

ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Inspection Report: 50-445/95-24  
50-446/95-24

Licenses: NPF-87  
NPF-89

Licensee: TU Electric  
Energy Plaza  
1601 Bryan Street, 12th Floor  
Dallas, Texas

Facility Name: Comanche Peak Steam Electric Station, Units 1 and 2

Inspection At: Glen Rose, Texas

Inspection Conducted: December 5-8, 1995

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Plant Support Branch

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Division of Reactor Safety

12/27/95  
Date

Inspection Summary

Areas Inspected (Units 1 and 2): Routine, announced inspection of the licensee's performance and capabilities during the full-scale exercise of the emergency plan and implementing procedures. The inspection team observed activities in the control room (simulator), technical support center, operations support center, and emergency operations facility.

Results (Units 1 and 2):

Plant Support

- The control room crew's performance was generally excellent. Command and control were well maintained. The crew quickly identified problems, developed appropriate mitigation strategies, and demonstrated a professional attitude. The shift technical advisor's performance was identified as a strength. Emergency events were properly classified and offsite notifications were promptly initiated. Room for improvement was observed in the areas of communications, procedure tracking, and plant announcements (Section 2).
- Overall, the technical support center functioned well. Facility personnel aggressively sought solutions for inplant casualties, provided proper technical support to the control room, established priorities to mitigate the scenario events, and communicated the priorities to other facilities in a timely manner. The technical support center manager provided excellent command and control during the exercise (Section 3).
- Overall, the operations support center staff's performance was good. The center was staffed with a sufficient number of individuals with appropriate expertise. The operations support center manager generally exercised good command and control. At times, the command and control area was crowded and busy to the point of distraction. Emergency team briefings and team problem solving and discussions were good. A failure of the operations support center to implement repair priorities established by the technical support center was identified as an exercise weakness (Section 4).
- The emergency operations facility performance in the areas of command and control, dose assessment, and news release preparation was good. An exercise weakness was identified for failure to issue a timely protective action recommendation following the general emergency declaration. Personal support for emergency response personnel was identified as a strength. Notifications, interactions with offsite officials, news release terminology, and status boards were identified as areas for improvement (Section 5).
- The scenario was sufficiently challenging to test emergency response capabilities and demonstrate onsite objectives. Exercise control was generally good; however, several examples of inappropriate controller performance were identified. The practice of using the same controller for conditions requiring multiple emergency team responses was identified as a strength (Section 6).
- Overall, the licensee's critique process was effective. The quality of the post-exercise facility critiques could be improved (Section 7).

Summary of Inspection Findings:

- Exercise Weakness 445/9524-01; 446/9524-01 was opened (Section 4).
- Exercise Weakness 445/9524-02; 446/9524-02 was opened (Section 5).

Attachments:

- ✓ Attachment - Persons Contacted and Exit Meeting

## DETAILS

### 1 PROGRAM AREAS INSPECTED (82301)

The licensee conducted a biennial full-scale emergency preparedness exercise on December 6, 1995. The exercise was conducted to test major portions of the licensee's emergency response capabilities, and to verify that any weaknesses identified during the previous evaluated exercise were corrected. The licensee activated its emergency response organization and all emergency response facilities. Offsite participation included the State of Texas and Somerville and Hood counties. The Federal Emergency Management Agency evaluated the performance of state and local participants. The results of the Federal Emergency Management Agency's evaluation will be documented in a separate report.

The scenario for the exercise was dynamically simulated using the control room simulator. Simulated scenario events included a large break loss of coolant accident in Unit 1 that resulted in core damage and an offsite release. The exercise began at 7:00 a.m. with the unit at 100 percent power. A containment ventilation evolution had just been completed. Following the containment vent, the inside isolation valve failed to fully close. The outside isolation valve had been verified shut. The following major events were simulated:

- At 7:15 a.m., a 25 gallon per minute leak started in the reactor coolant system. At 7:22 a.m., the containment air gas radiation monitor alarmed. The control room crew identified that the leak was greater than 10 gallons per minute and started reducing reactor power. The control room declared a notification of unusual event at 7:34 a.m.
- At 8:00 a.m., a fire started in the Train A emergency diesel generator. The control room received a trouble alarm at 8:05 a.m. and identified that there was a large fire at 8:09 a.m. Based on the reports of the fire, the control room declared an alert at 8:10 a.m. The fire was extinguished by 8:15 a.m.
- By 9:00 a.m., the leak had exceeded the capacity of the centrifugal charging pumps so the crew tripped the reactor. At 9:01 a.m., the containment outside isolation valve failed in a partially open position and started a minor radiological release. At 9:04 a.m., the technical support center declared a site area emergency.
- Next, a series of failures resulted in the loss of the Train B residual heat removal pump, all Train A emergency core cooling systems, and the refueling water storage tank. The emergency operations facility declared a general emergency at 10:07 a.m.

- By 10:19 a.m., the core began to show signs of uncover as core exit thermocouple temperatures started to rise significantly and remained high until the breaker for the Train B residual heat removal pump was repaired and the pump restarted at 12:45 p.m. For the remainder of the exercise, the licensee attempted to restore systems and recover the core. The exercise was terminated at 3:00 p.m.

## 2 CONTROL ROOM (82301-03.02)

The inspection team observed and evaluated the control room staff as they performed tasks in response to exercise events indicated by the control room simulator. These tasks included detection and classification of event-related conditions, detailed analysis of conditions, notification of licensee personnel, and notification of offsite authorities.

Command and control in the control room were generally excellent. Both the shift manager and the unit supervisor periodically provided briefings to ensure that all crew members understood the status of the casualty and the efforts to recover the plant. Additionally, the shift manager provided good oversight of crew activities. On one occasion, the shift manager noted that the unit supervisor started to use the incorrect functional restoration guideline for inadequate core cooling and directed that the correct procedure be used. The unit supervisor started to use Procedure FRC-0.1A for a "red" path, rather than Procedure FRC-0.2A for an "orange" path. The inspectors observed that control room personnel did not use a positive method to track the procedure in effect. Although no errors were observed, there were many instances where the unit supervisor had four or more procedures in use and out on the table.

While communications were generally good to very good, for a short period, communications were poor. Although no errors were noted, the inspectors observed several examples of poor communication practices for approximately 15 minutes following the manual reactor trip. First, while performing the actions of Emergency Operating Procedure Guideline E-0, the inspector often noted a lack of repeat-backs by the operators and a lack of acknowledgement by the unit supervisor. The inspectors concluded that verifying a component's condition without a repeat-back was acceptable; however, positioning a component prior to verification with a repeat-back introduced a high risk for errors due to mis-communications. Second, poor annunciation and the use of letters, rather than titles, led a communicator to incorrectly report that Procedure FR"Z" for containment integrity was in use, instead of Procedure FR"C" for inadequate core cooling. Third, the unit supervisor noted to the reactor operator that they could reduce seal injection flow. The reactor operator neither acknowledged nor implemented the suggestion, and the unit supervisor did not repeat it. Fourth, when one of the control board alarms annunciated, the operator informally stated, "that's me," rather than formally announcing that the particular alarm was due to restoring one of the

systems. The inspectors noted that without any apparent prompting, communications suddenly returned to a typical two-legged and often three-legged exchange. In addition to the above, the inspectors determined that a maintenance plan did not exist for the cordless telephone batteries.

The control room crew demonstrated a professional attitude during the exercise. Abnormal conditions were promptly recognized and appropriate strategies to mitigate the scenario events were developed. The crew understood the significance of a containment gas radiation alarm and, through a mass inventory, quickly recognized that a reactor coolant system leak was in progress. The crew also developed alternate methods to supply safety injection water, some of which were not anticipated by the scenario developers. The shift technical advisor provided outstanding, timely suggestions to the shift manager.

Prior to transfer of emergency coordinator duties, the control room properly classified emergency conditions and made timely notifications to offsite agencies. The notification of unusual event was declared 12 minutes after receiving the first indications of a reactor coolant leak, and the alert was declared 2 minutes after receiving a report of the fire. Offsite notifications were initiated 6 and 8 minutes after event declaration, respectively.

The shift manager made an incorrect announcement at the notification of unusual event classification level. The shift manager directed emergency response personnel to report to their assigned emergency response facility. Activation of the emergency response facilities normally occurs at the alert classification level. In a subsequent announcement, the shift manager directed personnel to standby for further instructions. During the post-exercise critique, the shift manager stated that the standard announcement form contributed to the error. Licensee personnel stated that the announcement form would be reviewed.

### 3 TECHNICAL SUPPORT CENTER (82301-03.03)

The inspector observed and evaluated the technical support center staff as they performed the tasks necessary to respond to the exercise scenario. These tasks included detection and classification of events; notification of federal, state, and local response agencies; analysis of plant conditions; formulation of corrective action plans; and prioritization of mitigating actions.

The technical support center was declared activated at 8:45 a.m., 35 minutes after the alert declaration. As directed, personnel began to arrive at the facility shortly after the notification of unusual event announcement. Although some minor confusion was observed, activation proceeded properly using applicable emergency plan procedures and position assistance documents. Initial facility staffing was selected, and personnel signed-in on the technical support center staffing board. Extra personnel were directed to report to the logistical support center.

Command and control in the technical support center were excellent. Immediately upon arrival, the technical support center manager/emergency coordinator established control, asserted command, and cautioned facility staff about previously identified areas of concern. Briefings were conducted hourly or as conditions changed. These briefings were thorough and technically adequate. Throughout the exercise, the technical support center manager/emergency coordinator interfaced directly and continuously with the staff and provided immediate feedback when informed of changes in-plant conditions/events.

The technical support center manager/emergency coordinator properly classified the site area emergency at 9:04 a.m. based on reactor coolant system leakage greater than available centrifugal charging pump capacity following a safety injection actuation. Offsite notifications were promptly made at 9:15 a.m. Facility engineering and dose assessment teams continuously reviewed emergency action levels. Condition changes which could have led to emergency action level changes were properly identified and transmitted to the technical support center staff and discussed with the emergency operations facility manager/emergency coordinator.

Actions associated with personnel protection were properly conducted during the exercise. Evacuation of non-essential personnel was properly directed following the declaration of the site area emergency. Evacuation routes were chosen to keep personnel out of the potential path of a release plume, even though no release was in progress at the time. Accountability was simulated utilizing Emergency Plan Procedure EPP-314, Revision 5, "Evacuation and Accountability." Actions were completed within the prescribed 30 minutes, and accountability was maintained throughout the exercise. Habitability was established early for the protection of technical support staff and maintained throughout the exercise. Although offsite protective actions recommendations and decisions were posted, no feedback was provided to the technical support center staff concerning the status of evacuations. This information could help assuage concerns regarding family members and help the staff focus on offsite consequences.

With one exception, the technical support center staff interface and engineering analysis of plant conditions, problem solving, and discussions were excellent. This interface assured that both dose assessment and engineering personnel were constantly aware of changes in plant conditions. Engineering, in concert with the control room, aggressively sought a method to cross-tie the Unit 2 reactor water storage tank with the Unit 1 safety injection system to obtain water for core cooling. However, the location of the operations coordinator did not facilitate coordination with other members of the technical support staff. At times, it was necessary for this individual to leave his station and interface with other personnel at the opposite end of the technical support center. Although it did not detract from performance during the exercise, transmission of plant information could have been delayed.

Although no release was in progress at the time, the dose assessment staff properly made "what-if" dose projections using current and timely meteorological data, as well as realistic projected values. Due to licensee identified software problems, the technical support center dose assessment staff assumed certain dose projection responsibilities from the emergency operations facility. Coordination between the two facilities was considered efficient and effective.

Use of visual aids and log-keeping were generally good during the exercise. Status boards were rapidly filled-in and usually maintained current throughout the exercise. However, there were times when status boards lagged current information and had erroneous information. For example, at one point the radiological status board indicated "no release," yet it was stated a release was in progress. Although written logs were kept, these logs did not appear to be complete and did not appear to include all of the information that would be needed to assist in the reconstruction of decisions made during an accident (e.g., signatures and times).

#### 4 OPERATIONS SUPPORT CENTER (82301-03.05)

The inspectors evaluated the performance of the operations support center staff as they performed tasks in response to the exercise. These tasks included functional staffing, providing support to operations, and inplant emergency response team coordination.

The operations support center was properly staffed and declared operational in a timely manner following the alert declaration, despite minor confusion resulting from the notification of unusual event plant public address announcement. Some responders indicated there was confusion about when to report to their facility; they indicated awareness that manning of the facility began with an alert declaration. As a result, some personnel responded at the notification of unusual event classification level, and some responded at the alert level. Nonetheless, the area was rapidly and efficiently set-up in preparation for team formation and dispatch. Appropriate communications were displayed between the operations support center manager and support staff, and technical support center personnel. Based on comments made by some facility personnel, the inspectors concluded that some emergency response organization pagers did not properly activate during the callout. This issue was also identified in the licensee's critique.

The operations support center manager generally exercised good command and control. Briefings were conducted frequently for the staff using an internal public address system. However, at times, the operations support center command and control area was crowded and busy to the point of distraction. This situation mainly occurred when repair team briefings were conducted in the area. Facility personnel exhibited good teamwork and coordination. Use of emergency organization activities log sheets appeared generally thorough and effective. Status boards were adequately used and generally updated in a timely manner. Operations support center habitability was properly monitored.



Communication and control of repair priorities at the operations support center were not fully effective in at least one instance. Two major priorities were identified: (1) the top priority was to restore the emergency core cooling system (ECCS) and (2) the second major priority was the repair of the diesel generator. Shortly after a 9:36 a.m. priorities briefing at the technical support center, the number one priority was reported to the operations support center as "Restore ECCS." Repair of the Residual Heat Removal Pump 1-02 breaker was communicated as a lead sub-element of that top priority. At 9:44 a.m., "Restore ECCS" was listed as the first priority on the operations support center priorities board, but no sub-elements were listed until 11:48 a.m. Due to an apparent mis-communication between the operations support center and the staging area supervisor, the need to repair the pump breaker before the diesel generator was not communicated. As a result, work was performed on the diesel generator instead of restoring ECCS. This delayed restoration of the emergency core cooling system for more than an hour. The failure of the operations support center to implement repair priorities established by the technical support center was identified as an exercise weakness (445/9524-01; 446/9524-01). The licensee's critique also identified this issue as an exercise weakness.

Emergency team members were given excellent briefings prior to being dispatched. Repeat-backs were occasionally used to ensure that assigned tasks were understood. The inspectors observed that numerous emergency work permits were not completed or logged as specified in Emergency Plan Procedure EPP-116, "Emergency Repair & Damage Control and Immediate Entries." No noticeable impact was identified; however, the failure to properly complete the emergency work permits could have a detrimental effect on the control of radiation protection activities and on event reconstruction. This item was also identified during the 1993 exercise. The following examples were noted:

- Debriefing statements on Emergency Work Permits 7, 8, and 14, were not appropriately filled-out by the team leader describing conditions found, problems encountered, work performed, etc. as required by Attachment 1, Block 12/13.
- No indication of immediate entry was recorded on Emergency Work Permits 8, 10, and 14, as required by Attachment 1, Step 1.
- Only one digit was used for the day in Emergency Work Permits 3, 4, 7, 10, 12, and 14, instead of two digits as required by Attachment 1, Step 2.
- Emergency Work Permits 5, 6, 8, and 9, used numerals to signify the month instead of a three letter abbreviation as required by Attachment 1, Step 2.
- No "Prepared by" signature was recorded on Emergency Work Permit 10.

The inspectors accompanied 6 of the 13 emergency response teams dispatched from the operations support center during the exercise. The emergency response teams observed were efficient, professional, and fully capable of performing all assigned tasks. However, two areas for improvement were identified by the inspectors. First, the response to the contaminated injury event was slow. The injured person used the implant gaitronics announcing system to call for help. It took 17 minutes for the first medical services person to arrive. It took another 25 minutes to evacuate the injured individual from the radiologically controlled area. Second, during the diesel generator fire, one of the fire hose teams left a simulated pressurized hose unattended for a brief period of time. The licensee's critique also identified the response to the medical emergency as an exercise weakness.

## 5 EMERGENCY OPERATIONS FACILITY (82301-03.04)

The inspectors observed the emergency operations facility's staff as they performed tasks in response to the exercise. These tasks included facility activation, event classification, development and issuance of protective action recommendations, notification of state and local response agencies, dose assessment and coordination of field monitoring teams, analysis of plant conditions, and direct interactions with offsite agency response teams.

As noted in the other facilities, activation of the emergency operations facility began shortly after the notification of unusual event announcement. There was some confusion when a follow-up announcement indicated that activation was not necessary and that personnel should standby. Despite the confusion, facility activation was conducted in a systematic manner using prepared checklists. Upon arrival, personnel indicated their presence on the magnetic staffing board, readied the facility, obtained necessary position assistance documents, and established communication links. Emergency response staffing was determined from the individuals who responded. Once the necessary positions were filled, extra personnel were released. The emergency operations facility manager declared the facility activated at 8:29 a.m., 19 minutes following the alert declaration. The emergency operations facility manager assumed emergency coordinator duties at 9:27 a.m.

Command and control in the emergency operations facility were good. The emergency operations facility manager/emergency coordinator conducted briefings to keep personnel informed of changing conditions and facility priorities. Input from functional area coordinators and offsite agency representatives was solicited during the briefings. At the emergency coordinator's request, during one of the facility briefings, the logistical support coordinator offered to contact the families of emergency response personnel, if there were concerns stemming from the offsite evacuations. This personal consideration was identified as a strength.

The emergency coordinator declared a general emergency at 10:07 a.m. based on degrading plant conditions and the expectation that projected doses would eventually exceed procedural limits at the exclusion area boundary [Environmental Protection Agency protective action guides (EPA-400)]. As

identified in the licensee's critique, the plant conditions for the general emergency were actually met at 9:40 a.m. (earlier than originally planned due to simulator modeling).

The emergency operations facility did not make a timely protective action recommendation following the 10:07 a.m. general emergency declaration. Offsite agency notification of the general emergency occurred at 10:16 a.m. The notification form stated that there were no protective action recommendations. A recommendation to evacuate emergency response zones in a 2-mile radius and 5 miles downwind was not communicated to the offsite agencies until 10:46 a.m. (39 minutes later). Based on a review of emergency plan procedure EPP-304, "Protective Action Recommendations," and considering the licensee's implementation of the procedure during the exercise, the inspectors concluded that the licensee's procedure did not fully reflect federal guidance concerning protective action recommendations for events involving severe core damage. Specifically, the licensee's procedure did not capture the need to consider anticipated/projected plant conditions and doses. In addition, the procedure based protective action recommendations on dose projections (if available), instead of plant conditions. The licensee's emergency planning staff disagreed with the inspectors' conclusion and stated that plant conditions did not indicate severe core damage. At the time of the general emergency declaration, the scenario conditions included a large break loss of coolant accident, significantly degraded emergency core cooling systems, and loss of containment; however, dose projections using existing release rates did not exceed procedural dose limits. As stated above, the general emergency declaration was based on degrading plant conditions and the expectation that projected doses would eventually exceed procedural limits at the exclusion area boundary. The failure to make a timely protective action recommendation was identified as an exercise weakness (445/9524-02; 446/9524-02).

Subsequent to the inspection, the licensee informed the NRC team leader that corrective actions had been taken to address this exercise weakness. Specifically, a permanent change notice had been generated to modify Attachment 1 (protective action flowchart) to Emergency Plan Procedure EPP-304. The licensee reported that the procedure change resulted in an automatic recommendation to evacuate Emergency Response Zone 2A (2-mile radius) for any general emergency. The effective date of the procedure change was December 29, 1995. In addition, the licensee stated that a bulletin had been issued to all facility managers (emergency coordinators) and applicable radiation protection personnel. The licensee also stated that the change had been verbally coordinated with the state and counties; no objections were voiced. Based on the licensee's followup corrective actions, the inspectors determined that no additional information was needed to address the weakness. However, the inspectors stated that formal closure of this exercise weakness will be determined based on the implementation of the licensee's corrective actions.

With the exception of the preceding notification involving the general emergency protective action recommendation, notifications made by the emergency operations facility were satisfactory. Two areas for improvement were identified. First, incorrect and confusing information was included on some notification forms. Message Form 4 indicated that there were new protective action recommendations; however, message Forms 3 and 4 both indicated that there were no recommended protective actions. The Hood County Advisor (a utility representative) called to obtain clarification. Message Form 7 indicated that Sector 2F was added (2E was crossed-out). The form should have said that Sector E was added. The terms sectors and zones were confused on the form (i.e., 2E and 2F refer to emergency response zones within Sector E). The Somerville County Judge called and requested clarification. Second, completion of the notification message form was delayed on several occasions, because the emergency operations facility communication coordinator had to consult several individuals to obtain the initiating events to include in the event description portion of the form. The communication coordinator was required to visit several work locations in order to find individuals that would check the information boxes on the forms. In some cases, the individuals were reluctant to check information boxes.

Interaction with offsite officials was generally good. Although certain individuals/positions periodically interacted with offsite agency representatives collocated in the emergency operations facility, interactions involving facility management were limited to requesting offsite agency input during briefings.

Status boards in the emergency operations facility appeared effective and were usually maintained. However, there were no status boards to track/display projected offsite doses, and existing status boards were not updated to display offsite protective action decisions and implementation status. Tracking this information would help facility personnel focus on offsite consequences and trends.

Dose assessment activities were satisfactorily performed in the emergency operations facility. Numerous dose projections using stack release rates were computed during the exercise. The licensee identified software problems when field team data was used to compute dose projections (the computer had to be initialized after each computation or the data would be summed). To avoid possible confusion, the responsibility to perform dose projections using field team data was transferred to the technical support center. Coordination with the engineering team was adequate. Habitability of the emergency operations facility was properly monitored.

News releases prepared by the emergency operations facility were generally good. One area for improvement was identified. News Releases 7-9 incorrectly referred to emergency response zones as emergency planning zones. The use of inconsistent terminology in news releases could be confusing to the public.

## 6 SCENARIO AND EXERCISE CONDUCT (82301)

The inspectors made observations during the exercise to assess the challenge and realism of the scenario and to evaluate the conduct of the exercise.

The inspectors determined that the scenario was sufficiently challenging to test emergency response capabilities and demonstrate onsite exercise objectives. Overall, exercise control was good. The practice of using the same operations support center controller for conditions requiring multiple emergency team responses was identified as a strength, because it kept the controllers abreast of current conditions and reduced possible confusion. The inspectors identified the following examples of inappropriate controller performance:

- During an emergency team response to investigate flow noise through a containment isolation valve, a controller gave the radiation technician a copy of the implant survey data sheet. This action was inappropriate, because it prevented the radiation technician from performing duties that would be required during a real event (e.g., logging survey data).
- During the contaminated injury event, a controller instructed a radiation technician to not use ropes and signs to establish a boundary surrounding a potentially contaminated area. The controller's instruction was not consistent with agreed upon onsite exercise objectives. Objective 16 was to "Demonstrate the ability to provide onsite contamination control."
- On one occasion, an emergency operations facility controller asked a player a leading question.

## 7 LICENSEE SELF-CRITIQUE (82301-03.13)

The inspectors observed and evaluated the licensee's post-exercise facility critiques and the formal management critique on December 7, 1995, to determine whether the process would identify and characterize weak or deficient areas in need of corrective action.

The inspectors determined that the post-exercise facility critiques were marginally effective (except in the control room simulator where the critique was considered good). Prior to the exercise, the licensee decided to change the manner in which the post-exercise critiques were conducted: the controllers were not to provide direct feedback to the participants. Instead, the controllers only asked clarifying questions (this was generally performed in small groups), and the participants performed a self-critique. The inspectors concluded that the new method detracted from the overall effectiveness of the licensee's critique process, because known performance errors were not immediately communicated to participants (i.e., a missed opportunity to correct errors). The licensee agreed with the team's

conclusion and added that the participants could have been more self-critical if the controllers had led the critique discussions. One strength was identified during the post-exercise critique in the emergency operations facility. The lead facility controller attached feedback sheets (corrective actions taken) from previous drills/exercises to critique forms distributed to participants. This practice demonstrated that participant comments were being addressed and provided an opportunity to further assess the effectiveness of the corrective actions (i.e., was additional work needed to resolve the issue).

An excellent formal management critique was conducted on December 7, 1995. The exercise lead controller presented the licensee's findings which included weaknesses, improvement items, and strengths (overall and specific). The licensee's organization identified five exercise weaknesses: (1) untimely classification of the general emergency, (2) overdue radiation worker training qualifications for one offsite monitoring team driver (the individual did not participate in the exercise, since the lapsed training was discovered the day before the exercise), (3) inadequate command and control of operations support center activities, (4) untimely communication of field radiological data, and (5) slow response to the medical emergency. Twelve improvement items were identified, many of which were also identified by the NRC evaluation team. The licensee's controllers/evaluators identified 2 overall strengths and 11 specific strengths.

## ATTACHMENT

### 1 PERSONS CONTACTED

- \*C. L. Terry, Group Vice President, Nuclear Production
- \*G. Bell, Supervisor, Emergency Planning
- \*J. Curtis, Manager, Radiation Protection
- \*D. Davis, Manager, Nuclear Overview
- D. Fuller, Senior Nuclear Specialist
- \*N. Harris, Regulatory Compliance Engineer
- \*N. Hood, Manager, Emergency Planning
- S. Johnson, Supervisor, Emergency Planning
- R. Kidwell, Senior Nuclear Specialist
- \*B. Lancaster, Manager, Plant Support
- \*J. Muffett, Manager, Station Engineering
- W. Nix, Senior Nuclear Specialist

\*Denotes those present at the exit meeting

### 2 EXIT MEETING

An exit meeting was conducted on December 8, 1995. During this meeting, the inspectors reviewed the scope and findings of the report. The licensee did not identify as proprietary any information provided to, or reviewed by, the inspectors. Licensee management stated that corrective actions to address the exercise weakness involving protective action recommendations would be implemented as appropriate.