

APPENDIX

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

NRC Inspection Report: 50-267/90-15 Operating License: DPR-34

Docket: 50-267

Licensee: Public Service Company of Colorado (PSC)
P.O. Box 840
Denver, Colorado 80201-0840

Facility Name: Fort St. Vrain Nuclear Generating Station (FSV)

Inspection At: Weld County, Platteville, Colorado

Inspection Conducted: November 6-8, 1990

Inspector:

J. B. Nicholas for

J. B. Nicholas, Senior Radiation Specialist
Radiological Protection and Emergency
Preparedness Section (NRC Team Leader)

12-11-90

Date

Inspection
Team:

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Protection and Emergency Preparedness Section
J. E. Whittemore, License Examiner, Operator Licensing Section
B. Murray, Chief, Radiological Protection and Emergency
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Approved:

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B. Murray, Chief, Radiological Protection and
Emergency Preparedness Section

12/11/90

Date

Inspection Summary

Inspection Conducted November 6-8, 1990 (Report 50-267/90-15)

Areas Inspected: Routine, announced inspection of the licensee's performance and capabilities during an annual exercise of their emergency plan and procedures. The inspection team observed activities in the control room (CR), technical support center (TSC), forward command post (FCP), and personnel control center (PCC) during the exercise.

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Results: Within the areas inspected, no violations or deviations were identified. Three exercise weaknesses were identified by the inspection team and are documented in paragraphs 5 and 8. These weaknesses included the prompting of exercise players by exercise controllers and observers, lack of management approval of notification information prior to dissemination, and the use of poor health physics practices during the search and rescue of the accident injury victims.

The licensee's response to the emergency exercise scenario was considered satisfactory and assured that the licensee's emergency preparedness program was adequate to protect the health and safety of the public. In general, licensee personnel performed well throughout the exercise. Decision making responsibilities were clearly assumed by emergency team management and mitigating actions to address the emergency were thoroughly evaluated prior to implementation in accordance with approved procedures. Communications between the CR, TSC, PCC, and FCP were excellent. The coordination of effort amongst the licensee's personnel was very good and they demonstrated professionalism and a positive attitude toward the accident assessment and the mitigation process. The licensee's self-critique identified several exercise weaknesses and improvement items and involved the participation of upper management.

DETAILS

1. Persons Contacted

PSC

- *A. C. Crawford, Vice President, Nuclear Operations
- *C. H. Fuller, Manager, Nuclear Production and Station Manager
- *F. J. Borst, Manager, Nuclear Training and Support
- *M. E. Deniston, Superintendent, Operations
- *M. J. Ferris, Manager, Quality Assurance (QA) Operations
- *J. M. Gramling, Supervisor, Nuclear Licensing
- *J. J. Hunter, Fuel Deck Superintendent
- *L. C. Hutchins, Health Physicist
- *R. L. Millison, Senior Emergency Planning Specialist
- T. E. Schleiger, Superintendent, Chemistry and Radiation Protection
- *J. C. Selan, Nuclear Licensing
- *P. F. Tomlinson, Manager, QA
- *D. D. Warenbourg, Manager, Nuclear Engineering

NRC

- *J. B. Baird, Technical Assistant, Division of Reactor Projects
- *D. L. Garrison, Acting Resident Inspector, FSV

*Denotes those present at the meeting on November 8, 1990.

The inspectors also held discussions with other plant and corporate personnel in the areas of security, health physics, training, QA, operations, and emergency preparedness.

2. Followup on Previously Identified Inspection Findings (92702)

(Closed) Violation (267/8811-02): Failure to Notify State in Required Time - This violation was identified in NRC Inspection Report 50-267/88-11 and involved the licensee's failure to notify the state of Colorado authorities within 15 minutes following the declaration of an emergency on April 4, 1988, in accordance with 10 CFR Part 50, Appendix E, IV, D.3 requirements. The licensee had conducted training for the CR operators and shift supervisors (SS) who were responsible for making the required notifications of an emergency situation at FSV to State, local, and Federal authorities. During the emergency exercise conducted on November 7, 1990, the inspectors observed the licensee demonstrating their capability to notify responsible State and local government agencies within 15 minutes after declaring an emergency. The licensee's performance during the 1990 emergency exercise was satisfactory to resolve the NRC's concerns in this matter.

(Closed) Exercise Weakness (267/8922-01): Diversion of Control Room Personnel - This emergency exercise weakness was identified in NRC Inspection Report 50-267/89-22 and involved the diversion of the shift technical advisor and senior reactor operator (SRO) in the control room from activities involving evaluation, analysis, and control of reactor emergency conditions during the initial phases of the emergency exercise conducted on November 15, 1989. During the emergency exercise conducted on November 7, 1990, the inspectors observed that the CR personnel performed their functions involving evaluation, analysis, and control of reactor emergency conditions adequately while carrying out the necessary actions to assess and mitigate the emergency consequences and implement the necessary emergency procedures. The licensee's performance during the 1990 emergency exercise was satisfactory to resolve the NRC's concerns.

(Open) Exercise Weakness (267/8922-02): Failure to Use Proper Health Physics Practices - This emergency exercise weakness was identified in NRC Inspection Report 50-267/89-22 and involved the failure to use proper contamination control during medical treatment of a contaminated injury victim and the improper use of respiratory protection equipment. During the emergency exercise conducted November 7, 1990, the inspectors observed that the medical emergency team members used proper procedures when donning the full facepiece of the self-contained breathing apparatus to provide the proper seal between the facepiece and the persons face and head prior to entry into a highly contaminated area. This portion of the exercise weakness is considered closed. However, the inspectors noted that while the contaminated injury victim was being attended to, contamination controls were still weak. For example, appropriate protective clothing was not worn, and adequate precautions against the spread of contamination when moving the injured victim were not implemented. The portion of the exercise weakness dealing with proper contamination control will remain open pending further NRC evaluation during future emergency exercises.

(Open) Exercise Weakness (267/8922-03): Inadequate Volume of the Plant Public Address System - This emergency exercise weakness was identified in NRC Inspection Report 50-267/89-22 and involved inadequate communications within the plant protected area during an emergency by using the plant's public address system. During the emergency exercise conducted on November 7, 1990, the inspectors noted that the plant's public address system was not understandable for communication of emergency announcements in the south truck bay and on the Level 5 walkway of the reactor building. This exercise weakness dealing with plant public address communication in various areas of the plant during emergency conditions will remain open pending further NRC evaluation during future emergency exercises.

3. Emergency Exercise Weakness Identified During This Inspection (82301)

An emergency exercise weakness is a finding that a licensee's demonstrated level of preparedness could have precluded effective implementation of the emergency preparedness plan in the event of an actual emergency. An

exercise weakness is a finding which requires licensee corrective measures. It is documented and tracked to ensure adequate followup is performed on matters of concern to the inspectors. The following exercise weaknesses were identified:

<u>Exercise Weakness</u>	<u>Title</u>	<u>Paragraph</u>
267/9015-01	Prompting by Exercise Controllers and Observers	5
267/9015-02	Approval of Notification Information	5
267/9015-03	Poor Health Physics Techniques Used by Fire Brigade/Rescue Team	8

4. Program Areas Inspected

The inspection team observed licensee activities in the CR, TSC, PCC, and FCP during the emergency exercise. The PCC and FCP are equivalent to the operations support center and the emergency operations facility, respectively, as referenced in NUREG-1054 and NUREG-0696. The inspection team also inspected the licensee's emergency response organization and staffing; activation of various emergency facilities; emergency detection, classification, and operational assessment; notifications of licensee onsite personnel and offsite agencies; formulation of protective action recommendations; offsite dose assessment; in-plant corrective actions; security/accountability activities; and recovery operations. The emergency exercise inspection findings are documented in the following paragraphs.

The inspection team identified various program weaknesses during the course of the exercise; however, none of the observed weaknesses were of the significance as defined in 10 CFR Part 50.54(s)(2)(ii) to be categorized as deficiencies. Therefore, each of the observed program weaknesses has been characterized as an exercise weakness requiring licensee corrective measures in accordance with 10 CFR Part 50, Appendix E.IV.F.5.

5. Control Room (82301)

The inspection team observed and evaluated the CR personnel as they performed tasks in response to the exercise. These tasks included detection and classification of events, analysis of plant conditions and corrective actions, protective action decision making and implementation, postaccident sampling, offsite dose assessment, and environmental monitoring.

The CR staff performed well throughout the exercise. They were able to correctly diagnose the loss of offsite power and diesel generator power to the essential busses using the exercise data and instrument indications. Actions were performed in accordance with approved procedures to address

the loss of power and resultant consequences to the reactor core cooling capability. The SS initially assessed the plant conditions which required the classification of events as a notice of unusual event (NOUE) and subsequently escalated to an ALERT classification in accordance with approved procedures and emergency action levels (EALs).

The SS was the only licensed SRO on shift in the CR during the entire exercise. Initially he was overwhelmed with the dual responsibility of mitigating the plant emergency situation (loss of all AC power and subsequent loss of reactor core cooling) and acting as the emergency director (ED). After the event classification was determined, the superintendent of operations assumed the responsibility for making the required notifications to local, State, and Federal agencies. These notifications were performed within the required 15 minutes following the declaration of an emergency. The inspectors observed the superintendent of operations giving orders to the CR staff on one occasion, usurping the SS's control of the event mitigation.

Approximately 30 minutes into the event and 5 minutes after the declaration of an ALERT, the operations and maintenance manager relieved the SS of his ED duties and assumed the position of control room emergency coordinator (CREC). At that point the SS and the CR staff concentrated on mitigating the plant problems. Throughout the exercise the CREC kept the CR personnel informed of plant and site status approximately every 10 minutes.

The inspectors noted several occasions when exercise controllers or observers prompted CR operators.

- a. At 09:03, the CR communicator inquired of a QA observer the status of the "A" diesel generator and was given the equipment status by the observer. At this time in the exercise scenario, the status of the diesel generators should not have been available from any nonplayer.
- b. At 09:22, the superintendent of operations inquired of an exercise controller the status of the reserve auxiliary transformer and was given the information requested. According to the exercise scenario, this information should not have been available at that time from a nonplayer.
- c. At 09:29, the CR communicator inquired of an exercise controller as to whether reactor core maintenance had been in progress at the time of the declaration of the emergency. The CR exercise controller responded negatively to the question from the CR communicator. Since initial plant and reactor conditions had been provided to the CR staff at 08:14 and questions had been addressed at that time as to plant activities in progress, the information requested by the CR communicator should not have been available from a nonplayer.

- d. At 09:55, an exercise controller volunteered the dimensions of the keyway sump to the CREC. This information was not provided as a contingency message in the exercise scenario and should have not been available from a nonplayer.
- e. At 10:57, a CR staff member inquired as to how many people were injured in the reactor building. An exercise controller volunteered the information of two injured persons. This information was conveyed by a controller message in the exercise scenario and should not have been volunteered verbally from a nonplayer.
- f. At 12:57, the CREC asked the CR staff what was on Level 4 of the reactor building and the exercise controller volunteered the information rather than an exercise player.

This volunteering of exercise information by exercise controllers or observers in response to questions posed by exercise players as a means of providing information not currently available from another exercise player is considered an exercise weakness (267/9015-01).

The inspectors observed several problems with the licensee's ability to follow the emergency notification steps contained in the licensee's Radiological Emergency Response Plan (RERP) - CR and RERP - Notification procedures. The following are examples of the problems observed concerning offsite notifications:

- a. The Emergency Event Notification Form - Sheet 2 from Procedure RERP-CR, Attachment B, was not reviewed and approved by the SS/emergency coordinator (EC) prior to the NOUE notification calls to the County and State agencies. The County and State agency notifications were made between 08:49 and 08:52. During that time period only Emergency Event Notification Form - Sheet 1 from RERP-CR, Attachment B, had been reviewed and approved by the SS/EC. Sheet 2 of the Emergency Event Notification Form was approved later by the SS/EC at 08:53.
- b. The information contained in line 4 of the Emergency Event Notification Form - Sheet 2 from Procedure RERP-CR, Attachment B, was not communicated to Weld County authorities during the initial notification call announcing the NOUE at 08:49. Line 4 contains information concerning offsite dangers posed by the emergency including protective action recommendations. The information conveying no danger to offsite personnel (line 4, Item A) was later communicated to Weld County officials at 08:51 in response to a return call to the CR from Weld County requesting the information concerning danger to the public.
- c. During the initial notification of the NOUE to the State authorities at 08:52, the event resulting in the NOUE classification was not communicated. This information was written on the notification form under the heading of plant responses.

- d. The emergency event notification form from Procedure RERP-CR, Attachment B, used for the exercise ALERT notification of offsite agencies, was not reviewed or approved by the CREC prior to the notification of offsite authorities at 09:06. The form had been approved by the SS, but he had been relieved of the CREC responsibilities by the operations and maintenance manager at 09:00, in accordance with Procedure RERP-CR, Attachment B, Step 7. Procedure RERP-CR, Attachment B, Step 6(a), directs the CREC to review and approve the completed notification forms.
- e. The followup notification form (RERP-Notification, Attachment A) was used to notify offsite authorities of the site area emergency at 10:45. Step 3 of this form did not indicate the current emergency classification.

The licensee's failure to obtain required reviews and approvals on notification forms prior to their use in performing offsite agency notifications and also not disseminating all of the required information contained on the notification message form is considered an exercise weakness (267/9015-02).

No violations or deviations were identified in this program area.

6. Technical Support Center (82301)

The inspection team observed and evaluated the TSC staff as they performed tasks in response to the exercise. These tasks included activation of the TSC, accident assessment and classification, offsite dose assessment, protective action decisionmaking and implementation, notifications, technical support to the CR, postaccident sampling, and environmental monitoring.

The TSC was staffed in an efficient and professional manner. The TSC staff appeared to be well trained to perform their respective tasks and performed very well during the exercise. Procedures and checklists were used to ensure that each TSC position was staffed and activated. Habitability within the TSC was verified initially and checked every 15 to 20 minutes throughout the exercise.

Technical assessment of plant conditions and trending of plant systems parameters were accomplished in an effective and timely manner by the TSC engineering staff. The engineering technical analysis coordinator (ETAC) and his team of engineers gave careful consideration to the methods to be employed for reenergizing the fuel handling crane to ensure that the suspended spent fuel cask was protected. The ETAC's engineering team, in coordination with the FCP staff, analyzed the consequences of dropping the spent fuel cask before movement of the crane. Following the incident of the spent fuel cask dropping into the reactor building keyway sump, the ETAC's engineering team analyzed and confirmed, based on in-plant instrumentation, that a critical mass had not been achieved by the positioning of the fuel from the broken cask. The engineering team, with

help from the FCP staff, also analyzed the effect of adding water to the reactor building keyway sump to act as shielding but not result in causing criticality by moving the spent fuel. This analysis resulted in the decision to use sand instead of water as a shielding material.

Throughout the exercise, the TSC staff demonstrated a professional approach to problem solving. The TSC director frequently assigned tasks to the various members of the TSC staff. The assignments were given in a clear and easily understood manner. The TSC director demonstrated a clear command and control of the emergency situation during the exercise. He provided frequent status updates of the emergency exercise conditions to the TSC staff. Communications to the CR, PCC, and FCP were good.

The TSC staff demonstrated good control of the maintenance and environmental monitoring teams dispatched from the PCC. Pretask briefings were prepared and given by the TSC staff prior to dispatching the respective teams from the PCC. The pretask briefings were concise but thorough. Status boards in the TSC were maintained and updated at 15 minute intervals with accurate and current data received from the various plant sources such as the CR, maintenance repair teams, reentry and rescue team, and environmental monitoring teams.

The inspectors noted that the TSC staff carefully considered each item on their checklist prior to considering entry into the recovery phase of the exercise and ensured that all plant system conditions were stable with no conditions present which might initiate a further release of radioactive material or endanger plant personnel or the public.

The inspectors observed that the chart recorders on Panel I7901 of the TSC monitoring instrument rack were labeled with temporary labels (paper taped to the chart recorders). No approval signatures or dates of installation were identified on the temporary labels. Specifically, on Recorder XR-7901, the recorder range of 80-180 was crossed out and a range of 50-250 was written on the temporary label without any indication of approval signatures. This observation was discussed with the licensee at the exit meeting on November 8, 1990.

No violations or deviations were identified in this program area.

7. Personnel Control Center (82301)

The inspection team observed and evaluated the PCC staff as they performed tasks in response to the exercise. The tasks included activation of the PCC, personnel staffing, and support to the CR, TSC, and FCP.

The PCC director was well organized, and setup and activated the PCC in accordance with RERP-PCC, Checklist 1. PCC personnel assignments were made and communications were established with the CR and TSC. The PCC was declared operational at 09:25, 30 minutes after the declaration of an ALERT classification. "A" Team (mechanical) was formed and dispatched to

repair water leaks on "A" diesel generator and "B" Team (electrical) was formed and dispatched to assist in determining the problems associated with the "B" diesel generator trip.

Two offsite radiation monitoring teams (EAB and EPZ) were manned, dressed, and equipped for dispatch. The teams were briefed by the TSC staff as to dosimetry requirements, respirator requirements, and meteorological conditions and dispatched and controlled at the direction of the field team director in the TSC. Communications were excellent between the TSC, PCC, and the field monitoring teams. The field monitoring teams were in constant contact with the TSC field team director and their activities were monitored and tracked by the PCC. Radiological data was quickly and accurately received from the field monitoring teams by the TSC staff and the TSC and PCC radiological status boards were kept up-to-date as to radiological conditions offsite throughout the exercise after exhaust stack radioactive airborne releases were indicated.

The PCC director requested from the TSC protective action recommendations several times during the course of the exercise. Based on the field monitoring team radiological data, no protective action recommendations were necessary. The PCC director handled the request from the TSC for medical support from St. Lukes Hospital in Denver, Colorado, in an efficient and timely manner and coordinated the transportation of the contaminated injury victims.

The PCC supported the TSC request to notify the Weld County Sheriff's Department to assist in implementing an offsite evacuation if offsite radiological conditions should warrant.

The PCC staff handled the insulin shock victim in the PCC satisfactorily in the PCC first aid room during the exercise. The Platteville Fire Department ambulance was requested and the victim was (simulated) transported to the Greeley, Colorado, hospital. All communications and logistics were handled efficiently and in a timely manner.

No violations or deviations were identified in this program area.

8. Fire Brigade/Rescue Team (82301)

The inspection team observed and evaluated the performance of the fire brigade/rescue team during their response to the medical emergency inside the reactor building following the incident of dropping the spent fuel cask.

The inspector observed the assembly of the emergency fire brigade/rescue team and followed the team into the reactor building to observe the rescue activities of the contaminated injury victims. The inspector noted several problems with the performance of the rescue operations in a very high radiation area. The following are examples of the problems observed during the rescue operation.

- a. The fire brigade/rescue team did not receive a briefing from the CR or TSC before entering Level 5 of the reactor building to begin their search and rescue activities. For example, the CR had radiation readings from various area radiation monitors in the reactor building in the areas the team was to enter, but this information was not discussed with the fire brigade/rescue team prior to entering the reactor building.
- b. The fire brigade/rescue team had difficulty donning their anticontamination clothing and respirator equipment prior to entering the reactor building. The team could have started the search and rescue attempt in the reactor building much sooner if help had been provided to assemble the necessary protective equipment and instruments and help the team get dressed.
- c. One fire brigade/rescue team member did not place his self-reading pocket dosimeter on the outside of his anticontamination coveralls. Self-reading pocket dosimeters should be readily accessible for immediate dose determination when entering and working in a high radiation area.
- d. The fire brigade/rescue team appeared rather disorganized. No single person was in charge of the team's activities. There should be assigned a team leader to oversee and be in charge of the team's activities and act as the communicator between the team and the CR or TSC.
- e. The fire brigade/rescue team entered the reactor building on Level 5 without the team's health physics technician in the lead position to monitor the radiation fields they were entering, since this information was unknown. This practice of health physics personnel surveying an area prior to entry is standard operating procedure. This matter was later corrected before the team entered the truck bay area.
- f. While removing the first injury victim from the reactor building truck bay area, the fire brigade/rescue team members were in radiation areas of 1-11 rem per hour (Rem/hr). However, no one checked his self-reading pocket dosimeter to determine the amount of radiation exposure he had received. Self-reading pocket dosimeter results were not read until the team arrived at the fuel storage building.
- g. The fire brigade/rescue team did not identify the second injury victim on the truck bed during the initial search. After the first injury victim had been transported to the fuel storage building, one of the team members mentioned that he saw another victim on the truck bed. However, this team member did not volunteer this information to the other team members until after several inquiries had been made by the CR concerning a second victim. Once it was determined that there definitely was a second injury victim still in the reactor building

truck bay, there appeared to be no urgency on the part of the fire brigade/rescue team to return to the reactor building truck bay to rescue the second victim. At 11:13 a team member stated he had observed a second injury victim. However, the team did not depart the fuel storage building until 11:32 to retrieve the second injury victim. During the time following the fuel cask incident which happened at 10:30, until 11:32, the second injury victim was in an approximately 11 Rem/hr radiation field.

The failure of the fire brigade/rescue team to work swiftly and efficiently and perform their task using proper health physics practices to minimize radiation exposure to themselves as well as to the injury victims and also to minimize the spread of radioactive contamination during the rescue effort is considered an exercise weakness (267/9015-03).

No violations or deviations were identified in this program area.

9. Forward Command Post (82301)

The inspection team observed and evaluated the FCP staff as they performed tasks in response to the exercise. These tasks included activation of the FCP, accident assessment and classification, offsite dose assessment, protective action decisionmaking and implementation, notifications, and interaction with State and local officials.

Activation of the FCP was timely, and it was staffed in an efficient and professional manner. The FCP staff performed their assigned tasks in a competent and professional nature. Communications and coordination with the State and local officials were satisfactory. The FCP director demonstrated a clear command and control of the FCP and worked extremely well with the TSC staff in helping them evaluate the accident conditions, propose solutions to problems, and provide assistance in obtaining necessary support materials, equipment, and personnel. The FCP director conducted frequent status updates of the emergency exercise situations to the FCP staff.

Status boards in the FCP were maintained and updated periodically. However, it was noted that the radiological status board did not identify the radiation dose units. This observation was discussed with the licensee during the exercise and at the exit meeting on November 8, 1990.

No violations or deviations were identified in this program area.

10. Licensee Self-Critique (82301)

The inspection team observed and evaluated the licensee's self-critique of the emergency exercise.

The inspectors determined that the process of self-critique involved participation of the QA audit team, exercise controllers, and upper management. However, input from the exercise players had not been included in the self-cirtique process at the time the licensee presented their exercise findings to the inspectors in a formal presentation on November 8, 1990.

The licensee identified seven weaknesses as summarized below:

- a. Plant procedures were violated in the CR by ordering the fuel deck crew to evacuate the fuel deck without adequate justification for doing so.
- b. TSC personnel held up response actions in trying to second guess the accident scenario. Real life actions were not being taken.
- c. FCP personnel held up response actions in trying to second guess the accident scenario. Real life actions were not being taken.
- d. An emergency medical technician (EMT) was dispatched without a proper briefing and was never issued dosimetry. Upon responding to the injury site, the EMT was instructed to wait in an area which was a radiation area at the time.
- e. A thorough search of the reactor building Level 5 truck bay was not performed resulting in only one of the injury victims being located and rescued initially.
- f. The lack of proper dissemination of complete information to the fire brigade/rescue team resulted in improper response to the search and rescue situation.
- g. The gaitronics on the south side of the turbine building was barely audible. Alarms were heard; however, announcements and messages were not clear and understandable.

The inspectors noted that the licensee was able to identify and characterize a number of exercise weaknesses and that several coincided with findings by the inspection team. The licensee's critique did not include any proposed corrective actions to the identified weaknesses.

During the licensee's critique of their 1990 emergency exercise, the licensee discussed the time required to evaluate the consequences of restoring electrical power to the disabled fuel handling crane in the reactor building and restoring electrical power. The licensee recognized their lack of complete understanding of the fuel handling crane's functions that might occur when electrical power was restored, following complete loss of electrical power with the crane loaded with a spent fuel cask suspended in the reactor building. The licensee stated that a complete understanding of the actions to safely restore electrical power

to the fuel handling crane would be researched, investigated, and documented in a plant procedure prior to the use of the reactor building crane for defueling the reactor. This matter will be inspected by the senior resident inspector during a future routine inspection.

No violations or deviations were identified in this program area.

11. Exit Meeting (30703)

The inspection team met with the acting resident inspector and the licensee representatives indicated in paragraph 1 of this report at the conclusion of the inspection on November 8, 1990. The inspectors summarized the scope and findings of the inspection as presented in this report. The licensee acknowledged their understanding of the exercise weaknesses delineated in the report and agreed to examine them in order to take appropriate corrective measures. The licensee did not identify as proprietary any of the materials provided to, or reviewed by, the inspectors during the inspection.