

There was a good and continuous exchange of information with representatives of the Commonwealth of Pennsylvania. Due to events rapidly occurring, the ERM was unable to provide a full briefing to Commonwealth officials until 47 minutes after the activation of the EOF. However, during this time, EOF staff members interacted with Commonwealth officials to provide needed information. During briefings, requests for information from the Commonwealth and the NRC that could not be answered immediately were recorded and responded to at the subsequent briefing.

The inspectors noted a minor problem with the EOF public address (PA) system. Throughout the exercise, ERM PA announcements were broken up and difficult to understand. However, the PA system worked well during announcements made from the other ERFs. There was no significant impact that resulted from the PA system problem.

When the exercise was terminated, the engineering staff had not yet identified the simulated cause of fuel damage or of the high radiation levels in the dry well. They were working toward resolution of these issues. The inspector determined that these issues were of sufficient technical difficulty to require several hours for resolution and, therefore, were beyond the scope of this exercise.

Overall, the EOF staff performed its response actions adequately, with no particular strengths or weaknesses observed.

#### 7.4.1 Dose Assessment

Shortly after the field monitoring teams detected the presence of radioiodine, the dose assessment staff correctly assessed the consequences of the initial simulated release. The safety of the field teams also was properly considered when the dose assessment team leader (DATL) directed that the field teams be kept out of the plume unless necessary for collecting additional samples.

The classification upgrade to the SAE, based on radiological conditions (i.e., radioiodine level), was appropriate. The staff continually developed "what-if" protective action recommendations (PARs). After the general emergency (GE) declaration, the initial PAR was appropriately developed, based on plant conditions, and was delivered to the Commonwealth in 13 minutes. The bases for the PAR were discussed in a conference with PA officials.

The EOF engineering and the dose assessment staffs did not identify the initial release pathway, which was through the "A" standby gas treatment system (SBGTS) because of filter breakthrough, in a timely manner. The DATL and his staff held several discussions with the engineering staff to explore the potential for the SBGTS filters to have been damaged by a quick and significant change in drywell pressure that had occurred. However, this release pathway was dismissed and efforts were undertaken to pursue the potential for a failed blowout panel. This delayed identification of the actual pathway. Although this did not affect the overall response, the inspector noted that the engineering assessment of the SBGTS as the release pathway was not very thorough or comprehensive.