

U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 50-219/84-13

Docket No. 50-219

License No. DPR-16 Priority -- Category C

Licensee: GPU Nuclear Corporation
Oyster Creek Nuclear Generating Station
P. O. Box 388
Forked River, New Jersey 08731

Facility Name: Oyster Creek Nuclear Generating Station

Inspection At: Forked River, New Jersey

Inspection Conducted: May 9-11, 1984

Inspectors: Ira Cohen
Ira Cohen, Exercise Team Leader

June 5, 1984
date

NRC Team Members
Robert Summers
Rosemary Hogan
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Approved by: H. W. Crocker
H. W. Crocker, Chief, Emergency
Preparedness Section, DETP

June 6, 1984
date

Inspection Summary: Inspection on May 9-11, 1984 (Report No. 50-219/84-13)

Areas Inspected: Routine, announced emergency preparedness inspection and observation of the licensee's emergency exercise performed on May 10, 1984. The inspection involved 186 onsite inspection-hours by a team of 6 NRC and NRC Contractor personnel.

Results: No violations were identified.

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DETAILS

1. Persons Contacted

The following licensee representatives attended the exit meeting on May 11, 1984.

R. D. Fenton, Manager Emergency Preparedness
P. B. Fiedler, Vice President, Director Oyster Creek
R. L. Long, Vice President, Nuclear Assurance
J. T. Carroll Jr., Director, Startup and Test
J. P. Muloney, Manager, Plant Materials
J. L. Sullivan Jr., Director, Operations
W. J. Smith, Manager, Plant Engineering
D. W. Turner, Director Radiological Controls

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

2. Emergency Exercise

The Oyster Creek Nuclear Generation Station emergency exercise was conducted on May 10, 1984 from about 1600 to 2300.

- a. Prior to the emergency exercise, NRC Region I representatives had telephone discussions with licensee representatives to review the scope and content of the exercise scenario. As a result, certain revisions were made by the licensee to the scenario package. In addition, NRC observers attended a licensee briefing for licensee controllers and evaluators on May 9, 1984 and participated in the discussion of emergency response actions expected during the various phases of the scenario. The NRC observers noted that the licensee had indicated which activities would be simulated and which events would require contingency messages.

The exercise scenario included the following events:

- A series of three earthquakes which caused a loss of offsite power and eventually a LOCA.
- Personnel Injury
- An off normal containment spray system alignment which permitted LOCA blowdown to bypass the suppression pool.
- A pressure spike which caused a break of primary containment through the torus, causing a release of radioactive material to the environment in excess of Protective Action Guides.

The above events resulted in the activation of the licensee's emergency facilities and permitted the state and counties to exercise their Emergency Plans.

b. Exercise Observation

During the conduct of the licensee's exercise, 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 the scenario events;
- (2) Direction and coordination of the emergency response;
- (3) Notification of licensee personnel and offsite agencies of pertinent information;
- (4) Communications/information flow, and record keeping;
- (5) Assessment and projection of radiological (dose) data and consideration of protective action;
- (6) Provision for in-plant radiation protection;
- (7) Performance of offsite and in-plant radiological surveys;
- (8) Maintenance of site security and access control;
- (9) Performance of technical support;
- (10) Performance of repair and corrective actions;
- (11) Performance of first aid and rescue;
- (12) Fire fighting;
- (13) Assembly and accountability of personnel;
- (14) Management of Accident recovery operations; and
- (15) Dissemination of public information.

The NRC team noted that the licensee's activation and augmentation of the emergency organization; activation of the emergency response facilities; and actions and use of the facilities were generally consistent with their emergency response plan and implementing procedures. The team also noted the following areas where the licensee's activities were efficiently implemented:

- Content and conduct of the initial briefing and critique;
- Initial shift activities of classification, notification and response to initial conditions. The Group Shift Supervisor (GSS) and his staff coordinated initial activities well and GSS provided the Emergency Director a good initial briefing;
- Initial accountability, continuous accountability, security at the plant and EOF;
- The RAC anticipated situations well and made advanced preparations for anticipated events;
- Performance of the medical team;
- Good briefings, were provided to inplant teams; there was effective use of operational support personnel;
- Radiation Controls did a good job in setting up self monitoring stations and providing habitability checks;
- Activities associated with offsite monitoring teams;
- Dissemination of public information;
- Dose assessment calculations at the EOF;
- Performance of activities within the Technical Support Center (TSC);
- Shift of activities from the TSC to the alternate TSC when the TSC became uninhabitable.

The NRC team findings in areas for licensee improvement were as follows:

- There was a failure in the control room to utilize alarm procedures which in the case of the Startup Busses was a significant oversight.
- A General Emergency should have been declared approximately 15 minutes sooner on the basis of two lost boundaries and the potential loss of the third.
- Control Room activities were not very well coordinated after the augmented response team arrived as there was no clear control or direction of personnel and there appeared to be too many people and too much noise within the control room.

- Since the control room communicators were hampered by the excessive noise level, headsets should be available.
- The Emergency Director should have a better status board to aid him in keeping track of plant problems and information as to which group is working on specific corrective actions.
- Control room personnel should have been periodically briefed concerning offsite conditions not only as a result of the release but also due to the earthquakes and in addition, offsite monitoring teams should have been periodically informed of plant status.
- The scenario forced the controllers in the Control Room to act as players at times, this activity appeared as prompting on the part of the controllers.
- Scenario Plant Status Sheets were confusing as to what equipment was available.
- Before 1800 the OSC coordinator was not clearly in control, gained some control after 1800 but did not appear to be clearly effective in his role.
- The HPN phone was inaudible in the OSC.
- A Group Operating Supervisor Trainee who was not on the watch list directed control room operators independent of the Group Shift Supervisor.
- The TSC Radiological Engineer Coordinator appeared reluctant to recommend either evacuation or non evacuation of the TSC.
- The TSC status board did not list the time the plant data was obtained.
- There were problems related to the scenario in that changes were made just prior to the exercise, there was no pre-planned status information after 6:01 p.m. (2 hours into the exercise), some pages were out of sequence and some pages were missing.
- The dose projection data display chart at the EOF has provisions for posting field I-131, however, the data was not posted.
- Computer runs for dose assessment need to have an indication of the time of calculation and release time. For dose assessment based on field data it is necessary to have an indication of the location and time of sample.

c. Exercise Critique

The NRC team attended the licensee's post-exercise critique on May 11, 1984 during which the lead evaluator presented a summary of observations. The licensee indicated that areas highlighted for improvement would be evaluated and appropriate action taken.

3. Exit Meeting and NRC Critique

Following the licensee's critique, the NRC team met with licensee representatives listed in Section 1. The team leader summarized the observations made during the exercise and discussed the areas described in Section 2.b. In addition, the team leader indicated that there was no repetition of any area for licensee improvement identified during the previous exercise (Report No. 50-219/83-15).

The licensee was informed that no violations were observed, and that although there were areas identified for improvement, 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 areas.

At no time during this inspection was written material provided to the licensee by the inspectors.