U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-373/92009(DRSS); 50-374/92009(DRSS)

Docket Nos. 50-373; 50-374 License Nos. NPF-11; NPF-18

Licensee: Commonwealth Edison Company
Opus West III
1400 Opus Place
Downers Grove, IL 60515

Facility Name: LaSalle County Nuclear Generating Station, Units 1 and 2

Inspection At: LaSalle Site, Marseilles, Illinois

Inspection Conducted: June 23-26, 1992

Inspectors: H. Simons — H. Simons — Date: 7/2/92

H. Simons for — S. Orth — Date: 7/2/92

P. Louden — Date: 7/2/92

Accompanying Inspectors:

C. Phillips
T. Lonergan
C. Meeker

Approved By: J. W. McCormick-Barger — J. W. McCormick-Barger, Chief
Emergency Preparedness and
Nor-Power Reactor Section — Date: 7/2/92

Inspection Summary

Inspection on June 23-26, 1992 (Reports No. 50-373/92009(DRSS); 50-374/92009(DRSS))

Areas Inspected: Routine, announced inspection of the LaSalle Station's annual Emergency Preparedness (EP) exercise, including review of the exercise objectives and scenario (IP 82302), evaluation of exercise performance (IP 82301), and followup on previously identified items (IP 82301). Six NRC inspectors evaluated licensee performance during the exercise.

Results: No violations, deviations or deficiencies were identified. The licensee's overall response to the simulated accident was good; however, five concerns were identified during the course of the inspection. In the Technical Support Center

(TSC), the emergency actions levels were not properly used to classify the Site Area Emergency (Section 6b). In the Operational Support Center, radiological surveys were not fully documented (Section 6c). Communication among facilities was not effective in relaying significant events such as changes in classification (Section 6a). The inspectors also had concerns with the storage of respiratory protection equipment (Section 6c) and the maintenance of the emergency ventilation system in the TSC (Section 6b). These concerns will be tracked as inspection followup items.

DETAILS

1. NRC Observers and Areas Observed

H. Simons, Technical Support Center (TSC), Operational Support Center (OSC)
C. Phillips, Control Room
C. Meeker, TSC
P. Louden, OSC and inplant teams
T. Lonergan, OSC and inplant teams
S. Orth, Corporate Emergency Operations Facility

2. Personnel Contacted

a. Licensee Representatives Contacted

K. Graesser, General Manager BWR Operations
G. J. Deiderich, Station Manager
W. R. Huntington, Technical Superintendent
J. Schmeltz, Production Superintendent
J. Houston, Emergency Preparedness Coordinator
D. Carlson, NRC Coordinator
L. Holden, EP Operations and Onsite Programs Supervisor
M. G. Santic, Assistant Superintendent Maintenance
T. Carr, Nuclear Quality Programs Inspector
K. Jackson, Corporate Emergency Preparedness
R. Shields, Technical Staff Superintendent
D. Hieggelke, Health Physics Services Supervisor
J. Arnold, OPEX Admin
J. H. Atchley, Operating Engineer
J. K. Walkington, Services Director
J. Tokary, EP Trainer

b. Others Contacted

J. Roman, Illinois Resident Inspector, Illinois Department of Nuclear Safety

The above licensee representatives attended the NRC exit interview held on June 25, 1992. The inspectors also contacted other licensee personnel during the inspection.

3. Licensee Action on Inspection Followup Items (IP 82301)
(Closed) Inspection Followup Item No. 373/91021-01: During the 1991 exercise, the notifications made to the state and counties were unclear.

During the 1992 exercise, the notifications made to the state, counties and NRC officials were presented in a clear and concise manner. Adequate details were given to satisfy the information needs of each agency. This item is closed.

(Closed) Inspection Followup Item No. 373/91021-02: During the 1991 exercise, the transfer of command and control from the Technical Support Center (TSC) to the Emergency Operations Facility (EOF) was untimely.

During the 1992 exercise, transfer of command and control from the TSC to the corporate EOF was timely. The corporate EOF staff quickly activated the facility. The corporate manager of emergency operations ensured that the EOF staff was ready to performed their assigned tasks, and he promptly assumed command and control. This item is closed.

4. General (IP 82301)

An announced, daytime exercise of the LaSalle County Nuclear Generating Station's Emergency Plan (GSEP) was conducted at the LaSalle site on June 24, 1992. This was a partial participation exercise for the State of Illinois, and Grundy and LaSalle Counties. The exercise tested the capabilities of the licensee's, state's and the counties' emergency response organizations to respond to an accident scenario resulting in a simulated release of radioactive material.

5. General Observations (IP 82301 and 82302)

a. Procedures

This exercise was conducted in accordance with 10 CFR Part 50, Appendix E requirements, using the Commonwealth Edison GSEP, the LaSalle Annex to the GSEP, and Emergency Plan Implementing Procedures (EPIPs).

b. Coordination

The licensee's response was coordinated, orderly and timely. If the scenario events had been real, the actions taken by the licensee would have been sufficient to allow State and local officials to implement appropriate actions to protect the health and safety of the public.

c. Observers

The licensee's controllers and evaluators monitored and critiqued this exercise, as was independently done by six NRC observers.

d. Exercise Critiques

The licensee held critiques with participants in each facility immediately following the exercise. On June 25, 1992, lead controllers summarized the licensee's preliminary exercise performance strengths and weaknesses. The inspectors summarized their

preliminary inspection findings during the exit interview conducted on June 25, 1992. A public meeting, hosted by the Federal Emergency Management Agency (FEMA), was held on June 26, 1992, to discuss both the onsite and offsite findings. FEMA will issue a separate report which addresses the offsite findings.

6. Specific Observations (IP 82301)

a. Control Room (CR)

The licensee used the simulator located at their Production Training Center Facility to drive the exercise. The facility is located some distance from the plant and there were some inconsistencies in data since the simulator and plant computers are not linked. However, use of the simulator provided realism to operators in mitigating the accident.

When the Shift Engineer (SE) was notified that incorrect oil was used in the diesel generators, he promptly declared them inoperable. He proceeded to declare an Unusual Event (UE). However, immediately after he made this declaration, he discussed the situation with an operating engineer and they agreed that since they had satisfied two UE emergency action levels (EALs), an Alert declaration would be appropriate. The procedure covering emergency classification allows an upgrade in classification level when two distinct EALs at the next lower level are satisfied. The emergency was upgraded to an Alert before the initial notifications went out to the state and counties.

The state and counties were promptly notified of the Alert declaration. The NRC was notified immediately following the state and counties. Information provided to each agency was appropriate in detailed and presented in a clear and concise format.

The SE exerted very good command and control in the CR. Procedures were used appropriately, and excellent facility briefings were provided frequently.

The exchange of information between the CR and other emergency response facilities was poor. The CR was not informed until 0945 hours that a Site Area Emergency had been declared at 0933 hours. This information was provided only after being requested by the CR. At 1116 hours, the shift foreman informed the SE that the options to recover the reactor water level were very limited and he recommended upgrading the emergency classification to the General Emergency (GE). When the SE relayed this recommendation to the Corporate Emergency Operations Facility (EOF), it was learned that the Corporate Manager of Emergency Operations

(MEO) had declared a GE at 1040 hours. The SE requested that operators be sent to the remote shutdown panels to monitor reactor water level; however, no supplemental reactor water level information was conveyed back to the SE. Communication of significant information among facilities will be tracked as an inspection followup item (no. 373/92009-01).

No violations or deviations were identified.

b. Technical Support Center (TSC)

The Technical Support Center (TSC) was quickly manned. The activation of the TSC was accomplished in a timely and organized manner. As each staff member reported to the TSC, they quickly assumed their positions. The station director (SD) properly assigned someone to assume the control room to TSC communicator position, where the designated person had not yet reported to the TSC. The SD promptly took command and control.

Briefings by the SD to the TSC staff were frequent and thorough. The loud speaker system used to update the TSC staff was very effective. Personnel were attentive during these updates. The SD held good table top discussions with his key staff. During these discussions, they effectively exchanged information and prioritized tasks.

The assistants that supported the SD, operations director, and the technical director provided good support and enhanced the capabilities of the directors to handle multiple tasks.

At 0933 hours, the SD declared a Site Area Emergency (SAE) which was a conservative classification for the plant conditions presented at this time. The SD did not use the Emergency Action Levels to classify the SAE, rather he based his declaration on degrading radiological conditions in the plant. None of the EALs pertaining to radiological conditions exceeding the threshold of the SAE had been met at this time. The use of EALs will be tracked as an inspection followup item (no. 373/92009-02).

Overall accident assessment in the TSC was good; however, the failure of the standby gas treatment system filter was not identified during the exercise. Even after the corporate EOF made a significant protective action recommendation due to high dose rates encountered by the field monitoring teams in the environment, the reason for these high dose rates was never fully discussed in the TSC.

The SD conducted a very comprehensive briefing to all the TSC directors after the one day time jump in the scenario occurred. These discussions were thorough and action items in all areas were considered.

Through discussions with the emergency preparedness coordinator after the exercise, it was learned that there is no maintenance or testing of the emergency ventilation system in the TSC. There are no procedures that require surveillance or testing. The licensee was in the process of determining what testing is appropriate and developing a procedure to perform the test. The inadequate maintenance of the emergency ventilation system in the TSC will be tracked as an inspection followup item (no. 373/92009-03).

No violations or deviations were identified.

c. Operational Support Center (OSC)

The Alert declaration was received in the OSC at 0841 hours. The OSC was manned within ten minutes by the OSC director, OSC communicator, OSC supervisor, and radiation protection (RP) dosimetry staff. Locations for status boards were established and crews began to assemble in the OSC. The facility was fully staffed by crews from each of the required departments within thirty minutes.

The OSC director provided update briefings approximately every one-half hour conveying current plant conditions and the status of inplant teams. The OSC supervisor also provided followup briefings to the crews located in a separate waiting area.

The inspectors observed pre-job briefings for maintenance, electrical, and RP personnel. All briefings appeared to be thorough and open discussions were encouraged to ensure that locations and work to be performed was specifically understood.

It was observed on many occasions, early in the exercise, that the dosimetry issue desk backed up causing a delay in getting inplant teams out to their job locations. This delay in conjunction with the status board not providing timely location of the inplant teams could lead to some confusion as to the exact location of a dispatched team.

It was noted that the step-off-pads (SOPs), to provide contamination control in the OSC, were not setup until two hours following the Alert declaration. The OSC supervisor's decision was based on reports that the radiological conditions in the plant at that time did not warrant such precautionary action. However, in the

event that radiological conditions would radically change without informative field data, inadvertent spread of contamination could have occurred.

After inplant teams reported back to the OSC, teams were debriefed on the radiological conditions. However, radiological surveys performed in the plant were not documented such that they could be used for other team briefings. Radiological surveys should be documented and used for team briefings. They should also be documented for historical purposes. The incomplete documentation of radiological surveys will be tracked as an inspection followup item (no. 373/92009-04).

The inspectors accompanied a team sent to investigate suspected problems with a Unit 1 Reactor Core Isolation Cooling (RCIC) system valve in the RCIC corner room. The team briefing conducted by the OSC supervisor was thorough and definitive dose rate level responses were conveyed and discussed. Protective clothing (PC) for the team consisted of a set of full PCs, plastics, and Self-contained Breathing Apparatus (SCBA) for respiratory protection. The team gathered the necessary PCs and obtained SCBAs located outside the hot lab area on the 710' elevation of the Auxiliary Building. Three SCBA packs were available on the cart; however, two of the packs had their inspection seal broken.

All team members dressed out in the PCs and plastics, and one member actually donned an SCBA briefly to demonstrate proper wearing of the device. Problems were noted with the tape used to secure the dosimetry packs to the plastics. The packs fell off the crew members' PCs and required extensive taping and repositioning to ensure that they would remain affixed to the suit. The team lead by the RPT headed for the Unit 1 Reactor Building; however, the RPT encountered dose rates well in excess of the team limits. A call was placed to the OSC to advise the facility of his findings, and the RPT awaited further instructions. The team had to wait approximately 25 minutes to get additional instructions from the OSC. This time delay under actual conditions could result in heat fatigue of the workers and require additional SCBA air supplies. The team arrived at the valve area and adequately performed and assessment of the situation. Mechanical maintenance personnel called the OSC to report the valve's condition. The RPT provided good coverage of radiological conditions in the area. Upon exiting the radiologically controlled area, the operator was found to be contaminated. The RPT took appropriate actions to decontaminate the individual, collected nasal swabs and blows, and informed the OSC Supervisor of the

personnel contamination event. The Supervisor stated that due to high radiological ambient conditions, that the operator would be taken to the licensee's Production Training Center facility to have a whole body count performed. The team then returned to the OSC.

The inspectors accompanied an RPT and an operator to investigate a bus problem associated with the standby gas treatment system. The briefing was thorough and dose limits were established for the entry. The team donned full PCs. Upon entering the Unit 1 reactor building, the RPT measured dose rates higher than the established limits. He immediately pulled back to a low dose area and called the OSC to convey his findings and await further instructions. Exercise play was then terminated.

A review of emergency supplies located in the OSC indicated that an ample supply of radiation meters, respirators, filter cartridges, and posting supplies existed in the storage cabinets. However, the storage of the respirators was rather haphazard and such stacking of respirators on top of each other could lead to deformation of the face piece seal. This observation along with other observations of the storage of respiratory protection devices in the field and in the TSC will be tracked as an inspection followup item (no. 373/92009-05).

No violations or deviations were identified.

d. Corporate Emergency Operations Facility (EOF)

The Corporate EOF was activated in a very timely manner. The security specialist arrived first and set up access control, unlocked the workspaces, and unlocked the cabinets which held the necessary procedures.

Command and Control was transferred to the Corporate EOF in less than one hour following the Site Area Emergency declaration. It was apparent that the corporate manager of emergency operations (MEO) was certain that his staff was ready to perform their emergency response duties. The corporate MEO ensured that the entire staff was cognizant of plant conditions before accepting command and control from the TSC.

Briefings were very comprehensive in the facility. The corporate MEO utilized the public address system which was audible in all of the various areas in the corporate EOF. A formal announcement was made declaring the facility in command and control.

Status screens were well maintained in the facility. The technical support staffs monitored important plant parameters and trended changing plant conditions.

The staff held good discussions to attempt to mitigate the scenario events. The staff realized that the offsite dose rates were not consistent with the standby gas treatment system filter operating and attempted to postulate another release path.

The staff ensured the accessibility of the evacuation routes from the site. They identified problems with a turned over vehicle on one of the routes, and they were appropriately concerned over the meteorological conditions which could have affected the habitability of the evacuation routes.

Notifications to offsite agencies were timely. The notification of the General Emergency (GE) was made within the regulatory time limit and contained the appropriate protective action recommendation. The noise levels in the communications area appeared to be interfering with the offsite notifications. When the GE notification was made, the communicator misread the form and called for evacuation of Sectors C,D,E,F instead of D,E,F. Because of the lack of clarity of the form, the protective measures director was attempting to give him the information at the same time he was transmitting it. A good decision was made to include the C sector instead of confusing the issue by retracting it.

The corporate MEO made good attempts to keep the mock NRC personnel updated of plant conditions. The mock NRC site team was briefed upon entering the facility. Questions raised by the NRC were given the proper attention.

The information which was released from the facility was mounted at various areas for staff access. This system was not well maintained. There were often nuclear accident reporting system (NARS) forms missing or duplicate ones hanging in the areas.

No violations or deviations were identified.

7. Exercise Scenario, Controller Performance and Critiques (IP 82301 and 82302)

The licensee submitted the exercise scope and objectives and a draft scenario package for review by the NRC within the established timeframes. The licensee adequately answered questions pertaining to the scenario for the NRC inspectors.

Overall control of the exercise was adequate. One minor controller prompt was noted. When the inplant team member was about to don a self-contained breathing apparatus. The controller questioned the player as to whether or not he had seen the broken seal.

The licensee's controllers and evaluators held critiques with the participants in each facility immediately following the exercise. Lead controllers met the following day to discuss observed strengths and weaknesses for each facility and the overall exercise. The licensee presented their findings to the NRC team. The licensee's findings were in good overall agreement with the findings developed independently by the inspectors.

No violations or deviations were identified.

8. Exit Interview

The inspectors held an exit interview on June 25, 1992, with the licensee representatives denoted in Section 2. The inspectors discussed the scope and preliminary findings of the inspection. The team leader stated that the licensee's overall response to the simulated accident was good; however, five concerns were identified during the course of the inspection. In the Technical Support Center (TSC), the emergency actions levels were not properly used to classify the Site Area Emergency. In the Operational Support Center, radiological surveys were not fully documented. Communication among facilities was not effective in relaying significant events such as changes in classification. The inspectors also had concerns with the storage of respiratory protection equipment and the maintenance of the emergency ventilation system in the TSC. These concerns will be tracked as inspection followup items.

The licensee was also asked if any of the topics discussed during the exit interview were proprietary. The licensee responded that none of the matters were proprietary.

Attachments:
1. LaSalle Nuclear Power Station
   1992 GSEP Exercise Scope
   and Objectives
2. LaSalle Nuclear Power Station
   1992 GSEP Exercise Scenario Narrative
   Summary

LASALLE COUNTY NUCLEAR POWER STATION
1992 GSEP EXERCISE
SCOPE OF PARTICIPATION

DATE: June 24, 1992

TYPE: Daytime, Partial

OFFSITE AGENCY PARTICIPATION

State of Illinois (Partial)
Grundy County
LaSalle County

PURPOSE:

Test the capability of the basic elements within the Commonwealth Edison Company Generating Stations Emergency Plan (GSEP). The Exercise will include mobilization of CECo personnel and resources adequate to verify their capability to respond to a simulated emergency.

CECo FACILITIES ACTIVATED:

- Control Room
- TSC
- OSC
- CEOF
- JPIC (Highland Park)

CECo FACILITIES NOT ACTIVATED:

- EOF

The "Exercise" Nuclear Duty Person will be notified of simulated events as appropriate on a real-time basis. The "Exercise" Nuclear Duty Person and the balance of the Corporate Emergency Response Organization will be prepositioned close to the CEOF to permit use of personnel from distant locations.

Commonwealth Edison will demonstrate the capability to make contact with contractors whose assistance would be required by the simulated accident situation, but will not actually incur the expense of using contractor services to simulate emergency response except as prearranged specifically for the Exercise.

Commonwealth Edison will arrange to provide actual transportation and communication support in accordance with existing agreements to the extent specifically prearranged for the Exercise. Commonwealth Edison will provide unforeseen actual assistance only to the extent that the resources are available and do not hinder normal operation of the Company.

LASALLE COUNTY NUCLEAR POWER STATION
1992 GSEP EXERCISE
JUNE 24, 1992

OBJECTIVES LIST

OBJECTIVES TO BE DEMONSTRATED ANNUALLY

1. Assessment and Classification

   Objectives

   a. Demonstrate the ability to assess, within fifteen (15) minutes, conditions which warrant initiating a GSEP classification. (CR, TSC, CEOF)

   b. Demonstrate the ability to determine applicable Emergency Action Levels (EALs) within fifteen (15) minutes of initiating classification. (CR, TSC, CEOF)

2. Notification and Communication

   Objectives

   a. Demonstrate the ability to correctly fill out a NARS form. (CR, TSC, CEOF)

   b. Demonstrate the ability to notify appropriate State and local organizations within fifteen (15) minutes of an Emergency classification or significant change in NARS information.

   c. Demonstrate the ability to correctly fill out NRC Event Worksheets. (CR, TSC, CEOF)

   d. Demonstrate the ability to notify the NRC immediately following State notification and within one (1) hour after making an Emergency classification. (CR, TSC, CEOF)

   e. Demonstrate the ability to provide hourly information updates to the States and within thirty (30) minutes of changes in latest reported conditions on the State Agency Update Checklist. (CR, TSC, CEOF)

   f. Demonstrate the ability to maintain an open-line of communication with the NRC on the ENS upon request. (CR, TSC, CEOF)

   g. Demonstrate the ability to provide hourly information updates to the NRC within thirty (30) minutes of changes in reportable conditions when an open-line of communication is not maintained. (ENS and HPN) (CR, TSC, CEOF)

   h. Demonstrate the ability to provide adequate informational announcement (e.g. assembly instructions, changes in plant conditions) over the plant public address system. (CR)

3. Radiological Assessment and Protective Actions

Objectives

a. Demonstrate the ability to collect and document radiological surveys taken for conditions presented in the scenario. (TSC, OSC, CEOF)

b. Demonstrate the ability to trend radiological information for conditions presented in the scenario. (TSC, OSC, CEOF)

c. Demonstrate the ability to take appropriate protective actions for onsite personnel in accordance with Station procedures. (e.g. respiratory protection, protective clothing, KI) (TSC, OSC)

d. Demonstrate the ability to adequately prepare and brief personnel for entry into High Radiation Areas in accordance with Station procedures and policies. (CR, TSC, OSC)

e. Demonstrate the ability to issue and administratively control dosimetry issued to teams dispatched from the OSC in accordance with Station procedures. (OSC)

f. Demonstrate the ability to establish radiological control in accordance with Health Physics procedures. (TSC, OSC, CEOF)

g. Demonstrate the ability to monitor, track and document radiation exposure for inplant operations and maintenance teams in accordance with plant procedures. (TSC, OSC)

h. Demonstrate the ability to identify appropriate Protective Action Recommendations (PARs) within fifteen (15) minutes of obtaining an Offsite Dose Projection or using a Protective Action Flowchart. (TSC, CEOF)

i. Demonstrate the ability to calculate Offsite Dose Projections in accordance with appropriate procedures. (TSC, CEOF)

j. Demonstrate the ability to perform contamination control onsite in accordance with plant procedures. (e.g. area access control, drinking, water, food supplies, return to normal use criteria) (TSC, OSC)

k. Demonstrate the ability to perform Core Damage Assessments in accordance with the EPIPs. (TSC, CEOF)

4. Emergency Facilities

Objectives

a. Demonstrate the ability to establish minimum staffing in the TSC and OSC within thirty (30) minutes of an Alert or higher Classification during a daytime event in accordance with procedures. (TSC, OSC)

b. Demonstrate the ability to augment the Control Room staff within thirty (30) minutes of an appropriate Emergency Classification in accordance with the procedures. (CR)

c. Demonstrate the ability to transfer Command and Control authority from the Control Room to the TSC. (CR, TSC)

d. Demonstrate the ability to transfer Command and Control authority from the TSC to the CEOF. (TSC, CEOF)

e. Demonstrate the ability to establish minimum staffing in the Corporate Emergency Operations Facility and Joint Public Information Center within approximately one (1) hour of the Site Emergency classification in accordance with CEOF and JPIC procedures. (CEOF, JPIC)

f. Using information supplied by the Exercise scenario, demonstrate the ability to record, track, and update information on the Status Boards at lease every thirty (30) minutes. (CR, TSC, OSC, CEOF)

g. Demonstrate the ability to document Operations and Maintenance Team activities in logs and on the appropriate Status Boards. (OSC)

h. Demonstrate the ability to track in-plant job status in logs and on the appropriate Status Boards. (CR, TSC, OSC, CEOF)

i. Demonstrate the ability to exchange counterpart activity information between the ERFs at least every sixty (60) minutes. (CR, TSC, OSC, CEOF)

5. Emergency Direction and Control

Objectives

a. Demonstrate the ability of the Directors and Managers to exert command and control in their respective area of responsibility as specified in procedures. (CR, TSC, OSC, CEOF)

b. Demonstrate the ability to coordinate and expedite Operations and Maintenance activities during abnormal and emergency situations. (TSC, OSC, CEOF)

c. Demonstrate the ability to prioritize resources for Operations and Maintenance activities during abnormal and emergency situations. (TSC, OSC CEOF)

d. Demonstrate the ability to acquire and transport emergency equipment and supplies necessary to mitigate or control unsafe or abnormal plant conditions. (TSC, OSC, CEOF)

e. Demonstrate the ability of the Shift Engineer, Station Director, OSC Director and MEO to provide briefings and updates concerning plant status, even classifications, and activities in progress at least every sixty (60) minutes. (CR, TSC, OSC, CEOF)

f. Demonstrate the ability to provide access for the NRC Site Team in accordance with Access Control procedures. (TSC, CEOF)

g. Demonstrate the ability to interface the NRC Site Team. (TSC, CEOF)

h. Demonstrate the ability to identify and designate non-essential personnel within thirty (30) minutes after deciding to evacuate the site. (TSC, CEOF)

i. Demonstrate the ability of individuals in the Emergency Response Organization to perform their assigned duties and responsibilities as specified in the Generic GSEP. (CR, TSC, OSC, CEOF)

6. Public Information

Objectives

a. Demonstrate the ability to respond to Media requests within sixty (60) minutes in accordance with CECo policies and procedures. (JPIC)

b. Demonstrate the ability to prepare accurate Press Releases within ninety (90) minutes of significant event while in a Site or General Emergency classification. (JPIC)

c. Demonstrate the ability to present Media Briefings within ninety (90) minutes to significant event while in a Site or General Emergency classification. (JPIC)

d. Demonstrate the ability to use visual aids to support Media Briefing information in accordance with CECo policies and procedures. (JPIC)

e. Demonstrate the ability to maintain a CECo representative in the JPIC at all times. (JPIC)

7. Recovery

Objectives

a. Demonstrate the ability to determine long-term recovery staffing requirements. (TSC, CEOF)

LASALLE COUNTY NUCLEAR POWER STATION
1992 GSEP EXERCISE
JUNE 24, 1992

OBJECTIVES TO BE DEMONSTRATED EVERY FIVE YEARS

8. Miscellaneous

Objectives

a. Demonstrate the ability to determine the magnitude of the source term of a release. (TSC, CEOF)

b. Demonstrate the ability to establish the relationship between effluent monitor readings and onsite and offsite exposures/contamination for various meteorological condition. (TSC, CEOF, Field Teams)

c. Demonstrate the ability to determine the magnitude of a release based on plant system parameters and effluent monitors. (TSC, CEOF)

d. Demonstrate the ability to explain the evacuation route, brief personnel and arrange for traffic control within one (1) hour of starting site evacuation. (TSC, CEOF)

e. Demonstrate the ability to collect and count field samples in accordance with Environmental Sampling procedures. (Field Teams)

f. Demonstrate the ability to collect and count field samples in accordance with Environmental Sampling procedures. (TSC, CEOF, Field Teams)

g. Demonstrate the ability to perform dose rate measurements in the environment for conditions presented in the scenario. (Field Teams)

h. Demonstrate the ability to dispatch the Environs Teams within forty-five (45) minutes of determination of the need for field samples. (TSC, OSC)

i. Demonstrate the ability to control/coordinate Environs Teams activities in accordance with Corporate Emergency Plan Implementing procedures (CEPIP's) or Station procedures. (TSC, CEOF, Field Teams)

j. Demonstrate the ability to transfer control/coordination of Environs Teams activities from the TSC to the CEOF in accordance with Station and CEOF procedures. (TSC, CEOF)

9. Public Information

Objectives

a. Demonstrate the ability to always maintain a CECo representative in the JPIC in accordance with CECo policies and procedures. (JPIC)

b. Demonstrate the ability to exchange event information with Non-CECo JPIC representative for Media Briefings in accordance with CECo policies and procedures. (JPIC)

c. Demonstrate the ability to coordinate information with Non-CECo JPIC representatives for Media Briefings in accordance with CECo policies and procedures. (JPIC)

d. Demonstrate the ability to activate Rumor Control. (JPIC)

10. Recovery

Objectives

a. Demonstrate the ability to identify the criteria to enter a Recovery classification in accordance with procedures. (TSC, CEOF)

b. Demonstrate the ability to generate a Recovery Plan which will return the plant to normal operations in accordance with CECo policies and procedures. (TSC, CEOF)

c. Demonstrate the ability to coordinate recovery actions with the State. (TSC, CEOF)

LASALLE COUNTY NUCLEAR POWER STATION
1992 GSEP EXERCISE
JUNE 24, 1992

NARRATIVE SUMMARY

"THIS IS AN EXERCISE!"

INITIAL CONDITIONS

UNIT ONE:

Unit One is operating at ~ 100% power on the 100% flow control line. HPCS was returned to service on the midnight shift following the changeout of the oil in the HPCS pump motor. The Unit 1 Standby Gas Treatment System (SBGT) is out of service for repair of the fan, placing Unit 1 in day 2 of a 7 day time clock per T.S. 3.6.5.3.a.

UNIT TWO:

Unit 2 is in week 8 of a refueling outage. Work activities for the refueling outage are progressing on schedule. LTS 800-204 (Unit 2 "0" Diesel Generator 24 Hour Run) Surveillance is in progress. The run began at 0450 a.m.. The Unit 2, Division 1, crosstie breaker ACB 2414 is out of service; work is in progress in the cubicle for repair of the breaker.

UNIT COMMON:

The Load Dispatcher has instructed that he be notified before any changes in electrical loading, because the system is currently "Yellow". The Mazon EOF is not currently available. Repairs to the building electrical distribution system are in progress and are expected to be completed by approximately 9 p.m. tonight.

Unusual Event
(0740-0840)

The "0" diesel generator trips on overspeed approximately two hours and fifty minutes into the 24 hour run, due to governor problems.

Expected Actions

The crew should dispatch an Equipment Operator to investigate the trip of the "0" diesel generator. Electrical Maintenance, Mechanical Maintenance and Tech Staff will investigate the problem with the diesel generator governor and determine that the wrong type of oil was used in the governor.

Review of the past maintenance records will show that the wrong type of oil was also used in the governors for the "1A" and "1B" diesel generators. The Shift Engineer is expected to declare the "0", "1A" and "1B" diesel generators inoperable and classify a GSEP Unusual Event per EAL 3.E (Loss of all associated diesel generators with the Unit in conditions 1, 2, or 3). The Acting Station Director should then initiate the actions for the GSEP Unusual Event. NOTE: The Shift Engineer could also declare an Unusual Event per EAL 3.A (Tech Spec required shutdown and power decrease has commenced).

ALERT
(0840-0940)

A Main Generator/Turbine Trip will occur at 0840, and the Automatic Reactor Scram will fail, but the Manual Scram will work. Minor fuel damage will occur immediately, as indicated by slowly rising Main Steam Line radiation levels.

Expected Actions

The Control Room operators will perform LGP 3-2 (Reactor Scram) and monitor the operation of plant systems. Since the automatic reactor scram failed but the manual scram function worked, the Acting Station Director should classify a GSEP Alert per EAL 3 H (Failure of automatic scram to initiate and manual scram was successful). The Acting Station Director should then take actions to implement the GSEP Alert.

At approximately 0900 the Unit 1 SBGT WRGM will fail and require the operators to investigate the cause. The failure will be due to a blown fuse which causes a low flow condition. It is anticipated, the SBGT WRGM will be repaired prior to the beginning of the release, such that the release will be monitored, except for the time auxiliary power is lost.

At approximately 0930, a small crack that had developed during the ATWS pressure spike, on the RCIC steam line, will propagate and become large enough to result in a substantial amount of steam leaking into the RCIC room. A failure of the automatic isolation valves on the RCIC steamline will result in the steam leak being unisolable. As a result of the steam leak a "B" operator will be dispatched to the RCIC room to investigate leak. The RCIC isolation failure is considered an unisolable breach of containment and thus, is a loss of 1 fission product barrier. This is a 2nd independent alert per EAL 2.G (Loss of or challenge to one of the three Fission Product Barriers) and the Station Director may upgrade to a Site Emergency.

Site Emergency
(0940 - 1115)

As a result of the fuel failure, the main steam line radiation increases to 3 x normal, resulting in an automatic Group I isolation.

Expected Actions

Based on the Main Steam Line high radiation and the unisolable RCIC steam line discharging into the Reactor Building, the TSC should declare a Site Emergency per EAL 2 L (Loss of or challenge to two of the three Fission Product Barriers). The TSC, which should be in command and control at this time, should perform the actions for a GSEP Site Emergency. Control Room Operators should follow the LGAs and depressurize the reactor.

At approximately 0950 the Operator investigating the steam line leak will become contaminated. The Radiation Protection Department will be notified and take actions to decontaminate the Operator.

The Unit 1 SAT will fail at approximately 0955 resulting in a temporary loss of A/C power. The "1A" and "1B" diesel generators will automatically start to restore A/C power to divisions 2 and 3. The Control Room Operators will take actions to verify the loss of A/C power and take actions to restore normal A/C power. These actions will involve cross tying to Unit 2 and back feeding Unit 1 through the Unit 1 UAT. The Unit 2 Division 1 cross tie (ACB 2414) is OOS. The Division 2 cross tie to Unit 2 will fail when closing is attempted.

At approximately 1010, SBGT which had started automatically, will begin to fail resulting in a elevated release.

Approximately 1 hour after the "1A" and "1B" diesel generators auto-started, they will experience governor problems, similar to those experienced by the "0" diesel generator earlier, and they will trip. This will result in a total loss of A/C power to Unit 1.

GENERAL EMERGENCY
(1115 - 1330+)

At approximately 1115, reactor level will drop below -129".

EXPECTED ACTIONS

Reactor level dropping below -129" with drywell pressure > 1.69 PSIG, results in the "loss" of the third Fission Product Barrier per the EALs. The MEO should upgrade to a General Emergency based on EAL 2.P (loss of or challenge to two of the three Fission Product Barriers with probable loss of the third Fission Product Barrier.)

At approximately 1130, Reactor Level will drop below the Top of Active Fuel (TAF), and fuel damage, and thus the release will increase.

At approximately 1145, some makeup capability to the reactor will be restored. The system(s) returned will be a function of the prioritization set by the participants for the repair of the degraded electrical equipment.

RECOVERY
(1400+ on 6/25/92)

At 1400, a 24 hour time jump will be introduced. Control Room and OSC participation will terminate. The outboard RCIC steamline isolation valve will be closed, and all A/C power to unit 1 will be restored by backfeeding through the UAT.

EXPECTED ACTIONS

The EOF is expected to plan recovery for the plant, pursuant to the conditions provided above, as well as planning long term manning requirements for Field Teams and the Emergency Response Facilities.