

U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No. 50-206/83-09

Docket No. 50-206

License No. DPR-13

Licensee: Southern California Edison Company  
2244 Walnut Grove Avenue  
Rosemead, California 91770

Facility Name: San Onofre Unit 1

Inspection at: Camp Pendleton, California

Inspection conducted: March 23, 1983

Inspector:

D. M. Kunihiro  
D. M. Kunihiro, Regional State Liaison Officer  
Team Leader

6/3/83  
Date Signed

Approved by:

M. D. Schuster  
M. D. Schuster, Chief, Security Licensing and  
Emergency Preparedness Section

6/6/83  
Date Signed

Summary:

Inspection on March 23, 1983 (Report No. 50-206/83-09)

Areas Inspected: Announced inspection of the emergency plan exercise and associated critiques. The inspection involved about 50 hours onsite by five (5) NRC inspectors and observers.

Results: No items of noncompliance or deviations were identified.

## DETAILS

### 1. Persons Contacted

R. Dietch, Vice President, Nuclear Engineering and Operations  
K. Baskin, Manager, Nuclear Engineering, Safety and Licensing  
F. Massey, Manager, Nuclear Affairs and Emergency Planning  
H. Ray, Station Manager  
W. Moody, Deputy Station Manager  
P. Dooley, Supervisor, Emergency Planning  
D. Bonnette, Emergency Planner  
G. Buzzelli, Emergency Planning Coordinator  
J. Wallace, Emergency Planning Coordinator

The above personnel were also present at the exit interview.

### 2. Emergency Exercise Development and Control

The Southern California Edison Company (SCE) Nuclear Affairs and Emergency Planning staff was responsible for the development and control of the March 23, 1983 emergency exercise. Development and control of the emergency exercise included the establishment of objectives, exercise ground rules, exercise scenario (including initial plant conditions), cue cards, data sheets and graphs, and exercise observer critique sheets. The scenario was controlled by SCE and distribution was limited to persons having a specific need, which included onsite and offsite observers from SCE and participating local agencies and members of the Federal organizations (NRC and FEMA) evaluating the exercise. This emergency exercise was intended to satisfy the provisions of 10 CFR 50, Appendix E, IV, F, and the commitments set forth in the Sections 8.1.2 and 8.1.3 of the San Onofre Nuclear Generating Station Emergency Plan.

### 3. Observers

The exercise was observed and evaluated by several organizations. The licensee provided controllers for all onsite areas where exercise activities took place. The SCE controllers served as evaluators. The function of the controller was to provide cue cards and data packages at the appropriate times and, if necessary, alter the course of the exercise or provide needed guidance. Controls were established to govern unexpected changes to the course of the exercise. The participating offsite jurisdictions provided observers for their portions of the exercise.

Observers from the NRC and the Federal Emergency Management Agency (FEMA) Region IX were also present during the exercise. The FEMA team of observers was evaluating the portions of the exercise that involved local and state agencies as well as the interface occurring at the EOF. The NRC observed activities in the Control Room (CR), Technical Support Center (TSC), Emergency Operations Facility (EOF). The NRC also observed the activities of a radiological monitoring team dispatched from the OSC.

On March 21 and March 23, 1983, SCE held a briefing for all of their controllers. Controlled copies of the exercise plan document were distributed at that time. The meeting provided an opportunity for discussion of the schedule of activities, the role of the controllers, personnel identification system and telephone numbers for controller communications. Reference was also made to the evaluation sheets that were to be completed by the observers and controllers.

#### 4. Exercise

The exercise was initiated at 8:00 a.m. on March 23, 1983, with an event classified as an "alert" emergency and escalated through a "site" level to a "general" emergency condition. The initiating event was a rupture of a full waste gas tank which released radioactive gases through the ventilation system and vent stack to the atmosphere. The scenario then developed into a loss of coolant accident with a release of activity inside containment and a subsequent release of activity to the environment resulting from the opening of a pressure equalization isolation valve. The meteorological conditions were changed during the period of the release so that all the intended offsite jurisdictions could participate in the exercise.

#### 5. Critique

Immediately following the termination of the exercise, SCE held a preliminary critique to review in general terms the results and findings of selected participants and observers. The majority of participants expressed satisfaction with the exercise play and the implementation of the established emergency plans and procedures. The following areas were identified as areas which require re-evaluation and possible improvement changes: EBS announcements, reactor system briefing diagrams for use in the EOF, and EOF in-processing procedures.

The written reports (critique sheets) submitted by all SCE observers/controllers represent the primary effort to evaluate (critique) the exercise. These reports which are to be examined by the Nuclear Affairs and Emergency Planning staff will be used to establish items needing corrective actions.

#### 6. Exercise Summary

On Friday morning, March 25, 1983, a summary of the exercise results was presented at the Oceanside City Council Chambers. Representatives of the following organizations summarized the exercise findings from their standpoint: FEMA Region IX, City of San Juan Capistrano, City of San Clemente, Orange County, San Diego County and California Parks and Beaches.

#### 7. Exit Interview

On March 24, 1983, following completion of the inspection, an exit interview was held to discuss the NRC findings. SCE personnel attending his meeting have been identified in paragraph 1. Mr. Dean Kunihiro

represented the NRC during the exit interview. The licensee was informed there were no items of noncompliance or deviations identified during the inspection. The following NRC observations, none of which were considered significant, were discussed during this meeting.

1. There appeared to be a deviation from the 15 minute notification requirement of EPIP S0123-VIII-10 item 2.2 in that the transmittal of the hard copy notification form was completed at 8:34 a.m., thirty minutes after the declaration of an Alert. However, further discussion revealed that verbal notification had been completed by 8:15 a.m. on the yellow phone circuit. The notification of offsite agencies by voice communication clearly satisfies the intent of the NRC guidance regarding timeliness of notification as well as the licensee procedure identified above.
2. Procedures appear to require use of headsets for the Shift Commander, Operations Leader, etc., however, headsets were not utilized. The licensee indicated that headsets were made available in the control room as a alternative communication aid for use at the discretion of control room personnel, and that provisions contained in the procedures were not intended to make use of the headsets mandatory. The licensee agreed to review the wording of the procedures and to modify if necessary to clarify the intent.
3. The control room ARM "read" high off scale. Information on dose rate and issue dosimeters to control room personnel did not occur for 28 minutes, at which time the reading was 200 mRem/hr. The assigned health physicist failed to effectively communicate with the Operations Leader so that possible preventative exposure measures (ALARA) could be taken. Discussion of this situation indicated that this problem was most likely due to the extent of "play" in the exercise by the health physicist. A similar "problem" under actual conditions, rather than specified by cue cards, would most reasonably not have occurred.
4. The radiological monitoring teams arrived and were dispatched in a timely fashion. However, the observed radiological monitoring team experienced several problems. The team encountered numerous "dead spots" and were unable to maintain radio contact with the Operations Support Center (OSC). This situation resulted principally because the OSC, which also serves as the communication base station, utilized a hand held radio. Two possible remedies to overcome the communication difficulties were discussed: installing an antenna in the OSC and/or using the TSC as a relay. The team also had difficulty in locating predetermined monitoring stations and in some cases could not locate them. The maps which were provided to the teams were not sufficiently scaled to be of much assistance. The team, on occasion, appeared hesitant and unfamiliar with certain equipment and associated monitoring procedures, it is not certain whether this impression was due to insufficient training or lack of realism and "extent of play" in this aspect of the exercise. In response to these observations the licensee expressed disappointment in the apparent performance of the monitoring team which had been accompanied. They stated that, although extensive training had been



provided to the monitoring teams, additional efforts, to include drills, would be expened to insure proficiency in their assigned responsibilities.