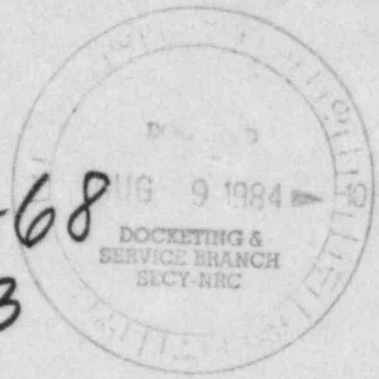
50-322 OL-3

SC EP68



I - SC-68
11/83

DOCKET NUMBER 50-322 OL-3

NOVEMBER, 1983

NUCLEAR REGULATORY COMMISSION

Docket No. 50-322-OL Official Exh. No. SCEP68

In the matter of Shoreham - Emergency Planning

Staff	IDENTIFIED
Applicant	RECEIVED
Intervenor ✓	REJECTED
Cont'g Off'r	
Contractor	DATE 6/15/84
Other	Witness
Reporter R. Eyster	

Area Evaluated | Monitors Rating

G. Access Control

1. Was an appropriate access control posture established? Yes=1 — 5 4 3 2 (1) N.O.

2. Was there an identifiable system implemented that effectively identified authroized personnel within the facility? (5) 4 3 2 1 N.O.

Yes=1

H. Summary

1. Describe any problems noted by the area being evaluated. Provide a description of the problem, its outcome or effect and any recommended corrective courses of action to alleviate or correct the deficiency. Any of the previously listed areas that receive an evaluation grade of 2 or 1 require a written explanation on this page.

One of the key participants in the traffic group did not show. One of the two communicators was reassigned to cover the Traffic Control Point Coordinators which made things tough for the sole remaining communicator.

[redacted] 1/11/15/03
Evaluators Signature / Date

Drill Date

Area Evaluated	Monitors Rating

G. Access Control

1. Was an appropriate access control posture established? — 5 (4) 3 2 1 N.O.

2. Was there an identifiable system implemented that effectively identified authroized personnel within the facility? — 5 (4) 3 2 1 N.O.

I. Summary

1. Describe any problems noted by the area beirg evaluated. Provide a description of the problem, its outcome or effect and any recommended corrective courses of action to alleviate or correct the deficiency. Any of the previously listed areas that receive an evaluation grade of 2 or 1 require a written explanation on this page.

Procedures

4. Home Coordinator's call out tasks include:
   - o Contacting invalids (OPIP 5.1.2 d)
   - o Alerting Hospitals of arrival (OP.P 5.1.2 c)
   - o ~~Contacting~~ Verifying Ambulances (OPIP 5.1.2 e)

This is too much for one coordinator

Material & Equipment

5. Needed some more Suffolk Cty. Hagstroms.

[redacted] 11/16/83
Evaluators Signature / Date

JANUARY 24, 1984

Area Evaluated	Monitors Rating

G. Access Control

1. Has an appropriate access control posture established? (5) 4 3 2 1 N.O.

2. Was there an identifiable system implemented that effectively identified authroized personnel within the facility? (5) 4 3 2 1 N.O.

H. Summary

1. Describe any problems noted by the area being evaluated. Provide a description of the problem, its outcome or effect and any recommended corrective courses of action to alleviate or correct the deficiency. Any of the previously listed areas that receive an evaluation grade of 2 or 1 require a written explanation on this page.

- ONE WAY TRAFFIC FLOW CONCEPTS/PAPERWORK NEEDS CLOSE REVIEW (C.4)
- 56 TRAFFIC POSTS TO BE MANNED, ONLY 50 T.C.'s ASSIGNED
- ATTACHMENT 9 TO OPIP 36.4 REV. 2 IS INCOMPLETE. NOT USABLE AT T.P.'s (C.4)
- SA COORDS. SHOULD BE GIVEN NECESSARY KEYS AT THIS POINT
- T.P. COORD. BOXES TOO LARGE & BULKY TO TAKE INTO FIELD.
- LEASE ATTACHMENTS / CO. CARS IS A BIG PROBLEM
- DEVELOP RADIO # LISTING IN ADVANCE FOR RADIO OP. USE (TRAFFIC GUIDE DISPATCH LOG)

[redacted] 1/28/84

Evaluators Signature / Date

Problems: The biggest problem area was the controlled parking lot. The problems stemmed from both lack of equipment and from lack of personnel. The monitoring/decon personnel used the available plastic traffic cones and the radiation area warning tape (plastic ribbons). The barrier was not very visable being only two feet off the ground. The wind would blow the traffic cones over. The tape and cones were lost from view once cars were parked beside them. The Decon Leader had only one (1) person to assign to park the arriving vehicles. The arriving traffic guides ignored the monitoring person's directions. Some went into the cafeteria for coffee before going down stairs to be monitored. Others entered the facility by other than the marked path ignoring the requests from the monitoring personnel. Part of the problem was that he was not clearly identifiable as a member of the Decontamination Facility.

Inside the facility the operation went better. The traffic guides waited in a controlled holding area until a monitor was free.

The monitoring personnel were scanning people a little too rapidly and they sometimes neglected to monitor the person's feet but after the first 5 people, each monitor fell into a pattern and the scanning was done more properly although still a little too rapidly. When confronted with a contaminated person, the monitoring personnel remembered to tell the decon leader and knew how to decontaminate the person but they had some trouble filling out the form. They also neglected to fully question the person to find out his/her location. Also they neglected to tell the people ajacent to them that they had a contamination problem. When questioned they knew the proper response. It seemed that they were having trouble fitting into fully participating after every response.

A problem was observed in the decon area. The decon leader had no spare people to station at the clean exit from the shower area and workers were using that door to enter and use the bathroom facilities in what was suppose to be a controlled area.

Area Evaluated	Monitors Rating

G. Access Control

1.	Was an appropriate access control posture established?	5 4 3 2 1 (N.O.)
2.	Was there an identifiable system implemented that effectively identified authorized personnel within the facility?	5 4 3 2 1 (N.O.)

H. Summary

1. Describe any problems noted by the area being evaluated. Provide a description of the problem, its outcome or effect and any recommended corrective courses of action to alleviate or correct the deficiency. Any of the previously listed areas that receive an evaluation grade of 2 or 1 require a written explanation on this page.

1. Another individual should be assigned to ensure that minute-by-minute duties of the dose assessment staff are performed. Much of the RHC's time is taken with the decision-making process and overall direction. This comment was also made by several participants.
2. The offsite dose rate table should be relocated in the dose assessment area.
3. All players should be educated in the role of the controller and how the players should or should not play their roles.
4. Phone numbers for the dosimetry contacts at the staging areas should be available

[redacted]
Evaluators Signature Date

FEBRUARY 8, 1984

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

Principle subject of observation was Traffic control. As noted, the lead traffic guides had no advance preparation training or information about tasks. (They were normally just traffic guides in prior drills.) This was a serious error on the part of those responsible for coordinating effort. Insufficient training and preparation, and lack of knowledge of the operation of non-traffic guide tasks led to unacceptable delays and omissions of data. The three leads deserve an A+ for effort in dealing with an unfamiliar and complicated task; an actual lead traffic guide probably would have performed better. But the results in general were not good enough for FEMA in this observer's opinion.

Refer to controller log sheets for specific details.

The lack of enough dosimeters prevented all the TCP's from being manned. That could flunk the excercise probably.

The staging area also didn't have enough route spotters (only one showed up!).

(1) of 8

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/8/84

Location: Post 10H

TIME | OBSERVATION/COMMENT of Ld Traffic Controller Observer

10:00 None of the lead traffic guides were trained or prepared for their tasks! [redacted]

Traffic Guide logs not available for leads. List of personnel not avail. Overheard Bus [redacted] ask "What's EPZ stand for."

10:15 Notification of alert, declared at 9:07 a.m. No synchronization of watches.

10:20 [redacted] suggests installing speakers for communications as an aside.

10:30 to 11:00 Three lead traffic guides attempt to familiarize with their tasks. It should be recognized that they have had no training!! Begin writing briefing info on boards (phones, remember to state that "This is a drill" in messages, etc.

Dispatch logs for Road Crews and Evacuation Route Spotters not available. Had to be improvised from other logs

11:15 Communications delegated to [redacted] prepared for briefings.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

Overall Grade - 'A' for effort
Probable FEMA Grade Between 'C' & 'D'. Easy graders.

Numerous key functions were being performed by people who had never done it before in a drill and some had never even seen the procedures before specially the Lead Traffic Guides who had never been other than traffic guides before. Also the Dosimetry Record Keepers (only 2 out of 3 showed) were 'virgins' and needed a lot of direction by their Controller/Observer to even get the drill to function. VERY POOR STAFFING SCHEDULING for a drill that was to be a 'hands off' Observer drill. Especially with regard to some of the sophisticated message tricks, key controller observers were wasted in the field waiting for messages to arrive to provide a contingency message reply. I strongly suggest this aspect of these drills be skipped for the other two replays.

STAGING AREA MODULE

I. Activation and Staffing

	Yes	No	N/A	N/O
1. Which Staging Area were you assigned to?	Port Jefferson TRAFFIC CONTROL			
2. Were mobilization and notification procedures demonstrated (as opposed to pre-positioning)?	✓			
3. If so what time was staffing complete for: - Group II? - Group III?	Not observed			
4. Was a full complement of staff present according to the plan?	see note (1) below			
5. Did the Staging Area personnel in general, display adequate training and knowledge?		✓ see note (2)		
6. Was 24 hour staffing capability demonstrated?				✓

Notes:

(1) Full staff probably present for most functions. However, lack of sufficient number of dosimeters prevented full participation and implementation of plan.

(2) The three lead traffic guides were not trained or prepared for their tasks, and had not been informed of their positions before arriving at staging area.

2/8/84

Port Jefferson Staging Area Critique

REALISTIC ATTEMPT AT STRIKE IN BUT has complicated many KEY FUNCTIONS

I Activation & Staffing

- BEING PERFORMED BY PEOPLE WHO HAD NEVER DONE THESE TASKS IN A DRILL SCENARIO BEFORE ESPECIALLY LEAD TRAFFIC GUIDES WHO HAD ONLY BEEN TRAFFIC GUIDES BEFORE & DOSIMETRY RECORD DISTRIBUTION PEOPLE WHO HAD NEVER CARRIED THE BALL IN A DRILL BEFORE AS WELL AS ADMIN ASSTS.

II Facilities and Eqpt

- 1 DESK WITH 5 PHONES & A RADIO ON IT. NEEDS MORE SPACE. THE STATUS BOARDS COULD HAVE BEEN USED TO GREATER ADVANTAGE. PEOPLE IN MANY CASES WERE WORKING WITH PROCEDURES THEY HAD NEVER SEEN BEFORE AND HAVE NO PERSONAL COPIES OF SAME TO REVIEW AT LEISURE
- DIFFICULTIES WITH THE LAYOUT AT PORT JEFF, NEEDS A PERMANENT PA System WITH MULTIPLE SPEAKERS ON TURBINE DECK. THE LARGER BRIEFING ROOM COULD HANDLE NO MORE THAN 50 AT A TIME WHICH MEANS 5 SEPARATE STAGGERED BRIEFS HAD TO BE HELD FOR JUST THE BUS DRIVERS & TRAFFIC GUIDES ON THE WAY OUT NOT TO MENTION THE SMALLER GROUPS. COMMUNICATIONS AREA HAD 5 PEOPLE AROUND

III Command & Control

- The Coordinator did a credible job especially in light of the inexperienced people he had to depend on. Unfortunately the Drill Controller/Observer had to direct some actions to facilitate the running of the drill. Good use was made of an experienced admin asst on the Turbine Deck who acted as the S.A. Coord rep.
- To specific Briefings & Dosimetry Briefings were OK. But there was little in the way of general plant briefings or radiological condition briefing for the troops.

IV Dosimetry & Exposure Control

- Problems encountered included insufficient Dosimetry available as well as Dosimetry Record Keepers with insufficient DRILL experience for a drill like this one was supposed to be, a hands off critically observed scenario. This was one area that required a lot of control & direction by the specific controller and adversely impacted the ability of the staging area to dispatch manpower efficiently & properly

V Communications

- Communications physically pretty good in and out of the Staging Area but needs improvement within the staging area itself - as mentioned the need for a P.A. system on the Turbine Deck & a portable bullhorn was insufficient. THERE WAS SOME CONCERN IN EVIDENCE WITH REGARD TO OFFICIAL & UNOFFICIAL LINES OF COMMUNICATIONS AVAILABLE DURING DRILL.

VI Scenario Drill

- OVERALL - 'A' BASED ON EFFORT NOT HIGHER THAN 'C' BY FEMA STDS & MAYBE LESS
- SUPPOSED TO BE A HANDS OFF OBSERVER DRILL BUT THE SITUATION AS IT DEVELOPED REQUIRED CONTROLLING and hence unable to critically observe

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

2. REPORTING WAS PREPLANNED WITH PRIOR NOTIFICATION. SOME STAFF ARRIVED EARLY. ROSTERS OF PERSONNEL WERE PROVIDED BY DRILL CONTROLLER - THEY SHOULD BE MADE AVAILABLE BY OTHER MEANS. STAGING AREA COORDINATOR DID NOT KNOW HOW MANY PEOPLE WERE REQUIRED FOR FULL STAFFING SO HE COULD NOT JUDGE WHEN CENTER WAS ACTIVATED FOR GROUP III.

4. ONE OF THREE LEAD TRAFFIC GUIDES DID NOT SHOW UP.

5. SEVERAL PEOPLE FROM EACH GROUP IN GROUP II DID NOT HAVE PREVIOUS DRILL EXPERIENCE. THEY WERE HELPED/TRAINED BY 'OBSERVERS' FROM CLCO WHO HAD THE EXPERIENCE FROM PREVIOUS DRILLS. THESE 'OBSERVERS' TOOK ACTIVE ROLES ON SEVERAL OCCASIONS DESPITE CONTROLLER INSTRUCTIONS AT DRILL COMMENCEMENT. THESE OCCASIONS WERE:
   1. CALLING THE EOC FOR THE LEAD TRAFFIC GUIDE TO REPORT A DOSIMETER READING OF A TRAFFIC GUIDE (200 MR).
   2. MAINTAINING SIGN IN POST AND ASSOCIATED RUSTERS.
   3. TAKING AN ACTIVE ROLE IN RESOLVING A MISSING TRANSFER POINT COORDINATOR BOX.
   4. PROVIDING VARIOUS INSTRUCTIONS AND/OR ADVICE.
   5. 2 PEOPLE HELPED BUS DISPATCHER DISPATCH DRIVERS.

STAFF GENERALLY UNFAMILIAR WITH TERMS SUCH AS 'PROTECTIVE ACTIONS', 'RELEASE STATUS' OR PLANT EVENTS REPORTED BY EOC WHICH ARE CAUSES OF PARTICULAR EMERGENCY CLASSES.

- 7 BUSES NOT AVAILABLE DUE TO LACK OF VEHICLES/LEASES. 20 BUS DRIVERS NEVER WENT OUT. 61 ROUTE/TRANSFER DRIVERS WERE AVAILABLE TO FILL 75 SLOTS NEEDED. IF ALL ROUTES WERE REQUIRED, 32 BUSES WOULD BE UNAVAILABLE.

- 3 TRAFFIC POINTS WERE NOT MANNED OUT OF 38 REQUIRE

(5) of 8

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/8/84

Location: Port Jeff

** Post TCP at outside perimeter of EPZ chosen in recognition of radiation danger.

TIME	OBSERVATION/COMMENT
	was relayed to Patchogue, message returns to send crew there anyway. Will take action after traffic guides sent out.
1:32	Running short of traffic guides to fill out list due to 2 man crews. Why?*
1:35	Female driver (only one present with dosimeter) sent to TCP #51. Radiological data not sought or given**. Last traffic guide sent out 1:38.
1:40	Road crews briefed. Some confusion over where destinations are due to lack of experience on part of leads. Martin Calleja has worked out confusion over pt. #35 satisfactorily. First crew leaves 1:49.
1:52	Supplementary message IV-59 given No crews had radios, so no crew dispatched for this message.

* due to shortage of dosimeters.

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/3/94

Location: Port Jeff

TIME	OBSERVATION/COMMENT
2:00	Only one of two route spotters shows. Were going to fill in with traffic guides but none had dosimeters and him no radio Not all the traffic ~~guides~~ control points were able to be manned. The following were manned: 141, 43, 147, 1, 49, 98, 51, 4, 140, 6, 5, 38, 56, 57, 41, 120, 122, 137, 139, 37, 40, 121, 95, 50, 52, 144, 119, 58, 145, 61, 59, 60, 97, 99, 100, 101, 102, 94, 93 TOTAL = 39 OF 56 The following were missing from the 1:00 message: 141, 142, 43, 147, 146, 42, 118, 1, 104, 103, 133, 117, 44, 74, 105, 96, 47, 49, 55, 48, 60, 98, 95, 51, 96 TOTAL = 25 OF 82

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

TRANSFER POINT (NORWOOD AVE PROPERTY)

GENERALLY THINGS WENT SURPRISINGLY SMOOTH MY MAIN CONCERN IS THAT AT LEAST THREE TRANFER PT. COORD. WOULD BE REQUIRED IN A REAL EMERG. ONE TO DISPATCH ROUTE PACKETS, ONE TO LOG IN & KEEP TRACK OF BUSES DISPATCHED, AND ONE TO GUIDE THE TRANSFER OF PEOPLE FROM ONE BUS TO ANOTHER.

THERE WAS SOME CONFUSION ABOUT WHAT ORDER (ON THE DISPATCH CHART) SHOULD THE BUS ROUTES BE DISPATCHED. AFTER SOME ANAL. THE BUSES WERE DISPATCHED CORRECTLY.

AT CERTAIN TIMES IT WAS DIFFICULT FOR THE COORD. TO DISPATCH BUSES & MONITOR THE RADIO TOO.

I DID SEE ONE PLAYER CHECK HIS DOSIMETRY ONCE. THE OTHERS I DID NOT SEE CHECK AT ALL DURING THE 2½ HRS. OUT @ THE TRANSFER POINT.

THERE IS NO LIGHTING PROVIDED @ THE TRANSFER PT.

A FEW BUS DRIVERS (4 OUT OF 80) COMPLAINED OF INACCURACIES IN THEIR MAPS. (WRONG STREET NAMES, ONE MAP WAS MISSING 3 PAGES) ALL DRIVERS WERE ABLE TO COMPLETE THEIR ROUTES THOUGH.

(CONT. ON BACK.)

V. Scenario

Summary

Comment on the adequacy of the scenario. Did it provide enough activity? Was it realistic? Did it test areas of earlier deficiency?

- ACTIVITY WAS SLUGGISH DURING THE START OF DRILL.
- IT PICKED UP WHEN PACKETS WERE DISTRIBUTED
- 2 MEN PER BUS WAS SEEN TO BE MORE EFFICIENT - 1 TO READ MAP & 1 TO DRIVE.
- DOSIMETRY WAS SUFFICIENT BUT NOT USED.

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: ~~FEB. 8, 1984~~

Location: ~~POST JEFFERSON~~
MILLER PLACE RD. T.P.

TIME	OBSERVATION/COMMENT
14:49	EVERY ROUTE HAS BEEN COVERED M. RUSSO (T.P.C.) HAS CALLED IN TO P.J.P.S. TO UPDATE STATUS. NO DOSIMETRY CHECKS 3 MEN: [redacted] 3 MEN MINIMUM PER. TRANSFER POINT IN REAL SITUATION SEE OVER →

STAGING AREA MODULE

DOSIMETRY ONLY

I. Activation and Staffing

		Yes	No	N/A	N/O
1.	Which Staging Area were you assigned to?	Port Jefferson			
2.	Were mobilization and notification procedures demonstrated (as opposed to pre-positioning)?	Was advised that personnel were pre-informed of drill			
3.	If so what time was staffing complete for:				
	- Group II?	One man short of 3 man Dosim Record Keeping crew			
	- Group III?				
4.	Was a full complement of staff present according to the plan?				
5.	Did the Staging Area personnel ~~in general~~, display adequate training and knowledge?		X		
6.	Was 24 hour staffing capability demonstrated?		X	X	

FEBRUARY 15, 1984

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/16/84

Location: Security + Decon

TIME	OBSERVATION/COMMENT
	- Security needs more people. Their procedure call for three people, however, they needed six people. - Walkie-Talkies would help the security people do their job - Decon. monitors need more training. They were monitoring poorly. If one Decon. monitor wears anti-C they all should. - The Decon Coord. sent a person to the hospital for thyroid uptake without doing decon.

(1) of (4)

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/15/83

Location: PORT JEFFERSON

TIME	OBSERVATION/COMMENT
10:00	Informed that 63 of 75 traffic guides were signed in at main staging area. Lead traffic guides have organized in preparation of dispatching various crews.
~~9:30~~	Staging area status board set up ~~at~~ on main turbine deck noting alert level wind speed & direction & reactor data -- good. (more available last week)
11:00	Lead traffic guide updating list of arriving personnel -- good procedure.
11:03	Lead traffic guides collect traffic guides for their dosimetry briefing.
11:14	Message re: boy scouts. dispatched one route alert driver at 11:17 to evacuate them. Man will call back when he gets to position. Note that at this time status board still indicates "Alert" level.
11:45	Last of traffic guides to arrive receive dosimetry briefing. Two guides have medical problems which would prevent them from using the potassium-iodide tablets. Alternative job tasks have to be assigned. At this time 6 road crews & 66 traffic guides have signed in, as tabulated by lead traffic guides.

(2) of (4)

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/15/84

Location: Port Jefferson

TIME	OBSERVATION/COMMENT
11:50	States board update to Site Area Emergency, and note that no release of radiation occurred.
12:00	Lead traffic guides will on top of count of no-shows, etc. Reports data to traffic coordinator.
12:04	Rte alert driver sends message that Boy Scouts were evacuated at 11:55. Coordinator notified promptly.
12:05	At time, 66 of 76 traffic guides (3 of 6 not yet in route) 7 of 10 road crews 1 of 2 route spotters 20 of 22 route alert + 1 rescue have signed in. The rest are no-shows.
12:50	2 more TG. showed up, but 2 went home sick.
1:00	Message: prepare to evacuate zones: A, B, C, D, E, G & H Traffic control points: (32 pts of 56) 4 140 6 5 38 40 139 41 121 120 122 137 37 57 56 144 50 145 59 119 61 59 60 97 52 95 99 100 101 102 93 94 (No indication of no. of pers per TCP.)

(3) of (4)

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: _____ Date: _____

Location: _____

TIME	OBSERVATION/COMMENT
1:03	Call for Rte spotters to ± 1001, 1003, 1006
	(note: only one rte spotter available)
1:05	Message for Road Crews (4) to 77, 70, 126, 30
	Lead traffic guides split up, each taking one of the groups.
1:13	First Road crew out. Last crew out by 1:16. No data re: weather, plume, etc given.
1:16	Dispatch of traffic guides in progress.
1:20	Rte spotter out .. informed re KI
1:24	message to change road crew destinations. Controller gives out contingency message IV-52 to send traffic guides to whatever remaining TCP's not given with 1:00 message they can fill up remaining people
1:25	Route alert drivers to: (message) 56A, 3K, 53F, 26F
	Good briefing re weather, plume & reactor status given to traffic guides.

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2-15-84

Location: Post Jeff Comm

TIME	OBSERVATION/COMMENT
*	NEED PREPRINTED FORM TO BY RADIO NUMBERS IN NUMERICAL ORDER (WITH COLS FOR ~~ROUTE #~~ CONTROL PT, INITIAL RADIO CHK, ARRIVAL @ CNTRLPT, DEPARTURE FOR BASE, ARRIVAL @ BASE) TO FACILITATE RADIO COMMUNICATIONS.
2:10	TOO MANY ~~TRAFFIC~~ TRAFFIC GUIDES ~~WERE~~ WERE CALLING THE BASE IN RAPID SUCCESSION WITHOUT WAITING FOR THE BASE TO RESPOND TO THE FIRST CALLER. THIS IS EITHER LACK OF COURTESY ON THE AIR (OR FOOLING AROUND BY THE DRIVERS) OR LACK OF KNOWLEDGE IN THE USE OF THE AIRWAYS. PERHAPS BETTER TRAINING IN THE USE OF RADIOS IS REQ'D.
2:15	ONE ROUTE DRIVER WAS LOST
	RADIO OPERATORS ARE BEING ASKED QUESTIONS ABOUT DRIVING X-ROUTES TO WHICH THEY HAD NO IDEA WHAT WAS BEING ASKED OF THEM. BETTER BRIEFING OF OPERATORS AS TO THE NATURE OF THE REQUESTS EXPECTED, ~~IF NECESSARY~~ AND WHO TO DIRECT THE REQUEST FOR RESPONSE TO, IS NECESSARY. OPERATORS REQUEST A LIST OF ~~WHO IS~~ WHAT IS CALLER IS SUPPOSED TO BE DOING.
*	SUGGEST 2 PEOPLE WORK RADIO WITH HEADSETS AND SPLIT LIST OF RADIOS IN TWO. TOO MANY TRANSMISSIONS IN ~~TOO SHORT~~ AN EXTENDED TIME FRAME FOR ONE OPERATOR TO HANDLE / NEVER GETS A CHANCE TO RECOVER

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

1. E.O.C. NOT GIVING TITLE ; SOURCE UNKNOWN.

2. #55, #63 TRAFFIC GUIDES

3. a. COMM TP. 6 OUT OF 60

b. TRAFFIC GUIDES 16 NOT INITIALLY MANNED.

c. ROUTE ALERT : 5 @ 11:30 - 12:00
6 @ 2:50

d. BUS DISPATCHER : PRE-STAGE (4:00 A.M.) THEN MARSHAL-ORDERS (LATER)

4. 1 HR 05 MINUTES. G.E. ANNOUNCEMENT.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

Item ④:

There were a number of no-shows as indicated in comment/observation sheets, specifically

a. 8 - traffic guides fail to come and 2 extremely late & 2 went home sick; also 3 have real-life medical problems that would prohibit them from taking the KI tablets; Thus they cannot be used in a real emergency.

b. ~~3 Rad drivers~~, 1 Rte spotter & 1 Rte alert drivers no-show.

Item - ②:

Lead traffic guides performed well in response to the messages received. However, without knowing the background information, it appears from the traffic control standpoint that communications from the EOC is not good.

The lead traffic guides were prompt in notifying coordinator of actions taken.

Item ③: Lead traffic ~~control~~ guides were responsive and well-prepared. A review of OPIP 3.6.2.3 (by them) is suggested.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

THE THREE TRANSFER POINT CORD. RAN THE DISPATCHING OF BUSES VERY EFFICIENTLY & SMOOTHLY. IT WAS CLEAR THAT THESE PEOPLE HAD BEEN THRU THIS BEFORE.

BEFORE BEING DISPATCHED TO TRANS. PT. THERE WAS CONFUSION ON WHERE TO WAIT FOR INFO. FROM BUS DISPATCHER. A BUS DISPATCHER MIGHT HAVE TROUBLE FINDING THE T. P. C(s). A FORMAL T.P.C. MEETING PT. IS REQD.

BUSES WERE DISPATCHED IN THE CORRECT MANER. THEY HAD BEEN TOLD TO DISPATCH BUSES IN SEQUENCE WITH THE CHART. THIS WAS DONE.

5 BUSES WERE DISPATCHED TO RELOCATION CENTER NO MAPS WERE PROVIDED IN ENVELOPES.

DOSIMETRY WAS CHECKED BY MOST PERSONNEL QUITE OFTEN. ONE BUS DRIVER WAS OBSERVED TO HAVE LEFT HIS DOSIMETRY IN HIS CAR. T.P.C. TOLD HIM TO PUT HIS INSTR. ON & REMINDED EVERYONE TO PERIODICLLY CHECK THEIR DOSIMETRY.

GIVING BUS ROUTE STATUS OVER THE RADIO WAS DIFFICULT, TIME CONSUMING, AND TRUNK UP VALUABLE RADIO TIME. SUGGEST USE OF A PHONE (ADDED TO T.P.C. KIT) TO COMPLETE THIS TASK. A PHONE LEAD WOULD BE REQD. AT THE TRANSFER POINT.

ONE THING I WOULD LIKE TO POINT OUT, A TRANSFER POINT CORD. ~~ALONE~~ COULD NOT RUN THE TRANSFER POINT ALONE. AT LEAST THREE ARE REQD. MIN! ONE T.P.C. TO ~~LOG~~ LOG IN BUS ROUTES, ONE TO

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION

NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2-15-84

Location: Port Jeff Staging Area

TIME	OBSERVATION/COMMENT
9:50	In meeting room with lead traffic guides. It was reported that 63 traffic guides on list. A lead traffic guide commented that 75 traffic guides are needed for this staging area for 56 TCP'S.
9:30	In turbine level area the "~~Staging~~ Area Status Board" calls an alert at 9:00
11:02	Lead Traffic guides assembling traffic guides for dosimetry in turbine area.
11:14	1st message received to Lead Senior Traffic guide to dispatch Route alert driver to warn Boy Scout troops to evacuate. dispatched 11:17, 1 person.
11:45	66 traffic guide have reported and as they arrive are given dosimetry info.
11:51	Site area emergency entered on the Status Board
12:04	Route alert driver called in and evacuation complete at 11:55.

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2-15-84

Location: Port Jeff. Staging Area

TIME	OBSERVATION/COMMENT
1:00	In meeting room A with lead traffic guides - just received a message from EOC to send traffic guides to TCP's - Total of 32 guides
1:04	Message to send out route spotters (3) but only one available
1:07	Message to send out 4 road crews
1:10	All traffic guides assembled in meeting room B
1:20	TCP #6 package handed to traffic guide Left to pick up radio
1:25	Took bus to parking area
1:30	Called in and heading to TCP #6
2:00	arrived at TCP #6 and called in.
3:20	Called in and returning to Staging Area
3:45	Arrived at staging area and called in

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

3. THE FOLLOWING DID NOT SHOW UP:

9 BUS DRIVER ~~1111~~ 111

ROUTE /LEAD DRIVER 11

TRAFFIC GUIDE 111

~~ED~~ ES

27 PEOPLE REMAINED AT STAGING AREA AFTER DISPATCHING. ONLY A HANDFUL WENT TO BRENTWOOD. REMAINING EITHER CAR POOLED OR HAD NO CLASSES.

5. LEAD TRAFFIC GUIDES UNSURE OF MEANING OR IMPACT OF EMERGENCY CLASSES. GUESSED AT EMERGENCY CLASS AND SO BRIEFED ROAD CREWS

A TRANSFER POINT COORDINATOR WAS UNSURE OF WHAT A ~~FE~~ TRANSFER BUS WAS.

4 BUS DRIVER WENT TO SCCC FIRST INSTEAD OF TRANSFER PT.

13. Responding to requests from public/commitments made.

a. Home Coord told individual that addition oxygen would be supplied by LERO with responding ambulance @ 1312, at 1415 action was finally initated by Ambulance coord

b. Rumor Control told a mother of a missing child that a car would pick her up to take her to each relocation center to look for her missing ch. Id. however no steps were taken to dispatch a vechile (see comment on missing persin procedure)

14. Staffing

During initial contacting of schools / facilities / invalid individuals there is a need for additional personnel. Some personnel not busy at the early stages of the emergency should be identified to support this relatively short lived activities (init. contact)

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: _____ Date: _____

Location: _____

TIME	OBSERVATION/COMMENT
—	Group the radios out early worked very well - rather than waiting for dispatching orders
—	R.H. had enough people to man 2 x P/Ts but could not man 4 if required.
—	R.H. tries to run the show by themselves and do not communicate with other E.A.O or the EOC. Symptomatic - different from the way their everyday jobs are done.
—	Time to dispatch people will be increased quite a bit if all equipment has to be given out i.e. cones, etc.

(3)

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION

NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: ______________________ Date: ______________

Location: ______________________

TIME	OBSERVATION/COMMENT
	Summary
—	Security procedure calls for 3 people manned 6 posts. Including one for EWOF
—	Security checks hot. No too many weary badges
—	Poor motivation on EWOF.
— ✓	Decon people should all dress-up in anti C's rather than some.
— ✓	Worker with contamination on the neck area was assumed to be thyroid uptake and was sent to the hospital. Should have washed him and then recheck for thyroid uptake. FEMA 1st
—	Bob Desmond (Security Coord) trying to do a good job but ~~has~~ has not been told his responsibilities ~~station~~ and what to do at ~~the~~ Relocation Center.
—	Need listing of names and addresses of all schools not just school districts.
—	Need listing of likely commodities needed during a drill.
—	Notification procedure does not address notification of the A.R.C.
—	

LONG ISLAND LIGHTING COMPANY and
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NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

(4)

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/15/84

Location: Port Jefferson Staging Area

TIME	OBSERVATION/COMMENT
	Obviously, a breakdown occured @ the EOC/ Port Jeff link. While waiting, the base station informed us they were in touch w the EOC and were awaiting further information. • What is the difference between a black and white cone symbol on the traffic guide intersection maps? My guides did not know that. • Suggest wording messages better – our was confusing and interpreted two ways. • Suggest 2 traffic guides per intersection in all states.