testing at the memory level of knowledge during an open reference test was not consistent with the guidance provided by NUREG-1021 (ES-602 Attachment 2 Table 1). The inspector also determined that the week two examination also contained a high percentage of memory level of knowledge questions. Examination report 50-271/92-03 previously identified that the facility licensee's 1992 written requalification examination required changes prompted by the NRC to raise the level of knowledge tested by the questions. Prior to the 1994 examination, the facility licensee had not assessed the questions in the written exam nation for level of knowledge tested.

In response to the inspector's assessment, the facility licensee assessed the week one classroom written examination for level of knowledge tested. The facility assessment indicated that only two questions were at the memory level, whereas the NRC staff determined eight questions were at the memory level. The facility assessment of the total exam substantially agreed with the inspectors on about 75% of the questions. The facility assessment was substantially different from the inspectors on about 25% of the questions. The facility acknowledged that memory level questions are not appropriate for open reference questions and agreed to include the assessment for level of knowledge tested by questions in future examinations.

Individual questions were selected in accordance with the licensee's examination sample plan. The week two examination contained 85% new questions. The inspectors determined the written examinations adequately sampled the items stated in 10 CFR 55.41 and 10 CFR 55.43.

The inspectors observed the administration and reviewed the grading of a sample of the written examinations. All operators passed the written examination. No discrepancies were noted.

The inspector concluded that the use of memory level questions in an open reference examination was a continuing weakness in the Vermont Yankee requalification program.

3.4 Job Performance Measures

The inspector observed the administration of the Job Performance Measures (JPMs) portion of the facility examination. The facility administered five JPMs, selected based on the sample plan, to each operator. Two were administered in the plant and three were administered in the plant reference simulator. No problems were observed during the administration of the JPMs. All operators passed the JPM portion of the examination; however, four out of five operators failed a surveillance procedure JPM for failure to properly fill out the surveillance documentation.

The inspector noted that, in certain instances, the cues contained in the in-plant JPMs provided the conclusion that the operator needed to make rather than allowing the operator to determine that the step was performed satisfactorily. For example, the operator was told that a valve was closed rather than telling the operator that the stem was lowering and the valve operator comes to a hard stop. NUREG-1021 (ES-603, Attachment 3) indicates that the cues provided to the operator should be what the operator would hear and see while performing the JPM.

3.5 Simulator Examination

The inspectors compared the scenarios to be administered for the examination cycle with the quantitative and qualitative criteria of NUREG-1021, ES-604. Overall, the scenarios met the minimum quantitative criteria for individual scenarios, but the scenario set did not meet the minimum quantitative criteria for total malfunctions. The malfunctions that preceded the major transient resulted in simple technical specification determinations for the SROs and did not require significant or comprehensive operator actions. These findings reflected a relatively lower level of knowledge tested on this portion of the examination when compared to the criteria of NUREG-1021.

Further, some of the evaluation standards in the simulator portion of the examination were not sufficiently specific or objectively stated to assure a consistent evaluation of operator performance. ES-604, Attachment 1, indicated that critical tasks require objective measurable performance indicators with acceptable limits. The facility licensee evaluators recognized this and had developed informal, additional standards to be used for the evaluation. For example, one crew's critical task was, "During an ATWS, with conditions met to perform power/level control, terminate and prevent injection, with the exception of boron and CRD into the RPV, until conditions are met to reestablish injection." The facility

evaluators also used a critical task criterion that high pressure injection system needed to be terminated, such that the Heat Capacity Temperature Limit (HCTL) limit curve was not exceeded. This additional standard was not documented in the scenario. The inspector questioned the adequacy of this approach versus documenting the scenario-specific objective standards in the scenario. The facility licensee indicated that they would include the scenario's specific objective standards in the scenario documentation in the future.

The inspector observed the simulator examinations administered by the facility to an operating crew during the week of February 14, 1994. The crew consisted of three senior reactor operators, two reactor operators and a nonlicensed shift engineer. Two scenarios were used. The operators were tested with three operators performing on the control boards and two SROs directing shift operations. Two of the SROs rotated between the control boards and the SRO position so that each SRO was evaluated in at least one scenario in an SRO position. The facility used five evaluators, including the Operations Manager. During both scenarios, the NRC inspector determined that the crew response was satisfactory; however, crew performance weaknesses were noted as follows:

- Crew communications were weak in that quiet private communications between operators were frequently conducted, which resulted in not all crew members being aware of plant status. Additionally, critical plant parameters and annunciators were not announced as appropriate to maintain the entire crew aware of transient plant conditions.

- Shift supervisor briefings did not consistently provide the crew with both current plant status, current operator actions and projection of future operator actions.

- The shift supervisor (SS) and supervisory control room operator (SCRO), at times, were both giving commands to the reactor operators, resulting in the shift supervisor not always maintaining the "big picture." Command and control and SS/SCRO interaction was substantially different when different individuals rotated into the SCRO position.

- On occasion, all of the licensed operators were focused on an individual problem. Total plant awareness, at times, was maintained by the shift engineer but not the licensed operators.

- Procedure adherence problems were noted with the crew execution of the emergency operating procedures (EOPs). Examples included delay in initiation of actions to insert control rods during an ATWS, delay in direction to trip the recirculation pumps during an ATWS, missed verification of emergency core cooling system (ECCS) actuation, and delay in direction of actions to initiate torus cooling. The inspectors noted that the human factor engineering in EOPs may have been a contributor to the operator execution problems. This is further addressed in section 5.0 of this report.

The facility evaluators adequately evaluated licensed operator performance. The crew competency evaluation developed by the facility evaluators was similar the standards of NUREG-1021. The facility licensee determined that the crews passed the simulator portion of the examination.

The simulator did not provide the expected area radiation alarms for a HPCI steam line leak in secondary containment. See the simulator fidelity report (Attachment 2).

The inspectors noted that the facility licensee did not test the crew in the simulator in a configuration that was similar to the way that the crew operated in the plant. The normal crew configuration in the plant was seven individuals with four licensed positions on shift:

Control Room

1 - Shift supervisor (SS) - SRO-licensed position.

1 - Supervisory control room operator (SCRO) - SRO-licensed position.

1 - Control room operator (CRO) - RO-licensed position.

1 - Shift Engineer - nonlicensed position.

Plant

1 - Assistant control room operator (ACRO) - SRO or RO-licensed position normally used in plant but may be called to the control room.

2 - Auxiliary operators.

The crew examined happened to have five licensed individuals to fill the seven shift positions. One of the licensed individuals normally performs in an auxiliary operator position and would not normally be used in the simulator. The facility licensee tested all five licensed individuals in the simulator at the same time, which is not the way this crew would actually respond to a transient. NUREG-1021, ES-601, indicates that the facility should examine their operators in the same crew configurations with which they normally operate in the plant.

The facility licensee indicated that they normally evaluate with four licensed individuals in the simulator. The inspector noted that this practice was also different from the way the facility licensee operates, since the ACRO is not normally in the control room.

During the week of February 28, 1994, the inspector observed a facility-administered simulator examination of an operating crew. This crew consisted of two senior reactor operators, two reactor operators, and a nonlicensed shift engineer consistent with normal

shift staffing. The crew interaction during this evaluation was better; however, it appeared to be tied to an exceptionally strong performance by the SCRO. The facility evaluators adequately evaluated licensed operator performance. It was evident, based on the facility discussions during the crew competency review, that the facility was evaluating for more than the minimum standards. Specifically, the examination team identified that the shift supervisor was not meeting the facility expectations for command and control; however, in this case, there were no related safety consequences. The facility examination team discussed the need for remediation; however, this was not identified in the examination documentation provided to the inspector.

The inspectors reviewed current and previous examination documentation of simulator evaluations. The facility maintains minimal documentation of noted performance deficiencies. The comments were typically brief and were often nonspecific. It was not clear if the minimal documentation of performance deficiencies had impacted correction of generic deficiencies. However, the inspectors noted that problems with crew command and control, communication and procedural adherence had been identified before by the licensee and by the NRC in previous examinations.

3.6 Performance of Individual Evaluations

The inspector reviewed two facility licensee evaluations from the 1993 simulator portion of the annual operating test. One of the crews failed the simulator examination by failing a critical task and subsequently being evaluated as unsatisfactory when the ES-604 crew competency evaluation was completed. The other crew did not perform a critical task in one scenario, performed the same critical task successfully in a second scenario, resulting in the facility evaluators coming to an inconclusive determination following completion of the ES-604 crew competency evaluation. After licensee middle management involvement, a decision was made to administer a third scenario. The crew successfully passed the third scenario.

The inspector questioned the facility representatives as to the individual evaluations performed when the critical tasks were not successfully performed as indicated in ES-604. The facility training representatives indicated that they did not formally perform or document individual evaluations. The inspector also did not observe the facility licensee evaluators performing or documenting individual evaluations during the simulator portion of the examination administered the week of February 14, 1994. However, individual performance evaluation was observed during the week of February 28, 1994. Documentation of the individual evaluation was minimal, similar to that found in Section 3.5.

3.7 Conclusions

With respect to performance on the simulator test, the inspectors noted repetitive deficiencies with crew communication and command and control, and adherence to EOPs. The facility had an appropriate threshold for identification of performance deficiencies; however, the documentation was weak. This was apparently due to the licensee recently redefining SS and

SCRO responsibilities in an effort to resolve these problems. Further, the licensee representative acknowledged the need for further improvement, but believed that the crews are still adapting to the new process. Also, written and simulator test development reflected a relatively low knowledge level tested. These weaknesses warrant further review by NRC staff (Inspector Followup Item 271-94-02-01, also section 4).

4.0 REMEDIAL TRAINING

Scope

During the week of February 28, 1994, the inspector observed the remedial training for failures from the facility licensee simulator examination administered the week of February 21, 1994. The remediation was primarily to address procedural adherence and command and control weaknesses identified with both senior reactor operators. The basis for this review was 10 CFR 55.59 (c).

Findings

All remedial training sessions were being video taped. The tapes are selectively reviewed based on the instructors discretion of training benefit. Goals are established and post-scenario critiques performed using a team skills approach. A white board is divided into a matrix of command and control, communication, and procedure use versus sequence, areas of success, improvements and commitments. This board is used to maintain focus on the crew's self-identified objectives. The crew guided by the instructor established crew strengths, weaknesses and areas for improvement. This information was used to develop a specific plan and to elicit individual commitments to support team improvements. The same remediation was done to address both the individual and the crew failure. All remediation plans were identical.

The instructor solicited operator feedback and input for areas of improvement prior to the exercise. The subsequent feedback provided at the end of each exercise was structured within the confines of the goals established for the training session. The feedback was also provided in a positive manner, and the crew was receptive to techniques for improvement. The crew was self-critical, and various members provided suggestions for further improvements. Documentation of the process was minimal.

Conclusion

The remedial training was implemented in a thorough manner, was well received, and was appropriate to the circumstances. The instructor exhibited an aggressive attitude in soliciting both crew input and individual buyin throughout the process. The instructor provided specific feedback to individuals relative to their contribution to crew performance. However, the inspector noted that the documentation of the process was minimal and did not accurately

represent the level of effort of the instructor and the crew being remediated. The area is considered to be a weakness warranting further NRC staff review (Inspector Followup Item 271-94-02-01, also Section 3.7).

5.0 EMERGENCY OPERATING PROCEDURES (EOPs)

Scope

During the simulator examination on February 16, 1994, the inspectors noted that the operators were challenged when the MSIVs shut during RPV emergency depressurization, since they were using the main condenser bypass valves. As a result, the inspectors further reviewed several EOPs and mitigation strategies for unnecessary challenges to the operators.

Findings

The RPV flooding procedure allows use of the turbine bypass valves preferentially over the use of safety relief valves (SRV). This methodology complicates the procedural directions for what appears to be marginal benefit. To ensure adequate core cooling is established, the RPV flooding strategy requires establishing a differential pressure between the RPV and the torus. However, establishing the required differential pressure would result in a loss of condenser vacuum that, in turn, would automatically isolate the bypass valve vent path. The operator would then need to establish a vent path via the SRVs; however, subsequent steps in the procedure do not address these required actions. Since RPV emergency depressurization is required prior to use of the RPV flooding strategy, only marginal benefit is derived from using the main condenser as a heat sink. Due to the transitional nature of the bypass valve vent path, the operator would have to implement the RPV flood procedure twice, which increases the risk of an error and delays establishing RPV flooding conditions.

The use of turbine bypass valves for RPV emergency depressurization, as well as RPV flooding is complicated by no procedural direction if, subsequent to opening the bypass valves, they became unavailable (i.e., MSIV closure). These procedures do not contain override steps that would direct the operator to monitor the status of the bypass valve vent path and subsequent to the loss of this path direct reentry at the appropriate place in the procedure. The licensee representatives stated that operators were trained to reenter the procedure at the beginning; however, this philosophy is not documented. Further, based on discussions with the plant staff, the method and point of reentry into the EOPs does not appear to be consistent.

The inspector noted that, when using the turbine bypass valves for a vent path, the applicable procedures do not contain a provision for identification and isolation of this path in the event of indications of fuel damage. Procedure OE 3106, "Radiation Release," would eventually require isolation of this vent path, however, probably not before process samples could be drawn and analyzed. It was probable that a fuel failure of any significance would result in an offgas isolation, a subsequent loss of vacuum and ultimately an MSIV isolation.

However, establishing a vent path outside of containment with indication of fuel damage would as a minimum complicate EOP implementation and may increase the risk of significant releases to the environment.

The EOPs required implementation of four concurrent paths between OE-3100 and OE-3101. The EPG, Revision 4, strategy would only require implementation of three concurrent paths. The additional procedure leg requires more prioritization by the operator and thereby complicates mitigation efforts.

Conclusion

A number of EOP procedures may complicate recovery efforts by placing undue burden on the operators to implement additional procedure paths and decision steps with no apparent significant safety gain. The licensee representative acknowledged that using the SRVs for RPV flooding was only a short-term option and created a potential risk to the operators due to a cumbersome procedural path. The licensee representative agreed to review the RPV flooding strategy and related procedures.

6.0 EXAM SECURITY MEASURES

Scope

During the week of February 14, 1994, the inspectors noted that examination material from the last three weeks of the six-week cycle was the same material as the first three weeks, but merely restructured in parts. As a result, the inspector reviewed the security measures taken to assure that there was no examination compromise during the administration of the examination (10 CFR 55.49).

Findings

During the week, the facility used scheduling and separation techniques to maintain examination integrity. The facility licensee procedure TDD-5.2, "Examination Development," described the examination development methods used to assure examination integrity over the six week cycle. The facility licensee also indicated that the security agreement used on the written examination also applies to all parts of the examination and is considered to be part of the examination integrity controls. After reading the written examination security agreement, which the inspector concluded did not apply to other parts of the examination, and reviewing the facility licensee examination development activities, the inspector determined that the controls are not sufficient to avoid examination compromise. The facility licensee indicated that they would increase the testing material included in this cycle of examinations and review their practices for ensuring examination integrity.

Conclusions

The inspector concluded that the scheduling and separation methods used by the facility licensee were adequate to ensure examination integrity for the week observed. The inspector noted that there was no evidence to suggest actual examination compromise; however, controls were not sufficient to avoid such compromise over the six week examination cycle.

7.0 MEDICAL RECORDS

Scope

The inspector reviewed the medical records of 12 licensed operators. The inspector also reviewed DP-0876, "Periodic Medical Examination," Revision 5, dated April 23, 1993, and VYP-105, "Medical Services Program," dated April 1, 1993. The basis for this review was 10 CFR 55.53(i) and 55.25.

Findings

The facility licensee performed annual medical examinations on licensed operators. The inspector noted that, for the files reviewed, no changes to medical status required NRC notification. The inspector noted that the medical records were maintained for the life of the facility. The previous two years were maintained in the files and, prior to that, in records storage. NRC Forms 396, "Certification of Medical Examination by Facility Licensee," were not in the medical files if the 396 forms were older than two years. The facility did not prepare new 396 forms unless there was a change in medical status or a license renewal was required.

The facility used a checklist to enable the physician to perform the medical assessment. The checklist forms were often not fully completed by the physician; however, the required examinations were contained in the medical files indicating that the facility licensee physician was not fully using the checklists. The diagnosis portion of the checklist was completed by the physician. The inspector noted that the checklist completed by the physician had no indication of the license medical restrictions, if any, that needed to be placed on the operator. The lack of license medical restrictions on the checklist made it difficult to determine if a change had occurred, which warranted NRC notification. The facility licensee representatives acknowledged the inspector findings and indicated that a change to the checklist would be initiated to include a statement of medical restriction and the physician reminded to use the checklists.

Conclusion

In the medical area, the licensee met NRC requirements with respect to medical examinations of the licensed operators and notification to the NRC of changes to the operator's license, because of medical reasons.

8.0 PROCESS FOR ACTIVATION OF OPERATOR LICENSES

The inspector reviewed the process for activation of two senior reactor operators in August 1993 to determine if it met the requirements of 10 CFR 55.53(e) and (f). Based on review of control room logs, five eight-hour shifts were performed. Based on a review of the activation documentation form and interview with the Operations Manager following completion of the 40 hours under instruction, operations and training management certified that the operators met all the requirements for activation. For maintenance of license status, the facility licensee had recently initiated, and were using, a logbook in the control room for each operator to document the 56-hour watchstanding minimum requirement. No unacceptable conditions were noted.

9.0 LICENSEE ACTIONS ON PREVIOUS INSPECTION FINDINGS

(Closed) Unresolved Item 271/92-80-02) Implementation of RPV pressure control strategy.

The facility licensee has revised OP-0109, "Plant Restoration," dated August 30, 1993. The procedure had been revised to eliminate the prerequisite for a reactor water level band and to direct reactor depressurization as the first step in the procedure. The facility change to the Plant Specific Technical Guide (PSTG) still was in final review during this inspection. Based on the procedure changes and the near-term schedule for change of the PSTG, this item was closed.

10.0 EXIT MEETING

At the conclusion of the site inspection, an interim exit meeting was conducted on February 18, 1994, and a final exit meeting was conducted on March 2, 1994. During these meetings, the inspectors reviewed the scope and findings of the inspection. Those personnel in attendance are noted in Attachment 1. The facility representatives acknowledged the inspection findings. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspectors.

Attachments:
1. Persons Contacted
2. Vermont Yankee Simulation Facility Report

ATTACHMENT 1

PERSONS CONTACTED

VERMONT YANKEE

#* L. Doane, Operations Manager
* B. Finn, LOR Program Coordinator
#* E. Harms, Operations Training Supervisor
#* M. Mervine, Training Manager
* J. Orris, Director of Human Resources
* R. Wanczyk, Plant Manager

NRC Personnel

* H. Eichenholz, Sr. Resident Inspector
* D. Florek, Sr. Operations Engineer
# A. Burritt, Operations Engineer

* Denotes those persons in attendance at the interim exit meeting on February 18, 1994.

# Denotes those persons in attendance at the exit meeting on March 2, 1994.

In addition to the personnel listed above, the inspectors contacted other personnel during this inspection period.

ATTACHMENT 2

VERMONT YANKEE SIMULATION FACILITY REPORT

Facility Licensee: Vermont Yankee

Facility Docket No: 50-271

Requalification Inspection Conducted from: February 14-March 2, 1994

This form is to be used only to report observations. These observations do not constitute audit or inspection findings and are not, without further verification and review, indicative of noncompliance with 10 CFR 55.45 (b). These observations do not affect NRC staff certification or approval of the simulation facility other than to provide information that may be used in future evaluations. No licensee action is required in response to these observations.

While conducting the simulator portion of the operating tests, the following item was observed:

ITEM	DESCRIPTION
1.	During scenario SEG-16, a HPCI steamline break occurred in secondary containment. Reactor building exhaust radiation levels were increasing rapidly, whereas the local area radiation monitors were not significantly changing. The scenario validation determined that area radiation levels would be increasing causing execution of the emergency operating procedures (EOPs). During the scenario observed, area temperatures were causing EOP activities, with little response observed on the area radiation detectors.