

Omaha Public Power District  
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402/536-4000

July 19, 1988  
LIC-88-575

U. S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
Mail Station P1-137  
Washington, DC 20555

Reference: Docket No. 50-285

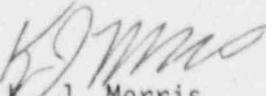
Gentlemen:

SUBJECT: 1988 Annual Emergency Exercise

Omaha Public Power District (OPPD) held its annual emergency exercise for the Fort Calhoun Station on June 22, 1988. During the post-exercise critique on June 23, 1988, Mr. Nemen Terc of your office requested that OPPD provide a compilation of the individual critique items. A copy of the attached list was telefaxed to Mr. Terc on June 28, 1988. This letter serves as the formal transmittal of the subject exercise critique items. The major critique items (Attachment 1) are shown on OPPD's list as deficiencies for timely attention in the form presented on June 23, 1988. Item 13, which was identified later was discussed with Mr. Terc on July 5, 1988. Items of lesser importance (Attachment 2) are designated as improvement areas as collected during our critique. Items with an asterisk have been designated as more significant.

If you require additional information or have any questions concerning these items, please contact us.

Sincerely,

  
K. J. Morris  
Division Manager  
Nuclear Operations

KJM/me

Attachment

cc: LeBoeuf, Lamb, Leiby & MacRae  
R. D. Martin, NRC Regional Administrator  
P. D. Milano, NRC Project Manager  
P. H. Harrell, NRC Senior Resident Inspector

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FORT CALHOUN STATION 1988 EMERGENCY EXERCISE  
MAJOR CRITIQUE ITEMS  
June 23, 1988

1. There was a failure to properly classify the Alert emergency.
2. Accountability was completed in thirty-five minutes instead of the required 30 minutes. A contributing factor is the apparent malfunction of the site nuclear alarm.
3. Full staffing achievement was only 90 percent within thirty and sixty minutes, instead of the required 100 percent.
4. Initial dose assessment at Site Area required thirty-six minutes and should have taken only 15 minutes in accordance with NUREG-0654.
5. Dose assessment initially was not performed in a timely manner. Apparent contributing factors are log-on problems; printer problems (not a significant contribution); switch from TSC to EOF.
6. OPPD and NRC procedures are not consistent for recovery operations mode.
7. Initial notification to States not fully in accordance with EPIP-OSC-2.
8. Dose projection methods based radioactive deposition (procedure EPIP-EOF-6) needs improvement.
9. Procedure to quickly evaluate steam generator rupture is weak.
10. A procedure is needed to go directly from an Emergency classification to Recovery without going through the downgrading process.
11. Receipt, interpretation and dissemination of information at the Media Release Center should be improved.
12. Communication weaknesses:
  - a. The telephone number was wrong to initiate call out for activating staff.
  - b. Intermittent problems were experienced with the FCS telephone system.
  - c. There was a poor flow of information at the EOF when the communicator was not present.
  - d. OPPD recommendation - need better accompanying discussion with States.
13. There was a failure to sound the Harrison County Alert Notification system sirens.

FORT CALHOUN STATION  
1988 ANNUAL EXERCISE  
OTHER CRITIQUE ITEMS

CONTROL ROOM

- \*1. Training
  - Shift Supervisor - dose assessments at 3 separate times were not reviewed/approved nor transmitted to states
2. Staffing
  - A full operating crew should have been assigned to the control room for the scenario.
3. Equipment
  - ERFCS should display channel/range, loop, etc., of instruments displayed
4. Scenario
  - A person on the operating exercise/drill crew should be used as the injured man
  - data at beginning of scenario left off information resulting in one prompt (pri-sec leak, purge valve history)
  - chemistry data should start earlier in the scenario
  - additional data should be supplied
    - Control Room radiation data
    - Turbine Building radiation data
    - RCS and boron concentration

TECHNICAL SUPPORT CENTER

1. Training needed
  - monitor coordinator
    - prepositioning of the monitor teams is recommended
    - periodic update of the offsite monitors on the status map should be made
    - \*- field team exposures should be tracked better
    - \*- monitor teams should have a RWP written prior to their dispatch
  - H/P technicians need training on the ERFCS
  - the re-entry Team needs to be trained on how to don and use the steam suit
  - the maintenance supervisor should have training on the following:
    - EPIP-RR-21 & EPIP-OSC-9
    - designation of group leader
    - writing MO's
2. Staffing
  - there should be one HP assigned to each monitor vehicle
  - emergency team members need to have access to the control room
3. Data Flow
  - put EAGLE on PC - The Eagle program should be on a dedicated computer (i.e. PC). The password to gain access to the mainframe had been changed and initially the program could not be accessed.

\* Other more significant critique items

4. Equipment
  - need an additional teletector
  - need additional RSO-500's
  - smears should be stapled in groups of 10
  - the gurney for an injured person transport is unsafe
  - need additional PC's in the Technical Support Center
  - the laser printer did not work initially causing a dose assessment problem
  - there was only one steam suit, which was damaged (hood broken)
  - need the addition of maps to GET, storeroom, and trailers in the emergency kit
  - need increased supply of anti-contamination clothing
  - experienced a radio problem with the mobile offsite monitor's van
  
5. Procedures
  - EAGLE logging on procedure
  - \*■ security procedures to allow personnel onsite caused excessive delay in emergency personnel reporting to station
  - \*■ EPIP-OSC-2 needs standard notification to site personnel for accountability
  - need to proceduralize write board, currently no one is tasked with this responsibility
  - shut down margin should be shown on status boards
  - HP log utilized but should be proceduralized
  
6. Scenario
  - a controller with HP training should be assigned to monitor teams

#### EMERGENCY OPERATIONS FACILITY

1. Training
  - \*■ Recovery Manager/Emergency Coordinator - should be better trained on the transition of functions from TSC to EOF
  
2. Staffing
  - EOF Communicator, Recovery Manager Secretary, and Clerical Assistant should be added to those needed at EOF during a NOUE instead of Alert classification
  - an additional person should be assigned to the environmental group
  
3. Equipment
  - need additional overhead slides for briefings by the corporate spokesperson
  
4. Procedures
  - a better method to calculate whole body and Thyroid dose rates based on ground deposition is needed
  - EPIP-RR-73 needs listing for routing of laser printer original copies
  - need clarification of dose assessment Data Collector procedure on what information is needed for interface with states on monitor teams
  - form FC-195 line 8 on estimated duration of release is in "hours", board and print out are in minutes. These should be consistent.

\*Other more significant critique items

- EPIP-EOF-19 needs to be revised to reflect transition to recovery and need for state and NRC concurrence
- a new procedure is needed on Recovery Phase
- procedures are inadequate to handle dose assessment from main steam/steam generator release at less than 1000 psia. (EPIP-EOF-6, OI-PAP-8)
- some of the telephone numbers in the emergency phone book were incorrect
  - INPO - add note to emergency number that it is also to be used in drill/exercises
  - backup emergency number is (404)953-0922

#### 5. Scenario

- requests for material should come from the cognizant group rather than handed out on a cue card
- the pressure in "B" steam generator did not track the RCS pressure. This was a problem with the thermohydraulic model supplied by CE.
- data updates did not include vessel level. This information should be included.

#### MEDICAL DRILL - AUXILIARY BUILDING & UNMC

##### 1. HP Practices

- the rescue squad monitor should wear P.C.'s while administering first aid
- the rescue squad monitor contaminated the stethoscope because P.C.'s were not worn

##### \*2. Medical Response

The medical response was slow. It was 29 minutes before the first vital sign check and 34 minutes before the injured person was removed from Room 81. The injured person was also left unattended for 4 minutes.

##### 3. Equipment

- the trauma kit should have surgical gloves

##### 4. Training

- re-entry and rescue squad monitor - a sheet should be used to prevent contamination spread by wrapping around both backboard and patient

#### MEDIA RELEASE CENTER (MRC)

##### 1. Training needed

- Public Information & Rumor Control staff
  - should have forwarded calls to State Public Information Officer
  - the position was not trained per requirements in Emergency Plan
- Corporate Spokesperson
  - should have training in the control of press and confrontation
  - should have training to better explain radiation/contamination differences

\* Other more significant critique items

2. Inadequate use of briefing material
  - an overhead was not used
  - large diagrams were available but were not used
- \*3. Staffing
  - MRC Technical Liaison
    - neither individual performed adequately nor did they appear to be capable of completely filling this position
  - the position should interface with the press so that the MRC director is not tied up with this function
- \*4. Timeliness of material released
  - public information should be released sooner. It took over 30 minutes to develop the first release
  - there is no process in place to handle the rapidly changing situation
  - specific questions about nature of the plume and field HP data could not be addressed
  - the time release started was incorrectly stated
  - the information flow from the EOF to MRC was inadequate
5. Data Flow
  - it is recommended that all material to be routed (including state) should go through clerical staff
6. Equipment
  - a blackboard is needed in briefing room
  - the telephone capabilities were not adequate to test the PI & RC
  - a Protective Action Guideline chart should be in the PI & RC
  - a copier with sorter is needed
  - a word processor would speed up the press release process
  - the plant map needs revision to show reliefs in proper room
  - a set of the Code of Federal Regulations should be located in the MRC
  - "Do's and Don'ts" for phone communication should be posted in PI & RC
7. Procedures
  - there is no method to notify press if time of conference is changed
  - not all individuals filling positions are in Appendix C of the Crisis Communication Plan
  - a copy of Appendix C was not given to the guard for access control
8. Scenario
  - a brief sheet to cover all aspects of plant/downgrade/recovery efforts which took place during 24 hour time shift is needed at the MRC

\* Other more significant critique items