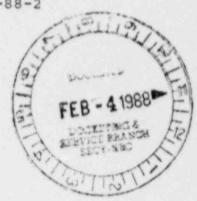
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LBP-88-2

# UNITED STATES OF AMERICA NUCLEAR REGULATORY COMMISSION

ATOMIC SAFETY AND LICENSING BOARD

Before Administrative Judges: John H Frye, III, Chairman Dr. Oscar H. Paris Frederick J. Shon



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In the Matter of

LONG ISLAND LIGHTING COMPANY

(Shoreham Nuclear Power Station, Unit 1) Docket No. 50-322-OL-5 (EP Exercise)

ASLBP No. 86-534-01 OL

INITIAL DECISION

(EMERGENCY PLAN EXERCISE)

February 1, 1988

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ASLBP No. 86-534-01 OL

February 1, 1988

#### INITIAL DECISION (EMERGENCY PLAN EXERCISE)

#### Appearances

Donald P. Irwin, Kathy E. B. McCleskey, Lee B. Zeugin, and Jessine A. Monaghan, Hunton & Williams, Richmond, Virginia, for the Long Island Lighting Company.

Martin Bradley Ashare, Hauppauge, New York; Herbert H. Brown, Lawrence Coe Lanpher, Karla J. Letsche, Michael S. Miller, P. Matthew Sutko, Susan M. Casey, and Geoffrey R. Kors, Kirkpatrick & Lockhart, Washington, D. C. for Suffolk County, New York.

Fabian G. Palomino and Richard J. Zahnleuter, Albany, New York, for Mario M. Cuomo, Governor of the State of New York.

Stephen B. Latham, Twomey, Latham, and Shea, Riverhead, New York, for the Town of Southampton.

George E. Johnson, Oreste R. Pirfo, and Charles A. Barth, Bethesda, Maryland, for the Nuclear Regulatory Commission Staff.

William R. Cumming, Washington, D. C., for the Federal Emergency Management Agency.

#### I. INTRODUCTION

#### A. PROCEDURAL HISTORY

This Decision addresses the question whether the February 13, 1986 Exercise of the offsite emergency plan for the Shoreham Nuclear Power Station revealed any fundamental flaws in that Plan. Earlier, we issued a Partial Initial Decision, LBP-87-32, 26 NRC \_\_\_\_\_ (December 7, 1987), in which we concluded that the February 13 Exercise did not comply with the requirements of 10 CFR Part 50, Appendix E, paragraph IV.F.1.<sup>1</sup> The history of this proceeding is recited in that decision and need not be repeated here.

In this decision, we determine the extent to which the Exercise demonstrated fundamental flaws. As a preliminary matter, we decide the question of the standard to be employed in making this determination. We also address Intervenors' legal arguments concerning whether the results of the Exercise may be used to support licensing of the plant for commercial operations.

The parties to this proceeding are the applicant, Long Island Lighting Company (LILCO); the Intervenors, Suffolk

<sup>1</sup>This decision decided Contentions EX-15 and EX-16. Because Intervenors took the position that a decision was not necessary, it also addressed but did not decide Contention EX-21.

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County, New York State, and the Town of Southampton (the last did not participate in the hearing); and the NRC Staff. We noted in LBP-87-32 that this proceeding marks the first time that a power reactor operating license applicant has, because of State and local opposition, taken on the responsibility for offsite emergency planning. LILCO has established a separate organization to carry out these functions which is known as the Local Emergency Response Organization (LERO). LERO is staffed by LILCO employess and contractors.

In this Initial Decision, we conclude that this record<sup>2</sup> reveals certain fundamental flaws which, while they remain uncorrected, bar the issuance of a full power, full term operating license for the Shoreham Nuclear Power Station. Although we found flaws related to the prompt dispatch of Traffic Guides and training, the great bulk of these flaws relate to communications. Breakdowns in communications occurred within LERO as well as between LERO/LILCO on the one hand and the public and media on the other. Errors

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<sup>&</sup>lt;sup>2</sup>This record was established in hearings which began on March 10, 1987, and continued over the course of four months, until June 18, 1987, when the record was closed. Thirty-four witnesses testified. The transcript numbered 8,694 pages and pre-filed written testimony added 3,218 pages. One hundred and forty-nine exhibits were offered. The text of the contentions, a list of witnesses, and a list of the exhibits offered is contained in the Appendix to LILCO's proposed findings.

occurred not only with respect to procedures, but also with respect to the substance of the information transmitted. Confusing and conflicting information was furnished to the public, and erroneous information to the media. It is clear that much needs to be accomplished if these problems are to be overcome.

All of the proposed findings of fact and conclusions of law submitted by the parties have been considered in formulating this Decision. Those not incorporated directly or inferentially in this Decision are rejected as unsupported in fact or law or as unnecessary to the rendering of this Decision.

While FEMA did not render an overall finding regarding the February 13, 1986 Exercise, we must nevertheless accord presumptive validity to FEMA's factual findings contained in its Post Exercise Assessment and testimony. This presumption is rebuttable and disappears in the face of a challenge. <u>See</u> 10 CFR 50.47(a)(2); <u>Metropolitan Edison Co</u>. (Three Mile Island Nuclear Station, Unit No. 1), ALAB-698, 16 NRC 1290, 1298 (1982), affirming LBP-81-59, 14 NRC 1211, 1460-66 (1981); <u>Carolina Power and Light Co.</u>, <u>et al</u>. (Shearon Harris Nuclear Power Plant), LBP-86-11, 23 NRC 294, 365 (1986). In this connection, we wish to comment on the testimony presented by the FEMA witnesses, Thomas E. Baldwin, Joseph H. Keller, and Roger Kowieski. We found these witnesses to be highly competent in the field of

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emergency preparedness. They had extensive knowledge of the plan and the exercise results, and their testimony was forthright and impartial. We found their testimony to be most valuable in the preparation of this Decision.

#### B. INTERVENORS' LEGAL ARGUMENT BASED ON THE ABSENCE OF A FEMA FINDING

In Contention EX-19, Intervenors make two arguments: first, that under NRC's regulations, it is necessary for NRC to base its finding as to reasonable assurance on FEMA's finding, so that the absence of a FEMA finding precludes an NRC finding; and second, that had it not been for FEMA's advance determination that it could not issue a finding in light of the absence of State and local government participation in the Exercise, it would have issued a negative finding. Intervenors' proposed findings, at 18-29.

In its September 11, 1987 brief on this contention, Staff urges that Intervenors' first argument coincides with the Board's view of the issue raised as expressed in the October 3, 1986 Prehearing Conference Order. Staff goes on to argue that Intervenors' position should be rejected. We agree with Staff that Contention EX-19 was admitted to consider whether FEMA's inability to make a favorable finding would preclude a finding by NRC. Because we have found fundamental flaws in the Plan which preclude a positive reasonable assurance finding so long as they exist,

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Intervenors' first argument is moot insofar as this Initial Decision is concerned. Consequently we do not decide it. We note that Intervenors' second argument is essentially correct. FEMA's witnesses testified that were a finding to be made, it would be negative. Tr. 8645-46, 8650-52. However, our finding that fundamental flaws exist also moots that argument.

#### C. DEFINITION OF "FUNDAMENTAL FLAW"

In CLI-86-11, 23 NRC 577 (1986), the Commission directed that this phase of the Shoreham litigation be confined to contentions which satisfy the requirements of 10 CFR 2.714 and which, if substantiated, would demonstrate a fundamental flaw in LILCO's emergency plan. The Commission based its direction on the proposition that:

> [u]nder [its] regulations and practice, Staff review of exercise results is consistent with the predictive nature of emergency planning, and is restricted to determining if the exercise revealed any deficiencies which preclude a finding of reasonable assurance that protective measures can and will be taken, <u>i.e.</u>, fundamental flaws in the plan.

Id. at 581.3

<sup>3</sup>Prior to this Commission decision, a Licensing Board had applied the fundamental flaw standard to the admission of contentions. <u>Carolina Power & Light Co., et al.</u> (Shearon Harris Nuclear Power Plant), LBP-85-49, 22 NRC 899, 908-13 (1985); <u>aff'd ALAB-843</u>, 24 NRC 200, 215 n.71 (1986).

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Intervenors urge that we follow this definition of fundamental flaw, noting that it is close to that which they urged at the close of the hearing.<sup>4</sup> Intervenors proposed findings, at 7-8. Moreover, as Intervenors point out, the Commission's definition closely parallels FEMA's definition of deficiencies: "...demonstrated and observed inadequacies that would cause a finding that offsite emergency preparedness was not adequate to provide reasonable assurance that appropriate protective measures can be taken to protect the health and safety of the public living in the vicinity...."

LILCO takes the position that:

A fundamental flaw is a pervasive, systemic, conceptual flaw in a plan that, because it substantially affects public health and safety, would prevent issuance of a license if left untended. A fundamental flaw is not readily correctable by equipment or training or simple, straightforward plan changes, but requires more basic changes to a plan because it is a fundamental defect in the way an emergency plan is conceived.

LILCO's proposed findings at 8.

<sup>&</sup>lt;sup>4</sup>The intervenors defined this term as "exercise results, events ... and/or omissions which singularly or with other results, events or omissions, preclude a finding of reasonable assurance that adequate protective measures can and will be taken on the basis of the LERO Plan. Thus, they reflect problems in the Plan and/or its implementation that would preclude a reasonable assurance finding." Tr. 8919-20.

LILCO urges that we apply a three-part test in determining whether a fundamental flaw has been established:

First, ... the alleged flaw must be "fundamental." The heart of an emergency plan is the protection of the public health and safety. Therefore, the threshold test is this: If the exercise had been a real emergency, would the alleged "flaw" have substantially affected the health and safety of the public?

Second, the problem must be systemic or pervasive, rather than merely one or more isolated and essentially independent problems. Intervenors must have shown that an essential component of the Plan is flawed conceptually; "minor or ad hoc problems occurring on the exercise day" are not fundamental flaws in an emergency plan. <u>Carolina</u> Power and Light Co. (Shearon Harris Nuclear Power Plant), LBP-85-49, 22 NRC 899 (1985); LBP-86-11, 23 NRC 294 (1986). Problems "which only reflect the actual state of emergency preparedness on a particular day in question" are not fundamental flaws. <u>Union of Concerned Scientists v. NRC</u>, 735 F.2d 1437 (D.C. Cir. 1984), <u>cert</u>. <u>denied</u>, 469 U.S. 1132 (1985).

Third, the alleged problem must not be readily correctable by means of additional training, the purchase of new equipment, or some other reliable and verifiable method. Rather it is a problem that is susceptible of correction only through substantial, potentially far-reaching revision of the written emergency plan. Even so, there is no obvious reason why a fundamental flaw should be thought of as being irremediable; as with any other shortcoming, whether it has been corrected turns on the facts of the remedial action taken.

Id., at 8-9.

\*

In the last element of its test, LILCO appears to make a distinction between ordinary fundamental flaws and bad fundamental flaws. This distinction is based on LILCO's perception that a FEMA deficiency describes "...a present condition that is 'not adequate' to provide reasonable assurance, but that does not necessarily require a far-reaching change to a plan to remedy," while a fundamental flaw precludes a finding of reasonable assurance and thus requires basic plan changes. LILCO's proposed findings at 10.

While there is indeed a difference between the NRC definition of a fundamental flaw and the FEMA definition of a deficiency, we believe that LILCO misperceives that difference. The former definition speaks of a condition which "precludes" a finding of reasonable assurance, while the latter speaks of a condition which "would cause" a finding that there is not reasonable assurance. Thus, while the NRC definition contemplates a situation in which a finding cannot be made, the FEMA definition contemplates a situation which requires a negative finding. Consequently, it appears that the situation described by a FEMA deficiency is more serious than that described by an NRC fundamental flaw. We see no basis for LILCO's position.

Be that as it may, we can find no basis on which to draw any meaningful distinction between a fundamental flaw and a deficiency. Both definitions describe conditions in which there is a lack of reasonable assurance that the public can be protected. That is a situation which the Commission is chartered to prevent. A hearing which is designed to discover any such conditions is fully consistent with the predictive nature of emergency planning. It is of

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no consequence whether the condition is correctable only through substantial and far-reaching changes to the plan. These considerations only affect the amount of effort required to eliminate the condition.

We agree with the first element of LILCO's test. Indeed, it does little more than restate the definition of a fundamental flaw found in CLI-86-11, supra. We also agree with the second element to the extent that it stands for the proposition that the failure demonstrated by the exercise must be pervasive as opposed to a minor or ad hoc problem. In this connection, we find Staff's discussion at pages 5 -7 of its proposed findings instructive. There, Staff points out that the demonstration in an exercise of a pervasive failure to carry out a portion of the emergency plan might preclude a finding of reasonable assurance, whereas an isolated failure would not. This view appears to coincide with FEMA's definition of a deficiency in that the latter speaks of "demonstrated and observed inadequacies" that would cause a negative finding. Thus, while it might be argued that an isolated failure of communications in an exercise demonstrates a failure to comply with the planning standard set out in 10 CFR 50.47(b)(6), it would not give rise to the finding of a fundamental flaw. But where, as we have found here, that failure is not isolated but pervades

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LERO's performance in the Exercise, a fundamental flaw is demonstrated.<sup>5</sup>

II. THE CONTENTIONS

#### A. PUBLIC NOTIFICATION

Contention EX-34 alleges that the Exercise revealed a fundamental flaw in the LILCO Plan in that LERO was incapable of providing prompt notification to the public in the event of siren failure, as required by 10 CFR 50.47(b)(5), 10 CFR Part 50, Appendix E, paragraph IV.D and NUREG-0654, paragraph II.E and Appendix 3 thereto. Intervenors maintain that these provisions require that a backup system be in place which is capable of notifying the residents of a failed siren area within 45 minutes.

Under the LILCO Plan, Route Alert Drivers are relied upon to notify the hearing impaired and to provide backup to the LILCO siren system. OPIP 3.3.4; LILCO EX-34 Testimony,

<sup>&</sup>lt;sup>5</sup>In their definition of fundamental flaw put forward at the close of the hearing, Intervenors took the position that a single failure might amount to a fundamental flaw. See footnote 4, <u>supra</u>. That may be so. However, the single failures presented in this record clearly do not rise to that level. Consequently, we need not address that position.

ff. Tr. 1327, at 6; Tr. 1361-62 (Daverio). Upon learning of any siren malfunction from among any one or more of LILCO's 89 fixed sirens, these Route Alert Drivers are dispatched to drive through the areas surrounding the failed sirens broadcasting a message to the public through loudspeakers. See Plan, at 3.3-4; OPIP 3.3.4; Suffolk EX-34 Testimony, ff. Tr. 1495, at 5.

During the exercise, FEMA observed LERO's response to message indicating a failed siren in each of the three Staging Areas. The results were as follows:

Staging Area	Time (Minutes)						
Port Jefferson	906						
Patchogue	70						
Riverhead	78						

FEMA concluded that these times were excessive and assigned an ARFI.<sup>7</sup> FEMA Ex. 5, at 141-42.

LILCO moved to strike Suffolk's testimony on this contention on the ground that the testimony was barred by

<sup>6</sup>Approximately one-half of the assigned area was covered in this period.

<sup>7</sup>This is an Area Recommended for Improvement, which FEMA defines as a problem area which does not affect the public health and safety. Although correction of an ARFI is not required, it would enhance an organization's level of emergency preparedness. FEMA Exhibit 1, p.8. res judicata. 8 LILCO based its position on the proposition that the question whether backup notification was required to be completed in 45 minutes had been decided in this proceeding in LBP-85-12, the Partial Initial Decision on Emergency Planning (PID). Specifically, LILCO relied on language in the PID, 21 NRC at 758-59, which looked with favor on the conclusion reached in Kansas Gas & Electric Co. (Wolf Creek Generating Station, Unit 1), LBP-84-26, 20 NRC 53, 67 (1984), that there was no requirement for backup notification procedures. The PID concluded that if there was no requirement, then there could be no time limit. We denied LILCO's motion because the contention which had been decided in the PID asserted that backup notification must be accomplished in fifteen minutes. The holding of the PID was that NUREG-065; contained no such requirement. The statement relied on by LILCO is dicta. See Tr. 1002, 478-500.

Now we must decide whether Intervenors are correct that there is a requirement that backup notification take place within 45 minutes. Intervenors take the position that LILCO was required to demonstrate that its route alerting personnel had the capability of providing notification,

<sup>8</sup>LILCO's Motion to Strike Direct Testimony ... on Behalf of Suffolk County Regarding Contention EX-34, Narch 5, 1987.

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within 45 minutes after the simulated failure of LILCO's siren system, to any segments of the EPZ population that would not have been initially notified of an emergency at Shoreham. See NUREG-0654, paragraph II.E and Appendix 3 thereto. They state that the language of NUREG-0654 is clear and unambiguous: it requires that, within 45 minutes of initial siren notification, any segments of the EPZ population who may not have received notification must be alerted to the emergency. See NUREG-0654, Appendix 3, paragraph B.2.c; see also Tr. 1505 (Michel).

The provision of NUREG-0654 in question states:

B. Criteria for Acceptance

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- Within the plume exposure EPZ, the system shall provide an alerting signal and notification by commercial broadcast (e.g., ESS) plus special systems such as NOAA radio. A system which expects the recipient to turn on a radio receiver without being alerted by an acoustic alerting signal or some other manner is not acceptable.
- The minimum acceptable design objectives for coverage by the system are:
  - a) Capability for providing both an alert signal and an informational or instructional message to the population on an area wide basis throughout the 10 mile EP2, within 15 minutes.
  - b) The initial notification system will assure direct coverage of essentially 100% of the population within 5 miles of the site.
  - c) Special arrangements will be made to assure 100% coverage within 45 minutes of the population who may not have received the initial notification within the entire plume exposure EP2.

\* \* \* The lack of a specific design objective for a specified percent of the population between 5 and 10 miles which must receive the prompt signal within 15 minutes is to allow flexibility in system design. Designers should do scoping studies at different percent coverages to allow determination of whether an effective increase in capability per unit of cost can be achieved while still meeting the objective of item 2.a. above.

Intervenors maintain that, up until the time of the Shoreham Exercise, it had been FEMA Region II's position that, based upon the above language, backup route alerting was required to be performed within 45 minutes. Tr. 8005-006, 8713 (Kowieski). Because none of the Route Alert Drivers observed by FEMA completed his route alerting task within the 45-minute period, FEMA found that Objective Field 5 was only partially met, and initially identified the performance observed as an ARCA.<sup>9</sup> See FEMA Ex. 1, at 57, 64 and 74; Tr. 8000 (Baldwin). See also Suffolk EX-34 Testimony, ff. Tr. 1495, at 7.

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Intervenors maintain that, subsequent to the Exercise, FEMA Region II was instructed by FEMA's Washington Headquarters that the failure of LILCO's Route Alert Drivers to complete their assigned routes within 45 minutes could not be identified as an ARCA; rather, only an ARFI was

<sup>&</sup>lt;sup>9</sup>FEMA assigns ARCAs, or Areas Requiring Corrective Action, to "... demonstrated and observed inadequacies of performance,..." which, although they require correction, do not, by themselves, adversely impact public health and safety. FEMA Exhibit 1, p. 8.

permitted. See Suffolk Ex. 104; FEMA Ex. 5, at 142-43; Suffolk EX-34 Testimony, ff. Tr. 1495, at 7; LILCO EX-34 Testimony, ff. Tr. 1327, at 8-9. Intervenors believe that this "instruction" was made specifically with respect to FEMA's evaluation of the Shoreham Exercise and despite the fact that in other exercises in New York State, backup route alerting in excess of 45 minutes had been identified as a serious problem. They cite Suffolk Ex. 105, at 5; Suffolk Ex. 65, at 62-63, 67 (backup route alerting for Indian Point should be completed within 45 minutes of initial siren notification). They also cite Tr. 1520-21 (Roberts); 8010 (Kowieski); 8013, 8604-605 (Keller); Suffolk EX-34 Testimony, ff. Tr. 1495, at 7-8. They maintain that, but for the "instruction" from Headquarters, Region II would not have taken a contrary position in the final Post Exercise Assessment, citing Tr. 8019 (Kowieski).

Staff takes the postion that:

No preclusion of a reasonable assurance finding could be based on the amount of time taken during an exercise to complete backup route alerting. See FEMA Ex. 1, at 8; FEMA Ex. 5, at 142-143; Tr. 8004-05 (Baldwin, Kowieski). Such backup alerting, while required to be in place, is essentially discretionary as to the time in which it need be completed. See <u>id</u>. A fundamental flaw in the plan, therefore, cannot be based on excessive route alert driver time.

Staff's proposed findings, at 87.

LILCO argues that Licensing Boards have consistently held that NRC regulations and guidelines do not require any backup notification system. It relies on the PID, 17 NRC at 758-59 ("If no such [backup] procedures are needed, <u>a</u> <u>fortiori</u>, no standard time limit need be met."), and <u>Wolf</u> <u>Creek</u>, <u>supra</u>. It urges that, because NRC regulations and NUREG guidelines do not require any backup to the prompt notification system,<sup>10</sup> the 15-minute and 45-minute time limits for public notification, set out in 10 CFR 50.47, 10 CFR Part 50, Appendix E, and NUREG-0654/FEMA REP-1, do not apply to the discretionary backup route alerting provided under the LILCO Plan. It cites: LILCO EX-34 Testimony, ff. Tr. 1327, at 4-6; Tr. 8004-05, 8008 (Kowieski), 8004 (Baldwin). It urges that the FEMA "instruction" to Region II, and the subsequent guidance embodied in FEMA Guidance Memorandum AN-1 (GM AN-1), are fully consistent with this position.

We do not agree with Intervenors that NUREG-0654 requires that backup alerting be accomplished within 45 minutes. Rather, we believe a more reasonable interpretation to be that initial notification of residents in certain hard-to-reach areas of the EPZ which are more than five miles from the plant must be accomplished within

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<sup>&</sup>lt;sup>10</sup>In this respect, LILCO position is contrary to that of Staff. The latter states that NRC requires that provision for backup alerting be made. Because the LILCO Plan provides for backup alerting, we need not decide whether a requirement exists.

45 minutes. This is the position adopted in GM AN-1. Requiring the same speed for backup route alerting would not make regulatory sense. Under the interpretation urged by Intervenors, a licensee would be required to provide a discretionary backup notification system that essentially meets the criteria of the mandatory primary system that has failed. Tr. 1413-14 (Daverio).

GM AN-1 "elaborate[s] upon the accepted FEMA interpretation and application of alert and notification system design objectives" in NUREG-0654 and discusses backup route alerting. FEMA Ex. 4, Att. I-1, I-5. It is consistent with this interpretation. It states that there is "no hard and fast time requirement for completing the backup route alerting process." Id. at I-5.

We find that there is no requirement that backup route alerting be completed within 45 minutes; consequently we decide Contention EX-34 in LILCO's favor.

B. EVACUATION OF THE EPZ

### 1. Removal of Roadway Impediments

Contention EX-41 alleges that the Exercise revealed a fundamental flaw in the LILCO Plan in that LERO failed to demonstrate an ability to remove impediments, in the form of traffic accidents, from roadways until long after evacuation had begun. It alleges, further, that the Exercise demonstrated that the LERO players were incapable of responding to and removing such impediments. The contention also alleges that the addition of a traffic engineer in the EOC will not eliminate the problems revealed by the Exercise. Finally, Suffolk contends that FEMA introduced an insufficient number of accidents into the February 13 Exercise.

In order to understand these allegations, it is necessary to have an appreciation of the scheme of operations laid out in the Plan. Under the Plan, the Evacuation Coordinator, who reports to the Manager of Local Response, directs actions in the areas of traffic control, transportation, and evacuation from the EOC in Brentwood. The Evacuation Coordinator is responsible for seeing that sufficient resources exist to carry out this responsibility. OPIP 2.1.1; 3.6.?.

The Traffic Control Coordinator, also located at the EOC, reports to the Evacuation Coordinator. The Traffic Control Coordinator's responsibilities include establishing and maintaining Traffic Control Posts, coordinating the road logistics aspects of a public evacuation, overseeing evacuation routes, and overseeing traffic flow considerations. Specifically, the Traffic Control Coordinator must ensure that sufficient manpower and material exist to perform these functions rapidly. In order to implement these activities, the Traffic Control

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Coordinator supervises and directs the Traffic Control Point Coordinator, the Road Logistics Coordinator, and the Evacuation Route Coordinator. The Traffic Control Coordinator is required to make status reports to the Evacuation Coordinator. See LILCO Plan at 2.1-4; OPIP 2.1.1; OPIP 3.6.3.

The Traffic Control Point Coordinator is stationed at the EOC and is responsible for 'oordinating the field activities of Traffic Guides, whose function is to facilitate the flow of evacuating traffic through intersections. He is also responsible for distributing directions to, and receiving information from, the Traffic Guides. This includes receipt of information about road blockages and unexpected traffic flow. The Traffic Control Point Coordinator is to make status reports regarding these data to the Traffic Control Coordinator. See OPIP 2.1.1; OPIP 3.6.3, Att. 1 (page 2 of 2).

The LILCO Plan relies on so-called "Road Crews" to remove accidents and stalled vehicles from evacuation routes, furnish fuel to vehicles which have run out, and, in one instance, to convert a section of roadway to one-way flow.<sup>11</sup> The Road Logistics Coordinator is responsible for

<sup>11</sup>Although it was not raised directly by the contention, Intervenors' testimony touched on the last (Footnote Continued)

coordinating the field activities of Road Crews by receiving information from and issuing directions to Road Crews. The Road Logistics Coordinator determines which Road Crew posts to activate based upon which EPZ zones have been ordered to evacuate, and determines the Road Crews to be deployed. The Road Logistics Coordinator reports to the Traffic Control Coordinator and is required to keep the latter apprised of conditions through status reports. See OPIP 2.1.1; OPIP 3.6.3.

The Evacuation Route Coordinator also reports to the Traffic Control Coordinator. The Evacuation Route Coordinator, also stationed at the EOC, is responsible for coordinating the field activities of the Evacuation Route Spotters. The latter travel the evacuation routes, make periodic reports of their condition, and make immediate reports of any problems. The Evacuation Route Coordinator is required to relay information on evacuation traffic flow problems to the Road Logistics Coordinator and the Traffic Control Point Coordinator, as well as keep the Traffic Control Coordinator apprised of such problems through status reports. In turn, the Traffic Control Coordinator is to

(Footnote Continued) function, converting a roadway to one way flow. This testimony is covered in connection with Contention EX-40E, which deals with the traffic control activities of Traffic Guides.

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report such problems to the Evacuation Coordinator. The Evacuation Route Coordinator is also responsible for keeping the Transportation Support Coordinator, who is responsible for bus operations, advised of problems. See FEMA Exhibit 1, at 36; OPIP 2.1.1; OPIP 3.6.3, Attachment 3, at sec. 3.

#### 1.a. Road Crew Performance

Subcontention EX-41A correctly alleges that during the Exercise, and according to the LILCO Plan, Road Crews were not notified of the emergency or required to report until after the Site Area Emergency had been declared. See OPIP 3.3.2, 3.3.3, 3.6.3. It alleges that although the Site Area Emergency was declared at 8:19, most Road Crews did not arrive at the staging areas until after 10:00 a.m., and goes on to allege specific numbers of Road Crew members responding at specific times. It alleges that, when the evacuation was ordered, only about 65% of LERO's Road Crews had been mobilized, in spite of the fact that the Exercise had been pre-announced. Finally, Subcontention EX-41A alleges that pursuant to LILCO's Plan, Road Crews were not dispatched from the Staging Area until after the evacuation had been ordered and dispatch was not completed at Riverhead until about 11:00, was not completed at Port Jefferson until about 12:40, and was not completed at Patchogue until about 11:28. Thus, LERO personnel essential to the implementation

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of the evacuation according the the LILCO Plan were not fully mobilized until after the evacuation was underway.

The LILCO Plan provides for the dispatch of a maximum of twelve Road Crews assigned to remove roadway obstructions, to be stationed at different locations throughout the EPZ. During the February 13 Exercise all twelve Road Crews were dispatched. Revision 6 of the Plan (in effect on February 13, 1986) provided that the Traffic Control Coordinator was initially to instruct the Road Logistics Coordinator to implement Road Crew operation. After an order to evacuate, the Road Logistics Coordinator was to determine, in light of the evacuation recommendation, which Road Crew posts should be staffed and then notify the Lead Traffic Guides in the three staging areas of the staffing decision. The Lead Traffic Guides then were to brief and dispatch the appropriate Road Crews. Upon arriving at their vehicles, Road Crews were required to check in on their radios with the Evacuation Support Communicator at the EOC and then to maintain periodic contact with the Communicator following their arrival at their posts. LILCO Testimony of Messrs. Lieberman, Weismantle, and Wilm On Contention EX-41 (LILCO EX-41 Testimony), ff. Tr. 272, at 5-6; see OPIP 3.6.3.

Pursuant to the Plan, LERO Road Crew members were notified of the Site Area Emergency at the plant shortly after it was declared at approximately 8:19. More than

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forty minutes later, at 9:00, only one Road Crew member had reported to the Riverhead Staging Area and none had reported to Port Jefferson or Patchogue. Under the LILCO Plan, Riverhead is supposed to have ten Road Crew members, and Port Jefferson and Patchogue are supposed to have fourteen each. Direct Testimony of Assistant Chief Inspector Richard C. Roberts, Inspector Richard Dormer, Inspector Philip McGuire, and Deputy Inspector Edwin J. Michel On Behalf of Suffolk County Regarding Contention EX-41 -- Mobilization and Dispatch of Road Crews and Removal of Impediments from the Roadways During the February 13, 1986 Shoreham Exercise (Suffolk EX-41 Testimony), ff. Tr. 1134, at 19. By 9:40, an hour and twenty minutes after notification to report, only five had reported to Riverhead, none had reported to Port Jefferson, and only four had reported to Patchogue. Thus, when a General Emergency was declared at 9:39, less than 25% of the Road Crew personnel needed to implement LILCO's Plan had been mobilized. Id. at 20; LILCO EX-41 Testimony, at 22. By 10:20, approximately two hours after a Site Area Emergency was declared, there were thirteen Road Crew members at Riverhead, nine at Port Jefferson, and thirteen at Patchogue. 12 Id. Suffolk's witnesses believe that in a

<sup>12</sup>There is no explanation in the record as to why there were thirteen Road Crew members at the Riverhead Staging (Footnote Continued)

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real emergency mobilization times would be even longer, because LERO personnel knew in advance that the Exercise would be carried out on February 13 and therefore should have been prepared in advance to report for emergency duty the day of the Exercise. Suffolk EX-41 Testimony, at 21.

LILCO's witnesses argue that it is necessary for only some Road Crews, not all Road Crews, to be dispatched shortly after the order to evacuate because they predict that there will be only four minor accidents during the evacuation. LILCO EX-41 Testimony, at 23. LILCO's witnesses Weismantle and Lieberman, however, acknowledged that there was a possibility that early in the evacuation, before the buildup of heavy and slow traffic, severe accidents might occur because evacuating vehicles could travel at high speeds. Tr. 982. At 10:24, when the order to evacuate was given, there were nine two-man Road Crews ready to be dispatched into the EPZ. Four Road Crews left the staging area for field locations at 11:00; four more left at 11:28; and two more left at 11:58. LILCO EX-41 Testimony, at 23. During the time from 10:24 until the Road Crews were finally dispatched presumably they were obtaining equipment and being briefed. After arriving at the staging

(Footnote Continued)

Area at 10:20 when Riverhead is supposed to have only ten Road Crew members. area, Road Crew personnel had to obtain emergency kits, obtain and put on dosimetry equipment, complete the Emergency Worker Dose Form, attend a briefing given by the Lead Traffic Guide, receive instructions from the Lead Traffic Guide regarding deployment locations, be assigned LILCO vehicles as those vehicles arrived, be instructed as to field procedures by the Lead Traffic Guide, and when instructed by the Lead Traffic Guide, depart for designated field locations. Road Crew personnel assigned to specialized functions, such as dispensing fuel or one-way traffic responsibilities, had other preparation responsibilities as well. Suffolk EX-41 Testimony at 22.

Suffolk's witnesses testified that unless LERO's Road Crews are in place at the outset of the evacuation, roadway impediments which occur at the outset would likely result in significant delays or even complete blockage of evacuation traffic. They believe that once an impediment is in place for any period of time, evacuees would take "self-help" measures in an endeavor to get around the impediment, such as driving on the road shoulder or using other traffic lanes. Consequently it would be difficult and perhaps even impossible for Road Crews to get to the scene. Moreover, if Road Crews succeeded in reaching the scene of an impediment that has been in place for some time, traffic patterns around the impediment would already have been set by the actions of evacuees before the Road Crews arrived; the heavy

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traffic could make the maneuvering required to remove the impediment impossible. Id. at 27-28.

FEMA stated in its direct testimony that no problems were identified by FEMA regarding the ability of LERO to mobilize staff and dispatch Road Crews from the staging areas. FEMA Ex. 5, at 16. The NRC Staff, in its proposed findings, likewise stated that it found no basis upon which to agree with the Intervenors' allegation that the mobilization of Rcad Crews was untimely, thus demonstrating a fundamental flaw in the LILCO Plan. Staff proposed finding 158, at 57. Staff agrees with LILCO that not every Road Crew is needed at the moment an evacuation order is issued. Staff proposed finding 157. Since some were promptly dispatched, Staff believes that these crews could handle the expected frequency of early accidents with the later-ready crews responding to those occurring later in time. <u>Id</u>.

Dispatch of the Road Crews to their field locations did not begin until 36 minutes after the evacuation order was issued. We believe that this initial dispatch should have been accomplished more quickly, particularly in light of the testimony that, in the early stages of an evacuation, any accidents which occurred might be severe. Tr. 982. However, we do not find that it was so untimely as to demonstrate a fundamental flaw. Moreover, we agree with LILCO and Staff that the four crews dispatched initially

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could handle any early accidents and other problems, leaving the following crews free to resond to subsequent problems. Consequently, we find for LILCO on Contention EX-41A.

#### 1.b. Response to Roadway Impediments

Subcontention EX-41B focusses principally on the response at the Emergency Operations Center (EOC) to two roadway impediments injected into the Exercise by means of so-called "free play" messages. 13 The first of these informed the players at the EOC of an evacuation route blocked by an accident involving a gravel truck, and the second informed them of a second evacuation route blocked by an accident involving a fuel truck. The contention alleges that, although FEMA's free play messages were given to the Evacuation Route Coordinator at about 10:40 for the gravel truck impediment and at about 11:00 for the fuel truck impediment, the LERO Evacuation Coordinator was not informed of either impediment until told by a FEMA Controller at about 12:13. As late as 12:40 the Transportation Support Coordinator had not been informed that the gravel truck was potentially blocking a bus evacuation route, and as of 13:48

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<sup>&</sup>lt;sup>13</sup>"Free play" messages are messages which inject problems into the Exercise which are not known in advance by the Exercise players. Thus they provide realism to the Exercise. Tr. 8197-98, 8489 (Kowieski).

the Road Logistics Coordinator had not been informed that there might be a need for equipment at the fuel truck site.

In addition, Contention EX-41B alleges that the Evacuation Route Coordinator failed to provide the Evacuation Support Communicator for Route Spotter/Road Crews with all essential information about the impediments, including the fact that the gravel truck impediment involved three cars as well as the truck, that the fuel truck accident presented a fire hazard because the truck was leaking fuel, and that the overturned fuel truck was blocking both shoulders of the road. The contention alleges that as a result of the foregoing delays and oversights, the Road Crew dispatched to the fuel truck did not arrive at the scene until approximately 14:10, over three hours after FEMA informed LERO of the impediment, and only one tow truck was dispatched to move the four vehicles involved in the gravel truck impediment. We deal with these two problems individually.

#### Gravel Truck Impediment

The chronology of events associated with the gravel truck impediment is as follows:

10:40 hours The following written free play message was handed by FEMA to the Evacuation Route Coordinator: A loaded gravel truck with a broken

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		driveshaft, which is upright, but turned sideways in the road is blocking the north and south-bound lanes and both shoulders of Yaphank-Middle Island Road, approximately fifty (50) yards north of the caution light at the "Y" intersection of Yaphank-Middle Island Road (in the vicinity of TCP #124). This is a multiple vehicle accident also involving three passenger cars that are blocking both the north and southbound shoulders of the road. There are no injuries to any individuals.
		The LERO responder to the site of this impediment should locate the FEMA evaluator who will be wearing a red armband.
10:45	hours	The Evacuation Route Coordinator sent the following written message to the EOC Communicator:
		Have Route Spotter 1004 verify a gravel truck is blocking the north and south bound lanes of Yaphank-Middle Island Road, approximately 50 yards north of the caution at the "Y" intersection of Yaphank-Middle Island Road, Main Street and Mill Road.
10:56	hours	EOC Communicator reported that Route Spotter had not found FEMA evaluator at gravel truck site.
11:04	hours	FEMA Controller at EOC gave EOC Communicator a note describing precise location of FEMA evaluator.
11:40	hours	Route Spotter #1004 met FEMA evaluator at gravel truck site.
11:50	hours	Route Spotter reported to EOC that gravel truck was east of the "Y" intersection.
12:00	hours	Road Crew departs to respond to gravel truck impediment.
12:13	hours	Evacuation Coordinator informed of

impediments by FEMA Controller.

12:20 hours	Traffic Control Point Coordinator, after consulting with Evacuation Coordinator, advised Patchogue Staging Area to reroute traffic around gravel truck impediment.
12:40 hours	Road Crew reported they were unable to find FEMA evaluator and were returning to field location.
12:45 hours	After being dispatched again, Road Crew found FEMA evaluator on Main Street.
13:30 hours	Road Crew reported that gravel truck had been cleared from roadway and traffic flow past site had resumed.
13:45 hours	EBS message advising public about gravel truck impediment was approved by Director of Local Response.

(Citations to the record for the foregoing times and events are given in the text below.)

The free play message about the gravel truck impediment was introduced at the LERO EOC by the FEMA Exercise Controller, who gave it to the LERO Evacuation Route Coordinator. Suffolk EX-41 Testimony, at 33; FEMA Ex. 1, at 30. According to LILCO's Plan, the Evacuation Route Coordinator should have immediately transmitted the message to the Road Logistics Coordinator and the Traffic Control Point Coordinator as well as to his supervisor, the Traffic Control Coordinator. See OPIP 2.1.1. He failed to do so, however, choosing instead to try to verify the reported impediments before informing his LERO associates. LILCO EX-41 Testimony, at 19-20; Suffolk EX-41 Testimony, at 34; Tr. 966-7. Nor was the Evacuation Coordinator informed about the impediments as required by the LILCO Plan, until advised by a FEMA Controller after about 12:13. FEMA Ex. 1, at 36; see OPIP 3.6.3. The late notification of the Evacuation Coordinator resulted in delays in LERO's response to the impediments. FEMA Ex. 1, at 36. Moreover, Contention EX-41B is correct in asserting that the Transportation Support Coordinator had not, as of 12:40, been informed that an evacuation bus route was blocked by the gravel truck impediment. Id.

The LERO message forr sent by the Evacuation Route Coordinator to the Evacuation Support Communicator for Route Spotters/Road Crews at 10:45, reporting the gravel truck impediment, failed to include the information that the gravel truck impediment included three cars as well as the truck. Nor did the message include the instruction that the LERO responder should locate the FEMA evaluator at the impediment site. Suffolk EX-41 Testimony, at 37-38. The message merely stated as follows:

> Have Route Spotter 1004 verify a gravel truck is blocking the north and south bound lanes of Yaphank-Middle Island Road, approximately 50 yards north of the caution [light] at the "Y" intersection of Yaphank-Middle Island Road, Main Street and Mill Road.

LILCO EX-41 Testimony, at 8. Subsequently the EOC Communicator reported back that the Route Spotter had found no one at the gravel truck location and therefore had returned to his route at 10:56. Because of this report that the Route Spotter failed to find the FEMA evaluator at the gravel truck site, the FEMA Controller in the EOC gave the EOC Communicator a note at 11:04 indicating that the FEMA evaluator was located 50 yards east of Yaphank-Middle Island Road at Everett Drive and Main Street. <u>Id</u>. at 9. Route Spotter #1004 was again dispatched to meet the FEMA evaluator, which he succeeded in doing about 11:40. FEMA Ex. 1, at 36.

A Road Crew was dispatched and departed from its field post at 12:00 to respond to the gravel truck impediment. LILCO EX-41 Testimony, at 9. The Road Crew was not informed that the impediment was a multiple vehicle accident, however, and only one tow truck was dispatched. FEMA concluded that this equipment would have been inadequate for removal of the loaded gravel truck plus three automobiles; in addition, no scraper truck was dispatched to remove spilled gravel, nor was a determination made as to whether any gravel had been spilled. FEMA Ex. 1, at 37, 65. Suffolk's witnesses agree with FEMA that the equipment dispatched to clear the gravel truck impediment was inadequate to tow anything larger than passenger vehicles and small commercial vehicles. Suffolk EX-41 Testimony at 38.

After the FEMA Controller brought the gravel truck impediment to his attention at 12:13, the Evacuation

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Coordinator consulted with several of his subordinates and was told by them that the accident was reported to be east of the "Y" intersection. He concluded that it would not affect evacuation flow because it was on a route that carried little or no evacuation traffic. When he advised the FEMA Controllers of this decision they informed him that the impediment was north of the intersection. The Evacuation Coordinator then consulted with the Traffic Control Point Coordinator, who dispatched a message at 12:20 to the Patchogue Staging Area advising that southbound traffic on Middle Island Road must be rerouted westbound on Bartlett Road. LILCO EX-41 Testimony, at 10. Thus LERO did not act to route traffic around the gravel truck impediment until well over an hour after the free play message was injected by FEMA, and then only after prompting by FEMA. FEMA Ex. 1, at 65.

## Fuel Truck Impediment

The chronology of events associated with the fuel truck impediment is as follows:

11:04 hours

The following free play message was handed by FEMA to LERO's Evacuation Route Coordinator:

On Route 25A, approximately 75 yards east of the intersection with Miller Place-Yaphank Road, (in the vicinity of traffic control post #41), a fuel tank-truck has jack-knifed and turned over on its side blocking both eastbound and westbound traffic lanes, as well as both shoulders of the road. In the course of the accident, the fuel tank was ruptured and leaking fuel. There is a possibility that the fuel could ignite causing a fire. There is no fire at present and there are no injuries to any individuals.

The LERO responder to the site of this impediment should locate the FEMA Evaluator who will be wearing a colored arm band.

11:06 hours Evacuation Route Coordinator gave the following message to the the EOC Communicator:

Have Route Spotter #1005 proceed to 25A, 75 yards east of the intersection with Miller Place-Yaphank Road. Fuel truck turned over on side, blocking both east and west bound lanes.

- 11:15 hours Unable to contact Route Spotter #1005 by radio, Evacuation Route Coordinator asked Port Jefferson whether Route Spotter #1005 had been dispatched to his route and was advised that he had not been dispatched.
- 11:30 hours FEMA Evaluator arrived at site of fuel truck accident.
- 11:40 hours Transportation Support Coordinator in EOC informed Port Jefferson Bus Dispatcher about the fuel truck impediment.
- 11:49 hours Port Jefferson Staging Area advised EOC Communicator that all Route Spotters had been dispatched.
- 12:02 hours Route Spotter #1005 instructed by EOC Communicator to proceed to scene of fuel truck impediment.
- 12:05 hours Port Jefferson Bus Dispatcher informed Transportation Support Coordinator that a visual check of fuel truck site indicated no problem.

12:13 hours Evacuation Coordinator was informed of the fuel truck impediment by FEMA Controller. Route Spotter #1005, who had met with 12:23 hours the FEMA evaluator, was released by the evaluator. 12:32 hours Attempts to get Miller Place Fire Department to respond to fuel truck accident were initiated. 12:37 hours Port Jefferson Lead Traffic Guide instructed to dispactch dosimetry equipment to support Miller Place Fire Department. Traffic Control Point Coordinator, having conferred with the Evacuation 12:47 hours Coordinator, directed Lead Traffic Guide at Port Jefferson to begin rerouting traffic around the fuel truck impediment. 12:50 hours Route Alert Driver with d simetry dispatched. 12:57 hours Traffic Control Point Coordinator was informed that traffic was being rerouted. 13:10 hours Traffic Guide at TCP #40, where traffic was being rerouted, advised Lead Traffic Guide at Port Jefferson that another Traffic Guide and additional traffic cones were needed. Additional guide and equipment dispatched from Port 13:32 hours Jefferson Staging Area. 13:48 hours Road Logistics Coordinator advised of need to send equipment to site of fuel truck accident. 13:50 hours Road Crew dispatched to scene of fuel truck accident. 14:00 hours Traffic Control Coordinator instructed Logistics Support Coordinator to contact owner of fuel truck.

14:00 hours FEMA Evaluator left site of fuel truck accident to proceed to other assignments.
14:10 hours Road Crew arrived at site of fuel truck accident.
14:15 hours Logistics Support Coordinator reported that fuel truck owner had arranged to off-load wrecked tanker.
14:45 hours Evacuation Support Communicator informed Road Logistics Coordinator that fuel truck accident had been cleared and

(Citations to the record for the foregoing time and events are given in the text below.)

road was open.

As was the case with the gravel truck impediment, after the Evacuation Route Coordinator was handed the free play message about the fuel truck impediment, he attempted to have the impediment verified before ordering a response to it. Thus at 11:06 he instructed the EOC Communicator to:

> Have Route Spotter #1005 proceed to 25A, 75 yards east of the intersection with Miller Place-Yaphank Road. Fuel truck turned over on side, blocking both east and west bound lanes.

This message, like the one concerning the gravel truck, did not include pertinent information. It failed to mention the facts that fuel was leaking from the overturned truck, that there was the possibility of fire, and that the truck was blocking both shoulders of the road. Also, it failed to include the instruction for the LERO responder to locate the FEMA evaluator. FEMA Ex. 1, at 30; LILCO EX-41 Testimony, at 19-20.

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The EOC Communicator was unsuccessful in his attempts to contact Route Spotter #1005 by radio. Therefore at 11:15 he inquired of the Port Jefferson Staging Area whether Route Spotter #1005 had been dispatched to his route. Port Jefferson responded that he had not been dispatched. LILCO EX-41 Testimony, at 14.

At 11:40 the Transportation Support Coordinator in the EOC informed the Port Jefferson Bus Dispatcher about the reported fuel truck impediment. Subsequently, at 12:05 the Port Jefferson Bus Dispatcher informed the Transportation Support Coordinator that a visual check of the fuel truck problem on Route 25A had indicated no problem to traffic control or evacuation completion.<sup>14</sup> LILCO EX-41 Testimony, at 14. At 11:49 the Port Jefferson Staging Area advised the EOC Communicator that all Route Spotters had been dispatched, and at 12:02 Route Spotter #1005 was instructed by the EOC Communicator to proceed to the scene of the fuel truck impediment. The Route Spotter found and met with the FEMA evaluator, who released him at 12:23. Id. at 15.

The Evacuation Coordinator, who learned about the fuel truck accident when finally told about both road impediments

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<sup>&</sup>lt;sup>14</sup>FEMA criticized this 12:05 message from the Bus Dispatcher because it "was partially illegible and was not written on a standard LERO message form." FEMA Ex. 1, at 30.

by a FEMA Controller at 12:13, did not begin discussing the fuel truck impediment with his associates until after the rerouting scheme for the gravel truck had been determined and actions had been taken to implement that decision. Eventually, at 12:47, the Traffic Control Point Coordinator directed the Lead Traffic Guide at Port Jefferson to have the Traffic Guide at TCP #40 stop all west bound traffic on Route 25A and reroute it around the fuel truck accident via North Country Road and Echo Avenue. At 12:57 the Traffic Control Point Coordinator was informed that traffic was being rerouted. Id. At 13:10, however, the Traffic Guide at TCP #40 radioed the Lead Traffic Guide at Port Jefferson and advised that an additional Traffic Guide and six additional traffic cones were needed to effectuate the rerouting. The additional guide and the necessary equipment was dispatched from Port Jefferson at 13:32. Id. at 16.

At about 12:32 attempts were initiated to get the Miller Place Fire Department to respond to the fuel truck accident; at 12:37 the Port Jefferson Lead Traffic Guide was instructed to dispatch dosimetry equipment to assist the fire department and at 12:50 a Route Alert Driver with this equipment departed. <u>Id</u>., Attachments C.9, C.10. The Road Logistics Coordinator was advised of a need to send equipment to the site of the fuel truck accident at about 13:50, when a Road Crew was finally dispatched to the fuel truck accident. It arrived at the scene at approximately

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14:10. By this time, the FEMA evaluator, who had been waiting at the site since 11:30, had left (at 14:00) when it became necessary for him to proceed to other assignments. FEMA Ex. 1, at 36-37, 58.

At 14:00 the Traffic Control Coordinator instructed the Logistics Support Coordinator to contact Hess Oil Company to advise them that one of their trucks had overturned and was leaking, and to request that they send a another truck to the scene for off-loading. At 14:15 the Logistics Support Coordinator reported that Hess had arranged with a local contractor to transfer the load, and at 14:45 the Evacuation Support Communicator informed the Road Logistics Coordinator that a Road Crew had reported that the fuel spill had been cleared, that the truck was off the roadway, and that the road was clear. LILCO EX-41 Testimony, at 18.

## Discussion

There is little if any dispute regarding the facts recited above. The parties differ markedly on the interpretation to be placed on them. LILCO witnesses argued that LERO largely demonstrated its ability to respond to roadway impediments. LILCO EX-41 Testimony, at 19. They pointed out that during the Exercise (1) the Evacuation Route Coordinator immediately attempted to verify both accidents; (2) following verification of the gravel truck impediment, a tow truck was promptly dispatched; (3) after

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verification of the fuel truck impediment, steps were taken to eliminate the fire hazard and to off-load the vehicle; (4) once the Evacuation Coordinator became involved, decisions were promptly made on rerouting schemes; (5) rerouting schemes were rapidly and effectively implemented in the field and then removed once the impediments were cleared; (6) an EBS message on the impediments was prepared and broadcast (simulated); and (7) the Transportation Support Group recognized the potential impact of the impediments ch bus operations and promptly informed the appropriate field personnel of the possible problems. Id.

LILCO witnesses acknowledged the existence of delays in LERO's response and attributed them to two causes: first, the Evacuation Route Coordinator's failure to perform as effectively as he should have and second, the manner in which FEMA introduced the impediment messages into the Exercise. <u>Id</u>. at 19-22. The witnesses admitted that the Evacuation Route Coordinator's failure to inform his co-workers and superiors in the EOC of the roadway impediments delayed LERO's response. <u>Id</u>. at 20; Tr.966-67 (Wilm). They testified that his omission of information in transmitting the original free play messages to field personnel resulted in delays and confusion because field personnel were unaware of the need to meet with the FEMA evaluators. LILCO EX-41 Testimony, at 20. This led to

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incorrect reports either that no impediment existed or that the impediment had been cleared. Id.

In presenting their case, Intervenors claimed that LILCO's response to the two impediments was wholly inadequate. According to the Suffolk County's testimony, for example, LILCO: took too long to respond to the impediments; failed to demonstrate that it could effectively communicate crucial information about the impediments within the LERO organization; failed to allocate sufficient manpower and equipment or material to deal with the impediments; and failed to reroute traffic properly around the impediments. See Suffolk EX-41 Testimony, at 33-37, 43-48. In the County's view, these problems, as revealed during the Exercise, demonstrated that LILCO's organizational structure, Plan design, and response personnel are unable to protect the public health and safety.

FEMA assigned a Deficiency, an ARCA, and an ARFI on account of LILCO's performance. In its proposed findings, Staff concluded that LILCO's performance demonstrated a fundamental flaw in implementation of the Plan.

Although the various elements of LERO's response called into question by this contention are closely related, for purposes of discussion we have divided them into three parts: Communications, Actions to Clear the Impediments, and Traffic Rerouting.

#### Communications

FEMA concluded that the lack of timeliness in LERO's response to the two evacuation impediments was the result of a failure in lateral and downward communication in the EOC. Tr. 8259. As a result of this and other communication problems at the EOC, FEMA identified a Deficiency in its Post Exercise Assessment, FEMA Exhibit 1:

DEFICIENCY

Description: Delays in responding to the two (2) evacuation impediment free-play messages inserted at the LERO EOC were caused by the failure to inform the Evacuation Coordinator in a timely manner. In addition there was a lack of internal communication in response to these impediment problems. Pertinent information was not included on the 1045 and 1106 LERO Message Forms from the Evacuation Route Coordinator to the Evacuation Support Communicator for Route Spotters/Road Crews regarding the simulated impediment involving the gravel truck and fuel truck problems. As a result of this lack of information, the impediment problems were not analyzed in a timely fashion and incomplete equipment was dispatched to handle the gravel truck impediment in the field. NUREG-0654, II, J.10.k.

Recommendation: Internal communications procedures should be reviewed and revised as necessary to ensure that information on impediments is promptly passed both up the chain of command to the Evacuation Coordinator and downward and laterally to all lead coordinators under the Evacuation Coordinator and their staffs. Additional training is needed to ensure that the procedures, whether new or current, are properly implemented. All coordinators at the EOC, and those who initiate messages, must be trained to include all pertinent information on the IERO message forms and to analyze the equipment requirements to clear impediments. FEMA Ex. 1, at 39.

In addition, FEMA identified one ARCA that resulting from LERO's responses to the impediments. We view the ARCA as also raising communications problems. It states:

AREA REQUIRING CORRECTIVE ACTION

Description: There was a delay of about fortyfive (45) minutes between the LERO EOCS (sic) first attempt to have Route Spotter #1005 verify the fuel truck impediment and the dispatch of that spotter from the Port Jefferson Staging Area. This delayed timely verification of the impediment. NUREG-0654, II, E.2.

Recommendation: Personnel need to be trained in the development of alternative approaches when delays are reasonably anticipated in the field verification of impediments to evacuation. Development of alternatives should include consultation between, at a minimum, the Evacuation Coordinator and the Evacuation Route Coordinator.

Id. at 41. Finally, FEMA also identified one ARFI that similarly raises communications issues. It states:

AREA RECOMMENDED FOR IMPROVEMENT

Description: The 1205 message concerning the "visual check" of the fuel truck impediment from the Bus Dispatcher at the Patchogue Staging Area to the Transportation Support Coordinator was partially illegible and was not written on a standard LERO message form.

Recommendation: LERO should consider whether operations could be improved by additional training stressing the mandatory use of standard message forms and the importance of legibility.

Id. at 42.

The NRC Staff, in its proposed findings, agreed with FEMA that LERO's responses to the fuel truck impediment, and to a lesser extent the gravel truck impediment, were generally ineffective and failed to demonstrate that LERO could deal with impediments to evacuation on roadways. It also agreed with FEMA that the deficiencies in regard to the removal of impediments were the result of a failure of communication and training. Staff's view is that these problems do not show the Plan to be flawed, but rather they demonstrate that if LERO members do not follow required procedures and promptly and accurately communicate evacuation problems, as called for by the Plan, the Plan will not work. Staff proposed finding 229, at 83. Nevertheless Staff concluded that ... "the Exercise revealed ... deficiencies which preclude a finding of reasonable assurance that protective measures can and will be taken, i.e., fundamental flaws in the Plan" in regard to the removal of roadway impediments. See CLI-86-11, 23 NRC at 581. ... [B]efore a finding of reasonable assurance is made that the Plan "can and will be implemented" a FEMA remedial drill or Exercise is necessary, after further training, to demonstrate that the LERO personnel have the skill and ability to implement the Plan. Staff proposed finding 231, at 83-84.

In their proposed findings, Intervenors have raised, in somewhat more detail, the same communications problems

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identified by FEMA.<sup>15</sup> See Intervenors' proposed findings, at 183-90, 198-205.

LILCO recognized that there were problems revealed in LERO's communications. Its position is perhaps best summed up by the following findings which it asks us to make:

> 237. Clearly, the Evacuation Route Coordinator's failure to communicate immediately information about the two impediments to his coworkers and his superiors in the EOC represented poor judgment and significantly delayed LERO's response to the two impediments. To a lesser degree, his failure to communicate all information to field workers also delayed the response, particularly to the extent field workers were confused about the need to find a FEMA evaluator.

> 238. In addition, we agree with LILCO that the manner in which FEMA input the free play messages, and the way they graded them in the field, affected LERO's response. LILCO correctly notes that had accidents of the severity hypothesized actually occurred, reports of their existence would have flowed to the EOC from numerous sources and would have highlighted the need for immediate action. FEMA should reevaluate its procedures for injecting impediment messages into exercises to try to make the process more realistic.

LILCO's proposed findings, at 88.

LILCO attacks the Staff's position on the basis that the examples relied on by the Staff to reach its conclusion

<sup>15</sup>Additionally, they have raised the matter of the timeliness of the simulated EBS messages concerning these impediments. See Intervenors' proposed findings 262, et seq., at 187, et seq. We deal with this subject in connection with Contentions EX-38 and EX-39, infra.

do not, on the grounds of timeliness, support that conclusion. LILCO supports its attack with the following, all of which relates to the fuel truck impediment:

First, the delay in the dispatch of a Route Spotter to verify the accident would not in fact have delayed verification if the accident had been real, or if FEMA had employed some means to identify the accident in the field, because then LERO workers would have observed the accident (or its simulation) and reported it;

Second, after being informed of the two impediments, the Evacuation Coordinator acted promptly to reroute traffic and summon the fire department:

Third, the Traffic Guides were prompt in assessing the need for additional equipment and assistance in rerouting traffic, and the Staging Area was prompt in its response to that need; and

Fourth, the timing of LERO's actions in sending a Road Crew and in contacting the owner of the truck to have it off-loaded may not be criticized because no message was inserted by FEMA to indicate when the fire hazard was brought under control so as to permit these activities. See LILCO's reply findings, at 29.

Finally, LILCO asserts that the Staff never explains how these allegedly untimely actions would adversely affect the public health and safety. LILCO notes that Staff has accepted the position that, in a real emergency, the

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existence of the impediments would come to light much earlier. Consequently, LILCO believes that Staff must also accept LILCO's position that, in that situation, prompt action would be taken as it was in the Exercise once the Evacuation Coordinator was informed of the impediments. <u>Id</u>. at 30.

Intervenors proposed findings, LILCO asserts, are defective in that they do not fairly present what in fact occurred at the Exercise and consequently create the impression that many more problems were uncovered than was the case.

We can in large part accept LILCO's arguments as factually accurate. We recognize that artifacts of the Exercise influenced the timeliness of LERO's response to these impediments and that to a certain extent, the lack of a timely response is attributable to FEMA's handling of the Exercise scenario. Nonetheless we cannot accept LILCO's conclusion.

Accepting LILCO's arguments summarized above, the fact remains that DERO's communications were inadequate in the following respects:

First, the Evacuation Route Coordinator did not inform his superior or his coworkers of the two traffic impediments on receipt of the free play messages. While we recognize that the Plan gives the Coordinator the discretion to verify the impediments if he believes that necessary, as

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he did during the Exercise, nonetheless we can see no justification for his withholding of information pending verification. Where, as here, the messages postulate the complete blockage of evacuation routes by major accidents involving heavy trucks, one of which posed a risk of fire, the Ccordinator should at a minimum have informed his superior and his co-workers of the information contained in the messages and the action he was taking.

Second, the information contained in the messages which the Coordinator had transmitted to the Route Spotters was incomplete in that it did not give details concerning the two accidents. While LILCO may well be correct that this information was readily obtainable by the Route Spotters on observation of the accidents, nonetheless its inclusion would have served as a prompt to ensure that the information contained in the free play messages was verified and, more importantly, relayed to those who would need it in mounting a response. It is a fact that LERO responded to the gravel truck accident with inadequate equipment. While, in a real situation, the Route Spotter might well have observed and relayed information which would have prompted a response with adequate equipment, inclusion of the details contained in the free play messages would have ensured that critical information was noted and passed on.

Third, the inquiry directed to the Staging Area as to whether Route Spotter #1005 had been dispatched should

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have included the information contained in the fuel truck free play message and a request that that Spotter be dispatched quickly to the scene of the accident. This would have prevented a delay in verification.

These inadequacies demonstrate a fundamental flaw. Further, the fundamental flaw involved is, Staff notwithstanding, a flaw in the Plan itself, revealed in the implementation but not simply engendered by it. We note that communications problems persisted in subsequent drills. Suffolk County introduced evidence to the effect that in a June 1986 training drill, which was evaluated by a LILCO contractor, Impell Corp., the two impediments used were identical to those used in the Exercise. Suffolk EX-41 Testimony, at 65. Impell criticized LERO's response to the impediments as follows:

> The Transportation Support Coordinator should have done a better job of keeping control and managing his group during the road impediment scenarios. No one individual was assigned to be in charge of handling these impediments. Because practically all groups in the EOC need to be made aware of such a problem it is important that one individual be responsible for coordinating this effort.

> The RHC [Radiation Health Coordinator] was not made aware of the impediment to evacuation until 2:15 PM; 1 hour and 30 minutes after the event had occurred.

> The EBS message telling of the road impediment was issued at 1:29 PM, almost 45 minutes after the event had occurred. In addition this important piece of information was included with the entire EBS message and might have been missed by the general public. A special EBS message should have been issued.

The message for the second road impediment was called into the EOC and was properly logged on the message form, however when the information was related to the field, the wrong road was mentioned; Route 25-A vs Route 25. The word came back from the Controller, simulating a route spotter, that there was no impediment at the location indicated. As that time it was assumed that the impediment was either a false alarm or had been cleared, and no follow up action was taken. It was not until the Controller in the EOC prompted the players three times to review the original message that any action was taken.

#### Id. at 65-66.

Suffolk's witnesses point out that during the June drill LERO personnel confused Route 25 and Route 25A, which led to an incorrect response and delays in responding to simulated roadway impediments; this situation was similar to the confusion over the location of the gravel truck and the resultant delays that occurred during the February drill. Id. at 67-68. Suffolk's witnesses attribute the communication problems in the EOC to LERO's "cumbersome, complex, and vertical decisionmaking and communication hierarchy...." Id. at 67.

Indeed, FEMA found that, in order to correct a discovered Deficiency:

Internal communications procedures should be reviewed and revised as necessary to ensure that information on impediments is promptly passed both up the chain of command to the Evacuation Coordinator and downward and laterally to all lead coordinators under the Evacuation Coordinator and their staffs. (FEMA Ex. 1, at 120)

We are fully aware that the OL-3 Board gave its blessing to the communications scheme incorporated in the

LILCO Plan. But that blessing was scarcely an enthusiastic one, recognizing as it did the difficulty the scheme would encounter if faced with impromptu problems. The OL-3 Board said:

> We found in our resolution of Contention 65 that traffic guides are only required to facilitate traffic flow at their assigned intersections and to guide traffic in preferred directions ... They have no specific assignment to alleviate traffic jams or to engage in ad hoc problem solving ... LILCO's planning shows a realistic grasp of the fact since its communications system is not intended to aid in a routine problem-solving function ... We conclude, however, that a timely evacuation of the EPZ could be accomplished even if there were no communication whatever among traffic guides. That being the case, we find that LILCO's administrative communications system is a useful provision for emergency response, even though there can be little doubt that the broadly versatile system the police advocate is in the final analysis a superior one.

21 NRC 644, 736-737.

Thus that Board gave the Plan its qualified approval, an approval based on inherent assumptions that traffic guides need only carry out preplanned actions, that "problem-solving" would not be required, and that ad hoc responses were not called for. Clearly, the Exercise, with its accompanying free-play messages, indicated that a response to an emergency-within-an-emergency was in fact a natural requirement for an adequate plan. In short, the OL-3 Board's approval was based on an assumption which the exercise proved untenable. And, as that Board clearly implied, if one accepts the "free-play" conditions of the exercise (and in deference to FEMA's standard practice we do) the communication system in LILCO's plan is fundamentally flawed in that it inherently hampers response to unexpected events.

We agree with FEMA that the communications system should be reviewed and revised, and that additional lateral lines of communication should be considered, and we recommend that the extent to which lateral communication may be incorporated should be examined in the light of a need to respond to unexpected and untoward occurrences during a radiological emergency.

#### Actions to Clear the Impediments

FEMA assigned an ARCA to the Patchogue Staging Area with respect to its response to the gravel truck impediment. FEMA did not observe the response to the fuel truck impediment. FEMA Exhibit 5, at 75. The ARCA states:

> Description: Appropriate personnel and equipment were not dispatched to clear the multiple vehicle accident simulated as an impediment to evacuation....

> Recommendation: The appropriate personnel at the Patchogue Staging Area should be trained to request more information from the LERO EOC when impediments to evacuation are indicated.

FEMA Ex. 1, at 67.

Staff did not specifically address this point. Intervenors essentially agree with FEMA that LERO did not dispatch adequate equipment to the gravel truck accident

(see paragraph 19, at 15, supra), and that some attention should have been paid by LERO to the possibility that gravel had been spilled on the roadway (Intervenors' proposed finding 275, at 193). Suffolk's witnesses testified that the Road Crew's response to the fuel truck accident was inadequate because only one 10,000 pound tow truck was dispatched to the scene. This vehicle would have been too small to remove an overturned tanker truck from the roadway. Suffolk EX-41 Testimony, at 48. LILCO believes that the equipment dispatched to the gravel truck was adequate in that it could have opened one lane to traffic and called for assistance, and that the spilled gravel was an afterthought in that the free play message did not mention that possibility. LILCO EX-41 Testimony, at 26-27; Tr. 1019-20 (Wilm). LILCO notes that the Road Crew dispatched to the fuel truck was to stand by to render assistance if necessary, not to remove the truck from the roadway. Tr. 1024-25 (Wilm).

Given its mission, we agree with LILCO that the equipment sent to the fuel truck impediment was adequate. The equipment sent to the gravel truck was not adequate to completely clear the roadway. While that Road Crew could call for assistance as LILCO points out, it would have been better to have sent the proper equipment initially. We do not regard this failure, by itself, as a fundamental flaw.

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Moreover, we find that it resulted from inadequate communications discussed above.

Intervenors also assert that the responses to the two impediments were untimely. See Intervenors' proposed findings 270-73, 297-300, at 191-92, 207-09. LILCO disagrees with this assessment. See LILCO's reply findings, vol. II, at 58-59, 64-66. We do not believe that LERO may properly be charged with a delayed response to the gravel truck impediment beyond that occasioned by its lapses in communications. The chronology reveals that, once the accident was verified, LERO's response was timely. The delays in responding to the fuel truck impediment are less easily explained. LILCO believes that they were necessary in view of the nature of the accident, and, in any event, were not of any consequence to the public health and safety in light of the rerouting of traffic. Assuming Intervenors are correct that LERO should have acted more promptly to complete the removal of this impediment, we do not find that this failure rises to the level of a fundamental flaw.

# Traffic Rerouting

FEMA reached no conclusion with regard to the efficacy of LERO's traffic rerouting around the two impediments. Staff, in its proposed finding 230, at 83, found both LERO's rerouting schemes and those alternative schemes put forward by Intervenors to be reasonable and workable.

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Intervenors spent a great amount of time exploring this topic at the hearing. Suffolk's witnesses testified that LERO's rerouting around the gravel truck impediment was improper first, because better schemes were available, and second, because the delay in implementing rerouting would likely have made rerouting ineffective because of the traffic congestion that would already have occurred at the impediment site. Suffolk EX-41 Testimony, at 50-51. They described, with the aid of aerial photographs and a map, a simple one block detour around the impediment via Waters Street and Everett Road, which would have returned the traffic to Main Street and the route it was traveling; this would have enabled the evacuating vehicles to reach the Long Island Expressway or the Sunrise Highway to exit the EPZ. Id. at 52-53.

LILCO's witness, Mr. Lieberman, a traffic engineer, testified that, while Suffolk's scheme was "viable," LERO's rerouting scheme was preferable because the Suffolk scheme would reroute traffic within sight of the accident, whereas the LERO scheme would divert traffic before the accident came into view. He stated that rubber-necking can reduce traffic flow rate by as much as one-half, saying, further, "Every policeman I've talked with is aware of the hazards associated with the rubber-necking phenomenon." Tr. 1089-91. Suffolk's witnesses, Inspector Dormer and Deputy Inspector Michel of the Suffolk County Police Department,

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testified that traffic would be moving so slowly as it approached the impediment and as it turned left to enter the detour route, that rubber-neckers would have ample time to satisfy their curiosity and rubber-necking would not significantly affect the flow rate of traffic. Tr. 1210-13. Witness Lieberman also stated that the simpler detour would have required more manpower than was there at the time the impediment took place. Tr. 1111. He acknowledged, however, that the simpler detour could have been implemented with two traffic guides. Tr. 1112. Traffic Guide Post (TCP) #124, situated at the intersection of Main Street and Yaphank-Middle Island Road, is required to be staffed by two Traffic Guides. Suffolk EX-41 Testimony, at 31 n.15. Thus, had it been staffed in a timely manner two Traffic Guides would have been available within sight of the accident when it occurred. During the Exercise, however, TCP #124 was not staffed until 11:30, 50 minutes after LERO learned of the gravel truck impediment. Suffolk EX-40 Testimony ff. Tr. 2180, at 26.

In addition, the rerouting scheme around the fuel truck impediment via North Country Road and Echo Road was not the most effective alternative, according to Suffolk's witnesses, because these roads serve an extremely congested area of the EPZ; consequently no more traffic than is absolutely necessary should be put onto North Country Road west of its intersection with Route 25A. A better rerouting

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scheme, according to Suffolk's witnesses, would have been to detour traffic on Route 25A south on Radio Avenue to Whiskey Road, then west on Whiskey Road to Canal Road, and Canal Road back to Route 25A. Suffolk EX-41 Testimony at 56-58. LILCO'S Mr. Lieberman also regards this scheme as "viable," but preferred LERO's scheme because it was shorter, involved fewer turns and a higher class of roadway, was more generally familiar, and would have returned traffic to its original route. Tr. 2274-86, 2317 (Lieberman). Moreover, Mr. Lieberman testified that rerouting schemes are generally not unique, that highway networks generally offer multiple possibilities for diverting traffic. Tr. 2273-74 (Lieberman).

We agree with Mr. Lieberman that rerouting schemes are generally not unique, and that both LERO's and Suffolk's solutions are workable. It is interesting that in the case of the gravel truck, Suffolk's scheme seemed to be the better of the two, while in the case of the fuel truck, LERO's seemed superior. No fundamental flaw was demonstrated in this regard.

# Traffic Engineer

Subcontention EX-41E alleges that LILCO's proposal to add a Traffic Engineer to the LERO personnel at the EOC will not eliminate the problems in the Plan that were demonstrated by the exercise. The Traffic Engineer is supposed to assist in evaluating road impediments and developing alternative routing. The Subcontention alleges that such assistance would have no impact on the basic problems with the Plan and the incapacities of LERO personnel described in Contention EX-41.

LILCO's witness Lieberman, who testified that he had served as the LERO Traffic Engineer in drills following the exercise, stated that he believed the addition of a traffic engineer to the EOC staff has improved the LILCO Plan by bringing new insights into the decisionmaking process. Because of the Traffic Engineer's understanding of traffic flows and potential sources of congestion during an evacuation and his familiarity with computer projections of traffic flow, witness Lieberman believes that the Traffic Engineer should help LERO respond more quickly and with more confidence to any roadway impediment or other traffic problems. LILCO EX-41 Testimony at 29-30.

Suffolk's witnesses, on the other hand, testified that the only way to identify, respond to, and solve traffic problems is to have trained and experienced field personnel who are able and authorized to quickly evaluate a traffic problem, consult with other field personnel to determine other problems and ramifications to be considered, and then reach and quickly implement a decision. Under LILCO's Plan, field personnel for the most part do not confer with each other. Traffic Guides, for example, cannot inform each

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other of problems that require joint response. LILCO'S Plan calls for most decisions to be made at the EOC by coordinating personnel who are neither trained nor adequately informed in subjects necessary to respond to traffic problems. Suffolk EX-41 Testimony at 77-78. LILCO'S witness Weismantle testified that the reason LILCO wanted rerouting decisions to be made at the EOC was to ensure that the decisions are coordinated and made by people who have the overall information about traffic posts and evacuation patterns, rather than being made by people in the field. Tr. 1102.

The NRC Staff, in its proposed findings, indicated that it did not consider the addition of a Traffic Engineer to the EOC to be relevant to the problems that arose during the Exercise. While it believes that the Traffic Engineer should be able to assist in evaluating road impediments and developing alternate routing schemes, these areas were not the principal source of problems on the day of the Exercise; rather, needed and useful information was not flowing to the persons who required it, with the result being an inadequate field response. Staff proposed finding 232, at 84.

During a drill held on October 1, 1986, the Traffic Engineer was present in the EOC. In its evaluation of LERO's performance, the Impell Corp. report on the drill made the following statement about the EOC performance:

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[0]ne of the major areas of concern during this drill continues to be the communications between the EOC and the Staging Areas. Long delays in getting information to the Staging Areas were experienced throughout the drills. Much more emphasis needs to be placed on communications both in accuracy and timeliness....It appears that the common denominator in communication delays is the EOC and emphasis must be placed in training that facility.

Id. at 78. Clearly the problem that was demonstrated to be a fundamental flaw in the LILCO Plan by the February 13, 1986 drill continued to plague LERO's performance as late as the October 1, 1986 drill. With regard to the performance of the Traffic Engineer during the post-exercise drills, Impell said the following in its report on the June 1986 training drill:

> The position of the Traffic Engineer was utilized for the first time. Their exact responsibilities was (sic) not very clear in their own minds. They became too involved in traffic engineering details, i.e. extent of the crown on the road and its effect on traffic flow, rather than quickly advising the Evacuation group of alternative evacuation routes and their effect on evacuation time estimates.

Id. at 79-80. The Impell report on a drill held on September 17, 1986, during which a Traffic Engineer was again present in the EOC, stated as follows with regard to the response to impediments:

Improvement could be made in generating the information and arriving at new evacuation time estimates.

A somewhat similar criticism was directed at the Traffic Engineer in Impell's report on the October 1, 1986 drill: The Traffic Engineer, however, had to be prompted to develop revised evacuation time estimates based upon the re-routed traffic.

Id. at 80. The foregoing evaluations of post-Exercise drills, in the opinion of Suffolk's witnesses, provide no basis to conclude that the addition of a Traffic Engineer has done anything to solve the problems in removing impediments and rerouting traffic as demonstrated by the February 13 exercise. Ibid. In their view there is no reason to believe that the presence of a Traffic Engineer in the EOC, not in the field and therefore dependent upon field workers and staging area personnel to provide him with information necessary for making informed rerouting decisions, will improve performance of LERO personnel. Id. at 79. The Traffic Engineer in the EOC represents an additional position and another communication layer in LERO's complex, vertical communications and decisionmaking hierarchy, and it does nothing to address the communications problems within the EOC and between the EOC and the field. Id. at 76, 78.

<u>Conclusion on Contention EX-41E</u>. FEMA found the poor communication within the EOC and between the EOC and the field during the February 13, 1986 exercise to be a deficiency. It recommended that that LILCO revise its internal communication procedures and train coordinators and others to more effectively transmit messages. Three drills and more than six months later, the Impell Corp. found that

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the October 1, 1986 drill demonstrated that LERO needed to place much more emphasis on training EOC personnel in accurate and timely communications. Clearly whatever steps LILCO took during the six months following the exercise to fix the problems noted by FEMA, including the addition of a Traffic Engineer to the EOC, the fixes did not succeed in curing the fundamental flaw in the Plan, viz., the deficient communication structure and procedures.

It may be difficult for LILCO to cure this fundamental flaw because of the training and experience of the personnel used to implement the Plan. As emergency workers, LILCO personnel are amateurs; this fact may be the root cause of the communication problems. While both FEMA and Impell call for more and better training in the area of communication, it is questionable whether utility personnel can ever achieve the level of performance that professional emergency workers, such as the police, display. Nor can Traffic Guides and Route Spotters, communicating with Staging Areas which in turn must communicate with the EOC for decisions, deal with evacuation traffic problems as efficiently and effectively as police who evaluate problems on-the-spot, solicit assistance by lateral communication, and make and implement decisions. Moreover, Traffic Guides and Route Spotters who must be mobilized and briefed before being dispatched to the field will probably never be able to respond as quickly to an emergency as police who are already

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on duty in the field. Consequently, the LERO approach is generally and fundamentally unsatisfactory, and it may be inherently so.

## 1.c. Exercise Realism

Contention EX-22I was not admitted separately but was dealt with under Contention EX-41. It challenged FEMA's injection of only two road impediments into the Exercise, on the grounds that LILCO itself has estimated that there would be four accident/breakdowns during an evacuation of the EPZ.

Suffolk County, on the other hand, claims that the reported accidents from the Sixth Precinct of the Police Department, which includes most of the EPZ, indicate that there were over 22 reported accidents per day during the period February 6-20, 1986, with more than four, on average, requiring one or more tow trucks and approximately two and a half requiring an ambulance. Suffolk EX-41 Testimony, at 70-71. Suffolk's witnesses believe that given LERO's problems with handling only two impediments, there is no way that LERO could effectively deal with even more impediments during a real Shoreham accident. Id. at 72.

LILCO argues that while the Sixth Precinct is roughly the size of the EPZ, the population of the Sixth Precinct is about 1.5 times that of the Shoreham EPZ. Thus, to make the Sixth Precinct statistics applicable to the EPZ, Suffolk's accident statistics should be divided by 1.5. Dividing 22

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accidents per day by 1.5 gives 14.3 accidents per day predicted for the EP2, or 0.61 accident per hour. 16 From this prediction, 3.05 accidents would be expected during a five-hour evacuation. Of these, only 0.61 would be predicted to require tow truck assistance, based on the Sixth Precinct statistics. LILCO EX-41 Testimony, at 30-31. LILCO's witness Lieberman calculated another prediction, based on data for the date of the Exercise from Precinct Six police tour two, the eight hour police shift running from 8:00 to 16:00 hours. Tr. 1051, 1054-55. The total of eleven accidents was divided by eight hours gave 1.375 per hour, which was then divided by 1.5 to normalize it to the population within the EPZ. The result, multiplied by five hours, yielded a prediction of 4.58 accidents during the evacuation. Less than one would require a tow truck. Tr. 1055.

Witness Lieberman acknowledged that a better prediction might be obtained if normalization of Precinct Six statistics to the EPZ was based on number of vehicle miles traveled rather than population, but that information was

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<sup>&</sup>lt;sup>16</sup>Dividing the number of accidents in the Sixth Precint by 1.5 because the population of the Sixth Precint is 1.5 times that of the EPZ seems to us to be inconsistent with witness Lieberman's other testimony that the traffic fatality rate in areas of high population density is lower than in low population density areas. See LILCO EX-41 Testimony, at 31; Tr. 1061.

not available to him. Tr. 1059. He also acknowledged that there is considerable uncertainty associated with his predictions, but expressed his belief that with twelve Road Crews in the EPZ, eight or ten accidents during an evacuation could be adequately handled. Tr. 1061. Furthermore, because many accidents and more severe accidents tend to occur during periods or in locations of low traffic volumes, witness Lieberman argued that normal accident rates probably overstate the number of accidents that would occur during an evacuation, when traffic would be heavy and moving slowly. LILCO EX-41 Testimony, at 31; Tr. 1061.

<u>Conclusion on Contention EX-22I</u>. The Board gives more weight to the uncertainty associated with predictions of number of accidents to be expected during an evacuation than to the predictions themselves. We agree that once evacuation traffic has reached heavy volume and is moving slowly, any accidents would probably not be very severe. On the other hand, early in the evacuation, we would expect frightened evacuees to drive at high rates of speed and perhaps be willing to take risks they might not normally take. Therefore severe accidents might well occur early in the evacuation, creating impediments that would cause delays for the heavy traffic to follow. In any event, there is no basis on which to conclude that FEMA injected an insufficient number of impediments into the Exercise.

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## 2. Staffing of Traffic Control Posts

LERO's Traffic Guides, according to the LILCO Plan, are to guide evacuees and encourage them to adhere to the evacuation routes prescribed by the Plan. They are to accomplish this by using traffic control strategies and techniques such as blocked lanes, barricades, and the channelization of selected portions of the evacuation network. Direct Testimony of Assistant Chief Inspector Richard C. Roberts, Inspector Richard Dormer, Inspector Philip McGuire, and Deputy Inspector Edwin J. Michel On Behalf of Suffolk County Regarding Contention EX-40 --Mobilization, Dispatch, and Staffing of Traffic Control Posts During the February 13, 1986 Shoreham Exercise (Suffolk EX-40 Testimony), ff. Tr. 2180, at 16; see Plan, Appendix A, at IV-5 thru -72e and V-2; OPIP 3.6.3. They are also expected to expedite traffic flow out of the EPZ by controlling and routing traffic flow through intersections, using hand and arm movements. Suffolk EX-40 Testimony, at 16; see OPIP 2.1.1. They help facilitate the traffic strategy outlined in the Plan and are available to perform other needed duties that fall outside the preplanned traffic strategy, such as reporting road impediments. Tr. 1563. The evacuation time estimate for controlled (i.e., guided by Traffic Guides) evacuation is based on the assumption that "[r]equired personnel to control traffic are mobilized and

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in place at outset of evacuation process or soon thereafter." Plan, Appendix A, at V-2.

Contention EX-40 alleges that the exercise demonstrated a fundamental flaw in the LILCO Plan because the Plan fails to provide traffic guidance for evacuees until long after they are likely to be on the roads attempting to evacuate. It alleges that the evacuation time estimates are based on the assumption that the Traffic Guides are at their Traffic Control Posts (TCPs) guiding motorists and implementing traffic control strategies during the entire evacuation process. The contention also alleges that beginning with the simulated 10:24 EBS message recommending evacuation, all EBS messages broadcast every 15 minutes thereafter stated that the Traffic Guides were in place to guide evacuees. Id. at 12.

Contention EX-40A focusses on the time it took the guides to report to their staging areas after call up. It points out that during the exercise, pursuant to the Plan, the Traffic Guides were not notified to report to the staging areas until after the declaration of a Site Area Emergency at 08:19. <u>Id</u>.; see OPIP 3.3.3 and 3.6.3. It then alleges the numbers of Traffic Guides who had reported to the three staging areas at 09:00 and 09:40, when a General Emergency was declared.

Contention EX-40B points out that during the Exercise, pursuant to the Plan, Traffic Guides were not dispatched

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from the staging areas until after the evacuation recommendation had been made to the public by simulated EBS message. It alleges that it took substantial amounts of time for Traffic Guides to reach and staff their posts.

Contention EX-40B also alleges that the Exercise demonstrated that the LILCO Plan fails to provide evacuation assistance and guidance until long after evacuees would be on the roads, even if no one attempted to evacuate prior to the announcement at 10:24. It asserts that LILCO lacks the capability to provide such assistance because the Plan as written provides that no Traffic Guides, except for those assigned to posts within two miles of the plant (see discussion of Subcontention EX-40E), are to be dispatched until after there has been an evacuation recommendation. Id. at 13-14.

Contention EX-40C alleges that EBS messages, beginning with the 10:24 evacuation recommendation, contained statements indicating that Traffic Guides were available to assist evacuees long before the Guides were, in fact, at their posts. It was litigated with Contentions EX-38 and EX-39 and is considered and decided in our discussion of those contentions.

Contention EX-40D was not admitted for litigation. Contention EX-40E alleges that the dispatch of Traffic Guides to TCPs within two miles of the plant (two-mile zone) upon the issuance of an evacuation order, even if dispatch

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were accomplished more expeditiously than it was during the Exercise, would not correct the defect in the LILCO Plan. Because of the notification and reporting provisions for Traffic Guides, and the fact that an evacuation order can swiftly follow a Site Area Emergency declaration, this attempted "fix" to the defect in the Plan is ineffective. Consequently, the LILCO Plan is, according to Suffolk, fundamentally flawed in that it fails to comply with 10 CFR 50.47(b)(10) and NUREG-0654, paragraph II.J. Suffolk EX-40 Testimony, at 40.

#### FEMA's Findings

FEMA found that the objective to demonstrate that TCPs can be established and staffed by Traffic Guides in a timely manner (Field 6) was met at the Patchogue Staging Area and partly met at the Port Jefferson and Riverhead Staging Areas. Riverhead was the only Staging Area at which FEMA found TCP staffing to be tardy. FEMA Ex. 5, at 9.

FEMA observed eight TCPs in the Riverhead Staging Area's jurisdiction and found that the time between deployment of Traffic Guides and their arrival at TCPs was excessive, taking between fifty and seventy minutes. FEMA Ex. 1, at 74. Following the 10:24 EES message recommending the initial evacuation, Traffic Guides were given their assignments between 10:53 and 11:01. They did not arrive at their TCP assignments until between 11:50 and 12:10. FEMA noted that travel times from the staging area to the TCPs were up to 20 minutes, and, on average, each Guide spent 30 minutes receiving briefings and field kits. <u>Id</u>. Consequently FEMA judged the procedure for deployment of Traffic Guides to be a deficiency, which it stated as follows in the FEMA Report:

DEFICIENCY

Description: The time between deployment of Traffic Guides from the staging area and their arrival at TCPs was excessive, taking between fifty (50) and seventy (70) minutes; approximately thirty (30) minutes was spent in line at the staging area receiving field kits and procedures (NUREG-0654, II, J.10.j).

Recommendation: A more expeditious means of dispatching the Traffic Guides from the staging area to the field should be developed.

FEMA Ex. 1, at 75.

#### LILCO's Arguments

LILCO regards the major dispute among the parties to center on the standard to be applied in determining whether the TCPs were timely staffed. LILCO's proposed findings, at 98. LILCO does not regard the time it took to implement the various steps in the mobilization process to be important so long as the TCPs were timely staffed. LI%CO EX-40 Testimony at 4. LILCO's witnesses put forward two standards against which mobilization should be judged: first, three hours (based on the finding contained in the PID that mobilization of all field workers, including Traffic Guides, could Le substantially completed in this time [LBP-85-12, 21 NRC at 723]), and second, one hour (based on LILCO's assumption that the onset of congestion of the roadways will occur one hour following an evacuation recommendation to the public [see <u>id</u>. at 720]). However, the witnesses also testified that not all TCPs need to be staffed at this point. Rather, only the so-called critical TCPs must be operational.<sup>17</sup> LILCO EX-40 Testimony at 6-8.

LILCO argues that both the three-hour and the one-hour tests should be employed. The first test should be applied with flexibility. LILCO believes that the second test measures whether Traffic Guide mobilization occurred quickly enough to effect a controlled evacuation. Therefore it should be applied only to the critical TCPs. LILCO's proposed findings at 101. LILCO then addresses the mobilization times observed in the exercise.<sup>18</sup>

<sup>18</sup>The mobilization times stated by LILCO are accurate. (Footnote Continued)

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<sup>&</sup>lt;sup>17</sup>A "critical" TCP is one whose operation is intended to: (1) be capacity-enhancing for the highway -- that is, increase the maximum number of vehicles that the highway can service -- and thereby reduce evacuation time; (2) serve a heavy volume of traffic and in addition, serve traffic evacuating from within two miles of the plant; and (3) in a few instances, serve more than one evacuation path in order to ensure that the capacity of each path is fully utilized. LILCO EX-40 Testimony at 10. LILCO classifies 47 of the total of 128 TCPs as critical. Id. at 10-11.

In the Patchogue Staging Area, 18 of 28 TCPs, including all critical ones, were staffed by 11:28, about one hour after evacuation was first recommended, and about three hours after call up. By 11:30, one hour and six minutes after the evacuation recommendation was first broadcast, 26 of the 28 TCPs were staffed. Id. at 13. The last Patchogue TCP was staffed at 11:40, one hour and 15 minutes after the first evacuation recommendation was broadcast. LIICO believes that the Exercise results show that the Patchogue Traffic Guides can be mobilized in time to assure a controlled evacuation. Id. at 14.

The Port Jefferson Traffic Guides began arriving at their TCPs at 11:25, sixty-one minutes after the evacuation recommendation was broadcast. By 12:00, 27 of 72 Fort Jefferson Traffic Guides had arrived at their TCPs, and by 13:00, 60 had arrived. The last Port Jefferson Guide arrived at his TCP at 13:26.

(Footnote Continued)

However, it should be borne in mind that the difference of a few minutes can mean a substantial difference in the number of Traffic Guides mobilized. Thus while LILCO accurately states that as of 11:25, 18 of 28 TCPs assigned to Patchogue were staffed, intervenors can, with equal accuracy, state that as of 11:24, one hour after the evacuation recommendation, only ten were staffed. We do not regard the difference of one minute to be significant.

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LILCO argues that it is the staffing times of critical TCPs that are relevant to whether mobilization and dispatch at Port Jefferson was timely. <u>Id</u>. Seventeen critical TCPs are listed in LILCO's testimony, of which twelve were staffed by 11:45. LILCO believes that this would be only 20 minutes after the anticipated onset of traffic congestion. The last critical TCP was staffed at 12:13, almost two hours after the evacuation recommendation was broadcast.

LILCO believes that at Port Jefferson the delays in staffing TCPs would have lengthened evacuation time by an insignificant amount, less than 19 minutes. Although these mobilization times do not satisfy the tests advocated by LILCO, nonetheless it believes that the Port Jefferson Traffic Guides were mobilized in a timely manner. <u>Id</u>. at 15.

In addition, Mr. Weismantle testified that on the day of the Exercise, the Traffic Guides at Port Jefferson parked in a lot that was about a 10-15 minute walk from the building. In an actual emergency they would park much closer to the building. He concludes that this difference should reduce mobilization time at Port Jefferson by as much as 20-30 minutes. Id. at 16.

LILCO's witnesses testified that they had lost the documents recording the times at which Riverhead Traffic Guides staffed their TCPs. The only times they could report were staffing times recorded by a LILCO observer for seven of the eight TCPs observed by FEMA; the observer did not actually observe the arrival of the Traffic Guides but recorded times that were reported to him verbally by the Guides. Id. at 16 and Att. D. These arrival times do not altogether agree with those contained in the FEMA Report. LILCO's times ranged from 11:15 to 12:10. Id. at 18. FEMA's times, on the other hand, which were recorded by FEMA observers at the eight TCPs in the Riverhead Staging Area, ranged from 11:50 to 12:10. FEMA Ex. 1, at 74. LILCO argues that the staffing of all TCPs by 12:10 would not have resulted in a significant lengthening of evacuation times. Therefore they argue that, for the same reasons advanced for Port Jefferson, the Riverhead Traffic Guides were mobilized in a timely fashion. LILCO EX-40 Testimony, at 18. LILCO acknowledges, however, that the Traffic Guide for TCP 26 had not arrived by 12:50, but states that this TCP is not critical to meeting the controlled evacuation time estimates. Id. at 19.

LILCO also argues that when FEMA's observed equipment issuance and travel times are added to the dispatch times from Riverhead, it is evident that the mobilization was timely. LILCO notes that the Traffic Guides who responded following the first evacuation recommendation were given their assignments between 10:52 and 11:08. LILCO EX-40 Testimony, at 17, Att. E 3; Suffolk EX-40 Testimony at 22; see Tr. 1658 (Weismantle). FEMA not a that equipment

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issuance took on average 30 minutes<sup>19</sup> and that travel time took up to 20 minutes. FEMA Ex. 1, at 74. Thus LILCO argues that mobilization from Port Jefferson would have been in time to meet substantially the controlled evacuation time estimates.

For the above reasons, LILCO believes that the Exercise results refute the FEMA finding of a deficiency in the Riverhead deployment process. LILCO EX-40 Testimony, at 19.

In its proposed findings (at 109-10), LILCO takes the position that, having demonstrated that no fundamental flaw exists with respect to the mobilization of Traffic Guides, it is unnecessary to address Contention EX-40E.

## Suffolk's Arguments

Intervenors agree that, in the PID, the Licensing Board concluded that mobilization of all field workers should be substantially completed in three hours and Traffic Guides should be in place approximately one hour after an evacuation recommendation. Intervenors' proposed findings at 283-84. Intervenors disagree with LILCO that its failure to meet these standards is insignificant. They assert that

<sup>&</sup>lt;sup>19</sup>LILCO notes that backups at the equipment trailer resulted because that trailer had only one door. It testified that this problem has been eliminated by the addition of a second door. LILCO EX-40 Testimony at 20-21.

LILCO's position is contrary to both the PID and the Plan, and they rely on FEMA's testimony to the effect that Traffic Guides are to be in place at the time contemplated by the Plan, one hour following an evacuation recommendation. <u>Id</u>. at 288; Tr. 8590-92, 8136, 8569. Moreover, they regard LILCO's identification of certain TCPs as critical to be a <u>post hoc</u> attempt to avoid the consequences of its performance at the Exercise. Intervenors' proposed findings at 288-89. Even if one accepts LILCO's position, Intervenors point out that LERO failed to staff the critical TCPs in a timely manner. <u>Id</u>. at 289-90. Further, Intervenors take issue with LILCO's position that this failure would not have significantly affected total evacuation time. Id. at 291-93.

Although Intervenors do not contend that it is a Plan requirement that the Traffic Guides be in place prior to an evacuation recommendation (Intervenors' proposed findings at 280), Suffolk's witnesses disagree with the assumption that no one would have attempted to evacuate prior to the evacuation recommendation at 10:24.<sup>20</sup> Suffolk EX-40

<sup>&</sup>lt;sup>20</sup>Indeed, given the circumstances during the Exercise, a shadow evacuation might well have occurred. The Licensing Board in the PID found that if confused or conflicting information was disseminated at the time of an accident, a large excess evacuation on Long Island could materialize. PID, 21 NRC at 670. We find, in our consideration of (Footnote Continued)

Testimony, at 30; Tr. 2196-97. Based on their experience as police officers, they believe that traffic throughout the EPZ would become congested rather quickly, even prior to the time evacuees begin to evacuate, both because of pre-evacuation trips necessary to prepare for evacuation and because of early evacuation. In their view, this congestion would delay Traffic Guides in getting to their posts even more than they were delayed on the day of the Exercise, when there was no unusual traffic confronting the Guides and the date of the Exercise had been announced in advance. Suffolk EX-40 Testimony, at 31; Tr. 2255-6.

In addition, the LILCO Plan calls for LERO Traffic Guides to use techniques such as blocked lanes, continuous flow treatments, and traffic channelization treatments in order to increase capacity on roadways and at intersections where traffic demand is high.<sup>21</sup> Channelization treatments involve controlling a traffic stream by adding a lane through use of

(Footnote Continued) Contentions EX-38 and EX-39, that confusing and conflicting information was, in fact, disseminated during the Exercise.

<sup>21</sup>A two-mile section of roadway including portions of Lower Rocky Point Road and North Country Road is to be converted to one-way westbound flow by a Road Crew. Suffolk EX-41 Testimony at 29. Our conclusion with respect to the timeliness of the dispatch of the Traffic Guides also applies to this Road Crew.

roadway shoulders, closing existing lanes, and/or adding lanes as turn pockets. These treatments are achieved by placing signs, barriers, cones, and vehicles on the roadway. Suffolk EX-40 Testimony, at 32-33; Tr. 1583-84. Suffolk's police witnesses believe that trying to implement this strategy after an evacuation had begun would be difficult if not impossible. Suffolk EX-40 Testimony, at 36. Not only is it virtually impossible to set up traffic cones and barriers in the middle of traffic congestion, it is very dangerous to attempt to do so. Tr. 2250-51.22 Moreover. to establish and maintain traffic flow, especially through intersections, requires special training and experience which Suffolk's witnesses believe LERO's Traffic Guides do not have. Id. at 35. If Traffic Guides do not arrive until traffic is already congested, it may be impossible for them to implement their traffic control strategies; as the police put it, "if you don't get in there early and get a handle on things before traffic begins to congest, you simply lose it." Tr. 2251, 2268-69.

<sup>22</sup>An example of the danger associated with attempts to set up traffic control strategies after evacuating traffic has become congested can be envisioned in the strategy for the interchange of the Long Island Expressway (LIE) and the William Floyd Parkway. The Plan calls for Traffic Guides to block the outside lane of the LIE upstream of the interchange, to expedite the merge of traffic coming on to the LIE from the William Floyd Parkway. Tr. 1584-85, 2227.

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Intervenors argue that the exercise demonstrated that the tardy staffing of TCPs has other important impacts on LERO's performance. They point out that the gravel truck impediment, which was introduced into the exercise at 10:40, was located 50 yards north of TCP 124. Suffolk EX-40 Testimony at 24-26. However, that TCP was not staffed until 11:30. LILCO EX-40 Testimony, Att. B. Thus that TCP would not have been of assistance until 40 minutes following the accident. Moreover, the TCPs relied on to reroute traffic once that action was taken, TCPs 35, 53, and 54, were not staffed until 11:00, 11:30, and 11:15, respectively. <u>Id</u>.; LILCO EX-41 Testimony at 10. Thus rerouting could not have been implemented promptly following this accident.

Intervenors make the same arguments with respect to the fuel truck impediment, which was introduced at 11:04. This accident was located 75 yards east of TCP 41, which was not staffed until 11:45. TCP 40, which LERO utilized to reroute traffic, was not staffed until 12:14. TCP 57, which was also utilized in the rerouting, was not staffed until 12:00. Suffolk EX-40 Testimony at 28, LILCO EX-40 Testimony, Att. C.

Intervenors do not regard the so-called "fix" of the FEMA deficiency, which is the subject of Contention EX-40E, to be effective. The "fix" requires that Traffic Guides who are assigned to posts within the two-mile zone be equipped and briefed separate from and in a vance of other Traffic

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Guides, so that they can be dispatched upon the issuance of an evacuation order. LILCO testified that FEMA has concluded that this modification is adequate. LILCO EX-40 Testimony, at 20. Intervenors point out that FEMA's approval is contingent upon satisfactory performance at another exercise. Tr. 8116-17 (Kowieski, Keller). They believe that dispatching the Guides after the evacuation order has been broadcast would not enable the Guides to be in place to render assistance to evacuees or implement traffic control strategies until after evacuation had begun. Suffolk EX-40 Testimony at 40-41.

Moreover, they also contend that LILCO's "fix" ignores many important intersections in the EPZ beyond the two-mile zone which, because of their significance to the evacuation scheme, would need to be manned early in the evacuation process if not before evacuation began. They listed several, including the following:

> LIE & William Floyd Parkway; Route 25A & Miller Place-Yaphank Road; LIE Exit 66 w/bound ramp & Patchogue-Yaphank Road; North Country Road & Mt. Sinai-Coram Road; North Country Road & Main Street; and Route 347 & Old Town Road.

Id. at 41-42. The witnesses state that evacuation traffic through these and other intersections would need to be kept moving during an emergency at Shoreham; otherwise LILCO's evacuation time estimates would be significantly lengthened. The LILCO Plan depends on the LERO Traffic Guides to

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implement the Plan's traffic control strategies; they can carry out such strategies only if they are mobilized and dispatched early enough to arrive at and set up their posts prior to or at the time of the evacuation order. As written, the Plan does not have the capability to accomplish this. Id. at 42.

Nonetheless, Intervenors contend that, for purposes of Contention EX-40, the Traffic Guides should have been in place shortly after the evacuation recommendation was issued. Because they believe LERO's performance was untimely under any party's view, they do not regard the issue of when the evacuation process would have begun to be important. Intervenors' proposed findings at 280-81.

# Staff's Position

Staff believes that we are bound by the PID with respect to the time when TCPs should be staffed. It regards this time to be set at one hour following an evacuation recommendation, citing LBP-85-12, 21 NRC at 720-24. Staff's proposed findings at 50. Thus, Staff believes that only the Patchogue TCPs were staffed in a timely manner. It views the staffing of both ordinary and critical TCPs assigned to Port Jefferson and Riverhead to have been tardy. <u>Id</u>. at 48-49.

Staff rejects LILCO's argument that this tardy staffing should be ignored because it has an insignificant effect on

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total evacuation time. Staff points out that under the Plan as approved in the prior litigation, LILCO must be capable of effectuating a controlled evacuation. Thus the significance of the effect on total evacuation time is irrelevant. Id.

Because the question of the adequacy of LILCO's fix of the problems identified must be evaluated by FEMA in another exercise, Staff does not believe that we should decide Contention EX-40E. Id. at 49-50.

## LILCO's Response

LILCO takes issue with the Staff's position that the significance of any delay in total evacuation time is not to be considered in judging whether a fundamental flaw exists. It points out that in the PID, the Board concluded that some evacuation time estimates were based on optimal conditions and that those estimates were not highly sensitive to moderate deviations from this assumption. LILCO argues that the significance of any delays must be considered and that, when considered, it dictates not only that no fundamental flaw exists, but that FEMA was in error in assigning a deficiency. LILCO's reply findings, Vol. 1, at 39.

LILCO criticizes Intervenors position for the same reasons, arguing that the effect that its tardiness might have on the public health and safety must be considered. LILCO denies that its designation of critical TCPs is a post

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<u>hoc</u> rationalization, pointing out that it presented testimony in the prior proceeding that a schedule for staffing TCPs in order of their importance had been devised. <u>Id</u>. at 42. LILCO regards the remainder of Intervenors' arguments to raise matters which were decided in the PID. <u>Id</u>. at 43. LILCO correctly points out that, while we denied its motion to strike Suffolk's testimony on these matters, we ruled that the testimony was admitted only as "... necessary background to understand Suffolk's position." Tr. 1003-04 (Judge Frye).

## Discussion

For purposes of this decision, all parties agree that the Traffic Guides are to be substantially in place at the onset of traffic congestion, which is assumed to occur one hour following an evacuation recommendation. We accept this as the standard against which LERO's performance is to be judged.

Applying this standard, we conclude that the mobilization of Traffic Guides from Patchogue was timely, but that mobilization from Port Jefferson and Riverhead was not. In the case of Patchogue, 64% of the Guides were at their posts in about one hour, and 93% in about one hour and five minutes. However, at Port Jefferson, only 38% were mobilized in one hour and 35 minutes, and only 83% in two hours and 35 minutes. At Riverhead, although the records

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were lost, FEMA placed the activation of TCPs between one hour and 25 minutes and one hour and 45 minutes. Accordingly, it assigned a deficiency.

LILCO attempts to rationalize this performance by arguing first, that the so-called critical TCPs were timely staffed, and second, where they were not, the delay would not have a significant impact on total evacuation time and consequently on the public health and safety. We cannot accept this position. We do not believe that, in drafting the PID, the Board premised its conclusions on the proposition that a controlled evacuation could be effected by the timely staffing of only a portion of the TCPs. Nor can we accept LILCO's invitation to consider whether the delay would have had a significant effect on public health and safety. Staff has correctly characterized that position as follows:

> LILCO's proposed findings (at 105-06) seem to argue that it does not matter if Traffic Guides did not arrive at TCPs in a timely manner as the differences in time between a "controlled" and an "uncontrolled" evacuation are not very substantial. However, this litigation examined the exercise of a plan which provided for a "controlled," and not an "uncontrolled" evacuation. The Licensing Board in its PID ruled that the traffic control procedures in the LILCO Plan are required by 10 CFR 50.47(a)(1) and (b)(10). 21 NRC at 917. The Appeal Board in ALAB-818, 22 NRC 651, 676-77 (1985), faced LILCO's arguments that the need for such traffic control procedures was "immaterial" in the case of Shoreham. It indicated that provisions for the evacuation of the public, including traffic control, in the event of a radiological emergency are a necessary part of an emergency plan. The

Commission, in CLI-86-13, stated that while there is no specific mention of traffic control procedures in NRC's regulations, traffic controls may nevertheless be necessary for the protection of the health and safety of the public. 24 NRC at 32. It stated that the question of whether these measures are necessary is principally a question of fact and remanded the question for further hearing in connection with proceedings on "realism." Id. The proceeding here was not conducted under that Commission order to see if provisions of the plan were "immaterial," but rather under CLI-86-11 wherein the focus was on whether the exercise of the LILCO Plan revealed any deficiencies which preclude a finding of reasonable assurance that protective measures can and will be taken. Indeed, the question of whether a "controlled" evacuation is needed is not before this Licensing Board whose sole charge is to examine the emergency planning exercise, but is before the Licensing Board considering other Shoreham issues.

Staff's proposed findings at 49 n.11.

Clearly, large numbers of TCPs were not staffed until well after traffic congestion would have occurred. Consequently, a controlled evacuation would probably not have been achieved. We agree with FEMA that a deficiency should be assessed, and conclude that LERO's performance demonstrates a fundamental flaw.<sup>23</sup>

<sup>&</sup>lt;sup>23</sup>During the course of hearing this contention, we requested that LILCO calculate the change in total population dose that would have been experienced as a result of the tardy mobilization of the Traffic Guides. Tr. 2017-18, 2022-28. LILCO supplied its calculations on May 4. On June 8, Intervenors opposed our consideration of LILCO's calculations absent an opportunity for discovery and cross examination. Intervenors also assert that many of the assumptions employed in making the calculations are suspect. (Footnote Continued)

We noted above that LILCO correctly pointed out that much of Suffolk's testimony on the difficulties that would have been encountered as a result of the tardy mobilization of Traffic Guides was admitted as background only. That testimony is not a necessary underpinning for our conclusion. However, it was offered by Suffolk County Police Officers with considerable experience. We agree with the conclusion that they are "...experts in the practical problems of the streets..." (PID, LBP-85-12, 21 NRC at 807), and therefore regard their testimony that it would be difficult, perhaps impossible, and dangerous to attempt to set up traffic cones and barricades in heavy traffic as very convincing. This testimony lends considerable credence to the conclusion that, given LERO's performance, a controlled evacuation probably would not have been achieved.

Intervenors have not asked us to decide when Traffic Guides must be dispatched from the Staging Areas in order to reach the TCPs in a timely manner. Moreover, we recognize that there could be an accident that progressed so rapidly that complete mobilization of Traffic Guides was not

#### (Footnote Continued)

The calculations raise a complex issue which, as noted above, was remanded by the Commission in CLI-86-13, 24 NRC at 31-32, and is pending before another board. Consequently, it would have been inappropriate for us to have considered them in this proceeding.

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possible and that this fact does not dictate that the Plan be disapproved. PID, LBP-85-12, 21 NRC at 723-24. Nonetheless, we note that LILCO's "fix" of the Plan made in response to the FEMA deficiency moves in the direction of a more prompt dispatch.

Pursuant to the "fix," all Traffic Guides posted within the two-mile zone plus any beyond two miles that are considered necessary to the evacuation of the two-mile zone will be equipped and briefed before an evacuation is ordered. They are to be dispatched immediately on issuance of an evacuation recommendation. Tr. 5818-20. If future exercises do not reveal a significantly improved performance on LERO's part as a result of this change, it may well be that the Plan must be changed further. At that point, consideration should be given to requiring mobilization and dispatch of Traffic Guides in advance of the decision to evacuate, at a time in the development of an accident when it appears likely that an evacuation may be imminent.

However, for purposes of this decision, we conclude only that the mobilization of Traffic Guides at the Exercise demonstrated a fundamental flaw. We leave it to the emergency planners to devise a means to eliminate this flaw.

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#### C. RECEPTION CENTER AND MONITORING

1. Reception Center

## The Allegations

Contention EX-22A alleges that a finding of reasonable assurance may not be made because, on the day of the Exercise, LILCO and FEMA assumed that the Nassau Veterans Memorial Coliseum was available as a reception center for evacuees lacking special needs. In fact that facility is not available. The contention alleges that Nassau County has expressly refused to permit the use of Nassau County facilities as part of, or to implement, the LILCO Plan. Because their underlying premise is legally and factually incorrect, FEMA's conclusions that objectives EOC 16 and Field 9, 17, 19, and 21 were met or partly met are without basis and are invalid.<sup>24</sup> Direct Testimony of David Harris and Martin Mayer on Behalf of Suffolk County Concerning

<sup>&</sup>lt;sup>24</sup>The October 3, 1986 Prehearing Conference Order (at 27) provided that the substance of Contention EX-46 was to be dealt with under Contention EX-22A. See also December 11, 1986 Memorandum and Order at 8. Contention EX-46 alleges that the Exercise demonstrated that the availability of the Nassau Coliseum (a) was the essential premise of the LILCO Plan as exercised, and (b) was an essential premise of the LERO players in attempting to implement the Plan during the Exercise. It also alleges that since LILCO did not demonstrate during the Exercise that it could implement critical aspects of its Plan if the Coliseum were not available, the Exercise demonstrated that LILCO did not comply with 10 CFR 50.47(b) (8) and (b) (10), and NUREG-0654, Section II.A.3, J.9, 10, and 12; hence the contention alleges that a reasonable assurance finding is precluded.

Contentions EX-47, EX-22A, and EX-49 (Suffolk EX-47, EX-22A,

and EX-49 Testimony), ff. Tr. 2992, at 36-37.

The objectives referenced in the contention are:

EOC 16. Demonstrate the organizational ability to manage an orderly evacuation of all or part of the 10-mile EPZ including the water portion.

Field 9. Demonstrate a sample of resources necessary to implement an orderly evacuation of all or part of the 10-mile EPZ.

Field 17. Demonstrate the ability to mobilize, staff and activate the Reception Center in a timely manner.

Field 19. Demonstrate through rosters the ability to maintain staffing at the Reception Center on a 24-hour basis.

Field 21. Demonstrate the adequacy of procedures for registration, radiological monitoring, and decontamination of evacuees and vehicles including adequate provision for handling contaminated waste at the Reception Center.

Id. at 38.

#### Intervenors' Position

Suffolk's witnesses attested that they were unable to address whether the basic premise underlying FEMA's conclusions was legally correct.<sup>25</sup> With respect to objectives EOC 16 and Field 9, however, they believe that it

<sup>&</sup>lt;sup>25</sup>Suffolk's witnesses were both medical doctors. Dr. Harris is the Commissioner of Health Services for Suffolk County, New York. Dr. Mayer is Deputy Director of Public Health in the Suffolk County Department of Health Services.

cannot be said that an "orderly evacuation" can be accomplished if there is no facility available to be the end point of the evacuation. In the absence of a facility where services would be performed to protect the health of evacuees, such as monitoring them for radioactive contamination, Suffolk's witnesses believe there is no basis for a conclusion that an orderly evacuation would or could be implemented. <u>Id</u>. at 39. Finally, the witnesses noted that objectives Field 17, 19, and 21 each expressly refer to a "Reception Center." They argue that conclusions based upon a nonexistent facility are not valid. Id. at 40.

In their proposed findings (at 336-37) Intervenors assert that the FEMA witnesses agreed that certain of their conclusions were no longer valid and that the LILCO witnesses similarly conceded that FEMA had evaluated certain functions which would not remain the same because of the unavailability of the Coliseum.

#### LILCO's Position

LILCO's witnesses testified that at the time of the February 13, 1986 Exercise, the Nassau Veterans Memorial Coliseum was identified as the Reception Center for evacuees in the LILCO Plan. Therefore it was included in the scenario and activities in the Exercise. LILCO's Testimony on Contentions EX-22A and EX-49 (Monitoring at Nassau Coliseum) (LILCO EX-22A and EX-49 Testimony), at 3-4. They

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argue that the Exercise tested organizational functions, not merely resources, so that the exchange of one resource in a plan does not invalidate the results of the Exercise. Provisions for setting up a monitoring system, training people to monitor evacuees, transporting evacuees who need transportation to a place where they can be monitored and, if necessary, decontaminated, documenting the monitoring and decontamination effort, planning ahead so a place is provided for these activities, and notifying the public were all items that were tested in the February 13 Exercise. <u>Id</u>. at 4. The subsequent withdrawal by Nassau County of the Coliseum for use in LILCO's Plan necessitated changes in the Plan to make arrangements for other facilities to be used. Those changes, however, are being litigated before the OL-3 Board and are outside the scope of this proceeding. Id.

## FEMA's Testimony

FEMA testified that the Nassau County Coliseum was available for use as a Reception Center the day of the Exercise, and the fact that it became unavailable four months after the Exercise has nothing to do with the results of the Exercise. Moreover, FEMA believes that an orderly evacuation does not depend on the specific location of a reception center, because any reception center must be beyond the 10-mile EPZ and evacuees would already have evacuated the risk zone before they arrived at the reception

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center. FEMA Ex. 5, at 21-22. FEMA also notes that the issue of the new reception center is being litigated before the OL-3 Board. Id. at 22.

# Staff's Position

The NRC Staff, in its proposed findings, stated that the testimony of Suffolk's witnesses failed to address the issue admitted and was "little more a than the witnesses' ipsi (sic) dixit that without a facility for use as a Reception Center, that function cannot be accomplished." Staff went on to point out that the FEMA Report found that the Reception Center at the Nassau Coliseum was fully mobilized by 10:15, that the capabilities for 24-hour staffing were demonstrated, and that procedures for monitoring evacuees were generally good. Staff proposed findings 391 and 392, at 139-40; see FEMA Ex. 1, at xvii, xix, and 79-81. Moreover, Suffolk failed to present any evidence that would show the Coliseum as a Reception Center to be any different from any other large facility which could be used as a Reception Center. Staff proposed finding 390, at 139.

# Conclusion

We agree with FEMA, the Staff, and LILCO. The fact that four months after the February 13 Exercise the Nassau Coliseum was made unavailable for use in LILCO's Plan does

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not invalidate the findings of FEMA during the Exercise. The Nassau Coliseum was the designated Reception Center on the day of the Exercise, and there is no evidence to suggest that LERO's performance there would be any different from LERO's performance at another facility. As Staff points out, there is no evidence that there is anything unique about the Nassau Coliseum as a Reception Center. We conclude, therefore, that Contentions EX-22A and EX-46 are without merit.

2. General Population Monitoring

### The Allegations

Contention EX-49 alleges that during the Exercise, LERO demonstrated that it has insufficient staffing and equipment to perform the necessary registration, monitoring and decontamination of evacuees to comply with 10 CFR 50.47(b)(1), (b)(8), and (b)(10). The contention is divided into three subparts, each of which will be considered separately. Suffolk EX-47, EX-22A, and EX-49 Testimony at 40.

Contention EX-49A, which subsumes Contention EX-31, notes that the LILCO Plan requires LERO's personnel assigned to radiological monitoring to monitor one evacuee every 90 seconds. It alleges that during the Exercise, monitoring frequently took up to five minutes per evacuee. At that monitoring rate, Suffolk contends that the 78 monitors assigned to the Reception Center could monitor only 11,232 evacuees in twelve hours. NUREG-0654, Section II.J.12 requires that evacuees be registered and monitored within twelve hours. Id. at 40. The contention notes that LERO's simulated EBS messages advised all evacuees from zones A, B, F, G, K, and Q, more than 100,000 individuals, to report to the Nassau Coliseum for radiological monitoring. Such a number of anticipated evacuees could not be monitored within twelve hours. Id. at 40-41.

Contention EX-49B alleges that features of the "alternate" monitoring plan specified in OPIP 4.2.3, Section 5.11, which involve telephoning the Institute of Nuclear Power Operations (INPO), other power plants, and other entities to obtain additional monitoring personnel, were not implemented during the Exercise. Id. at 41. Thus there was no demonstration of the capability of those entities either to provide the personnel or equipment needed or to provide them in a timely manner. Id.; see FEMA Ex. 1, at 81. Intervenors conclude that the Exercise provides no basis to find that the alternate monitoring plan can be implemented or, if it can be, that it would result in an ability to perform the necessary monitoring of the number of evacuees expected to report to the Reception Center. Suffolk EX-47, EX-22A, and EX-49 Testimony, at 41.

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Contention EX-49C deals with voluntary evacuees who might go to the Reception Center to seek radiological monitoring. It was litigated and considered with Contentions EX-22F and EX-44.

#### Intervenors' Position

Suffolk's witnesses testified the two FEMA evaluators assigned to observe the radiological monitoring at the Reception Center both noted that the LERO monitors spend 4-5 or 4-6 minutes per person, which is considerably longer than the 90 seconds called for in the procedures. <u>Id</u>. at 45. They believe that the 90-second monitoring rate is essential if there is to be any reasonable ability to process evacuees through the center in a timely manner. They attest that if one assumes that only 32,000 evacuees arrived at the Reception Center for radiological monitoring, it would take the 78 LERO monitors 10.25 hours to monitor them at the rate of one every 90 seconds, provided no one took a break.<sup>26</sup> Id. at 46. Suffolk's witnesses argue that if some evacuees

<sup>&</sup>lt;sup>26</sup>We checked this calculation and found it to be correct. Because Suffolk stated that LERO's EBS message advising people to report to the Reception Center actually addressed 100,000 evacuees, we calculated how long it would take 78 monitors to monitor that many people at the rate of 90 seconds per person. It would take them slightly over 32 hours, provided they took no breaks. Obviously, to monitor that many people in twelve hours, LERO needs far more than 78 monitors.

take more than 90 seconds to monitor and if the monitors take reasonable breaks, LERO would not meet the twelve-hour monitoring requirement contained in NUREG-0654. <u>Id</u>. Further, they quote a FEMA admission stating that, based on its evaluation of LERO's performance during the Exercise, FEMA inferred that LERO did not have sufficient personnel to handle evacuees in excess of 32,000. Id. at 46-47.

Suffolk's witnesses further argue that with tens of thousands of people lined up waiting long periods of time to be monitored, contamination could easily be spread, for example by children who may not know they should not touch persons or things prior to being monitored, or who may be unable to refrain from doing so. In addition, the witnesses state, people will need to eat and use restrooms and other facilities, which could also result in the spread of contamination. Id. at 47. Furthermore, they argue that anxiety levels will be high when the evacuees reach the Reception Center because they may have been exposed to radiation during their evacuation. Suffolk believes their anxiety levels will rise even more, potentially to the point of panic, if they are forced to wait long periods of time before they are monitored. Id. at 47-48.

Suffolk stated that during discovery depositions LILCO witnesses asserted that during a real accident, LERO monitors would perform their jobs faster than they did during the Exercise. Id. at 48. Suffolk's witnesses

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suggest that if the pressure of a real accident caused LERO monitors to work faster, there would be reason to be concerned about the accuracy and adequacy of the monitoring. They believe that, if anything, the knowledge that people were potentially really contaminated should make the monitors be more careful rather than cause them to speed up. They point out that individual citizens, having no monitoring equipment of their own, would have no way of knowing if they are contaminated except through the LERO monitors. Id. at 49.

Suffolk's witnesses testified that the allegation of Contention EX-49B that the alternate monitoring plan for evacuees was not implemented or demonstrated during the Exercise was based on a statement in the FEMA Report that the alternate evacuee monitoring plan was not evaluated at the Exercise. Suffolk EX-47, EX-22A, and EX-49 Testimony; see FEMA Ex. 1, at 81. They state, however, that apparently there were telephone calls during the Exercise to INPO and simulated calls to other organizations to request additional monitoring personnel, but none of these organizations participated in the Exercise or actually provided personnel. Suffolk EX-47, EX-22A, and EX-49 Testimony at 50. Consequently, Suffolk argues that the Exercise provides no basis for concluding that additional personnel would be available or could get to the LILCO Reception Center in a timely manner. Id. at 50-51.

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Suffolk's witnesses conclude by arguing that LERO failed to demonstrate during the Exercise that it could monitor, register, and decontaminate the large numbers of individuals that must be expected at a reception center. Consequently Suffolk believes that the Exercise provides no basis for concluding that Exercise objective Field 21 was met or even partially met. Moreover, since on several occasions LERO monitors were not able to perform their monitoring function in the time prescribed by their procedures, Suffolk thinks that there is no basis to conclude that LERO could do so in an actual emergency. <u>Id</u>. at 51.

## LILCO's Position

LILCO's witnesses testified that occasions when monitoring took up to 4 or 5 minutes occurred only a few times when Federal evaluators were the individuals being monitored. LILCO EX-22A and EX-49 Testimony at 8-9; Tr. 2777-78. Consequently, they believe that 32,000 evacuees could be monitored within twelve hours. Id. at 9. They testified that the whole-body frisking technique used by the monitors can be accurately accomplished in an average of 90 seconds or less per person. Id.; Tr. 2774-75. Moreover, they state that the FEMA Report makes it obvious that the vast majority of the monitoring at the Reception Center was completed in 90 seconds or less per person during

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the Exercise. LILCO's witnesses believe that the fact that there were relatively few evacuees (simulated) to be monitored, as a result of which the monitors were under no pressure to perform their jobs expeditiously, caused the monitors to scan more slowly than was necessary. LILCO EX-22A and EX-49 Testimony at 9.

LILCO believes that a modified monitoring technique provided in OPIP 4.2.3, Section 5.11 (Rev. 6), would have enabled 100,000 people to be monitored on the day of the Exercise. The modified monitoring technique calls for monitors to monitor the hands and thyroid of the driver of each car coming to the Reception Center and to take a swipe sample of the car hood and wheelwell. The result of these observations determine whether additional monitoring is indicated. This modified monitoring was initiated during the Exercise when it was learned that approximately 100,000 evacuees had been directed to the Reception Center. LILCO's witnesses believe that the 100,000 evacuees could have been monitored the day of the Exercise by utilizing the modified monitoring technique. Id. at 10; Tr. 2787-2801 (Watts).

With regard to Contention EX-49B, LILCO's witnesses testified that INPO provides for mutual aid by participating utilities in a radiological emergency. It maintains a 24-hour emergency number for requests for assistance. Because INPO's agreement is with LILCO and not LERO, the initial requests for assistance by LERO are relayed through the LILCO EOF. Subsequently LERO and INPO communicate directly. LILCO EX-22A and EX-49 Testimony, at 11.

On the day of the Exercise, the Manager of Local Response requested at approximately 12:00 that the EOF contact INPO and make arrangements for additional monitoring resources. At approximately 12:30 INPO called the LERO EOC and was informed by the Manager of Local Response of the potential need for assistance. At 13:00 the Manager called INPO and was told that 88 people from five utilities would be available in about six hours. At 13:40 the Manager called INPO again and requested 200 more people. At 14:45 INPO called and told LERO that the additional people would be available in approximately twelve hours. 27 Id. at 11-12. When asked whether this information was valid, witness Weismantle replied in the affirmative. He stated that during the January 30, 1986 practice exercise LERO requested assistance from INPO, and INPO actually contacted senior management personnel at numerous utilities to obtain details on the numbers of personnel actually available and their expected arrival times. INPO used those data on February

<sup>&</sup>lt;sup>27</sup>At least some of these phone calls were observed by the FEMA evaluators. The FEMA witnesses, however, testified that they had no way of knowing whether the calls were really being made to INPO and other utilities or whether they were just simulated calls. Tr. 7734-39.

13, because it felt it would be inappropriate to call the utilities again after only two weeks. Id. at 12.

## FEMA's Findings

FEMA found that the facilities at the Reception Center were capable of handling 32,000 evacuees within the required twelve-hour time limit. FEMA Ex. 1, at 80; FEMA Ex. 5, at 29; Tr. 7723-24. FEMA's witnesses acknowledged that the overly long monitoring sessions occurred when the individual being monitored was a FEMA evaluator. FEMA Ex. 5, at 29; Tr. 7729. Nevertheless, FEMA assigned an ARCA to the fact that on several occasions radiological monitoring took four to five minutes per individual, and recommended that all monitoring personnel assigned to the Reception Center be trained to monitor individuals within 90 seconds as prescribed in the LERO procedures. FEMA Ex. 1, at 81. On cross-examination, the witnesses pointed out that LILCO's modified procedure for monitoring evacuees in excess of 32,000 was acceptable as an ad hoc solution, and that it was not evaluated at the Exercise. Tr. 7721-23 (Keller).

FEMA also noted that the decontamination facility at the Reception Center was set up according to the Plan and that the operational activities generally ran well. On one occasion, however, the FEMA evaluators observed that an evacuee with a contaminated hand (simulated) was told to don plastic booties, which could have resulted in their

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contamination. Then he was told to put on anticontamination gloves after he had put his booties on using his contaminated hand. FEMA noted that the booties were not necessary, because his feet were not contaminated. This faulty decontamination procedure was rated an ARFI, and FEMA recommended that the decontamination staff be given additional training on evacuee decontamination procedures. Id.

## Staff Position

In its proposed findings the Staff agreed with FEMA's recommendation that additional training be given the decontamination personnel. It did not, however, see this problem as rising to the level of a fundamental flaw in LILCO's Plan.

## Conclusion

We agree with FEMA and the NRC Staff on the monitoring time and decontamination issues. Since from the evidence before us we can identify only three instances of monitors spending four to five minutes monitoring an individual, and all three of those were FEMA evaluators, we do not find that the monitoring time problem rises to the level of a fundamental flaw. Nor were the faulty decontamination procedures used with one evacuee of sufficient severity to reflect a fundamental flaw in the Plan. We join FEMA and the Staff in recommending additional training for the monitoring and decontamination personnel, however, so that the minor flaws that occurred during the Exercise will not be repeated in the future. We conclude that the Exercise demonstrated that LERO can monitor up to 32,000 people within a twelve-hour period as i' is required to do. See the concluding PID, LBP-85-31, 22 NRC 410, 422-23 (1985).

A more difficult issue emerged from the testimony on LERO's ability to monitor in excess of 32,000 evacuees. The concluding PID obligates LILCO to plan for monitoring all evacuees who seek it. Id. at 430-31. The question of the number of evacuees which LILCO should provide for is currently pending before the OL-3 Board. During the Exercise, the population of the zones advised to seek monitoring totalled about 100,000. LILCO's testimony that its modified monitoring plan could have accommodated this number in a twelve-hour period stands uncontradicted. However, during the Exercise LERO sought assistance in performing the monitoring task through the Institute for Nuclear Power Operations (INPO). LILCO's witnesses testified that at 13:00 hours LERO was advised by INPO that an additional 88 radiological monitors would be there in six hours, i.e., at 19:00 hours. After requesting an additional 200 to assist in monitoring the expected 100,000 evacuees, INPO advised LERO at 14:45 that it would take twelve hours for them to arrive, i.e., they would arrive at 02:45 the

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next morning. Clearly, if these additional monitoring personnel were needed for large numbers of evacuees, it would be difficult or impossible for LERO to comply with NUREG-0654, Section II.J.12, which states:

> 12. Each organization shall describe the means for registering and monitoring of evacuees at relocation centers in host areas. The personnel and equipment available should be capable of monitoring within about a 12 hour period all resident and transients in the plume exposure EPZ arriving at relocation centers.

In their proposed findings on this issue (at 350-52), Intervenors take the position that we must reject LILCO's position that it adequately demonstrated the ability to implement its alternative monitoring system because FEMA did not evaluate LERO's performance in this regard. We believe that this position misperceives our charter, which is to determine whether the Exercise demonstrated fundamental flaws, not whether LILCO adequately demonstrated each element of its Plan called into play by the Exercise. While, on this record, we cannot conclude that the ability to monitor in exc = of 32,000 evacuees in twelve hours was adequately demonstrated, neither can we conclude that the demonstration which took place revealed a fundamental flaw in this regard. Clearly, the additional monitors from INPO at best would have arrived late in the monitoring process and, by themselves, probably would not have been in time to

Enable LERO to monitor 100,000 evacuees in twelve hours.<sup>28</sup> However, LILCO's uncontradicted testimony is that its alternative monitoring system could have accommodated the 100,000 in twelve hours. We suspect that that system, if help from the INPO personnel were available, might have come close to achieving that goal.

# 3. Registration, Monitoring, and Decontamination for Special Facility Evacuees

The crux of Contention EX-47 is that the Exercise provides no basis for evaluating the adequacy or implementability of LILCO's proposals for registration, radiological monitoring, or decontamination of the evacuees from special facilities who would be transported to special reception centers during a Shoreham accident. It is premised on the NUREG-0654 requirement of an ability to register and monitor evacuees at reception centers within approximately twelve hours, as well as other cited regulations requiring an ability to implement an evacuation of mobility-impaired EPZ residents. It is undisputed that,

<sup>&</sup>lt;sup>28</sup>The timeliness of the arrival of these monitors depends to some degree on when the twelve hour period begins to run. The EBS message recommending that this number of evacuees seek monitoring was approved at 13:45. Tr. 2542-44 (Weismantle); Att. B to LILCO's Testimony on Contentions EX-38 and EX-39, ff. Tr. 3300. If the period begins at that time or sometime after, these monitors would have had a substantial impact before the twelve hours expired.

during the Exercise, LERO personnel did not separately demonstrate the registration, monitoring or decontamination of special facility evacuees. LILCO EX-47 Testimony, ff. Tr. 2879, at 2; Tr. 7740 (Kowieski); Suffolk EX-47 Testimony, ff. Tr. 2992, at 8. Furthermore, there was no dispute that Revision 6 of the LILCO Plan, which was exercised, contains no detailed procedures concerning how evacuees sent to special reception centers would be registered, monitored, or decontaminated.

Contention EX-47 also alleges in Subparts A-E, that a LILCO proposal in Revision 7 of its Plan, generated after the Exercise to address the lack of planning for special facility residents, was inadequate, unworkable, potentially dangerous, and failed to take into account the practical realities involved in dealing with and caring for individuals with special needs. This proposal has been superseded. See LILCO Brief at 126. Consequently, we do not rule on Contention EX-47A-E.

Intervenors' position is that the Exercise revealed the existence of a fundamental flaw in the LILCO Plan -- the failure of the Plan to include implementable provisions for registering, monitoring, and decontaminating special facility evacuees -- because this capability was not demonstrated during the Exercise. Thus Intervenors contend that the Exercise results preclude a finding of reasonable assurance that LILCO could or would corrected evacuate, or register, monitor, and decontaminate special facility residents in the event of a Shoreham emergency. See generally Harris and Mayer, ff. 2992, at 8-9, 21-22.

LILCO points out that Intervenors have not raised any issue under this contention which is related in any way to the Exercise. LILCO reply findings, Vol. 1, at 48-49.

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FEMA's witnesses testified that objective Field 21 specifically limited its evaluation to the Reception Center which, at the time of the Exercise, was the Nassau Coliseum. FEMA Ex. 5, at 26. FEMA found that the objective of demonstrating procedures for the registration, radiological monitoring, and decontamination of evacuees and vehicles, including adequate provisions for handling contaminated wastes, was partly met at the Reception Center (Field 21). FEMA Ex. 1, at 80.29 FEMA's witnesses further testified that the exercise objectives did not include any demonstrations of registration, monitoring, and decontamination of evacuees from special facilities who would have been transported to reception centers other than the Nassau Coliseum. FEMA Ex. 5, at 26. Objective Field 13 pertains to the demonstration of resources necessary to effect an orderly evacuation of the institutionalized

<sup>29</sup>We discuss FEMA's findings on Field 21 in our consideration of Contentions EX-22A and EX-49A and -49B. That discuss a need not be repeated here.

mobility-impaired individuals within the EPZ. FEMA's evaluation of that objective was addressed in response to Contention EX-21D. Id.

In its proposed findings, the NRC Staff agrees with FEMA that the February 13, 1986 Exercise objectives did not include a demonstration of registration, monitoring, and decontamination of evacuees from special facilities. Staff proposed finding 379, at 134; see Tr. 8532 (Keller, FEMA witness). Staff argues that since these functions were not exercised, it must follow that the Exercise did not demonstrate a fundamental flaw in the Plan with regard to these functions. Staff proposed finding 380, at 135. Moreover, Staff argues that neither objective Field 13 nor 21 required a demonstration of registering, monitoring, and decontamination of mobility-impaired individuals at the Reception Center. Id. In addition, Staff points out that the PID adequately treats LILCO's failure to designate reception centers for special facility evacuees. 30 Staff proposed finding 381, at 135.

<sup>30</sup>In the PID, the OL-3 Board ruled: "It will be necessary for LILCO to identify reception centers for special facilities that could be evacuated in an emergency at Shoreham and to support this identification with letters of agreement prior to operation of Shoreham at full power." 21 NRC at 840.

Conclusion on Contention EX-47. We agree with the NRC Staff and FEMA. The registration, monitoring, and decontamination of special population evacuees was not one of the objectives in the February 13, 1986 Exercise. Nor do we find that FEMA's failure to require these functions as objectives of the Exercise indicates that FEMA's review procedures are defective. We also agree that Intervenors' perception of the scope of objectives Field 13 and 21 was incorrect; those objectives do not apply to special population evacuees. Moreover, Intervenors are incorrect in their position that the failure to demonstrate the capability to register, monitor, and decontaminate special facility evacuees precludes a finding of reasonable assurance. That position would be correct only if such a demonstration had been called for by the Exercise objectives. We conclude, therefore, that Contention EX-47 is without merit.

# D. PROTECTIVE ACTION DECISIONMAKING

Contention EX-36 alleges that LERO personnel made protective action recommendations that were inappropriate and failed to consider alternative protective measures that could have resulted in more dose savings; consequently LILCO failed to satisfy exercise objectives EOC 8 and 12. Specifically, the contention alleges that EBS messages

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broadcast every 15 minutes between 12:06 and 15:48 contained the recommendation that persons in the downwind zones (A-M, Q and R) leave their homes and evacuate. It alleges, further, that documents generated in the EOC fail to show that LERO personnel in the EOC ever considered whether the recommendation to evacuate continued to be the most appropriate protective action throughout this entire period of time. The contention alleges that while these messages were being broadcast, the EOF was projecting a wind shift to occur about 15:00, which would carry the plume away from the original downwind zones. In light of that projection, it may have been more appropriate for people who had not left their houses by 14:00 or 15:00 to remain sheltered until after the wind shift occurred. They could then evacuate with less exposure and smaller doses. Finally, the contention alleges that the failure to consider such an alternative was significant because the LERO players knew that as of 14:40 there were still 20,550 people who had not yet evacuated. Direct Testimony of Gregory C. Minor on Behalf of Suffolk County Concerning Contention EX-36 (Suffolk EX-36 Testimony), ff. Tr. 2612, at 4-5.

Exercise objectives EOC 8 and 12 state:

EOC 8: Demonstrate that the appropriate official is in charge and in control of an overall coordinated response including decisions on protective action recommendations.

EOC 12: Demonstrate the ability to receive and interpret radiation dosage projection information,

and to determine appropriate protective measures, based on PAGS<sup>1</sup> and information received from the Brookhaven Area Office (BHO).

FEMA Ex. 1, at 9-10.

Suffolk's witness testified that specific factors which should be considered prior to the recommendation of protective actions are set forth in OPIP 3.6.1, as follows:

> The dose saving effectiveness of protective actions can be influenced by many variable factors such as expected duration of the releases, involved population, weather conditions, projected evacuation times, and plant conditions. Whenever possible, the factors shall all be considered prior to the recommendation of protective actions.

Suffolk Ex. 1, at 7-8, citing OPIP 3.6.1, Section 3.1. In addition, OPIP 3.6.1 describes actions to be taken by the Nuclear Engineer using data concerning plant status, meteorological conditions, survey data, dose projections, release data, and evacuation time estimates to determine protective action recommendations for review by the Radiation Health Coordinator. <u>Id</u>. at 8, and Atts. 2, 3, and 4; LILCO's Testimony on Contention EX-36 (Wind Shift) (LILCO EX-36 Testimony), ff. Tr. 2364, at 5-6.

The information available to EOC personnel during the Exercise included: data on plant conditions, including projected release rates and measurements; dose projections

<sup>31</sup>PAGs is the abbreviation for EPA Protective Action Guides.

and protective action recommendations from the EOF; current and projected meteorological data, including wind direction; and smear and air samples from field surveys. <u>Id</u>. at 9-10; Tr. 2480-83.

At 10:10 on the day of the Exercise LERO'S Director of Local Response made the initial evacuation decisions for zones A-M, Q and R after consulting with the Nuclear Engineer, the Radiation Health Coordinator, the Manager of Local Response, and the person simulating the County Representative in the EOC. He was advised by the Nuclear Engineer that if the situation at the plant continued there could be a core failure and dramatic release of radioactive material. Applying the guidance set forth in Atts. 5 and 6 of OPIP 3.6.1, the Director of Local Response, Radiation Health Coordinator, and Manager of Local Response conferred and agreed that the appropriate protective action was the evacuation of zones A-M, Q and R. LILCO EX-36 Testimony, at 6-7; Tr. 2414-18.

# Intervenor's Position

Suffolk's witness, Mr. Minor, testified that at the time the evacuation recommendation was made, the Radiation Health Coordinator had not performed computer calculations using release data to determine appropriate protective action recommendations, although the EOC did perform a calculation using hypothetical release data shortly afterwards and another later using data from the Exercise scenario. Suffolk EX-36 Testimony, at 10. When the evacuation recommendation was made at 10:24, the wind was blowing from the ENE toward the WSW at five miles per hour, and it was projected to shift about 18:00 to blow from the WNW toward ESE. Id. at 11. At 11:46 the Director of Local Response, on the recommendation of the Radiation Health Coordinator, decided to extend the evacuation recommendation to include zones N, O, P, and S, because of the expected wind shift and the long duration of the anticipated release. Id. at 11-12.

The meteorological data changed with respect to the timing of the projected wind shift. As of 10:29 the wind shift was expected about 16:00. As of 11:09 the shift was predicted between 15:00 and 18:00. Finally, at 11:52 it was projected that the wind shift could occur as early at 15:00 Release data and dose projections also changed during the accident. The initial evacuation recommendation was based on plant condition and a single reading from the plant's reactor building standby ventilation system. Subsequently field survey data from air and smear sampling as well as additional dose projections became available. <u>Id</u>. at 13. According to witness Minor, the Radiation Health Coordinator recorded the results of a smear reading taken at 14:00 seven miles WSW of the plant; the reading was 2700 cpm/cm<sup>2</sup>. <u>Id</u>. at 17. At 12:45 he recorded an air dose of 3130 mR/hr

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located 0.5 miles downwind of the plant, and at 12:10 another air dose reading of 180 mR/hr two miles WSW of the plant. Id. at 18.

People in the original downwind zones were subject to both a ground dose and a cloud dose once the plume arrived over these zones and before the wind shift. Witness Minor testified that in a car they would receive no shielding from the cloud dose and only a small reduction in ground dose. In the average house, on the other hand, they would have received a 30 percent reduction in cloud dose and an 80 percent reduction in ground dose. After the wind shift, these individuals would continue to receive a ground dose but a smaller potential cloud dose. Id. at 17. Witness Minor acknowledged, however, that the appropriate dose pathway for consideration in assessing the protective actions was the child thyroid inhalation dose, and that the 0.7 reduction for cloud dose and 0.2 reduction for ground dose do not necessarily apply to the child thyroid dose pathway. Tr. 2615-6.

Witness Minor stated that "EBS messages repeated every 15 minutes from 10:23 through the end of the Exercise recommended that people in the original downwind zone should evacuate if they had not already done so." He alleges that these messages went out without any apparent calculation based on updated data or other confirmation that evacuation was still the response that would likely result in maximum

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dose savings. Suffolk EX-36 Testimony at 18. When LERO personnel learned that 20,000 people in the original downwind zones had not left their homes as of 14:40, with a projected wind shift away from those zones anticipated about 15:00, Suffolk's witness believes that LERO should have reassessed the relative dose savings from sheltering versus evacuation.<sup>32</sup> <u>Id</u>. at 18-19. He does not attest that LERO should have necessarily rescinded the original evacuation recommendation, but rather that LERO should have performed updated calculations of relative dose savings from sheltering versus evacuation. <u>Id</u>. at 19. He admits that the decision to continue with evacuation may have been correct, but he contends LERO never performed an analysis that would justify its decision. <u>Id</u>. at 20; Intervenors' proposed finding 455, at 314-15.

In addition, witness Minor believes that rather than relying throughout an accident on pre-calculated evacuation

<sup>&</sup>lt;sup>32</sup>In the Intervenors' proposed findings, LILCO's witness Watts, LERO's Radiation Health Coordinator during the Exercise, is alleged to have acknowledged that the effect of shelter on overall dose savings "continues for at least six hours." Intervenors' Finding 463, at 321. Dose reduction figures, with which witness Watts agreed during cross-examination, are quoted for successive hours from one to six. These dose reduction figures, however, do not reflect a dose savings that "continues" for six hours; in fact, the dose reduction during the six hour period is based on a 50% dose saving during the first hour and none thereafter, as witness Watts attempted to make clear during his cross-examination. Tr. 2489-90.

times for the dose calculation, the Radiation Health Coordinator should analyze the real data on traffic. For example, when the roadway impediments became known to LERO, the Radiation Health Coordinator should have been consulted. Suffolk EX-36 Testimony at 21. Additionally, LERO was continuing to recommend evacuation of the original downwind zones at 15:45 when evacuees could have been delayed in traffic by impediments; it may have been more dose-saving to keep them in their homes for a few more hours and then ask them to leave when the plume was no longer in the vicinity. Id. at 22.

# LILCO's Position

LERO'S Radiation Health Coordinator testified that it is not correct that he did not perform up-dated calculations throughout the Exercise. He attested that they ran computerized dose projections at the EOC throughout the Exercise. LILCO EX-36 Testimony at 7; Tr. 2425-40. Moreover, a wind shift projected for sometime between 15:00 and 18:00 was not a sufficiently compelling reason to change the protective action from evacuation to sheltering, because other factors unequivocally indicated that continued evacuation was appropriate. LILCO EX-36 Testimony at 8.

The other factors that had to be considered were, first, the fact that LERO knew it was faced with a probable long-term release. The release was projected to continue for approximately nine hours. Tr. 2445. Second, plant release rates and offsite dose rates resulting from the exercise scenario reached much higher levels than those assumed earlier in formulating the original decision to evacuate. Tr. 2508-9; Intervenors' proposed finding 296, at 114. Third, sheltering would not have been an effective protective action for people who had not left their homes by 14:00 or 15:00, because by then their homes had already been immersed in the plume for at least an hour, and there was substantial contamination in the downwind portions of zones A-M, Q and R. LILCO EX-36 Testimony at 8; Tr. 2419-20; Tr. 2445, 2447.

The degree of protection offered by sheltering depends upon the source of the radiation. For a thyroid dose received by inhalation, the protection afforded by sheltering in a house decreases as outside air infiltrates into the house. LERO considered the critical dose pathway to be the child thyroid dose. After a house has been in a plume for over an hour, the inside air can become almost as radioactive as the outside air. Moreover, sheltering was never advised and consequently ventilation controls probably had not been implemented in many of the occupied houses, which would render them an ineffective shelter even more

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quickly.<sup>33</sup> By 14:40 the houses in the downwind area had been immersed in the plume for at least an hour and there was substantial contamination in the area; hence homes no longer afforded effective protection from inhalation of radioactive iodine. LILCO EX-36 Testimony at 10; Tr. 2438-94; 2511-12. If the remaining population had sheltered and waited until after the wind shift to evacuate, the dose actually received would have been greater than that received with evacuation. LILCO EX-36 Testimony at 10-11; Tr. 2505-7, 2519.

After the initial recommendation, the Radiation Health Coordinator performed periodic calculations based on information being received at the EOC which showed that plant releases and resulting dose projections would be much higher than first projected. LILCO EX-36 Testimony at 4, 7, Attachments D, E, and F; Tr. 2446, 2451-2, 2508 (Watts). As a result, the Coordinator concluded that there was no reason to perform additional calculations to see if sheltering rather than evacuation should be recommended. Tr. 2508-09

<sup>&</sup>lt;sup>33</sup>Ventilation control in houses was not recommended during the Exercise because sheltering was never recommended. A ventilation control recommendation is part of the EBS message only when sheltering is the protective action recommendation (PAR). Tr. 2494. This Board believes that house ventilation control should be recommended in EBS messages whenever there has been a release of radioactive material to the atmosphere, regardless of whether the principle PAR is evacuation or sheltering.

(Watts). The EOC protective action decisionmaking team continued to receive and exchange information on weather conditions (including wind shift projection) and road conditions during the day. Tr. 2566, 2594 (Weismantle); Tr. 2604 (Kessle.); Tr. 2568-71 (Watts). The projected wind shift led, in fact, to the recommendation to evacuate additional zones at 11:46 a.m. Tr. 2567 (Kessler). Monitoring of the situation continued in order to confirm the validity of earlier evacuation decisions. Tr. 2576 (Watts).

In addition to the foregoing considerations, LILCO's witnesses testified that if LERO had changed its protective action recommendation from evacuation to sheltering when large numbers of people were already evacuating, it would have created public confusion. Both evacuees and persons sheltering would have heard that others in their geographical area were being advised to engage in a different protective action. Consequently some evacuees may have sought shelter and some people advised to shelter may have begun to evacuate. Still others may have waffled, starting one protective action and then changing their minds and beginning the other. In the judgment of LILCO's witness Mileti, the purpose of emergency planning is to minimize the potential for confusion in emergency response. LILCO EX-36 Testimony at 12-13; Tr. 2529-33; Intervenors' proposed finding 295, at 114.

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LILCO's witnesses believe that evacuation was clearly the appropriate protective action, given the probability of a long term release. LILCO EX-36 Testimony at 15-16; Intervenors' proposed finding 296, at 114. Indeed, FEMA in its post-accident assessment found that appropriate protective action recommendations were made by EOC personnel. LILCO EX-36 Testimony at 15-16; see FEMA Ex. 1, at 30-31.

#### FEMA's Testimony

FEMA testified that LERO personnel made appropriate protective action recommendations, both with respect to the original evacuation recommendation issued at 10:24, and the second evacuation recommendation issued at 12:00 in anticipation of the wind shift. FEMA Ex 5, at 24-25. The NRC Staff agrees that LERO's Radiation Health Coordinator used good judgment in making protective action recommendation decisions and made proper recommendations based on the consideration of appropriate factors. Staff proposed findings 251-260, at 91-95.

# Conclusion

The Board finds the evidence presented by LILCO's witnesses to be persuasive on Contention EX-36. We agree with Intervenors' that "...the consideration of the relative dose savings from alternative protective actions is the fundamental premise and basis of LILCO's protective action recommendation procedure...." Suffolk EX-36 Testimony at 21-22. We find that LERO engaged in that process in a fundamentally sound manner.

According to the findings in the PID, sheltering would provide a 50 percent thyroid dose reduction for the first hour and much less after that time. See PID, 21 NRC at 772-74. LERO personnel in the EOC did consider updated information and based their recommendations on adequate evaluations of this information. Specifically, they considered the fact that the actual releases were several times greater than those they had assumed when the evacuation recommendation was made initially; in light of this fact LERO decided that it was appropriate to get the people out, and we agree. Moreover, by 14:40, when LERO learned of the people remaining in the downwind zones, their homes had already been immersed in the plume for an hour or more and hence sheltering afforded little protection from inhalation of radioactive iodine. In addition, we agree that a recommendation to shelter at 14:40 when much of the population in the original downwind area was already responding to the earlier recommendation to evacuate would have caused confusion. We find Contention EX-36 to be without merit.

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# E. PUBLIC INFORMATION

#### 1. Overview

These contentions are closely related and were heard together. In Contention EX-38, Intervenors argue that the Exercise demonstrated that LERO was unable to provide timely, accurate, consistent and non-confusing information to the news media at the ENC, thus failing to implement Section 3.8.B and OPIP 3.8.1 of the LILCO Plan. Contention EX-39 alleges that the Exercise revealed that LILCO is incapable of dealing with rumors or responding to inquiries from the public during an emergency as required by 10 CFR 50.47(b)(7) and NUREG-0654 II.G. Intervenors believe that the Exercise demonstrated that there are fundamental flaws in the Plan as it relates to LERO's public information functions.

The Emergency News Center (ENC) exercise objectives which Intervenors assert were not satisfied are:

1. Demonstrate the ability to mobilize staff and activate LERO functions at the ENC in a timely manner;

3. Demonstrate the ability to brief the media in a clear, accurate, and timely manner;

4. Demonstrate the ability to share information with other agencies at the ENC prior to its release;

5. Demonstrate the ability to establish and operate rumor control in a coordinated manner; and

 Demonstrate that the ENC has adequate space, equipment, and supplies to support emergency operations.

The LILCO and Suffolk witnesses hold different views concerning the media's role during an emergency. While LILCO witnesses cite the importance of providing accurate information to the media, they believe that the top priority in an emergency public information network is the Emergency Broadcast System (EBS), which uses EBS network radio broadcasts to disseminate emergency information directly to the public. LILCO EX-38 and EX-39 Testimony ff. Tr. 3207, at 8. LILCO attempts to focus the public's attention on the EBS messages because they contain the information that is essential to the public, such as the status of the emergency, the potential risk associated with emergency events, and protective action recommendations. Id. at 8-9; Tr. 3236, 3261 (Mileti). LILCO witnesses assert that the primacy of the EBS network in the overall emergency public information scheme is underscored by the NRC requirement that EBS messages go out in 15 minutes (LILCO EX-38 and EX-39 Testimony, at 9; Tr. 3234 (Daverio)), and by the lack of any comparable requirements for press conferences or news releases.

In LILCO's view, other means of communicating emergency information to the public are of secondary importance when compared with EBS messages. LILCO EX-38 and EX-39 Testimony at 12. Thus, although the LILCO Plan provides detailed procedures for operating a news center, conducting joint LILCO/LERO press conferences, and disseminating both LERO

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and LILCO news releases, the LILCO witnesses consider these functions a less important means of communicating emergency information to the at-risk public. <u>Id</u>. They view the media mainly as a vehicle to follow up and elaborate on EBS messages. <u>Id</u>. at 13. LILCO witnesses testified that the media's primary function during an emergency is to cover the event, not to provide information to enhance the public's health and safety. Tr. 3357 (Patterson).

Intervenors assign much more importance to the media's role in an emergency situation. Suffolk witnesses testified that it is the media's responsibility "to provide the public with timely, precise and easily understood information on the basis of which members of the public can make rational individual decisions on the best course of action to insure their personal health and safety." Suffolk EX-38 and EX-39 Testimony, ff. Tr. 3786, at 38. Intervenors assert that LILCO has put too much emphasis on the EBS system (Tr. 4087, 4089-90 (Rowan)), and that "the media is now and would be in a crisis the primary conduit to the public." Suffolk EX-38 and EX-39 Testimony at 88. In short, Intervenor witnesses argue that LILCO "does not understand the media, does not really want to deal with the media, and does not comprehend how good media relations would be essential in a real crisis." Id. at 79.

FFMA in general agrees with LILCO that the EBS system is the "primary means of giving necessary emergency

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information to the public." FEMA Ex. 5, at 32. Staff, citing 10 CFR 50.47(b)(5) and Appendix E, paragraph IV, agrees with LILCO that the regulations designate the EBS system as the primary means for notifying the public. Staff proposed findings at 97, 99.

We find that both LILCO's and Intervenors' arguments have some merit. Clearly, LILCO is correct that the EBS system is the primary means for conveying information to the public and LILCO is correct in placing its principal reliance on it. However, Intervenors are correct to the extent that they assert that the media have a larger function than simply to report the event. EBS messages are, of necessity, limited to furnishing the public with essential information needed to properly respond to an emergency. Consequently there is little room in the EBS format for much background information or elaboration which would place that essential information in context. The media will step into this void. If they are provided with clear, accurate, and timely information, they will be able to supplement the EBS system and help to insure an orderly public response. On the other hand, if such information is not provided, the media will at best be a neutral influence and at worst detrimental to an orderly response. Consequently, 10 CFR 50.47(b)(7) requires that the principal points of contact for the media and procedures for the coordinated dissemination of information to the public be

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established. We have considered these contentions in this light.

2. Activation of The Emergency News Center

Contention EX-38A correctly notes that the ENC was declared operational at 08:25, and that there was no contact with the media by LERO personnel at the ENC until after that time. Tr. 3443. The first press briefing was held at 08:40. Thus, the ENC provided no information at all to the media until almost three hours after the alert was declared, and long after the 6:52 EBS message announcing the Alert condition and school closings had been broadcast. Intervenors maintain that, in a real emergency, such a delay would result in substantial confusion, speculation, rumor generation, lack of confidence in LILCO's ability to deal with the emergency, and refusal to believe information, advice or instructions subsequently disseminated by LILCO personnel. Suffolk EX-38 and EX-39 Testimony at 40, <u>et seq</u>.

Although it concedes that a serious radiological emergency at Shoreham would spur great media interest (LILCO proposed findings at 136; Intervenors' proposed findings at 382-83), LILCO maintains that the ENC was activated in a timely manner. It notes the lack of regulatory guidance on this issue. LILCO also maintains that there is no substance to the argument that the delay in opening the ENC would have had adverse consequences. LILCO notes there are other sources of information available. In that period, LILCO issued two press releases (which, in a real emergency, would have been carried by AP and UPI) and an EBS message was simulated. Further, it is well known to the media that the LILCO Corporate Communications Department makes a professional available to answer telephone inquiries on an around-the-clock basis. LILCO EX-38 and EX-39 Testimony at 16-18; Tr. 3441.

Intervenors do not agree that the information which was available would have been adequate. Suffolk EX-38 and EX-39 Testimony at 49-60. They postulate an immediate and intense interest on the part of the media following the first word of a problem at the plant. This would, in the Suffolk witnesses' view, mean that many reporters would be clamoring for information prior to the activation of the ENC. Because this thirst for information could not be satisfied at the ENC, these reporters would seek other, less reliable sources of information. Thus not only would the media be forced to rely on and consequently report inaccurate information, they would quickly grow to mistrust LERO as a reliable source. Id. at 44-46, 50, 61-62.

FEMA concluded that objective ENC 1, mobilization of staff and activation of the ENC, was demonstrated and that "[o]verall activation of the ENC was done well." FEMA Ex. 1, at 52. FEMA noted that mobilization of the ENC began at the Alert stage (which is consistent with the practice at

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other nuclear plants in FEMA Region II), that ENC personnel began arriving about 0641 (22 minutes later), and that mobilization was completed in about two hours. FEMA considers this a reasonable amount of time and consequently believes the activation was timely. FEMA testified that a press briefing held within 15 minutes of activation of the ENC is adequate. FEMA Ex. 5, at 33; Tr.7756-66. Staff believes the information which was available was adequate. It points out that the public received timely information via the EBS network, so that activation of the ENC at 08:25 does not constitute a flaw. Staff proposed findings at 102.

We agree with FEMA's conclusions. Obviously, a function such as the ENC cannot spring into operation instantaneously, and nothing in the record indicates that activation was tardy. The flaw in the Suffolk witnesses' testimony is their assumption that at the initiating event of an accident, a large and intensely interested press corps would instantly materialize. We do not find this assumption credible. First, we believe that the interest of the media would develop over a period of time as the accident unfolded. Second, it is obvious that, just as it takes some time to mobilize the ENC staff, it will also take some time to mobilize the press at the ENC. Moreover, Staff's point that the public would have received timely information from the EBS system is well taken.

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LILCO correctly points out that other sources of information were available during this time. While, from the media's point of view, these sources were less than ideal, we find that they were adequate considering their timing prior to the recommendation of any protective actions (other than the closing of schools for the day) and prior to any release to the environment. Suffolk witnesses paint a dire picture of the reaction of the media. While we agree that activation of the ENC at 0825 would create some problems for the media, we find that Suffolk witnesses have greatly overstated those problems. No fundamental flaw is demonstrated on this account.

# 3. Districution of LERO News Releases and EBS Messages

#### a. Timeliness

Contention EX-38B concerns LERO News Release No. 1, which announced the Alert declared at 06:17 and the fact that there had been no release of radiation to the environment. This release was not provided to the press by the ENC until sometime after 08:25. LILCO EX-38 and EX-39 Testimony at 19; Tr. 3445. Although a Site Area Emergency had been declared at 08:19 and the ENC was informed of that declaration between 08:21 and 08:25 (LILCO EX-38 and EX-39 Testimony at 19-20; Tr.3445-46), apparently no mention was made to the media of the Site Area Emergency, the fact that a minor release of radiation had occurred, or of the recommendation to place dairy animals on stored feed until the first press briefing at 08:40 (LILCO EX-38 and EX-39 Testimony at 20-21). Thus, the first LERO press release contained dated information at the time it was released to the media at the ENC.

Contention EX-38C concerns LERO News Release No. 2 covering the Site Area Emergency, radiation release, and dairy animal recommendation. These were announced in EBS Message No. 2 broadcast ... 38:38. LERO News Release No. 2, which included the information in that EBS message, was not available to the media at the ENC until sometime after 09:15. Tr. 3466. The media were orally informed of the content of EBS 2 at the first press briefing which began at 08:40.

Contention EX-38G concerns LERO News Releases 3 through 7. It alleges that these were distributed much too late, and were inaccurate and in conflict with other data in the public domain by the time they were provided to the media. Although the ENC received LERO Press Release No. 3 at 10:15, it was not posted at the ENC for the press until 11:10. LERO Release No. 4 was received by the ENC at 10:45, but was not posted until 11:56. LERO Release No. 5 covered the 10:24 evacuation recommendation for zon... A-M, Q and R. It was approved by the LERO Director at 11:02, but did not even arrive at the ENC until 11:36, and was not made

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available to the press until sometime later. LERO Release No. 6, approved by the Director at 12:25, was not posted at the ENC until 14:10; LERO Release No. 7, approved at 13:11, was received by the ENC at 13:47, but not posted for the press until 15:07.<sup>34</sup>

Contention EX-39A raises a related point. There, Intervenors allege that during the Exercise, the LILCO District Offices and Call Boards, which are part of the Rumor Control organization, consistently had incorrect or superseded information concerning the emergency and the protective action recommendations, resulting in the provision of inaccurate and incomplete information to members of the public. Intervenors also allege that this information was incomplete and inconsistent with that being released by other LILCO personnel at other locations (for example, in EBS messages or press releases). The specific factual allegations of the contention, about which there is no dispute (see Intervenors proposed findings, paragraph 601; LILCO proposed findings, paragraph 389, et seq.) are as follows.

(i) The logs kept by all the LILCO Call Board operators, including, for example, those kept by

<sup>34</sup>The times of arrival and posting at the ENC for press releases 5, 6, and 7 are not revealed by the record. However, there does not appear to be any dispute regarding the times alleged. See LILCO EX-38 and EX-39 Testimony at 28-30. the Port Jefferson, Patchogue, and Brentwood Customer Call Board operators, indicate that the information available to them until approximately 11:00 stated that a Site Area Emergency existed, even though a General Emergency had been declared at 9:39.

(ii) The logs kept by the Call Board operators indicate that the operators did not receive word that people in zones A-M, Q, and R had been advised to evacuate until approximately 12:35, even though that advisory had first been issued to the public at 10:24.

(iii) The logs kept by the Call Eoard operators indi ate that the operators did not receive word that LERO had recommended evacuation of the entire EPZ until approximately 2:00, even though that advisory had first been made at approximately 12:00 noon.

(iv) The logs kept by the Call Board operators indicate that the operators did not receive word of the declaration of an Unusual Event until approximately 8:15, although that declaration was in fact made at 5:40; similarly, the Call Board operators did not receive word that an Alert had been declared until approximately 8:30, although the declaration was made at 6:17 and an EBS message was simulated at 6:52.

(v) The Call Bcard logs indicate that most Call Board operators did not receive word that schools were supposed to be implementing early dismissals until approximately 8:50, although an PBS message regarding early school closings was simulated at 6:52.

Contention EX-38D correctly notes that insufficient copying capabilities at the ENC contributed to delays in the distribution of information. Copier breakdowns delayed the posting of EBS messages, and the posting and distribution of press releases to both the media and Rumor Control. LILCO EX-38 and EX-39 Testimony at 23-24. FEMA assessed a deficiency as a result of the delays in providing EBS messages to the media and up-to-date information to Rumor Control. FEMA Ex. 1, at 53. It noted that there is no time requirement for the distribution of news releases. FEMA Ex. 5, at 36.

Contention EX-38Q alleges that neither LILCO's proposal to expedite the dissemination of information by substituting summary information for press releases and transmitting it by computer to the ENC, nor its proposal to add an extra LERO spokesperson at the ENC, would resolve the deficiencies revealed during the Exercise. Nor would replacement of copying machines. This subcontention misstates the improvements in the information distribution system put in place by LILCO. First, summary sheets are not intended to replace news releases, which will continue to be available and will contain information almost identical to that in the EBS messages. Rather, the summary sheets will contain the basic protective action information found in the EBS messages and will be available almost immediately after each EBS broadcast. They are a substitute for the marked-up EBS messages. Second, there is no plan to add a LERO spokesperson at the ENC. Rather, that position has been made official. During the exercise, the spokesperson was referred to as a member of the Public Information Staff. LILCO EX-38 and EX-39 Testimony at 49-50; Intervenors proposed findings at 401 n.367.

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In their testimony, the Suffolk witnesses begin by saying that the news releases are little more than a regurgitation of the EBS messages. This, in their view, means first, that the news releases are useless because they provide no information not already available, and second, that by the time they were made available the contained information was outdated, inaccurate, and inconsistent with subsequent information. As a result, the witnesses believe that the news releases were counterproductive. Suffolk EX-38 and EX-39 Testimony at 66-67. The witnesses go on to note, however, that the media at the ENC would either hear or be told of the EBS messages as they were broadcast. Th a would prompt the media to demand the text of each message in order to relay it immediately and accurately. The failure of the ENC to provide such information would create inaccuracies in the reporting and distrust of the ENC as a source of information. Id. at 69-71.

The Suffolk witnesses' criticism appears addressed to two points: first, the failure of the press releases to provide a timely source of information in addition to that contained in the EBS messages, and second, the failure to provide the text of the EBS messages themselves on a timely basis. In their proposed findings (at 396-400), Intervenors argue that it is necessary to provide accurate, timely, and consistent information to the media, that LILCO failed to do so through the use of news conferences and EBS messages, and

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that therefore we must find that the delayed issuance of press releases, the only remaining way of communicating with the media, constitutes a fundamental flaw. LILCO takes the position, and FEMA agrees, that the news releases are of secondary importance and are compiled mainly for historical purposes rather than to provide a timely source of information. LILCO EX-38 and EX-39 Testimony at 8-9, 13, 20-23, 28-30; FEMA Ex. 5, at 35. LILCO agrees with the County that the news releases provide essentially the same information as that contained in the EBS messages. <u>Id</u>. at 13.<sup>35</sup>

Essentially, LILCO attributes the problems in the distribution of EBS messages and press releases to copier breakdowns.<sup>36</sup> LILCO EX-38 and EX-39 Testimony at 59-60. To

<sup>36</sup>LILCO regards EX-39A(iv) and (v), which concern events which occurred prior to 08:25, as requiring the Call Boards to be able to furnish up-to-date information even (Footnote Continued)

<sup>&</sup>lt;sup>35</sup>In view of the fact that the news releases in question are little more than a restatement of rather than a supplement to the EBS messages and were late, we agree with the County's witnesses that they are largely useless as a current source of information. We also agree that the text of the EBS messages should be furnished to the media on a timely basis. However, Intervenors' argument in their proposed findings that the failure of the primary means of informing the media requires that a fundamental flaw be found with respect to the news releases is itself flawed in that it seeks to put the news releases in the place of the EBS messages as the primary means. If the primary means failed, it (not the backup) would be found fundamentally flawed.

avoid a recurrence of this sort of problem, LILCO now proposes to electronically transmit summary sheets containing key emergency information to the Call Boards and District Offices simultaneously with the broadcast of EBS messages. News releases will also be electronically transmitted. Id. FEMA has withheld its review of LILCO's corrections pending the latter's evaluation of the copier problem, and, once approved, must evaluate it at another exercise. FEMA Ex. 3, Att. 1, at 6-7, and Table 3.4, at 1-2; Tr. 7851-52 (Keller). Although Staff recognizes that the failure to provide current information to the Call Boards is a problem, it views LILCO's corrective actions as adequate. Hence it finds no fundamental flaw. Staff proposed findings at 120. Similarly, it does not view the

(Footnote Continued)

before they are activated. It notes that under approved onsite procedures, Call Boards and District Offices are required to be activated when the ENC is. Thus, there was no requirement that they be able to answer inquiries before the ENC was activated at 08:25. LILCO EX-38 and EX-39 Testimony at 58-59. Intervenors believe that this position is inconsistent with LILCO's testimony that the Call Boards and District Offices are continuously available to the public to answer inquiries regardless of any emergency. Tr. 3632. Regardless of whether LILCO's position is entirely consistent, we may not fault exercise performance which substantially comports with approved procedures. Here, whether or not the Call Boards and District Offices are in operation at the earliest stages of the emergency, they may not be held accountable for providing information before the Plan contemplates. Of course, they must be prepared to answer inquiries when the public is advised to call them, whenever that may be.

failure to timely distribute press releases to the media as a fundamental flaw because other sources of information would be available and because LILCO has taken steps to correct this problem. Id. at 105.

In support of the allegations that LILCO's corrective actions will not work, Suffolk witnesses testified that, although the ENC was aware at 12:22 that evacuation of the entire EPZ had been recommended, this information was not passed on to the media until the next briefing at 12:47. Moreover, they argue that insufficient copying capability should have been compensated for by more frequent briefings, and that LILCO does not understand how to deal with the media and does not wish to do so. Suffolk EX-38 and EX-39 Testimony at 77-78. In their proposed findings (at 400-04), Intervenors also argue that the copier problems recurred at a drill held after the Exercise, that there has been no change in the way news releases are distributed, and that the summary sheets contain substantially less information than the EBS messages themselves.

We agree with Intervenors that the failure to keep the Call Boards and District Offices advised with respect to the current state of emergency response recommendations issued by LERO constitutes a fundamental flaw. The examples cited in Contention EX-39A(ii)-(iii) reveal that the Call Boards were provided protective action recommendations about two hours late. Consistent with our view that the media have an

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important role to play in ensuring an orderly public response to an emergency, we agree with FEMA's assessment of a deficiency with regard to the failure to promptly provide the EBS messages to the media, and regard that failure as an integral part of the above mentioned fundamental flaw. 37 However, we do not agree that we should pass on the efficacy of LILCO's corrections. We noted above that FEMA has withheld its review of LILCO's corrections pending the latter's evaluation of the lack of copying capability for distribution of EBS messages to the media and, once it has approved the corrections, must evaluate them at another exercise. If we were to rule on the contention that these corrections are not efficacious, our ruling would either improperly bind FEMA to a particular result in advance of its review or would have to be viewed as having no effect. Therefore, it would be inappropriate for us to determine whether LILCO's corrections will remedy this fundamental flaw.

<sup>&</sup>lt;sup>37</sup>We find that the circumstances surrounding the distribution of news releases are not fundamentally flawed or a contributing factor to the fundamental flaw we have found.

# b. Clarity

Contention EX-38F alleges that copies of EBS messages provided to the media contained extraneous information that should have been deleted, and thus were unclear, confusing, and inconsistent with radio broadcasts. It relies on FEMA Ex. 1, at 53, 54. There, FEMA stated that "...some hard copies of EBS messages that were provided to the press contained extraneous information (clearly marked for deletion) that should have been omitted to avoid possible confusion." Id. at 53. FEMA identified this as an ARCA. In its testimony, FEMA reiterated that the extraneous information was marked for deletion and that its concern was that possible confusion could result, although none did. FEMA Ex. 5, at 38. LILCO asserts that the EBS messages posted during the Exercise were not confusing and that, in any event, corrective action has been taken in that summary sheets highlighting pertinent protective action information have been substituted for the marked-up EBS messages. LILCO EX-38 and EX-39 Testimony at 26-28. Staff believes that LILCO has solved this problem. Staff proposed findings at 107. Suffolk witnesses believe that this situation could raise questions regarding LILCO's competence in the minds of the reporters at the ENC. Suffolk EX-38 and EX-39 Testimony at 75-76.

We agree with Suffolk and FEMA that the EBS messages need to be cleaned up before distribution. These messages are the primary means for communicating with the public; hence it is important that the copies made available to the media are clear in order to prevent the reporting of inaccurate or inconsistent information. The copies used during the Exercise are replete with hand written insertions and deletions which made them confusing. However, because no confusion was shown to have resulted from the EBS messages given the media during the Exercise, we do not conclude that this problem by itself rises to the level of a fundamental flaw. Nor do we view it as a contributing factor to the fundamental flaw discussed above.

# 4. Communications With The Media

# a. Timeliness

Contention EX-38H states that the LERO Director recommended evacuation of the entire EPZ at 11:46 and that that recommendation was broadcast in a 12:00 noon EBS message. However, the ENC did not inform the media of the Director's decision, or the content of the 12:00 EBS message, which was supposedly repeated every 15 minutes thereafter, until 12:47. Suffolk witnesses believe that this was a calculated decision which illustrates a systemic problem. Id. at 77-78, 84-87. LILCO concedes that it would

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have been better to have informed the media on learning of the recommendation (LILCO proposed findings at 141), but notes that the media would have been informed by the EBS broadcast (LILCO EX-38 and EX-39 Testimony at 31) and that it is the LERO spokesperson's responsibility to determine when to make herself available to the press based on consultations with other public information officers and the demands of the press (Tr. 3511). Staff does not believe that LERO's delay would have poisoned its relations with the media. Staff proposed findings at 108-09. FEMA agrees that the media would have been informed by the EBS broadcast and notes that it assessed a deficiency based on LERO's inability to promptly furnish copies of EBS messages. FEMA Ex. 5, at 40.

Clearly, in an actual emergency, the media would have learned of the evacuation recommendation and demanded information from the LERO spokesperson. Nonetheless, we believe that the spokesperson should have immediately informed the media of the recommendation. Waiting until asked does not inspire confidence, and may give rise to the inference that information is being withheld. However, we conclude that this failure by itself does not rise to the level of a fundamental flaw.

#### 4.b. Candor

Contention EX-38I concerns the fact that although LERO workers were instructed to simulate ingesting KI tablets at 9:45, LERO ENC personnel did not inform the media of that fact. Intervenors characterize this as the concealment of pertinent information about the health threatening effects <sup>\*\*</sup> of the accident which, if found out, would result in further reductions in LILCO's credibility.<sup>38</sup>

LILCO and FEMA, on the other hand, take the position that, in light of New York's policy not to make KI available to the general population (a policy which LERO will follow), there was no reason to inform the public through the media. The information would be of no value to the public, although the ENC was prepared during the Exercise to answer questions had any arisen. LILCO EX-38 and EX-39 Testimony at 32-34; FEMA Ex. 5, at 41; Tr. 7838-42, 8564. Staff concurs. Staff proposed findings at 110. This position is clearly correct.

<sup>&</sup>lt;sup>38</sup>The subcontention originally alleged that the media were informed and asked not to report the story, although in their direct testimony the County's witnesses have accepted LILCO's version which is given above. Suffolk EX-38 and EX-39 Testimony at 71-75; Intervenors proposed findings at 409.

# 4.c. Accuracy<sup>39</sup>

## Responses to Questions on Evacuation

Contention EX-38J alleges that, during press conferences, the LERO spokesperson was unable to respond satisfactorily or accurately to questions about evacuation, specifically traffic conditions, conditions or evacuation activity on the water portion of the EPZ, protective actions for the correctional facility in the EPZ, manpower at bridges and tunnels on evacuation routes, or the activities of the Nassau County Police. In addition, this subcontention alleges that LERO Public Information personnel were unable to contact Marketing Evaluations, Inc. in a timely manner and therefore had no information concerning siren activation failure.<sup>40</sup>

Suffolk's testimony touches on these allegations at 97, et seq., while LILCO discusses them at 35-43. Staff does not believe that this contention is well taken. Staff

<sup>39</sup>All of the allegations dealt with under this topic concern LERO's performance in press conferences.

<sup>40</sup>Because the sirens were not sounded, Market Evaluations did not participate in the Exercise, and Intervenors have not addressed this particular allegation in their proposed findings. proposed findings at 110-12. FEMA states that it has no basis on which to form an opinion as to the accuracy of these allegations. FEMA Ex. 5, at 42.

We have reviewed the transcript of the press briefings and conclude that LILCO's characterization of the situation is accurate. With the exception of the fuel and gravel truck incidents, discussed below, the LERO spokesperson appears to have furnished accurate information. The fact that that information was not adequate to respond to the media's needs clearly results from the fact that the spokesperson was reporting simulated events and thus did not have detailed information.

#### Response to Questions on Traffic Impediments

Contention EX-38L alleges that the log kept by ENC personnel recorded that at 12:01, the gravel truck impediment was being removed. In fact, as of that time, no equipment had yet arrived at the site of the gravel truck impediment, and when it eventually did arrive, it was inadequate to remove the impediment. Thus, it is alleged, ENC personnel had inaccurate information which, if released, would have misled the public into believing the intersection was clear when in fact it was not. At the hearing, the LILCO witness acknowledged that at the 12:47 news conference, the gravel truck impediment was erroneously

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reported to have been cleared by the LERO spokesperson.<sup>41</sup> Staff does not regard this to be significant because the erroneous information would not have significantly affected the public. Staff proposed findings at 112. It is unclear precisely what information had been received at the ENC with respect to this impediment. Tr. 3538-45.

Contention EX-38M notes that at the 1:48 press conference, the LERO spokesperson was not able to respond to detailed questions about the fuel truck impediment, although that impediment had arisen almost three hours earlier. Suffolk EX-38 and EX-39 Testimony at 97. LILCO takes the position that in noting that the fuel truck was blocking the roadway and that traffic was being rerouted, it provided all the information necessary, and that it was unnecessary to inform the media of the condition of the truck and whether fuel was leaking. LILCO EX-38 and EX-39 Testimony at 44-45. Staff concurs. Staff proposed findings at 113. FEMA takes no position. FEMA Ex. 5, at 44. We agree with Intervenors that the LERO spokesperson should have been able to respond to detailed questions on these traffic impediments to the extent that those details were contained in the free-play messages.

<sup>41</sup>This matter is also raised by Contention EX-38N.

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# Alleged Misstatements

Contention EX-38N asserts that at press conferences, LERO personnel frequently misstated facts and provided inaccurate information. Suffolk witnesses testified that, although the ENC had learned of the recommendation regarding milk producing animals between 08:21 and 08:25, at the 08:40 press briefing the LERO spokesperson incorrectly stated that the only protective action recommendation concerned the schools. Suffolk EX-38 and EX-39 Testimony at 81-82. Also, it was incorrectly announced at the first briefing that the Site Area Emergency had been declared at 8:23. The correct time was 8:19. Similarly, at the 11:38 briefing, LERO incorrectly announced that the winter population of the EPZ is higher than the summer population.

Dr. Brill, a scientist from Brookhaven National Laboratory was present and commented on the health effects of the simulated release. In so doing, he made an error in assuming that the "weathering factor" was threefold when the factor stated in the Plan is 0.7. This led him to state a dose of 60 millirem/hour instead of 126. Also, he contradicted LERO's evacuation recommendation by stating that although he lived in the affected zone, in all likelihood he would not evacuate. Id. at 91-93.

We agree with LILCO and Staff that the misstatements concerning the time of the Site Area Emergency and the population of the EPZ are trivial. LILCO EX-38 and EX-39 Testimony at 45-46; Staff proposed findings at 113. The

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misstatement concerning the protective action recommendation is more serious, and was not addressed by LILCO in its direct testimony. Clearly, the LERO spokesperson should have been able to relay complete and accurate information with regard to this matter. Equally clearly, either LILCO or LERO should have corrected Dr. Brill's calculation based on his assumption of an incorrect "weathering factor," and should have taken precautions to ensure that he would not contradict the protective action recommendations made by LERO.<sup>42</sup> These failures, together with the inability to provide accurate responses to questions on the traffic impediments, do rise to the level of a fundamental flaw.

#### 5. Rumor Control

The main function of Rumor Control is to spot potential rumors (usually indicated by two or more questions on the same topic) and dispel them with corrective announcements at

<sup>&</sup>lt;sup>42</sup>Staff points out (proposed findings, at 114-15) that the LILCO witnesses asserted that Dr. Brill's statement concerning evacuation was immediately corrected by the News Manager and that the purpose of the news center is not to prevent contradictory statements, but to provide a forum in which to deal with them. Tr. 3572-74 (McCaffrey, Robinson). However, the transcript of the news conference does not confirm the first assertion. Id. While we concur with the second assertion that the news center is not to engage in censorship, the provision of inconsistent information by LERO, LILCO, or its consultants in an emergency situation is detrimental to the public health and safety.

the ENC, although Rumor Control personnel answer every inquiry received. LILCO EX-38 and EX-39 Testimony at 51-56. LILCO'S Rumor Control network is headquartered in the ENC, with personnel in each of LILCO's eleven District Offices and four Customer Service Call Boards. Rumor Control is an onsite function run exclusively by LILCO personnel. <u>Id</u>. at 52. LILCO instructs members of the public to call any of the District Offices or Call Boards with their questions during an emergency; if the Rumor Control personnel at those offices cannot answer the questions they forward them up an established chain of command to the ENC, and if necessary, the EOC (for LERO-related matters) or onsite facilities (for LILCO matters) for answers. Id. at 52-56.

## 5.a. Promptness of Responses

Contention EX-39B alleges that during the Exercise, LILCO Rumor Control personnel were unable to provide prompt responses to simulated telephone inquiries from members of the public to LILCO Call Boards and District Offices. The contention provides the following examples. LILCO does not dispute the times stated.

> (i) A rumor message inquiring whether the appliances in the caller's home were radioactive was given to the Patchogue Call Board operator at 13:45; a response was not relayed to the caller until 14:24.

> (ii) A rumor message inquiring what to do about a daughter not yet home from Shoreham-Wading River High School was given to the Patchogue Call Board

operator at 10:00; a response was not relayed to the caller until 10:52.

(iii) A rumor message inquiring whether the caller, from Bellport, should evacuate was given to the Patchogue Call Board operator at 12:05; a response was not relayed to the caller until 13:00.

(iv) A rumor message inquiring about how extensive evacuation will be, and what to do about trucks going into the Shoreham area, was given to the Hicksville Call Board operator at 07:51; a response was not relayed to the caller until 08:20.

(v) A rumor message inquiring whether the cooling towers on the Shoreham plant had blown up was given to the Riverhead Call Board operator at 13:30; a response was not relayed to the caller until 13:53.

(vi) A rumor message inquiring if lobsters caught off the Shoreham jetty that morning were safe to eat was received by the Riverhead District Office at 11:30; a response was not relayed to the originating party until 12:28.

(vii) A rumor message from a caller whose husband works at the plant and was not home yet, inquiring whether he had been hurt, was given to the Brentwood Call Board operator at 12:43; a response was not relayed to the caller until 13:30.

(viii) A rumor message inquiring whether the plant had been taken over by Arab terrorists was received at 09:54; a response was not relayed to the caller until 10:37.

(ix) A rumor message inquiring what to do with a horse was given to the Port Jefferson Call Board operator at 10:14; a response was not relayed to the caller until 10:47.

(x) A rumor message inquiring how to get off Shelter Island because the ferry had been cancelled was given to the Hampton Call Board operator at 14:51; a response was not relayed to the caller until 15:24. (xi) A rumor message from a caller who lived in Medford, but worked in Melville, inquiring what he should do was given to the Huntington Call Board operator at 14:32; a response was not relayed to the caller until 15:05.

(xii) A rumor message inquiring if he could eat the food in his refrigerator was given to the Babylon Call Board operator at 11:59; a response was not relayed to the caller until 12:29.

(xiii) A rumor message from a dairy farmer asking what to do if he is asked to evacuate was received at 09:38; a response was not relayed to the caller until 10:12.

The above are 13 examples out of a total of 35 inquiries made to Call Boards, District Offices, and Rumor Control at the ENC. LILCO EX-38 and EX-39 Testimony at 63. The responses in these examples took from 23 to 58 minutes, and averaged 39 minutes.

Suffolk witnesses attributed the delays to the rigidity and inefficiency inherent in LILCO's "cumbersome system" for responding to public inquiries. Suffolk EX-38 and EX-39 Testimony at 128. Callers would not wait for responses during a real emergency, Suffolk witnesses testified; they would ignore LILCO's instructions and act on their pre-existing fears instead. Moreover, these delays would, in these witnesses' opinion, foster the development of rumors and damage LILCO's credibility. <u>Id</u>. at 128-30, 138. LILCO witnesses, however, testified that Rumor Control's responses were timely, emphasizing accuracy over speed, and that the timeliness of response depends on the nature of the information sought in the question. LILCO EX-38 and EX-39 Testimony at 61. FEMA witnesses agreed that accuracy of response is more important than immediacy of response. FEMA Ex. 5, at 51. We find no fundamental flaw with respect to this matter.<sup>43</sup>

# 5.b. Adequacy of Responses

## Alleged Lack of Good Judgment

Contention EX-39C alleges that Rumor Control personnel were unable to provide accurate, satisfactory, or reasonable advice or information to simulated public inquiries; instead, they frequently provided inaccurate or superseded information or demonstrated poor judgment in responding. The contention provides seven examples.<sup>44</sup> We address those examples covered in Intervenors proposed findings, dealing first with the purported examples of poor judgment.

> (ii) In response to an inquiry at 11:30 (Rumor Control Question No. 11) whether lobsters caught that morning on the Shoreham jetty were safe to eat or touch, the Riverhead Call Board operator responded (at 12:28) that there was no reason to

<sup>&</sup>lt;sup>43</sup>We agree with Staff's observation that Rumor Control personnel should have basic information on radiation, the plant, the EPZ, and the protective action recommendations readily at hand. Staff proposed findings at 121. See our conclusion on Contention EX-39C.

<sup>&</sup>lt;sup>44</sup>In their proposed findings, Intervenors have specifically abandoned EX-39C(vii) (proposed findings at 440 n.411), and have not addressed three others (EX-39C(i), (iii), and (iv)). Additionally, they have added three examples: EX-39B(i), (iii), and (xii).

believe, and no data to indicate, that anything was wrong with the lobsters. As of 12:28, however, there had already been a major release of radiation, and the entire EPZ had been advised to evacuate. In light of these facts, it was inappropriate to advise the simulated caller to eat the lobsters, without even inquiring as to when that morning they had been caught, and where the caller was located.

LILCO maintains that this response was correct given the facts that the simulated release was airborne and that the lobsters were taken early in the morning. LILCO EX-38 and EX-39 Testimony at 67. Intervenors do not quarrel with the accuracy of the answer given, rather they point out that it did not go far enough. The call was placed from Rocky Point, within the area in which evacuation had been ordered. Thus Intervenors maintain that the caller should have also been advised to evacuate but was not. Tr. 3657-58, 3667; Attachments R and S to LILCO EX-38 and EX-39 Testimony. We agree with Intervenors that this failure illustrates poor judgment.

> (v) A rumor message simulated at 11:45 was purportedly from Dan Rather, who wanted "to take a TV crew into the Shoreham plant," and inquired how to get there. In response, the Rumor Control responder stated "We don't advise going to the plant. There is a Site Area Emergency. You will be in the way." The responder then gave directions to the plant. At 9:39, however, a General Emergency had been declared and as of 11:45, LILCO was recommending that almost all of the EPZ be evacuated. (At 11:46, the decision was made to evacuate the entire 10-mile EPZ.) The suggestion that going to the plant was inadvisable but nonetheless possible was incorrect, and such suggestion, combined with the giving of road directions to the plant, indicated extremely poor judgment.

The controversy over this contention is more complex. The facts are not disputed. LILCO maintains that the response was proper because:

1. LERO could not prevent anyone from entering the EPZ and going to the plant, although LILCO could prevent entry to the plant; and

2. The operator's advice was proper in the circumstances even though a General, rather than a Site Area Emergency was in effect. LILCO EX-38 and EX-39 Testimony at 68.

Intervenors maintain that the response was deficient because Rather should have been advised that:

 A General Emergency was in effect and evacuation of the area surrounding the plant had been advised;

2. LILCO would prevent his entry to the plant site; and

3. He should go to the ENC for more information. Tr. 3701-04.

We find that good judgment would have dictated that the information specified by Intervenors be supplied in addition to that supplied.

The allegations of Contentions EX-39B(i) and (iii) were also cited by Intervenors as an example of inadequate responses by Rumor Control. The first of these concerns the answer to an inquiry whether the caller's appliances, located in Patchogue, were radioactive, and the second concerns the answer to a question whether a caller, living in Bellport, should evacuate. Both inquiries were referred up to the EOC prior to being answered. LILCO EX-38 and EX-39 Testimony, Att. R and S. Intervenors maintain that both inquiries should have been handled on a lower level and more promptly by reference to a map of the EPZ. <u>See</u> Tr. 3645-51.

The allegations of Contention EX-39B(xii) concern the answer to an inquiry whether a caller, living in Coram, could eat the food in his refrigerator. That answer was affirmative, and included the advice that if the caller was within the EPZ, he should evacuate. LILCC EX-38 and EX-39 Testimony, Att. R and S. Intervenors maintain that the caller should have been told whether he needed to evacuate.

Again, we agree that good judgment would have produced the kind of response which Intervenors say should have been made. However, the lack of that judgment illustrated by all of these instances does not rise to the level of a fundamental flaw in the Plan.

#### 5.c. Alleged Inaccurate Information

The contention cites the following as examples of inaccurate or superseded information:

(iii) In response to a rumor message from The New York Times, simulated at 8:45, and inquiring "what's going on" at the Shoreham plant, the Rumor Control responder related that at 5:40 an Unusual Event had been declared, and at 6:17 an Alert had been declared. By 8:45, however, a Site Area Emergency had been declared, schools had been closed and simulated EBS messages had advised that dairy animals be put on stored feed. Thus, the information provided by LILCO's Rumor Control personnel was inaccurate, misleading, and inconsistent with information being disseminated by other LILCO personnel.

(vi) In response to a rumor message simulated at 1:17 inquiring "what areas are to be evacuated," the Rumor Control responder at 1:21 related that zones A-M, Q and R should evacuate. By 12:00, however, a simulated EBS message had advised that the entire 10-mile EPZ was to evacuate. Thus, the information provided by LILCO's Rumor Control personnel was inaccurate, misleading, and inconsistent with information being disseminated by other LILCO personnel.

LILCO concedes the facts stated in these two examples and attributes the delay to the copier problem. LILCO proposed findings at 154. These matters were considered earlier with respect to Contention EX-39A.

Except to the extent noted in connection with Contention EX-38, we find that the allegations of Contention EX-39 do not demonstrate a fundamental flaw.

#### 6. Miscellaneous

Contention EX-38E reflects FEMA's comment that there were insufficient and inadequate maps and displays in the media briefing room at the ENC; FEMA identified this as an ARCA. FEMA Ex. 1, at 52, 54. LILCO asserts that this shortcoming has been corrected. LILCO EX-38 and EX-39 Testimony at 25-26. Suffolk did not address this point in its direct testimony, and Intervenors have accepted LILCO's representation that the matter has been corrected. <u>See</u> Intervenors proposed findings at 423. Contention EX-380 notes that although LILCO Press Releases 4 and 5 were received by the ENC at 8:45 and 9:05, respectively, they were not given to the Media Monitoring personnel at the ENC until 9:31. Intervenors address this point at 421-22 of their proposed findings. LILCO notes that it is acceptable to delay transmitting news releases to the media monitors because the news reports which they monitor for accuracy are necessarily delayed accounts of past events. Thus their function is not impaired if the delivery of the news releases is delayed. LILCO EX-38 and EX-39 Testimony at 47-48. The facts alleged in this contention do not rise to the level of a fundamental flaw.

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#### 7. Summary of Fundamental Flaws Contentions EX-38 AND EX-39

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We find that the following matters, discussed above, constitute fundamental flaws:

First, the inability of LERO to furnish timely information on the protective action recommendations in the form of copies of the EBS messages to the media at the ENC and to Rumor Control. Although the contentions do not squarely raise the question of the tardiness of the EBS messages given the media, we believe that this issue was aired in terms of the failure to provide copies of Press Releases and agree with FEMA's conclusion that a deficiency should be assessed. Moreover, to ignore the delays in providing EBS messages to the media while finding a fundamental flaw in the delay in providing the same messages to Rumor Control, would exalt form over substance to the detriment of the public health and safety. Contention EX-39A clearly raises the timeliness of the information furnished the Call Boards and District Offices, and Contention EX-39C(iii) and (vi) provide examples of inaccurate information being given out as a result.

Second, the provision of inaccurate information at press conferences. Specifically, the failure to:

(1) respond fully to questions concerning thefuel truck impediment (Contention EX-38M);

(2) respond accurately to questionsconcerning the status of the gravel truckimpediment;

(3) respond accurately concerning protective action recommendations (Contentions EX-38L and EX-38N);

(4) correct Dr. Brill's assumption concerning the "weathering factor" and his consequent miscalculation of the population dose; and

(5) correct Dr. Brill's contradictory advice concerning protective actions (Contention EX-38N). Together, these failings constitute a fundamental flaw.

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## 8. Shadow Phenomenon

In the remaining contentions considered with EX-38 and EX-39, Intervenors assert that there would be a substantial shadow evacuation that would further hinder LILCO's ability to carry out its Plan. These contentions are: EX-44, EX-49C, EX-22F, and EX-40C.<sup>45</sup>

Only the first sentence of Contention EX-44 was admitted and it was consolidated with Contentions EX-38 and EX-39. It alleges that, because accurate, clear, consistent, and nonconflicting information was not provided during the Exercise, a substantial evacuation shadow would have developed. Contention EX-49C asserts that, for the same reasons set forth in Contention EX-44, a substantial monitoring shadow would also develop.

Contention EX-22F was not separately admitted, but its allegations were set down for consideration with Contentions EX-38 and EX-39. It alleges that the assumption employed during the Exercise -- that the public would follow LERO's protective action recommendations and no evacuation shadow would occur -- was false and that consequently FEMA's conclusions on exercise objectives EOC 12, 16; SA 9; and

<sup>&</sup>lt;sup>45</sup>FEMA takes the position that Contentions EX-22F and EX-44 state planning issues and thus, apparently, should not have been admitted. It believes that Contention EX-49C is being addressed by the OL-3 Board.

Fields 6, 9, 10, 11, 13, 14, 21, and 22 are invalid. As a result, the contention asserts that no finding of reasonable assurance can be made and that accordingly, the Plan is fundamentally flawed.

Finally, Contention EX-40C alleges that LILCO's fifth and succeeding EBS messages falsely stated that Traffic Guides were in place to assist the public in evacuating, when in fact they were not. Intervenors take the position that while this allegation does not in itself rise to the level of a fundamental flaw, it does support their public information allegations. Intervenors proposed findings at 482. In its testimony (FEMA Ex. 5, at 70), FEMA suggested that the EBS messages be reworded to state that Traffic Guides are being dispatched to assist with the evacuation. LILCO regards the messages used at the Exercise as carrying some potential for misleading the public and suggests that we direct that they be reworded as suggested by FEMA. LILCO proposed findings at 158. We adopt LILCO's suggestich and do not further consider this contention.

In the planning phase of this litigation, the Licensing Board heard extensive testimony on the shadow phenomenon, including sociological data on human behavior in emergencies and several public opinion polls taken on Long Island by Intervenors and offered in support of their assertion that people would evacuate even when it was not recommended that they do so. The Licensing Board concluded that

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a rational public will behave predominantly in accordance with public information that is disseminated at the time an emergency happens,

PID, LBP-85-12, 21 NRC at 670. It also concluded that public opinion polls

have no literal predictive validity because the residents of Suffolk and Nassau Counties do not now have that additional information [that would become available at the time of an accident] that respondents would need to determine their actions in an emergency.

Id. at 667. However, these conclusions were not unqualified:

The Board's ultimate finding on this contention strongly depends on there being clear nonconflicting notice and instructions to the public at the time of an accident. If for any reason confused or conflicting information was disseminated at the time of an accident, the Board accepts that a large excess evacuation on Long Island could materialize.

Id. at 670. See generally id. at 655-71. In its concluding Partial Initial Decision, LBP-85-31, 22 NRC 410, 429, the Board reiterated these conclusions.

The parties are in agreement that EBS messages should include specific, clear and understandable information about the risk involved in a radiological accident. They agree that messages should describe the risk agent (radiation); explain where it is located and where it will be in the future; tell people its potential effect on their health and safety, what they should do to protect themselves, and how much time they have to do it. <u>See</u> Intervenors proposed finding 631, at 455, citing LILCO EX-38 and EX-39 Testimony at 8-9, 11; Tr. 3242-44, 3264 (Mileti); Suffolk EX-38 and EX-39 Testimony at 190-91.

The Suffolk witnesses testified that the Exercise EBS messages were seriously flawed on this score. They asserted that the messages were vague; that they did not attempt to explain the health effects of what had occurred or what was projected to occur during the emergency; that they failed to tell the public what was happening, or why particular LILCO recommendations should be followed; and that the information about radiation releases and doses was expressed in terms either so ambiguous, or so technical, as to be essentially unintelligible. Suffolk EX-38 and EX-39 Testimony at 188-218.

LILCO'S EBS messages speak for themselves. They appear in Attachment B to LILCO's prefiled testimony, ff. Tr. 3300. Intervenors maintain that LILCO conceded that the EBS messages contain little explicit information on the radiation risk, including where the radiation is, where it is going to be, or its potential health impact, citing generally Tr. 3237-80. It is true that the EBS messages do not contain statements such as "The radiation is in Zone X" or "A dose of X amount may cause cancer." However, a perusal of the cited testimony reveals that LILCO maintains that such information is implicit in the messages. Thus for example, according to LILCO, the public would have concluded where the radiation was going to be from the statements in

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the EBS messages about which zones needed to evacuate. See Tr. 3263-3268 (Mileti). Intervenors ask us to find this method of communication inadequate and inappropriate. We decline to do so. We conclude that the EBS messages convey the necessary information effectively, and we would be extremely reluctant to reach a conclusion that could have the effect of making these messages more complex.

Intervenors ask us to find that the Exercise EBS messages are deficient in failing to provide clear reasons for the recommended protective actions. They assert that the lessons learned from TMI suggest that to get the public to respond to a recommendation, particularly when it runs counter to their natural instincts or firmly held beliefs or fears, the public must be given reasons for taking the actions recommended. Suffolk EX-38 and EX-39 Testimony at 214-15. Thus, they regard this alleged flaw in LILCO's EBS messages as particularly significant with respect to the early messages which told the public there was no need to evacuate. Id. at 208. Intervenors assert that their data demonstrates that such advice would conflict with the natural inclination of the majority of Long Island residents -- to evacuate upon first learning of a Shoreham accident. Id. at 159-60, Att. 14, at 10-11, 20.

We agree that more information could be provided the public regarding the nature of the risk requiring protective action. However, we believe that this matter was adequately

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addressed in the PID, where the Board considered the adequacy of the radiological information furnished the public in LILCO's public information brochure and concluded that the brochure did not provide any real guidance on the effects of radiation at the levels which might be expected in an accident. It therefore directed that these effects be guantified to the extent of indicating "... that a few hundreds of rem could cause acute illness or death and that a few tens of rem could increase the risk of cancer and genetic effects." It deemed this important because of the quantitative mention of projected doses in the EBS messages before it. The Board obviously was concerned that there be a source of information readily available to the public which would provide some explanation of the doses given in the EBS messages. However, the Board refused to order "...anything near the detail that Suffolk County's witnesses provide...." LBP-85-12, 21 NRC at 769-70.

Intervenors could not question LILCO's compliance with this direction.<sup>46</sup> Because the EBS messages do provide for dose information, we believe that compliance with this direction should provide the information which Intervenors believe is necessary.

<sup>46</sup>The Public Information Brochure was not evaluated in the Exercise. <u>See LBP-87-32</u>, 26 NRC \_\_\_\_\_ (Slip op. at 27 n.13).

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Intervenors highlighted several inconsistencies in the EBS messages which would detract from their effectiveness and decrease the likelihood that LERO's protective action recommendations would be followed.

EBS No. 2 stated that "A very minor release has occurred . . . " and then, in the same message, stated that a release was "not imminent." LILCO admitted that this could have been confusing and that it was not "trivial." LILCO EX-38 and EX-39 Testimony at 14-15; Tr. 3212-13, 3365-66 (Mileti). Dr. Mileti argued, however, that in his opinion, the confusion arising from EBS No. 2 would have only made the public "more vigilant" and more likely to keep tuned to LILCO's EBS system. LILCO EX-38 and EX-39 Testimony at 15; Tr. 3376-77 (Mileti).

Intervenors disagree. First, they note that the only basis Dr. Mileti gave for this conclusion was his assertion that "early on in an emergency like this, people initially when they get emergency information try to seek out more information . . . " Tr. 3376 (Mileti). Intervenors believe that even if people were to seek to have their confusion removed, there is no reason to believe they would choose to do so by continuing to listen to a source which generated the confusion in the first place. Moreover, any subsequent "vigilance" to LILCO's EBS network during the Exercise would only have been rewarded by hearing the same message broadcast every 15 minutes until EBS No. 3 was aired about 56 minutes later. See Suffolk EX-38 and EX-39 Testimony, Att. 10.

LILCO also conceded that there was a problem with EBS No. 7. The message stated that the expected thyroid dose was 40 percent of the EPA evacuation guidelines "at 10 miles downwind of Shoreham"; it went on to advise, however, that "If you are outside the 10-mile emergency planning zone, there is no reason to take action." EBS No. 7. LILCO acknowledged that this message contained conflicting information. Tr. 3391-92 (Mileti). Dr. Mileti said that more explanation of why a 40 percent risk at the EPZ border required no action, when the entire EPZ was being advised to evacuate, could have resulted in "better understanding" on the part of people on the EPZ border. He also acknowledged that EBS No. 7 was inconsistent with LERO News Release No. 7, which stated that people outside the EPZ need not take any action because the released radiation was not expected to reach beyond the 10-mile EPZ. LILCO EX-38 and EX-39 Testimony at 15; Tr. 3382-83, 3889-90, 3393 (Mileti).

EBS No. 2 was also recognized to be internally inconsistent and confusing. It tells the public they need take no action beyond figuring out what zone they reside in, but at the same time recommends sheltering milk producing animals. This information clearly raises a question whether, if animals need shelter for protection, humans are

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in some danger. Suffolk EX-38 and EX-39 Testimony at 206-207; see EBS No. 2; Tr. 3245-46, 3256-59.

The Suffolk witnesses testified about additional problems with the Exercise EBS messages. See generally Suffolk EX-38 and EX-39 Testimony at 191-222. Their testimony was essentially uncontroverted. We find the following problems to be significant.

First, some of those messages give dose projections while the LILCO news releases and Mr. McCaffrey in the news conferences spoke in terms of dose rate projections. See LILCO EX-38 and EX-39 Testimony, Atts. E and P; Tr. 3695, 3699 (McCaffrey). There is a difference between the two, and that difference needs to be explained to the press.

Second, the messages described the releases in terms such as 'small', 'minor', 'major', and 'significant'. Some quantification of these terms needs to be provided, perhaps in the public information brochure, and they must be consistently applied. <u>See</u> Intervenors proposed findings at 192.

Third, the messages state the emergency classification which has been declared and that it is one of four classifications. Some explanation needs to be given of where the current classification stands in the heirarchy. Id. at 198.

While there is much information which is well presented in the EBS messages, we agree with Intervenors that the

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above inconsistencies detract from the effectiveness of the EBS messages and are likely to confuse the public. We view this matter as an integral part of the fundamental flaw found under Contentions EX-38 and EX-39.

Contention EX-49C alleges that there is no basis to assume that only those persons expressly advised by LERO to report to the reception center for monitoring because of potential exposure during evacuation activities would actually seek such monitoring. It alleges that, upon hearing that residents of so many zones had potentially been exposed, and in light of the large voluntary evacuation likely to occur for the reasons set forth in Contention EX-44, substantially more people than the number expressly advised to report would be likely to seek such monitoring.

Intervenors maintain that considerably more people would seek monitoring for many reasons. For example, the County's witnesses testified that large numbers would be likely to discount the zone concept altogether; individuals' fear of radiation, combined with a lack of understanding of its effects, would make them seek monitoring; some people might focus on only the parts of the EBS messages stating that "the public" will be monitored for radioactive contamination, or that "they may have been exposed"; and people who were not residents of the named zones might seek monitoring because they might not know which zones they had

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gone through, or traveled near, during their trips out of the EPZ. Suffolk EX-38 and EX-39 Testimony at 279-81.

We decline to decide this Contention. The issue of the number of persons whom LERO should be prepared to monitor is currently pending before the OL-3 Board. Hence it would be inappropriate for us to consider this issue.

The October 3, 1986 Prehearing Conference Order rulud on Contention EX-22F as follows:

The substance of basis F will be dealt with under Contention EX-38 or EX-39, and need not be admitted here.

See at 14. Later in that same Order, Contention EX-44 was discussed at length.

The factual question raised by this contention is whether or not an evacuation shadow phenomenon will arise in an evacuation as a result of an inability of LILCO to provide clear nonconflicting information to the public. This contention is therefore of a contingent nature. Its resolution is dependent on the outcome of litigation on the information contentions numbered EX-38 and EX-39. An acceptable basis for the contention is traceable to our initial decision where the Board found:

The Board's finding on this contention strongly depends on there being clear nonconflicting notice and instructions to the public at the time of an accident. If for any reason confused or conflicting information was disseminated at the time of an accident the Board accepts that a large excess evacuation on Long Island could materialize. 21 NRC 644, 670 (1985).

Other than a citation to our initial decision, Intervenors provide nothing more in their discussion of Contention EX-44 that would provide an acceptable basis for admission of matters that have been previously litigated. We need not look again at consequences of shadow evacuation because this was previously litigated and decided and because Intervenors have shown no basis for believing they could learn anything new on this subject from an exercise that did not include a public evacuation.

We find no basis for assertions of Intervenors that we must require LILCO to test its preparedness for a large shadow evacuation or to plan for an <u>ad hoc</u> expansion of the EP2. ... If Intervenors prevail on Contention EX-38 and EX-39 and the evidence is sufficient to conclude that a large shadow evacuation will occur, Intervenors will be free to claim that this constitutes a fundamental flaw in the plan because the evacuation could not be controlled. We see no value in taking the matter further than that. ...

Id. at 25-26.

In their proposed findings (at 448), Intervenors argue that the ruling quoted above is the law of the case and that, under it, they needed only to demonstrate that LERO disseminated unclear, confusing, or inconsistent information "...in order to prevail on their contention that the Exercise assumption of no voluntary evacuation was false, rendering the Exercise results invalid."

We agree with the Intervenors that the quoted ruling is the law of the case. However, we do not entirely agree with the remainder of their statement. We have found that confusing and conflicting information was promulgated during the Exercise. That finding brings the PID's conclusion that an excess evacuation could occur into play. In such an event, a controlled evacuation, which is required by the Plan, probably could not be achieved.<sup>47</sup> Thus, we conclude that a fundamental flaw was demonstrated.<sup>48</sup>

The existence of this fundamental flaw does not justify the conclusion that the Exercise results are invalid. Indeed, the Prehearing Conference Order relied on by Intervenors expressly held that there was no basis to require LILCO to test its preparedness for a large shadow evacuation or to plan for an <u>ad hoc</u> expansion of the EPZ. To the extent that these contentions argue that the Exercise results must be thrown out because LERO's ability to deal with a large shadow was not tested, they are denied.

In light of the conclusions we have reached above, we find it unnecessary to consider the survey and focus group data offered by Intervenors in support of these contentions.

<sup>47</sup>See our discussion of the requirement that a controlled evacuation be achieved in connection with Contention EX-40, at

<sup>48</sup>Aside from the requirement that a controlled evacuation be achieved, we have concluded that the weaknesses demonstrated in the public information program demonstrate a fundamental flaw in LERO's capability to communicate emergency information and protective action recommendations to the public. Moreover, these weaknesses appear to be a part of a pervasive problem in LERO's communications generally.

## F. TRAINING

#### 1. Overview

Contention EX-50 consists of nine subparts (A-I) which allege, based on references to the FEMA Report and to other contentions, that the Exercise revealed a fundamental flaw in the LILCO Plan in that LERO personnel are unable to carry out the Plan effectively or accurately because they have been inadequately trained. The Contention alleges that the bulk of LERO personnel had undergone training annually for three years prior to the February 13, 1986 Exercise. It alleges, further, that the large number of training problems revealed during the E.ercise demonstrates LILCO's lack of compliance with 10 CFR 50.47(b)(14) and (15).<sup>49</sup>

The Shoreham OL-3 Licensing Board found, in the PID, that "the LILCO Plan training program meets the regulatory standards," but went on to state that "[t]his conclusion is made subject to confirmation by a finding, to be made by FEMA after a graded exercise, that the Plan can be satisfactorily implemented with the training program submitted and that LILCO possesses an adequate number of LERO workers." LBP-85-12, 21 NRC 644 (1985), 756. Thus, the issue of the adequacy of LILCO's training program was left open and subject to test in the Exercise. FEMA

<sup>&</sup>lt;sup>49</sup>Contentions EX-42 and EX-45 and the factual allegations in Contentions EX-23, EX-27, and EX-28 were consolidated with Contention EX-50 and will therefore be considered here.

identified a significant number of training problems and inadequacies in its Report on the Exercise, and it did not make a finding that the Plan can be satisfactorily implemented with the training program in use at the time of the Exercise. Tr. 8296-8.

# 2. The Purpose of Training

Suffolk's witnesses, all of whom were either university professors or police experienced in police training, presented testimony on the purpose of training emergency workers. A successful emergency response organization must be comprised of individuals who work individually and together in an efficient and effective manner in confronting both the routine and non-routine demands which arise during a response to an emergency. Training is the process by which an organization and its constituent members learn to work individually and together so that the organization can perform in an integrated manner. Suffolk Ex. 95, at 25-26. Training for organizations responding to a nuclear emergency must go beyond the training required for some other organizations. Any organization must train to perform routine tasks, and some tasks under the LILCO Plan, such as driving a bus or reading a dosimeter, would fall into the routine category. For an emergency, however, training must also prepare personnel to perform non-routine, unexpected tasks. In fact, Suffolk's witnesses believe that it must

become "routine" for LERO personnel to perform as necessary in dealing with non-routine events. <u>Id</u>. at 26-27; Tr. 6390-91.

Training to achieve this goal is especially necessary for LERO, because its personnel do not routinely perform the emergency functions to which they are assigned under the LILCO Plan. It has been found that organizations whose daily operations can be switched to the emergency at hand perform better than organizations that must change their predisaster functions to perform in a disaster. NUREG/CR-3524 (Suffolk Ex. 57), at A-2; Tr. 6421-25. For example, if police are required to direct traffic during a nuclear emergency, they are applying skills that they routinely use in their work; it is reasonable to assume that they can do the same thing successfully in a nuclear emergency. LERO Traffic Guides, on the other hand, are not skilled at directing traffic, although it is assumed that they can do so during an emergency at Shoreham. The only way to give them such skill is through adequate training. Tr. 6539-40; 6774-78.

Effective emergency response training involves the use of several training techniques. The first can be called "basic training," which uses instruction and other rote methods to teach people how to respond to predictable, repetitive events. The next training level involves "learning by doing" and includes training through drills and

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exercises, training gained through experience, and training gained by interacting with others and by responding to particular events. Suffolk Ex. 95, at 28-29. Learning by doing should focus on unusual events and teaching persons to perform tasks that require communication, coordination, and cooperation. Communication should include information exchange among personnel and dealing with the media. The final training hurdle is teaching persons to deal with unanticipated and unrehearsed events, including teaching them how to use good, independent judgment. This type of training occurs in exercises or drills, where complex exceptions to the routine are simulated (as in free play messages) or occur naturally. Id. at 30-32.

#### 3. LILCO's Training Program

LILCO's training program for offsite emergency response personnel involves classroom presentations, drills/tabletop sessions, and exercises. The classroom instruction provides basic training, utilizing video presentations, workbook materials, and instructor discussions and demonstrations. It covers radiation protection and basic dosimetry for everyone, and then job-specific training for LERO personnel. Id. at 22-23; see also Plan at 5.1-3 thru -5 and Figure 5.1.1. LILCO employees annually participate in drills and tabletop sessions. The purpose of drills/tabletop sessions may vary, depending on the level of training of the trainees or the difficulty of a given task. Early in LILCO's training, LILCO observers critique trainees as they go through the drill/tabletop session, to correct inappropriate performance or to reinforce appropriate performance. Suffolk Ex. 95, at 23-24; see Plan, at 5.1-2, 5.2-1 thru -6. The final phase of LILCO's training program involves specific preparation for a FENA-graded exercise, in which a full-scale dress rehearsal is conducted. During the two months prior to the February 13, 1986 Exercise, LILCO held at least three full-scale dress rehearsals. Suffolk Ex. 95, at 25, 37; Tr. 5477-84; 8292.

## 4. Standards for Evaluation

The standards that should be used by the Board in evaluating LILCO's training program were addressed by LILCO, the Intervenors, and by the NRC Staff in its proposed findings. LILCO took the position that the Board should determine whether the alleged problems with training establish a systemic problem or pattern of defects with the LERO training program, rather than a group of isolated, independent problems. LILCO Testimony on Contention EX-50 (LILCO EX-50 Testimony), ff. Tr. 4368, at 12-13. LILCO argues that organizational performance is the standard by which its training program should be evaluated. Id. at 11.

LILCO's witnesses acknowledged, however, that to draw conclusions about the ability of an organization to

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accomplish its tasks, functions and goals, it is necessary to look at individual behavior. Tr. 4979-80; 4693-94. Moreover, they also acknowledge that errors in the performance by individual members of an organization can be the result of an inadequate training program. Tr. 4983. Indeed, LILCO's witness Dr. Mileti, who was an author of NUREG/CR-3524 (which deals with organizational effectiveness), stated that individual performance and actions must be used to measure organizational behavior and effectiveness because:

> The only real unit that exists are (sic) individuals. I mean you can't really observe an organization if you take the individuals out of it. There is nothing left.

## Tr. 4978-79.

The Intervenors took the position that the FEMA Report identified a large number of training inadequacies. Tr. 6542-43. They acknowledged that a much larger number of LERO workers were mobilized than were observed by FEMA, but of the small number observed, more had problems than they would have expected. Tr. 6544-45. Considering the large amount of training provided for the LERO workers prior to the Exercise, Suffolk's witnesses believe the large number of problems observed by FEMA reflects the fact that the training program was inadequate. Suffolk Ex. 95, at 37-38. Intervenors also argue that the drills conducted since the February 13, 1986 Exercise, have revealed that the sericus inadequacies that became apparent during the February 13 Exercise continue to exist. Id. at 44-46.

FEMA's witnesses testified that in those instances where participants demonstrated inadequate actions, the effectiveness of the training program must be enhanced to assure that the LERO personnel will be able to carry out their assigned roles. FEMA Ex. 5, at 73.

The Staff emphasized the necessity of looking to the provisions of the regulations that deal with training, principally 10 CFR 50.47(b)(15), and the criteria used by the NRC and FEMA in evaluating compliance with that standard, NUREG-0654, Rev. 1. In addition, Appendix E to Part 50 establishes required elements of training, notably those related to the participation in training and drills and the testing of this implementation of procedures, equipment, communications and notification through an exercise. Staff proposed finding 406, at 146-47. Staff also agreed with LILCO that to indicate a breakdown in the training program which would preclude the finding of reasonable assurance that adequate protective measures could be taken in the event of a radiological emergency at SNPS, the training problems would have to be pervasive or systemic in nature. Staff proposed finding 414, at 150.

There is merit to some of the arguments from all the parties about the standards we should use to evaluate the success of LILCO's training program. The position we are taking with respect to the standards by which LILCO's training program shall be judged is somewhere between the positions taken by these the parties, and of course we agree with the Staff that we must consider the regulations. We agree with LILCO that it is appropriate for us to look for a systemic problem or pattern of defects, and we believe this can be done only by noting the performance of individuals. We agree with Suffolk that we must analyze the results of the Exercise and additionally determine whether problems found during the Exercise have recurred during post-Exercise drills. With these standards in mind, we turn now to testimony on the subcontentions.

## 5. Subcontention EX-50A

Subcontention EX-50A alleges that the LILCO training program has not adequately trained LERO personnel to respond properly to unanticipated and unrehearsed situations. An unanticipated situation is one that is not expected to occur and which therefore takes one by surprise. Since it is unexpected, it is a situation for which specific training is not given. An unrehearsed situation is an occurrence for which a response has not been practiced; it may or may not be also unanticipated. Thus, during the Exercise the overturned fuel truck probably presented both an unanticipated traffic impediment, because presumably it was unexpected, as well as an unrehearsed situation, because a

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response to an overturned fuel truck had not been practiced prior to the Exercise. Suffolk Ex. 95, at 55-56.

LERO's response to the two evacuation impediment free play messages is considered in detail by us under Contention EX-41, where we found that the vertical communications chain called for by the Plan constituted a fundamental flaw. We also noted there that LERO personnel were not adequately trained in emergency decision-making and communication. FEMA, which found a Deficiency in LERO's response to the road impediments, recommended additional training, in the following words:

Additional training is needed to ensure that the procedures, whether new or current, are properly implemented. All coordinators at the EOC, and those who initiate messages, must be trained to include all pertinent information on the LERO message forms and to analyze the equipment requirements to clear impediments.

FEMA Ex. 1, at 39. FEMA identified a significant number of training problems and inadequacies in the FEMA Report. Tr. 8297.

LILCO's witnesses testified that they considered just about everything that happened during the Exercise to have an element of surprise. They stated that LERO players did not know the time events would be declared, the progression of the accident, the free play messages that would be injected, nor the area to be evacuated. LILCO EX-50 Testimony at 34. With regard to the responses to the impediment free play messages, they argue that during an

actual emergency there would be no delays in response, because the impediments would be visible to LERO workers and others and hence reported promptly. They believe that much of the delay in responding to them during the Exercise resulted from artifacts of the scenario which hindered detection or verification of the impediments. Id. at 37. They also argue that their traffic engineer, Mr. Lieberman, believes that any accidents during the evacuation would probably be minor and would not block major roadways. Consequently their training focused on less severe accidents than were presented in the Exercise. Id. at 38. Finally, LILCO's witnesses argue that some of the examples of misinformation dispensed by LERO during the Exercise, which are cited in Contention EX-50A, are so isolated and trivial that they cannot be considered to demonstrate a flaw in the LERO training program. Id. at 40.

Suffolk's witnesses, on the other hand, interpreted the delays in response to the impediments, the incomplete messages about them, the improper rerouting schemes used, and the inadequate road clearing equipment dispatched to remove the impediments all to demonstrate inadequate training of LERO personnel. They believe that the response by LERO to the road impediments demonstrates that LILCO's training program has been ineffective in training personnel to respond to unanticipated and unrehearsed situations. Suffolk Ex. 95, at 61-65. They listed a number of actions

which they said were not carried out but would have been had the training been effective: follow-up to ensure that instructions were being carried out; redundant communications along parallel channels to ensure that communications got through; getting people to the scene to verify the logic of rerouting schemes; and verification that proper equipment had been sent. Id. at 65-66. Finally, Suffolk's witnesses testified that as experienced trainers they had learned that when mistakes are made they usually reflect how well the individuals who made the mistakes were trained. They recognize that different people possess differing levels of competence, so that it cannot be assumed automatically that an entire training program is inadequate because of a few mistakes by a few individuals. However, because so may basic mistakes were made by so many different people during the Exercise, the witnesses believe that the most reasonable conclusion is that the training program was flawed. Id. at 68.

In addition to finding a Deficiency in LERO's response to the impediment free play messages, FEMA also found an Area Requiring Corrective Action (ARCA) in connection with the response to the impediments. The ARCA resulted from the delayed dispatch from Port Jefferson of the Route Spotter assigned to verify the fuel truck impediment. FEMA recommended additional training in response to this ARCA just as it did in response to the Deficiency, in the following words:

Personnel need to be trained in the development of alternative approaches when delays are reasonably anticipated in the field verification of impediments to evacuation. Development of alternatives should include consultation between, at a minimum, the Evacuation Coordinator and the Evacuation Route Coordinator.

FEMA Ex. 1, at 41. FEMA found the impediment response as evidence that at the time of the Exercise LILCO's training program was inadequate. Tr. 8298.

Finally, the NRC Staff, in its proposed findings, concluded that the evidence on LERO's response to the road impediments during the Exercise supports the allegation in EX-50A that LERO personnel are not sufficiently trained to effectively deal with unanticipated events that have the potential to disrupt the taking of protective actions. Staff proposed finding 429, at 160.

<u>Conclusion on Subcontention EX-50A</u>. We conclude that the training of LERO personnel in responding to unanticipated and unrehearsed events, in communicating information about such events, in analyzing the kind of equipment needed to respond to serious roadway accidents, and in the development of alternative actions when actions called for by the Plan do not or will not work effectively, has been inadequate. We have already found that the communication problem constitutes a fundamental flaw in the Plan; this flaw resulted in part from the long chain of communication and in part from inadequate training. We believe that LILCO must significantly expand and improve its training program in communications before there can be reasonable assurance that adequate protective measures can and will be taken in the event of a Shoreham emergency (see Conclusion on Subcontention EX-50C).

### 6. Subcontention EX-50B

Subcontention EX-50B alleges that the Exercise demonstrated that LILCO's training program has been ineffective in teaching LERO personnel to follow and implement the LILCO Plan and procedures, and in imparting basic knowledge and information essential to implementing the procedures. As a basis for these allegations, the contention cites several other contentions and the FEMA Report. Suffolk Ex. 95, at 99.

Suffolk's witnesses testified that an ability to follow and understand the Plan and procedures is "absolutely critical" if LERO personnel are to be able to then improvise in response to unanticipated and unrehearsed situations. If routine tasks cannot be done by rote, then performing them will take all the time and intellectual energy that LERO personnel have, leaving none to deal with non-routine problems of a real emergency. <u>Id</u>. at 101-2; Tr. 6400-01. The witnesses listed the following examples from the

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Exercise which they believe demonstrate the ineffectiveness of the training program to teach LERO personnel the basic knowledge needed to follow and implement the Plan and procedures:

> The difficulties experienced by LILCO's Bus Drivers in locating residences and going to wrong locations (<u>e.g</u>., FEMA Report at xv, xvi, 65 and 66);

Erroneous announcements of pertinent information by personnel (e.g., FEMA Report at 33, 68 and 69);

Mr. Brill, the BNL scientist assisting LILCO at the ENC, provided answers inconsistent with the EBS Messages (Videotapes of Press Briefings held at ENC during the Exercise);

Inadequate use and readings of dosimetry equipment and failure to know excess exposure levels, excess exposure authorization procedure, KI ingestion procedures (e.g., FEMA Report at 59, 68-70, 76 and 77);

Excessive route alerting times (e.g., FEMA Report at xiv, xv, and xvii);

Delayed dispatching of personnel (e.g., FEMA Report at xvi, xviii, 37, 41, 57-58, 62, 66-67, 74-75);

Use of wrong security procedures (e.g., FEMA Report at xv, 61 and 63);

Incorrectly completing message forms (e.g., FEMA Report at xvii, 42, 71-73);

Excessive time in monitoring personnel (e.g., FEMA Report at xvii, 80-81);

Confusion in contacting the FAA (e.g., FEMA Report at 29, 39);

Pertinent information not included on message forms (e.g., FEMA Report 30, 37, 39, 65);

Untimely internal communications of information (e.g., FEMA Report at 36-37, 39);

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Failures to provide press information in timely manner (e.g., FEMA Report at 52-53);

Extraneous information included in EBS messages (e.g., FEMA Report at 53);

Dissemination of outdated information by rumor control personnel (e.g., FEMA Report at 53);

Traffic Guides not knowing location of reception center or where public was to be directed for monitoring and decontamination (e.g., FEMA Report at 64);

Personnel not reporting to assigned location or where directed to go (e.g., FEMA Report at 64-65);

Failures to update status boards (e.g., FEMA Report at 72, 73);

Personnel directed to wrong places by their superiors (e.g., FEMA Report at 65, 67).

### Id. at 102-04.

In addition, Suffolk's witnesses cited a number of instances during LERO's responses to the impediments which, they believe, represent failures to follow or implement the Plan and procedures. For example, the Evacuation Coordinator is supposed to direct LERO's actions in the areas of traffic control, transportation, and evacuation. During the Exercise, however, he was never informed by LERO personnel about the impediments, even though such communication is required by OPIP 3.6.3. <u>Id</u>. at 105; see FEMA Report at 36. This and other allegedly similar failures to follow the Plan or implement its procedures led to substantial delays in LILCO in responding to the impediments. Suffolk Ex. 95, at 105.

Moreover, LERO personnel in the EOC failed to include on LERO message forms essential information communicated to ther in the free play impediment messages, nor did they otherwise communicate such critical information to LERO personnel expected to respond to the impediments, as required by OPIP 3.6.3 and 4.1.2. For example, the Evacuation Route Coordinator's message to the Evacuation Support Communicator for Route Spotter/Road Crews about the gravel truck impediment failed to mention that three cars as well as the truck were involved. Similarly, the message to the Communicator about the fuel truck impediment failed to mention that fuel was leaking from the truck, that there was danger of a fire, and that both shoulders of the road were blocked. LILCO's Plan requires that such essential information be communicated. Suffolk Ex. 95, at 105-107; see FEMA Report at 30, 37, 39.

Another example of LILCO's failure to teach personnel to follow the Plan and procedures, according to Suffolk's witnesses, was the failure of LERO personnel to use LERO message forms to communicate essential information correctly or to use LERO message forms at all. FEMA noted this problem during the Exercise, and listed it as an ARFI. FEMA Ex. 1, at 30, 42, 71-2. FEMA recommended additional training that stresses the mandatory use of standard message forms and the importance of legibility. <u>Id</u>. at 42, 39. This problem recurred during the June 6, 1986 drill and also

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during the September 10, 1986 drill, when messages often were written on scraps of paper. Suffolk Ex. 96, Att. 7, at 3; Att. 8, at 3. During the September drills messages written on paper were often later transcribed to LERO message forms, which caused delays in delivering the messages and caused transcription errors. Id. Some messages were not written at all, but were delivered verbally to the communicator for transmittal. Id. at 11. Again during the December 2, 1986 drill an estimated 20 percent of the message writers used scraps of paper rather than the standard LERO message forms. Suffolk Ex. 96, Att. 9, at 3. Intervenors argue that the fact that this problem occurred not only during the Exercise but also during most of the subsequent drills supports the conclusion that the LILCO training program is incapable of teaching LERO personnel the LILCO Plan and procedures. Suffolk County, State of New York, and Town of Southampton Proposed Findings of Fact and Conclusions of Iaw on the February 13, 1986 Shoreham Exercise (Intervenors' proposed findings), Vol. II, at 564. Suffolk's witnesses attributed this continuing problem in performance to an underlying major problem in LILCO's training methodology. Tr. 6506.

As an example of the failure of the LILCO training program to impart the basic knowledge necessary for Plan implementation was the fact that only one Traffic Guide out of 14 from the Patchogue Staging Area interviewed by FEMA

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knew the location of the Nassau Coliseum Reception Center, and one Traffic Guide believed that the public was to be directed to LILCO'S Emergency Worker Decontamination Facility (EWDF). Suffolk Ex. 95, at 117; see FEMA Ex. 1 at 64. FEMA found this to be an ARCA, and recommended improved training as the appropriate corrective action. <u>Id</u>. at 67. Suffolk's witnesses argue that this lack of basic knowledge on the part of Traffic Guides indicates that the LILCO training program has failed to impart the basic knowledge to LERO personnel that they need to implement the LILCO Plan. Suffolk Ex. 95, at 118. The NRC Staff agreed that this lack of knowledge was "clear evidence of a failure to provide adequate training." Staff proposed finding 467, at 175.

Suffolk's witnesses allege that the performance of LERO personnel during drills held since the February 1986 Exercise reinforces the conclusion that LILCO's training program has been unsuccessful in teaching personnol to follow the LILCO Plan and implement its procedures. Suffolk Ex. 95, at 118. For example, during the Exercise some personnel failed to demonstrate an understanding of procedures regarding allowable exposure levels, a problem which basic training should be able to correct easily. <u>Id</u>.; see FEMA Report at 68, 76. During the June 6 and again during the September 10 drills, a number of Traffic Guides were still unclear as to the maximum allowable doses and the procedures governing the use of KI. Suffolk Ex. 95, at 119;

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Suffolk Ex. 96, Att. 7, at 6; Att. 8, at 4-5, 6. Yet again, during the October 1 drill, Traffic Guides were unclear as to the maximum allowable doses. Suffolk Ex. 95, at 120; Suffolk Ex. 96, Att. 8, at 11. Suff \_k's witnesses argue that learning the maximum allowable doses is a relatively easy task that is relevant to the workers' own health and safety, and if these procedures have not been learned, other material not as crucial to personal safety surely has not been learned. Suffolk Ex. 95, at 120.

There were numerous other problems during drills that Suffolk's witnesses believe reflect inadequate training. During the September 10 drill there was poor coordination between the Director of Local Response and Coordinator of Public Information over the coordination of siren activation and the broadcast of EBS messages (<u>id</u>. at 121); the Radiation Health Coordinator ordered the ingestion of KI without performing the required calculations needed to justify this action (<u>id</u>); the personnel who reported to establish the EWDF were unfamiliar with their jobs, failed to use a checklist as required by the Plan, and took no action until prompted by the Controller (<u>id</u>. at 121-22); personnel at the staging areas were unfamiliar with their duties and had to be prompted and trained during the drill by the Controllers (<u>id</u>. at 122-23).

Drills conducted on December 2 and 10 involved Shift 1, which had last participated in the February 13 Exercise

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(Suffolk Ex 96, Att. 9, at 1); the December 2 drill was intended to allow the participants to use the first drill as a learning process to become familiar with the latest procedures, and the December 10 drill was intended to reinforce the knowledge gained the preceding week (id.); in both drills, as was the case during the February 13 Exercise, some Traffic Guides did not arrive at their posts until more than an hour after the EBS broadcast recommending evacuation (Suffolk Ex. 95, at 123 n.54; Suffolk Ex. 96, Att. 9, at 19-21, 24, 27-8; Suffolk Ex. 95, at 124; Att. 9, at 32, 35, 39-40); once again, as was the case in the February 13 Exercise, pertinent information concerning a simulated impediment on the Long Island Expressway was not properly communicated during the December 10 drill, resulting in confusion and delays in responding to the impediment (Suffolk Ex. 95, at 124; Suffolk Ex. 96, Att. 9, at 4).

Suffolk's witnesses conclude that the many mistakes made and many examples that exist of failures by LERO personnel to follow and implement the Plan demonstrate that the problems revealed during the Exercise are the rule and not the exception. The drills demonstrated that despite the training, LERO personnel still have not been successfully trained to carry out the functions they are assigned under the LILCO Plan. Consequently, they believe that LERO personnel would be unable to implement the actions called

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for by the Plan to protect the public health and safety in the event to an emergency at the SNP. Suffolk Ex. 96, at 125.

LILCO's witnesses testified that in view of the fact that over 1000 LERO personnel participated in the Exercise over an 11-hour period the incidents cited by the Intervenors are sporadic and not representative of a pervasive failure in training. In addition, they state that I my of the instances cited are either not relevant to the training issue or are without merit because they are factually baseless. LILCO EX-50 Testimony, at 41; Tr. 5523-25. With respect to the other contentions listed in Subcontention EX-50B as providing bases, LILCO's witnesses state that of the contentions cited, Contentions EX-36, EX-38, EX-39, EX-45, and EX-49 contain allegations that have nothing to do with training. LILCO EX-50 Testimony at 41. Contention EX-49 alleges that the radiological monitoring procedure frequently took longer than the prescribed 90 seconds, which indicates that the training program did not effectively train the monitoring personnel to follow procedures. LILCO's witnesses state, however, that monitoring occasionally, not frequently, took longer than 90 seconds, and this occurred when FEMA evaluators were being monitored. Id. at 42. Apparently it was true that the only times when monitoring was observed to take more than about 90 seconds was when FEMA evaluators

were being monitored. Tr. 7982-85. Nevertheless, FEMA found that taking 4 to 5 minutes to monitor some individuals was an ARCA. FEMA Ex. 1, at 81; Tr. 7985. Finally, LILCO's witnesses maintain of the contentions cited in Subcontention EX-50B, Contentions EX-37D, EX-38N, and EX-45E and PSA-ARCA-3 raise issues that are insignificant or minor. As an example they cite PSA-ARCA-3, which states that LERO personnel used second floor telephones at the staging area, contrary to OPIP 4.7.1. LILCO claims that this incident was a practical solution to the need for telephones even though it meant LERO personnel did not follow procedures to the letter. LILCO EX-50 Testimony at 43.

FEMA did not explicitly address Subcontention EX-50B; indeed, FEMA chose not to address any of the subcontentions EX-50A through H, on the grounds that they accurately reflected the contents of the FEMA Report by citing various Deficiencies of ARCA's directly from the Report. FEMA stated in general, however, that most of the Exercise inadequacies which were identified as either Deficiencies or ARCAs were attributable to breakdowns in the LILCO training program. FEMA Ex. 5, at 73.

The NRC Staff, in its proposed findings, noted that enough workers made errors to indicate a pattern related to deficiencies in training. Staff suggested that until the ability to maintain emergency response skills has been demonstrated, it retained serious doubts about the adequacy

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of the LILCO training program. Staff proposed finding 468, at 176.

Conclusion of Subcontention EX-50B. While we recognize that the absolute number of instances a LERO player was observed to fail to follow the LILCO Plan and procedures may be small relative to the total number of LILCO personnel that participated in the Exercise, this comparison is not the appropriate one. The appropriate comparison is the number of failures in the total sample of observed participants. Viewed from this perspective, the proportion of LERO workers observed failing to follow the Plan or procedures was disturbingly great.<sup>50</sup> These failures occurred frequently enough to suggest that there is, indeed, a pervasive problem in training LERO workers to follow the Plan. We conclude, therefore, that the allegation made in Subcontention EX-50B is valid; LILCO's training program has not adequately trained LERO personnel to follow the LILCO Plan and procedures.

<sup>&</sup>lt;sup>50</sup>To illustrate the point, FEMA observed eight bus drivers for the general population, of which three either got lost or missed part of their route. Tr. 8547-48. Thus approximately 37 percent of the sample of eight failed to carry out their function properly. If the eight observed by FEMA were a truly representative sample of the total of 333 general population bus drivers who were mobilized during the Exercise, then one might expect 37 percent of 333 bus drivers, or approximately 125, to fail to carry out their function properly. Tr. 8548.

# 7. Subcontention EX-50C

Contention EX-50C (along with Contention EX-23 and the bases for EX-45) alleges that LILCO's training program has failed to teach LERO personnel to communicate necessary and sufficient data and information, to inquire and obtain such information, or to recognize the need to do so. Contention EX-50C cites a number of other contentions and FEMA findings which are alleged to describe Exercise events that support this contention. Suffolk Ex. 95, at 125-26.

Suffolk's witnesses identified a number of examples of breakdowns in communications during the Exercise which they attribute to a failure in LILCO's training program. The first and "most glaring example" is that of the communication difficulties that occurred during LERO's handling of the free play impediments. <u>Id</u>. at 127. This has been discussed in detail in our consideration of Contention EX-41 and need not be described again here. Suffice it to say that FEMA found those communication problems to be a Deficiency, and we found them to constitute a fundamental flaw in the Plan. As we have noted above, similar communication problems occurred during the response to a simulated impediment during the June 6 and December 10, 1986 drills.

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Suffolk's witnesses cited some other Exercise events which they believe illustrate breakdowns in communications between LERO personnel. One involved LERO's response to the free play message requesting LERO to provide a bus and driver to assist in transporting forty children from the Ridge Elementary School. The request was communicated to the Special Population Bus Dispatcher within about 10 minutes, but Suffolk alleges that the staging area personnel did not respond quickly or appropriately in processing the communication. <u>Id</u>. at 128. Suffolk's witnesses believe that LILCO's training program has failed to instruct LERO personnel on the need to communicate information in a timely manner and to follow up on communications to make sure that tasks are completed. Id. at 128-29.

Additional examples of communication breakdown cited by Suffolk include the following:

- -- LERO was unsuccessful in attempting to communicate with the FAA in order to get air traffic diverted from the EPZ (id. at 130; see FEMA Report at 29);
- -- The Long Island Railroad (LIRR) was not contacted during the Exercise in order to divert trains from the EPZ (id.);
- -- The downwind distance of a sample taken by a DOE RAP field monitoring team for one of the thyroid dose projections was incorrectly reported as 7000 meters rather than 700 meters. The error was corrected in about five minutes, but it meant that the initial calculation of thyroid dose was 9000 mRem/hr at 4.3 miles downwind instead of 9000 mRem/hr at about 0.5 miles downwind (Suffolk Ex. 95, at 130; FEMA Ex. 1, at 33);

-- Several extrapolated doses at various distances

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were reported on the dose assessment status board as actual measurements rather than as projected doses, an error which went uncorrected for two and one-half hours (Suffol' Ex. 95, at 130-31; FEMA Ex. 1, at 33);

-- Several times the Director of Local Response was not in the command room and not available to take calls over the RECS telephone or the dedicated telephone. His secretary, who took the calls in the Director's absence, told the callers that the Director would call back. Because both telephones are used to communicate vital emergency information, FEMA found this situation to be an ARFI and recommended that persons answering the telephone when the Director was busy elsewhere be trained to take the message in writing and then deliver it to the Director immediately upon completion of the transmission (Suffolk Ex. 95, at 131; FEMA Ex. 1, at 31, 42).

Suffolk's witnesses also list the following examples of what they believe to be the failure of LILCO's training program to effectively train personnel to communicate necessary and sufficient data and information, as evidenced by the inability of LERO personnel at the staging areas to accurately, appropriately, or in a timely manner obtain, record, or transmit, or act upon emergency data:

-- At the Riverhead Staging Area, LERO Personnel did not properly record or identify event status information on the Emergency Event Status Forms or on the status board (Suffolk Ex. 95, at 132; FEMA Ex. 1, at 72);

<sup>&</sup>lt;sup>51</sup>Suffolk's witnesses included two other examples involving status boards which were mentioned in the FEMA Report, but our reading of the Report indicates that those were more in the nature of equipment problems. See Suffolk Ex. 95, at 130, 131; and FEMA Ex. 1, at 29-30. Therefore we are not considering those two examples here.

- -- The Bus Dispatcher at the Patchogue Staging Area repeatedly announced incomplete and misleading information to bus drivers about the dose levels at which they should call in (Suffolk Ex. 95, at 132; FEMA Ex. 1, at 68);
- -- The bus Transfer Point Coordinator at Brookhaven National Laboratory Transfer Point directed one bus driver to proceed to the EWDF despite an earlier message transmitted by the Bus Dispatcher to all Transfer Point Coordinators requesting that all drivers arriving before 16:00 be directed to the Reception Center (Suffolk Ex. 95, at 133; FEMA Ex. 1, at 65);
- -- At 9:19 the LERO Manager was informed that no County resources would be available to assist in the Exercise, with confirmations coming at 10:15, 10:26, and 10:36. Despite this fact, the Evacuation Coordinator recorded in his log at 9:20 that the SCPD had offered its assistance on traffic control, and between 10:02 and 10:15 the Traffic Control Coordinator informed the staging areas that they should expect a large number of SCPD officers to report for briefing. This misinformation was transmitted to Lead Traffic Guides, Dosimetry Recordkeepers, and various other staging area personnel. The erroneous information was finally corrected sometime between 10:26 and 10:50 (Suffolk Ex. 95, at 133-34).

Suffolk's witnesses testified that communication problems have occurred repeatedly during post-Exercise drills. For example, during the June 6 drill LERO personnel relayed inaccurate information about the location of a traffic impediment, as occurred in the Exercise, again resulting in delays in responding to that impediment. <u>Id</u>. at 139-40; Suffolk Ex. 96, Att. 7 at 5. In our discussion of Contention EX-50B, we have already noted that a similar situation occurred during the December 10 drill. There were also delays in issuing EBS messages in the June 6 drill. For example, the EBS message announcing the Alert was not broadcast until 48 minutes after the Alert was declared, which resulted in the early dismissal of schools being delayed, and the EBS message informing evacuees of the road impediment was not broadcast until 45 minutes after the simulated accident had occurred. Further, it took LERO 25 minutes to issue the EBS message for the General Emergency after the decision to initiate protective action. Suffolk Ex. 95, at 140; Suffolk Ex. 96, Att. 7 at 2, 4-5.

During the September 10 drill, the EBS messages for the traffic impediments were slow in being generated, and the messages were ambiguous and not concise. Suffolk Ex. 95, at 141; Suffolk Ex. 96, Att. 8, at 2. Further, there was approximately a 1/2 hour delay by the Road Crew Communicator in getting the message transmitted to respond to one of the road impediments. Suffolk Ex. 95, at 141-42; Suffolk Ex. 96, Att. 8, at 3. Moreover, the dose assessment staff at the EOC and the dose assessment staff at the EOF had problems communicating. According to the Impell report, "the lines of communication for technical data was (sic) almost nonexistent." Suffolk Ex. 96, Att. 8, at 3; Suffolk Ex. 95, at 141-42. At the Riverhead Staging Area it took 20 minutes for a message from the EOC to go from the Administrative Support Staff to the Lead Traffic Guide, as a result of which the dispatch of Route Spotters was delayed. Id. at 142; Suffolk Fx. 96, Att. 8, at 5. A Road Crew from

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the Port Jefferson Staging Area dispatched to respond to a traffic impediment never arrived at the impediment site. Id.

During the September 17 drill, information flow from a Staging Area to the EOC needed improvement. Messages were often left on the communicator's desk for 10 to 15 minutes before they were transmitted to the proper individual at the EOC. Suffolk Ex. 95, at 143; Suffolk Ex. 96, Att. 8, at 6-7. In addition, the message from the EOC indicating that an alert had been declared was sent at 10:38, after the alert was declared at 10:14. Suffolk Ex. 8, at 143; Suffolk Ex. 96, Att. 8, at 7. Another communications problem was the fact that telephones of key coordinators would go unanswered when they were at staff meetings. Suffolk Ex. 95, at 143. Finally, LERO personnel often failed to use message forms; as we have already noted, many messages were written on plain paper and later transcribed onto message forms, which resulted in delays and the transmission of erroneous information because of transcription errors. Id.

Communication problems recurred during the October 1 drill. The distribution of RECS messages from the Patchogue Staging Area to the EOC staff was very slow. Suffolk Ex. 95, at 144; Suffolk Ex. 96, Att. 8, at 11. A message from the EOC to the Staging Area concerning failed sirens was sent at 9:48. Apparently because of inefficient message handling at Patchogue, however, the Route Alert Drivers were

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not dispatched until 10:25. The message to dispatch traffic guides at the Port Jefferson Staging Area was not transmitted until 13 minutes after the decision to recommend evacuation was known to the EOC personnel. Id. Moreover, three separate dispatch messages arrived in the Staging Area within a few minutes of each other, causing confusion and further delaying the dispatch of the Traffic Guides. Suffolk Ex. 95, at 144; Suffolk Ex. 96, Att. 8, at 11-12. The message to dispatch the bus drivers did not reach the Riverhead Staging Area until 13:30, despite the fact that a release of radiation had occurred at 12:35, and even then only after the Riverhead Bus Dispatcher had requested it from the EOC. And the Staging Area was not told of the 12:35 . elease until 13:40; thus the bus drivers were dispatched into the plume without knowledge of it. Suffolk Ex. 95, at 144; Suffolk Ex. 96, Att. 8, at 12.

The Impell Report on the September and October drills came to the following conclusions with regard to communications:

> One of the major areas of concern during this drill series continues to be the communications between the EOC and the Staging Areas. Long delays in getting information to the Staging Areas were experienced throughout the drills. Much more emphasis needs to be placed on communications, both in accuracy and timeliness.

> Delays in the response by the Staging Areas can be traced back to delays in transmitting information or instructions by the EOC. The information flow from the EOC to the ENC also proved to be [the] major deficiency in one particular drill. It

appears that the common denominator in communications delays is the EOC, and emphasis must be placed in training that facility.

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Another area of communications that has been a problem in the past, and is still a problem with certain shifts, is the communications link between the EOC and the EOF in the area of dose assessment. The exchange of information from the EOF to the EOC needs to be improved. This will continue to be examined in future drills where the EOF and EOC are both participating.

Suffolk Ex. 96, Att. 8, at 13-14.

Problems with communications also occurred during the drills on December 2 and 10. During the December 2 drill, as we noted in our discussion of Contention EX-50B, approximately 20 percent of the players wrote messages on scraps of paper rather than on standard LERO message forms. Suffolk Ex. 95, at 145; Suffolk Ex. 96, Att. 9, at 3. Also the EOC issued status reports containing conflicting information. Suffolk Ex. 95, at 145; Suffolk Ex. 96, Att. 9, at 4. Further, EOC personnel receiving calls for/about LERO workers did not return the confirmations of delivery of the messages to Family Tracking pursuant to procedures but were instead returning them to the original caller. Procedures call for the EOC to deliver the messages to Family Tracking; Family Tracking will then make the confirmatory call after the message has been delivered to the LERO worker. Suffolk Ex. 95, at 145; Suffolk Ex. 96, at 12.<sup>52</sup>

The December 10 drill scenario included four road impediments, and communications problems arose in LERO's response to two out of the four. The most serious problem involved a pretended brush fire on the Long Island Expressway (LIE); information in the internal communications about the brush fire changed as the message was transmitted through the LERO organization. The initial message stated that the brush fire was causing a complete blockage of the east and westbound lanes of the LIE and also the north and southbound lanes of Patchogue-Mt. Sinai Road. The Lead Controller at the EOC decided to initiate the message at the ENC rather than EOC as the message dictates. When the

<sup>&</sup>lt;sup>52</sup>Some Traffic Guides were more than an hour getting to their TCPs, a fact which Suffolk's witnesses attribute to untimely communications. It is not clear from the record, however, that the delayed arrivals of Traffic Guides during the December 2 drill resulted from communication delays. Suffolk Ex. 96, at 20. In addition, Suffolk's witnesses discuss three Traffic Guides who were unable to communicate with their Staging Areas. The record is not clear, however, as to the cause of this inability to communicate. Finally, one TCP could not be reached with a re-routing message by either the EOC, Port Jefferson Staing Area, or an adjacent TCP. The Traffic Guide at that TCP reported later that he had attempted to radio the Staging Area to verify his re-routing responsibilities but could not get through because the frequency was busy. Id. These communication failures are certainly communications problems, but it is not clear that they resulted from inadequate training.

information was transmitted at 09:30 from the ENC to the LERO EOC, the information on which roads were blocked was omitted. After being prompted by the Public Information Controller, the Public Information Group in the ENC recontacted the EOC at 09:42 with the complete information. Then at 10:25 the Patchogue Traffic Controller, simulating a Route Spotter, reported that only the westbound lanes of the LIE were blocked. Suffolk Ex. 95, at 146-47; Suffolk Ex. 96, Att. 9, at 4. The other impediment about which LERO had problems communicating was a simulated duck truck accident. The message was introduced to the ENC at 12:00, and again the ENC transmitted erroneous information; this time it incorrectly stated that the EOC was already aware of the impediment. After being prompted by the Public Information Controller, the ENC gave the message to the Evacuation Coordinator at 12:23. At 12:52 he called for a Road Crew to remove the impediment. The Road Crew did not arrive at the scene until 13:53, and the duck truck was moved from the road at 14:00. In this drill the evacuation recommendation was issued about 12:54. Since the impediment occurred prior to the evacuation recommendation, LERO did not respond promptly because it initially considered the

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duck truck to be a Suffolk County problem.<sup>53</sup> Suffolk Ex. 96, Att. 9, at 10; Tr. 5793-97.

Suffolk's witnesses concluded that the recurrence of communications problems and the repeated instances of communication failures, in spite of dress rehearsals, drills, and tabletops over a period of three years, demonstrates that LILCO's training program has been ineffective in training personnel to communicate properly. Moreover, the repeated instances of communications failures show a failure to instill necessary communications discipline, which also indicates a flawed training program. They conclude that the Exercise demonstrated fundamental flaws in LILCO's training program, and that nothing since the Exercise leads to any different conclusion. Suffolk Ex. 95, at 148.

<sup>&</sup>lt;sup>53</sup>The December drill report gives a generally more favorable impression of LERO's performance than the reports on the June, September, and October drills. The earlier reports were all prepared by the Impell Corporation, under contract with LILCO. The December drill report, on the other hand, was prepared by an in-house consultant for LILCO, working full-time for and under the supervision of LILCO. Tr. 5739-41. When asked why LILCO had changed contractors, LILCO's witness Daverio answered that it was his understanding that LILCO's Emergency Preparedness Division wanted to have "more input and control in formulating the report." Tr. 5740. Suffolk's witness Cosgrove testified that many negative comments that were in the observer reports from the December drill never got into the December drill report. Tr. 6739.

Suffolk's witnesses argue that timely, accurate, and common sense communications provide the backbone of a successful response to an emergency situation. Such communications are important not only in terms of the abilities of emergency response personnel to perform their tasks, but also in terms of the media and the public having confidence in those responses. Successful communications depend upon detailed training and extensive learning by doing. Suffolk Ex. 95, at 136. The police witnesses attested that for police personnel, effective communication is perhaps the most difficult task to be learned, requiring repeated learning by doing experiences before an adequate proficiency is reached.<sup>54</sup> Id. at 136-37.

LILCO's witnesses argue that the contentions cited as having bases that support Subcontention EX-50C are actually

<sup>&</sup>lt;sup>54</sup>As experienced trainers, the police witnesses were able to describe how police recruits are taught to communicate successfully. One technique that has been used effectively in training recruits in proper communication skills involves having the instructor tell one recruit a story involving numbers, dates, etc. This recruit then tells the story to a second recruit, who tells it to a third recruit, and so on. The entire process is videotaped. The results the first time recruits go through this process are distortion of critical information due to inattention to detail and failure to listen carefully. The recruits learn the consequences of these mistakes. The needed communication skills are emphasized through frequent, almost daily, role-playing, drills, and written exercises. Through training of this type, the recruit learns both the proper methods of communicating and the consequences of improper communication. Suffolk Ex. 95, at 137 n.58.

irrelevant to whether the Exercise revealed a flaw in the training program which renders LERO personnel incapable of communicating effectively. With regard to Contention EX-45, which was consolidated with Contention EX-50, LILCO's witnesses argue that not one of the eight subparts of the contention supports the allegation that the training program failed to train LERO personnel to communicate effectively. LILCO EX-50 Testimony at 45. Subcontention EX-45A alleges that the delay in responding to traffic impediments resulted from communication failures. LILCO ascribes the delay to: (1) the fact that the Evacuation Route Coordinator failed to transmit all of the information contained in the free play messages to staging area and field personnel, and he failed to inform co-workers and superiors in the EOC of the impediments; and (2) the manner in which FEMA introduced the free play messages. Id. at 45-46. LILCO's witnesses argue that LERO responded appropriately to the traffic impediments and therefore the responses do not reflect adversely on the communication training program. Id. at 46.

LILCO's witnesses acknowledged that there was a problem in communication, but they argued that it should not be blamed entirely on deficient training. LILCO argued further that the Evacuation Route Coordinator's actions were not really inconsistent with his procedures, but resulted from the fact that he failed to appreciate the severity of the accident and what the consequences were, and also initially he took the message of be a rumor. They acknowledged, however, that he should have communicated information about even the suspected impediments to his superiors and co-workers. Moreover, LILCO attributes the delays in communications about the impediments to artifacts of the scenario and FEMA's unrealistic simulation; they argue that in the real world information about the accidents would have been communicated back to the EOC by LERO workers in the field who saw the accidents, which would have resulted in a more timely response. LILCO EX-50 Testimony at 36-38; Tr. 966-68, 973-74, 5497-98, 5549-52; also see LILCO's proposed findings at 164.

With regard to the free play message requesting dispatch of a bus to pick up students at the Ridge Elementary School, LILCO's witnesses testified that the bus driver was dispatched at 11:23, 33 minutes (rather than 40 minutes) after the Special Populations Bus Dispatcher received the request. LILCO believes that this was not an inordinate delay considering that the Dispatcher was concurrently handling the dispatch of approximately 44 other vehicles. The driver, after picking up his bus, arrived at the school at 12:14. He then traveled to the Nassau Coliseum Reception Center where he arrived at 13:51. LILCO EX-50 Testimony at 46-47. The Public School Coordinator at the EOC called the school Superintendent (simulated) at 11:28 and requested that the Superintendent call him when

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the bus arrived. After waiting for the call from the Superintendent until 13:23, the Public School Coordinator again called the Superintendent (simulated) who confirmed that the bus had already arrived and had left for the Reception Center. The Public School Coordinator called the Reception Center at 16:11 requesting confirmation. LILCO's witnesses argue that it is not surprising that the Reception Center personnel called the Public School Coordinator at 16:23 to tell him that they could not confirm the arrival of the bus, because the bus had come and gone three hours earlier. Id. at 47. LILCO's witness does not believe that the failure of the Reception Center personnel to advise the EOC of the arrival of the bus was a communications breakdown because the Reception Center personnel were unaware that the bus had arrived. Tr. 5564-65. There was nothing to distinguish that particular bus from the other buses that arrived at the Reception Center. LILCO EX-50 Testimony at 47-48.

With regard to the alleged failure of LERO to notify the FAA and the LIRR, LILCO's witnesses testified that the Evacuation Coordinator did contact the FAA, but the number listed in the procedure was "not the best number to call." Procedures existing at the time of the Exercise did not call for notification of the LIRR. Since the Exercise, procedures for notifying the FAA have been modified and procedures for notifying the LIRR have been included in the

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Flan. Id. at 48; Tr. 5571-74. FEMA found that the confusion regarding the method for notifying the FAA and the absence of procedures for notifying the LIRR were ARCAs, and stated that procedures should be reviewed and revised and the LERO staff trained accordingly. Tr. 5574; FEMA Ex. 1, at 29, 39. Thus, LILCO's witnesses do not consider this situation to result from a training problem. Tr. 5574.

With regard to the Director sometimes not being available to answer the RECS telephone, LILCO's witness Daverio testified that FEMA was wrong because the FECS phone isn't in the command room. Tr. 5575. FEMA mentioned both the RECS phone and the dedicated telephone, however, and the dedicated phone is in the command room. Tr. 5576; FEMA Ex. 1, at 42. The witness does not believe any urgent calls came in on the dedicated line while the Director was absent. Tr. 5576. Moreover, LILCO believes that had an urgent call come in, the caller would have stated that the call was urgent. LILCO EX-50 Testimony at 176. LERO has not changed any procedures to respond to this problem, even though as we noted, <u>supra</u>, FEMA judged it to be an ARFI. Tr. 5577; FEMA Ex. 1, at 42.

Finally, LILCO attributed the misinformation about assistance from the Suffolk County police to FEMA. LILCO's witnesses testified that FEMA personnel simulating Suffolk County personnel gave inconsistent input to the LERO EOC. LILCO EX-50 Testimony at 50-51. LILCO's witness Behr

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testified that he was in the command cell and observed the confusion, which he stated was caused by the simulators and also possibly by a "lack of consistency" by the FEMA Controller who, he opined, really did not know what their position was going to be on the issue. Tr. 5587. Because of confusion coming from the county executive simulator and the Suffolk County Police simulator, at one point the Lead Controller in the command cell stopped operations in the command cell to make sure it was clear to everybody what FEMA's position was on the use of Suffolk County Police for LERO emergency response activities during the Exercise. Tr. 5588. At that point it was communicated to the EOC that the information about police assistance had been wrong and that the police would be used only for crime control. Tr. 5589-90.

LILCO's witnesses also testified on the post-Exercise drills. The drills are analyzed to evaluate the effectiveness of the LERO organization and to determine whether changes in procedure or training need to be made. They also serve as training experiences for the LERO personnel. Tr. 5733-34. The witnesses testified that in general they did not dispute the statements in the drill reports, although they might find individual comments that they felt were overly critical. Tr. 5745.

LILCO's witnesses do not take issue with Impell's conclusion from the September and October drills that

emphasis must be placed on training the EOC to communicate in a more timely manner. Tr. 5770, 5772. During the October drill information flow from the EOC in accident status reports was not timely, as a result of which field personnel were working with information and data that was up to 30 minutes old. Ir. 5767-69. The witnesses also agreed t t LERO took too long to issue EBS messages during some of t ..... 'ills, notably the June 6 drill, although they noted that we shift that participated in the June 6 drill did a better job issuing EBS messages during the October 1 drill. Tr. 5750-51. The time required to dispatch Traffic Guides has been too long because the Traffic Control Point Coordinator must refer to the OPIP and, based on the protective action recommendation, make a list of the zones to be evacuated; he then gives the list to the Evacuation Support Communicator who transmits the information to the staging area. An additional delay may result from messages backing up at the communicator's desk. To try to solve this problem, LERO intends to have the administrative support staff transmit information directly to the staging areas rather than turning them over to the communicator when a backup occurs. This practice may sometimes cause a problem, however, such as occurred in the October 1 drill when three messages reached a staging area at the same time. Tr. 5763-64, 5780-83.

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LILCO's witnesses were unable to explain why the Road Crew dispatched from Port Jefferson to an impediment during the September 10 drill never arrived at the impediment site. When asked whether they could identify the people who were on the missing Road Crew, the witnesses answered that they thought they could do that but apparently no one had done so. Tr. 5786-87. Similarly, the witnesses were unable to explain why, during the December 2 drill, a Traffic Guide took 75 minutes from dispatch at Patchogue to reach his TCP. Tr. 5810, 5813. They testified that this was another problem that LERO intended to attack in the coming months. Id.

FEMA's witnesses attested that they agreed with the facts presented in Contention EX-45, but in many instances they disagreed with the conclusions or analyses presented in the contention. Tr. 8251. They believe that the FEMA Report accurately reflects the seriousness of the problems it identified, whereas the contention in many cases goes beyond that. Id. The root of the Deficiency which FEMA identified as causing LERO's delayed response to the impediment free play messages during the Exercise was the performance in the EOC. FEMA Ex. 5, at 75; Tr. 8252. The poor performance involved a failure in communicating information about the impediments to the Evacuation Coordinator in a timely manner, and a lack of internal communication in that pertinent information was not included

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in messages from the Evacuation Route Coordinator to the Evacuation Support Communicator for Route Spotters/Road Crews. Thus the root of the deficiency was failed communications in the EOC. FEMA's recommendation for correcting the Deficiency included additional and improved training. FEMA Ex. 1, at 39.

Several of the ARCA's identified by FEMA likewise involved communication, and in two of those additional or different training was recommended by FEMA as all or part of the corrective action. The confusion regarding the notification of the FAA was identified as an ARCA, and FEMA recommended that the EOC staff be trained so that the FAA can be notified in a timely manner. Id. The failure to notify the LIRR was also identified as an ARCA, and part of the recommendation to correct it was training the EOC staff in revised procedures so that the LIRR can be notified in a timely manner. Id. at 39-40. Another ARCA which resulted at least partially from a failure in internal communication was that given because of the delay in the dispatch of Route Spotter #1005 to verify the fuel truck impediment. FEMA's recommended corrective action involved training personnel in the development of alternative approaches when delays are anticipated, with consultation between at least the Evacuation Coordinator and the Evacuation Route Coordinator. Id. at 41.

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The NRC Staff, in its proposed findings, found that the evidence adduced with regard to LERO's response to the evacuation impediments supports Suffolk's Subcontention EX-50C. Staff proposed finding 470, at 170 77. The other situations described by Suffolk as being examples of inadequate training in communication, however, do not, in Staff's view, support Subcontention EX-50C. But in its consideration of EX-50C, Staff did not address the communication failures which have recurred during the post-Exercise drills.

Conclusion on Subcontention EX-50C. LERO EOC and/or ENC personnel failed to communicate accurate and complete information about roadway impediments not only during the February 13, 1986 Exercise, but also during the June 6, 1986 drill and again during the December 10, 1986 drill. This recurrence of a problem which produced a Deficiency in FEMA's assessment of the Exercise strongly suggests that LILCO's training in the area of communications, at least, is woefully inadequate in that it has failed to teach LERO personnel how to improve their performance.

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Other less serious, but nonetheless bothersome, communication defects likewise persisted during post-Exercise drills. For example, internal communication between the EOC and one or more staging areas was often slow and occasionally erroneous or incomplete during the June 6, September 10 and 17, October 1, and December 2 and 10

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drills, as well as during the February 13 Exercise. Communication between the EOC and the EOF in the area of dose assessment was poor during the September and October drills. Some important EBS messages were slow to be geverated during at least the June 6 and September 10 drills, as well as during the Exercise.

LILCO argued that the communication problems during the Exercise, to the extent that they were attributable at all to LERO, resulted from poor judgment on the part of their Evacuation Route Coordinator. SRO shift 1, which participated in the February 13 Exercise, participated in only the December 2 and 10 drills. Shift 2 participated in the June 6 and October 1 drills and shift 3 participated in the September 10 and 17 drills. The fact that shift 1 demonstrated the same kind of communication problems in Ducember 1986 that they demonstrated in February 1986 indicates that either the training program taught them little about effective communications between February and December, or that the EOC personnel on shift 1 are incapable of learning. The fact that the same kind of communication problems occurred in other drills, on the other hand, suggests that the level of training in other shifts is comparative to that in shift 1. The conclusion that must be drawn that the raining program as conducted before and sir sir the failed to teach LERO personnel how to con a information effectively.

Because the consequences of poor communication during the Exercise resulted in a finding of a Deficiency by FEMA and a Fundamental Flaw by us, and because we agree with Suffolk's witnesses that timely and accurate communications provide the backbone of a successful emergency response, we conclude that LILCO's training program is fundamentally flawed in the area of communications. We recommend that LILCO institute a training program in emergency communications modeled after that described in footnote 54, supra.

## 8. Subcontention EX-50D

Subcontention EX-50D alleges that the Exercise demonstrated that LILCO's training program has not successfully or effectively trained LERO personnel to follow directions given by superiors during an emergency. Suffolk Ex. 96, at 148; LILCO EX-50 Testimony at 51. As bases for the allegation, the subcontention cites several other contentions and a number of the findings in the FEMA Report. Suffolk Ex. 96, at 148; LILCO EX-40 Testimony at 51.

Suffolk's witnesses testified that they were not in a position to agree or disagree with the contention because of insufficient data. They cited two examples of LERO workers failing to follow directions: (1) bus drivers who failed to read their dosimeters every 15 minutes in spite of directions to do so, and (2) a Transfer Point Coordinator

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who directed a bus to go to the EWDF in spite of instructions to direct buses to the Reception Center. On the basis of the deca available to them, the witnesses testified that they could not provide additional bases to support this subcontention. They stated, however, that their lack of support for the subcontention should not be construed as constituting an agreement that LILCO's training program has been successful in this regard. Suffolk Ex. 96, at 149-50.

LILCO'S witnesses, citing as an example FEMA'S favorable evaluation of the performance of the Port Jefferson Staging Area Coordinator, argue that good performance by supervisors must mean that those they are supervising are following their directions. See FEMA Ex. 1, at 56. They also argue that the fact that LERO succeeded in deploying approximately 1000 workers indicates that LERO personnel are correctly responding to directions. LILCO EX-50 Testimony at 51-52. The few instances of failure of LERO workers to follow directions cited by the Intervenors are, in the opinion of LILCO, isolated, minor incidents that do not demonstrate a flaw in the LILCO training program. Id. at 53-54.

Staff likewise does not believe that enough incidents have been cited by Intervenors to support this subcontention. Staff proposed finding 476, at 178-79.

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Conclusion on Subcontention EX-50D. The parties are in agreement that there is insufficient evidence to support the allegation that LILCO's training program failed to teach LERO workers to follow the directions of their superiors. We agree; therefore we find Subcontention EX-50D to be without merit.

#### 9. Subcontention EX-50E

Subcontention EX-50E alleges that LILCO's training program has not successfully or effectively trained LERO personnel to exercise independent or good judgment, or to use common sense, in dealing with situations encountered during an emergency or in implementing the LILCO Plan and procedures. The subcontention cites several other contentions and the FEMA Report as providing bases and support for EX-50E. Suffolk Ex. 95, at 150.

Suffolk's witnesses stated that examples of failure of LERO workers to exercise independent or good judgment or common sense can be found in LILCO's inability to handle unanticipated or inrehearsed situations as discussed in EX-50A, as well as in EX-38/39. In addition, they cit: a number of other situations which they believe demonstrate a failure by LERC workers to use independent or good judgment or common sense. For example, they consider the failure of LERO personnel to obtain additional information about the gravel truck impediment, which recalled in LERO's

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dispatching a single tow truck that was incapable of clearing a loaded gravel truck from the roadway, to demonstrate poor judgment on the part of LERO players. Similarly for the fuel truck, LERO again failed to dispatch a truck that could have handled the job, again demonstrating poor judgment by the LERO personnel. <u>Id</u>. at 152; see FEMA Ex. 1, at 37, 65. Suffolk's witnesses cited still other examples of the exercise of poor judgment by LERO workers, as follows:

- -- The decision by the Evacuation Coordinator to choose a traffic rerouting strategy without consulting persons familiar with the roadways in the area of the impediments, which resulted in a decision to employ an illogical rerouting strategy. Suffolk Ex. 95, at 153.
- -- A field monitoring team stopped to report dose assessment data while still within the plume. Id.
- -- A simulated evacuee who had been found to have contaminated hands while being monitored at the Reception Center was advised to put on rubber booties before he was advised to put on anticontamination gloves. Id.
- In response to an inquiry from a person who had trucks going to Suffolk about how extensive the evacuation would be, a LERO Call Board operator advised that the only protective action was closing of schools, and that evacuation had not been recommended. Suffolk contends that it would have been better judgment to have as few people and vehicles as possible in the EPZ and suggests that it would have been more appropriate had the operator exercised such judgment independently. Id. at 154.
- -- In response to an inquiry whether lobsters caught that morning on the Shoreham jetty were safe to eat, a Call Board operator responded at 12:28 that there were no data to indicate that anything would be wrong with the lobsters. Suffolk contends that

a response advising caution would have shown better judgment, and that giving a response without even asking what time the lobsters had been caught demonstrated a further lack of judgment and common sense. Id. at 155.

-- In response to a simulated call from Dan Rather, who wanted to take a TV crew to the SNPS, the LERO responder advised against going to the plant because "You will be in the way" and then gave directions to the plant. Suffolk contends that the fact that the responder advised against going to the plant yet told Rather how to get there demonstrates poor judgment and lack of common sense. Id. at 155-56.

- -- LERO's failure to contact the LIRR in order to tell the railroad to divert its trains from the EPZ resulted from a failure by LERC personnel to use independent judgment. Id. at 156.
- -- The Emergency News Manager delayed opening the ENC from 8:08 to 8:25 because one apparently nonessential staff member had not arrived. He showed pocr judgment in delaying the operation of the ENC until roll call had been completed. Id.
- -- Although the EBS message ordering evacuation of the entire EPZ was broadcast (simulated) at 12:00 and the LILCO spokesperson in the ENC received this information at 12:22, she waited until the 12:47 press briefing to release this information to the press. Suffolk contends that there was no reason for this delay, which reflected both poor judgment and defective training. Id. at 156-57.
- -- Another error in judgment was displayed in the ENC when Dr. Brill from Brookhaven National Laboratory, whom LILCO had available in the ENC, told reporters that he would not follow LERC's evacuation recommendation. Id. at 157.
- -- Suffolk contends that LILCO showed poor judgment in not checking the compatibility of the electrical system in the ENC with the copying equipment to be used there in advance of the graded exercise. Moreover, given the failure of the copying machines. LERO personnel in the ENC showed poor judgment by not attempting to compensate for the useless copying machines by

relaying information from the EOC to reporters orally. Id. at 157-58.

-- Finally, the public information staff at the EOC displayed poor judgment in preparing EBS messages by filling in the "sample" fill-in-the-blank EBS message contained in the LILCO Plan, which resulted in unintelligible or confusing messages. Common sense and good judgment dictated the rewriting of the messages to tailor them to specific situations. Id. at 158-59.

Suffolk's witnesses attested that their review of LILCO's training program indicated that the training program was so procedure-specific that LERO workers are taught, if anything, not to use independent judgment. Suffolk's witnesses believe emergency personnel must be taught to think on their own, because to be able to handle unexpected occurrences, emergency response personnel must be able to "think on their feet." Id. at 159-60.

LILCO's witnesses testified that LERO's training program is not intended "to train a group of free thinkers; LERO personnel, particularly in non-management roles in LERO, are to implement the Plan, not develop <u>ad hoc</u> responses in the field." LILCO EX-50 Testimony at 55. Further, they believe that many of the examples of use of poor judgment or lack of common sense cited by Suffolk from other contentions or in remarks by FEMA were not, in fact, examples of such. Rather, the LILCO witnesses believe that LERO's response to the traffic impediments demonstrated, in several instances, the use of good judgment in response to unanticipated events; they noted as examples the Traffic Guide who called for traffic cones and another Traffic Guide at his TCP; the telephone calls to Hess Oil Company and the Miller Piece Fire Department; and the dispatch of a Route Mert Driver to monitor the radiation exposure of fire department personnel. Id. at 56.

LILCO'S public information consultant Dr. Mileti testified that he believed people could be trained to use better and more informed judgment and probably independent judgment. He did not think you could teach people common sense, however; either they have it or they don't, in his view. Tr. 5169-70. He agreed that flexibility was important in an emergency response organization, because in an emergency, circumstances arise when workers need "to exercise good judgment and not go by the letter of the book." Tr. 5170-71.

FEMA witnesses Keller and Baldwin agreed that the failure of LERO personnel to contact the LIRR showed a lack of independent judgment, although they acknowledged that the Plan did not call for notification of the railroad. Tr. 8273-74. Witness Baldwin added that it would have been good judgment for LERO to notify the railroad, even though such notification was not called for in the Plan. Tr. 8274. It is FEMA's position that this inadequacy, as with most of the Exercise inadequacies which it identified, is attributable to a breakdown in the LILCO training program. FEMA Ex. 5, at 73.

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The NRC Staff accepted FEMA's findings on Contention EX-50E and stated that LERO failed to show redundancy and diversity in its response to the road impediments. Staff proposed finding 444, at 167.

Conclusion on Subcontention EX-50E. We conclude that the weight of the evidence supports Suffolk's contention that LERO workers are not adequately trained to use independent and good judgment in response to unanticipated events. LILCO itself admits that its training program is intended to teach LERO workers to implement the Plan and not to make ad hoc decisions during an emergency. We are convinced, however, that situations would arise during a radiological emergency at SNPS that could be dealt with effectively only if the emergency workers are able to make good, independent judgments and ad hoc decisions. Professional emergency workers, such as the police, are certainly required to make independent, ad hoc decisions. LILCO should expect the same for its emergency workers. LILCO's training program should be modified to teach LERO personnel that they can and should exercise independent judgment and common sense when faced with unanticipated events that require a prompt, effective response.

### 10. Subcontention EX-50F

Subcontention EX-50F alleges that the Exercise demonstrated that LILCO's training program has not

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successfully or effectively trained LERO personnel to deal with the media, or to otherwise provide timely, accurate, consistent, and nonconflicting information to the public through the media during an emergency. Several contentions and comments by FEMA are cited as supporting Subcontention EX-50F. Suffolk Ex. 95, at 166. Suffolk's witnesses stated that they would cite only several examples of exercise events that support the subcontention; other examples, they said, are considered under Subcontention EX-38/39. <u>Id</u>. at 167.

The first example presented by Suffolk dealt with the time of activation of the ENC. Although the first EBS message was broadcast at 6:52, it was not until 8:25, an hour and a half later, that the ENC became operational. Suffolk's witnesses believe that the media would have begun pressing LILCO for information shortly after the 6:52 EBS broadcast, and that the delay would probably have resulted in confusion, speculation, rumor generation, and a lack of confidence in LERO's ability to deal with the emergency. Id. They argue that LERO's an hour and a half delay in setting up the ENC reflects a lack of adequate training and a "substantial lack of good judgment." Id. at 168.

Suffolk's second example was LERO News Release No. 1, announcing an Alert Condition and stating that there had been no release of radiation; this announcement was made at 8:21. At 8:19, however, the ENC had been informed that a

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Site Area Emergency had been declared, that a minor release of radioactive material had occurred, and that LILCO recommended that dairy animals be placed on stored feed. Suffolk's witnesses think that the short time between the ENC's notification of the Site Area Emergency and the issuance of News Release No. 1 makes it somewhat explainable that News Release No. 1 reported the earlier condition. Id. That they consider inexcusable, however, is the fact that no prompt correction was released; the Site Area Emergency and radiation release was not made known to the press until the issuance of News Release No. 2, which still had not been released to the press as of 9:15. LERO News Release No. 3 was received at the ENC at 10:15, but it was not posted for the press until 11:10. News Release No. 4 was received at 10:45, but was not posted until 11:56. News Release NO. 5, which covered the 10:24 evacuation recommendation for zones A-M, Q, and R, was approved by the Director at 11:02 but did not arrive at the ENC until 11:36, and was made available to the press some time later. Id. at 169. News Release No. 6 was approved by the Director at 12:25 but was not posted until 2:10, and Release No. 7 was approved by the Director at 1:11, received by the ENC at 1:47, but was not posted until 3:07. Finally, although the decision to evacuate the entire EPZ was reached by the Director at 11:46 and announced in an EBS message at 12:00, the ENC did not inform

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the media of the decision or the content of the EBS message until 12:47. Id. at 170.

Suffolk's witnesses argue that these examples demonstrate that LERO personnel were unable to provide timely, accurate, consistent, and nonconflicting information to the public through the media. They believe that during an emergency the ability to provide timely and accurate information to the media is essential to ensure that the public is kept informed concerning the status of the emergency and the protective actions being recommended. The witnesses suggest, further, that fear of nuclear hazards could cause the public to react irrationally if it is not kept informed and up-to-date regarding the status of the emergency. Id. at 170-71.

The police witnesses testified that they frequently confront situations in which immediate media contact is likely, and therefore they have trained respondents to deal with the media on a rapid basis. From experience with natural disasters, hostage-taking situations, and technological disasters such as chemical spills, the police witnesses attested that the media immediately seek out officials who are in charge and demand information from them about what has happened and what to expect in the future. If the officials are not prepared to respond immediately, the media publicize the lack of preparation and seek other, potentially unreliable, sources of information. Id. 4t 172.

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Suffolk's witnesses testified that from their review of the documents, LERO personnel had no understanding of how important it was to have the ENC in operation at the earliest possible time or consider a meaningful alternative means of communicating with the media prior to ENC activation. They believe that this lack of understanding by LERO personnel demonstrates that LILCO's training has been inadequate. Adequate training would have stressed to LERO parsonnel the need to take charge of information flow to the news media almost from the minute the first EBS message was broadcast. <u>Id</u>. at 173. Suffolk believes that the exercise revealed that LERO personnel had not been trained to realize or understand the importance of appearing to be a credible source, or how one goes about presenting that image to the media. Id. at 174.

Suffolk's witness Colwell testified that he had personally held numerous local, state-wide, and national news conferences, and that he had appeared "live" on national news networks, where he was interviewed concerning events such as aircraft hijackings, kidnappings, shooting incidents, fugitive apprehensions, bombings, and major legal cases such as ABSCAM. He stated that if a spokesperson for a news disseminating organization is to be effective, the spokesperson must instill a sense of confidence that full disclosure is being made. Once the media believe that the most current and accurate information is not available at

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the news center, they will leave to pursue other lines of inquiry and other sources. <u>Id</u>. at 181-82. In addition witness Colwell pointed out that the ability to deal effectively with the media could be gained only through experience or through extremely realistic role-playing exercises, and that in these simulated situations the role-player should be put under pressure because he will be under intense pressure from the media in a real emergency. He stated that the media in this country are known for, and pride themselves on, asking the hard questions and refusing to be put off by vague or ill-informed answers. <u>Id</u>. at 182-83.

Finally, witness Colwell attested that while he was unaware of the specific training that the LILCO spokesperson had received for her job, nevertheless her performance during the Exercise indicated that the training had been inadequate. He testified that the ENC continually lagged behind the EBS station in releasing information, at least in part because the spokesperson would await the next scheduled press briefing to release information rather than issue a news release immediately. Witness Colwell attested that he had viewed the ENC videotapes made during the Exercise, and that the spokesperson frequently appeared flustered by the questions she was asked. <u>Id</u>. at 183. In witness Colwell's opinion, the spokesperson's performance made it clear that, although she was the LERO spokesperson, she exhibited little

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understanding of the operational details of LERO, little access to higher levels in the organization and the information flowing from them, and little skill in establishing rapport with the media and effectively fielding their questions. Id. at 184-85.

LILCO's witnesses believe that the Exercise demonstrated that LERO personnel were capable of providing the public with timely, accurate information about the emergency. They attribute delays in transmitting information to the media to the breakdown of the copying machines at the ENC rather than to the training of LERO personnel, and they further state that there are now five copying machines available to the ENC. LILCO EX-50 Testimony at 57; Tr. 5652. The witnesses contend that the public was given accurate information directly and in a timely manner through the EBS messages, and the media received essential information through periodic news conferences held at the ENC by LERO and LILCO personnel. Id. at 57-58.

As we noted in our consideration of Subcontention EX-38, prior to activation of the ENC information could have been provided the press by the Corporate Communications Department (CCD), which maintains a telephone line that is covered 24 hours a day, seven days a week. See <u>id</u>. at 49-60; Tr. 3435-41. The role of the CCD in an emergency is described in EPIP 4-3. See Suffolk Ex. 47. In addition, in discussing EX-38, we noted that FEMA had concluded that activation of the ENC was done well. We agreed with FEMA, and we also concluded that other sources of information wou'd have been available to the media prior to activation of the ENC.

With regard to the lapse of time between issuance of the EBS messages and the news releases, we noted in our consideration of EX-38 that the first LERO News Release contained dated information at the time it was released, although FEMA did not consider this to be a serious problem. We also mentioned the fact that FEMA noted that there is no time requirement for the distribution of news releases.<sup>55</sup> FEMA's position is that news releases are of secondary importance because EBS messages are the primary means by which essential emergency information and instructions are communicated to the public. See FEMA Ex. 5, at 35.

Both Suffolk and FEMA criticized LERO for providing the press with hard copies of EBS messages which contained

<sup>&</sup>lt;sup>55</sup>FEMA's witnesses were uncertain whether the media were given the content of EBS messages verbally shortly after they were received by the ENC. The evaluator at the ENC stated EBS messages were received by phone at the ENC in a timely fashion, but there was a delay in getting hard copy posted in the press area. Tr. 7823-24. Our reading of the Exercise Evaluation Critique Form prepared by the ENC Evaluator suggests that EBS messages were not promptly read to the press. The Evaluator commented that the time "lag means that reporters do not have an accurate picture of the protective actions." Suffolk Ex. 101.

extraneous information marked for deletion. They thought that confusion might result. In our consideration of EX-38 we agreed with Suffolk and FEMA that the EBS messages should be cleaned up before being distributed to the press. The fact that they were not, during the Exercise, probably reflects an inadequacy in the training program.

It took the ENC 47 minutes following the first broadcast of the EBS message containing the evacuation recommendation to get that information to the press in a news release. Suffolk and FEMA agree that the media would have been informed of the evacuation recommendation via the EBS messages. We observed in cur discussion of EX-38 that upon thus learning about the evacuation, the media would have demanded more information from the ENC. But the media's confidence in the ENC would have been eroded, and it might even appear that the ENC was withholding information. LILCO's spokesperson should have made it a point to get the evacuation recommendation out to the press as promptly as possible. Her failure to do so probably reflects another inadequacy in the training program.

In its proposed findings the NRC Staff concluded that while the ENC lagged behind the EBS messages in giving out information, the media had the same access to EBS messages as the public and therefore it seems unlikely that confusion would have resulted from the lag. Staff proposed finding 483, at 180. Further, Staff believes that the detailed

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information that the spokesperson could not provide correctly was not essential information, and therefore there is no evidence that there was a failure to properly train the spokesperson. Staff proposed finding 474, at 180-81.

In our consideration of EX-38 we agreed with Suffolk that LILCO's spokesperson should have been able to respond to detailed questions about the fuel truck impediment, to the extent that details were contained in the free play message. FEMA took no position on this issue. We also found in our consideration of EX-38 that the LILCO spokesperson should have been able to relay accurate information about the gravel truck impediment; instead, she incorrectly reported that it had been cleared approximately 4<sup>r</sup> minutes before it was, in fact, cleared. The fact that the spokesperson was unable to respond adequately to questions about either roadway impediment probably results from inadequate training.

Conclusions on Subcontention EX-50F. The delays and inaccuracies in communicating information about exercise events to the media is undoubtedly another reflection of the inadequate training LERO personnel have received in communication skills. If and when LILCO follows the advice we offered, <u>supra</u>, regarding footnote 54, the ability and skill of the LILCO/LERO spokespersons in communicating with the media should improve.

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# 11. Subcontention EX-50G

Subcontention EX-50G alleges that LILCO has failed to provide training to persons and organizations who are not employed by LILCO but who are relied upon for implementation of the LILCO Plan. Suffolk Ex. 95. at 186; LILCO EX-50 Testimony at 59-60. Contentions EX-27 and EX-28 plus several EOC-ARCAS are cited as support for EX-50G.

Suffolk's witnesses cited the FEMA Report which assigned several ARCAs because bus drivers used for school evacuation had not been trained in dosimetry, because neither ambulette drivers nor the bus drivers had been trained in KI policy and the use of KI, and because neither ambulette drivers nor bus drivers used for school evacuation had been trained regarding who can authorize exposure in excess of the general public Protective Action Guides (PAGs). Suffolk Ex. 95, at 188-89; see FEMA Ex. 1, at 45-46.

Another example cited by Suffolk was the performance of Dr. Brill, LERO's scientist from Brookhaven National Laboratory, who appeared at the ENC press briefings and who (1) gave out technically incorrect information, and (2) contradicted the LERO evacuation recommendation when asked by the press what he would do given that recommendation. Suffolk Ex. 95, at 189. Suffolk alleges that LERO members in the ENC when Dr. Brill made the latter statement failed

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to correct it immediately. Suffolk argues that Dr. Brill's performance demonstrates that LILCO has failed to provide adequate training for non-LILCC employees who are relied upon to help implement the Plan. Id. at 190.

LILCO's witnesses testified that the ambulance and ambulette drivers had received training prior to the Exercise in radiological protective procedures. They attested, further, that their investigation of the problem noted by FEMA during the Exercise had determined that it resulted from attrition among drivers who had been trained. To combat this attrition problem, training of ambulance and ambulette drivers has been conducted monthly since the Exercise. LILCO EX-50 Testimony at 60; Tr. 5685-88. LILCO's witnesses also stated that while some school bus drivers had been trained before the Exercise, training of all school bus drivers had not been accomplished because only the Shoreham-Wading River School District was going to participate in the Exercise. They testified, further, that procedures were being developed to facilitate the participation of all school bus drivers in the radiological training sessions, but as of May 12, 1987, plans had been formalized with the Shoreham-Wading River School District only. LILCO EX-50 Testimony at 61; Tr. 5682-84.

FEMA's findings with regard to the allegations of Subcontention EX-50G were that dosimetry and training had not been provided to the school bus drivers, which was

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identified as an ARCA. FEMA found that some of the ambulette drivers were not aware of when to take their KI, which was identified as an ARCA. FEMA also found that school bus drivers had not been trained in KI policy, nor was the supply of KI for bus drivers sufficient; this, too, was identified as an ARCA. FEMA Ex. 1, at 45, 76. Finally, FEMA found that neither all ambulette drivers nor any of the school bus drivers had been trained regarding who can authorize exposure in excess of the general public FAGS; each of these inadequacies was identified as an ARCA. <u>Id</u>. at 46.

Staff does not consider the failure to provide dosimetry training to personnel belonging to organizations not participating in planning to be an inadequacy in the LILCO training program, although Staff acknowledges that it nevertheless could be a problem. Staff proposed finding 462, at 174-75.

Conclusions on Subcontention EX-50G. We agree with Suffolk that the training problems identified by FEMA resulted from an inadequate training program prior to the Exercise. Whether the post-Exercise training of ambulette drivers and the proposed training of school bus drivers will solve the problems remains to be seen. In its review of Revision 7 and 8 of LILCO's Plan (the February 13, 1986 Exercise was based on Revision 6) FEMA's Regional Assistance Committee (RAC) found that LILCO had adequately addressed the ambulette driver problem, but it found LILCO's response to training the bus drivers to be inadequate. Tr. 5688; see FEMA Ex. 3, at 16. Whether the problems cited in Subcontention EX-50G have been adequately solved must be demonstrated in another graded exercise.

### 12. Subcontention EX-50H

Subcontention EX-50H alleges that LERO personnel are not adequately trained in the area of dosimetry, radiation exposure control, KI use, understanding of radiation terminology, and related areas. Consequently LERO personnel cannot assist members of the public and non-LILCO personnel who are relied upon to help implement the Plan during an emergency as SNP, and who would expect LERO personnel to be able to respond accurately and effectively concerning these subjects. Suffolk cites Contentions EX-42 and EX-45 and several ARCAs identified by FEMA as providing support for Subcontention EX-50H. Suffolk Ex. 95, at 186-87.

Other examples cited by Suffolk in support of EX-50H were the following:

- A LERO Route Alert Driver who thought he would receive KI authorization in an EBS message. Id. at 192; see FEMA Report at xvi, 69-70.
- -- Traffic Guides at two TCPs who did not know dose authorization limits. Suffolk Ex. 95, at 193; see FEMA Report at 70.
- -- Traffic Guides at two TCPs who did not fully understand the chain of command for excess exposure authorization, plus some Traffic Guides

who indicated that they might question the authority of the Lead Traffic Guide to issue the authorization for excess exposure. Suffolk Ex. 95, at 193.

- -- Two of the eight Traffic Guides observed by FEMA who did not fully understand the difference between low-range and mid-rage direct reading dosimeters (DRDs). Id.; see FEMA Report at 76.
- -- The Patchogue Bus Dispatcher who misinformed bus drivers when instructing them via bull horn on how to read their dosimeters. Suffolk Ex. 95, at 193; see FEMA Report at 68, 69.

Suffolk's witnesses argued that these few examples are significant because of the small number of LERO workers observed by FEMA. They believe that the existence of so many training deficiencies in the small number of workers evaluated by FEMA suggests that such problems are widespread. Suffolk Ex. 95, at 193-94.

LILCO's witnesses contend, on the other hand, that Suffolk has cited only minor examples of individual failures, and argue that instances of field workers not reading the dosimetry or ingesting their KI would not impair protection of the public health and safety. They do not believe that these breaches in personal radiological procedures by LERO personnel individually or collectively demonstrate a flaw in the LILCO training program. LILCO EX-50 Testimony at 62. Nevertheless, because LILCO is concerned about the safety of its personnel, it has made several modifications in its personnel dosimetry and exposure control training to emphasize to trainees the importance of reading dosimetry, of knowing when to take KI, and of knowing who and by what means excess radiation exposure is authorized. Id.

LILCO's witnesses argue also that dosimetry and related areas are generally a problem at FEMA exercises because people find it difficult to remember detailed information that they rarely use. LERO's post-Exercise approach to correcting this problem has been to issue Identification Badges to all LERO workers to be worn on the outer garments for easy identification. On the back of the badges personal radiological protection procedures are listed for quick reference in the field. <u>Id</u>. Thus, eliminating the need to memorize dose limits plus increasing the emphasis in training on personal radiological procedures will, LIICO's witnesses believe, be an effective solution to the problem. <u>Id</u>. at 62-63.

LILCO'S witnesses also do not believe that Contention EX-42, one of two contentions cited by Suffolk as supporting Subcontention EX-50H, in fact supports EX-50H. LILCO points out that only subpart D of EX-42 is relevant. It notes that three Traffic Guides did not understand the procedures for excess exposure. <u>Id</u>. at 63; Tr. 5705. Since FEMA questioned 33 Traffic Guides about dosimetry, these three isolated instances do not demonstrate a programmatic flaw in LERO training, according the LILCO. LILCO EX-50 Testimony at 63.

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Similarly, LILCO believes that the other contention cited by Suffolk, Contention EX-45, has a single relevant subpart, subpart H, dealing with personal radiological procedures. It alleges that the Bus Dispatcher at Patchogue made inaccurate announcements to bus drivers about dosimetry. LILCO argues that it is untrue that he made inaccurate statements; rather he failed to be complete and precise. Moreover, they state that the Dispatcher was only quickly refreshing the drivers' memories just before their departure about comprehensive dosimetry instructions they had received only minutes earlier. But even if Suffolk's allegations were true, LILCO does not believe that Contention EX-45G, either alone or in combination with other "sporadic instances" demonstrates a flaw in LERO's training in dosimetry, KI use, or procedures for excess dose authorization. Id. at 63-64.

Although FEMA found that most of the emergency workers it evaluated demonstrated knowledge of use of dosimetry and actions required in response to certain radiation level readings, it nevertheless did not view the Patchogue Bus Dispatcher's instructions to drivers as lightly as LILCO would have us view them. It assigned an ARCA because of his performance. FEMA Ex. 1, at 68-69. It also assigned an ARCA because one evacuation route Bus Driver read DRDs only twice, when instructed to do so by the Transfer Point Coordinator, while another read his DRDs only when it was

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convenient. Id. FEMA also assigned ARCAs because Traffic Guides at two TCPs did not know dose authorization limits, because a Route Alert Driver believed that he would receive KI authorization in an EBS message, and because Traffic Guides at two TCPs did not fully understand that the Lead Tr fic Guide had the authority to authorize excess exposure by radio and some Traffic Guides indicated that they might question this authority. Id. at 70. FEMA also assigned ARCAs because two of eight Traffic Guides observed at Riverhead did not fully understand the difference between low- and mid-range DRDs. Id. at 77. An ARCA was also assign at Riverhead because one Bus Driver simulated ingestion of his KI prematurely, before he was assigned an evacuation route. Id. For all of these ARCAs, FEMA's recommendation called for additional training. Id. at 69-70, 77. Under cross-examination, FEMA's witnesses stated that the problems with knowledge of dosimetry and use of KI observed during the Exercise were similar in nature to those identified at other sites in New Jersey and New York State. 56 Tr. 8535. In response to LILCO's claim that problems with dosimetry are a general problem in FEMA

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<sup>56</sup>FEMA's witnesses distinguished the problems with knowledge of dosimetry and KI from the problems with the road impediments, however, because counties in the State of New York generally handle impediments very well. Tr. 8535-36.

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exercises, which FEMA's testimony would seem to suggest, Suffolk stated that a review of all other Region II exercises demonstrated that there were more dosimetry-related problems at Shoreham than at virtually any other exercise. Suffolk proposed finding 792, at 570; see Suffolk Exs. 62-80.

The NRC Staff would have us find that the lack of knowledge concerning personal radiation protection was pervasive, but these problems do not directly affect the health and safety of the public. Staff suggests, further, that the problem appears to be readily correctable through the use of the ID badge information aids and more training. Staff also agrees with LILCO's witnesses Lindell and Mileti, who, when asked why they thought LERO workers would look at the back of the badges when they forgot to even look at their personal dosimeters, stated that in a real emergency LERO workers would look at their badges and dosimeters because of concern for their own safety. Tr. 5200-02.

Conclusions on Subcontention EX-50H. The fact that FEMA believes that all of the ARCAs it identified with respect to radiation dosimetry, KI use, and procedures for excess dose authorization can be corrected by more and/or better training leads us ineluctably to the conclusion that LILCO's training prior to the Exercise was somewhat inadequate. The fact that most of the LERO workers demonstrated satisfactory knowledge about these matters

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indicates that the training program was not totally flawed, but obviously it needed to be improved. Whether the measures that LILCO has instituted to respond to FEMA's criticisms are adequate remains to be demonstrated by another graded exercise. We agree with the Staff, however, that the lack of adequate knowledge about personal radiation protection by LERO workers should not directly affect the public health and safety. Therefore the training problem relating to personal radiation protection is not a fundamental flaw in the LILCO Plan.

### 13. Subcontention EX-50I

Subcontention EX-50I alleges that LILCO's post-Exercise modifications to its training program intended to correct the problems identified in the FEMA Report will not bo successful in correcting the problems revealed by the Exercise. Suffolk Ex. 95, at 196; LILCO EX-50 Testimony, at 64. Suffolk's witnesses testified that they were familiar with SNRC-1269, which lists the modifications LILCO has made to the training program in response to FEMA's findings, and with a few minor changes to the training program in addition to those listed in SNRC-1269. Suffolk Ex. 95, at 197.

Suffolk believes that the minor changes in the training program proposed and implemented since the Exercise will not solve the "many problems in LILCO's program" because the Ø

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training program is conceptually no different than it was when first implemented three years ago. Id. at 198. Suffolk's witnesses cited several examples of changes which they think will be ineffective. For example, they state that LILCO now proposes to tell trainees during classroom lectures and tabletop drills to be "aware" of the particular jobs and the functions they need to perform. Suffolk's witnesses view this as merely repeating what the LERO workers have already been told during three years of prior training. Another example of a minor change is the creation by LILCO of "action diagrams" which Suffolk's witnesses characterize as nothing more than charts depicting job tasks of LERO personnel that are highlighted in different colors. They suggest that LILCO's training materials must already have contained information which depicted job tasks. Id. at. 199. Changes such as these, in the opinion of Suffolk's witnesses, do nothing more than tell LERO personnel what to do, which LILCO has been doing for three years of prior training. They do not teach personnel how to accomplish their jobs nor institute learning by doing, which Suffolk thinks is what is needed. Suffolk thinks that LILCO's training methodology is no different than it has been for the past three years, and consequently there is no basis to conclude that the training program will be any more successful in the future. Id. at 199-200.

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Suffolk supported its view by citing several post-Exercise drills in which dosimetry-related problems occurred. Suffolk proposed finding 793, at 571. During the June 6, 1986 drill several Traffic Guides were still not clear on the procedure regarding reaching certain exposure levels. Id. at 572 n.538; see Suffolk Ex. 96, Att. 7, at 6. During the September 10, 1986 drill, of nine Traffic Guides questioned, most were unaware of the maximum allowable dose and the procedures governing the use of KI. Suffolk proposed finding 793, at 572 n.538; see Suffolk Ex. 96, Att. 8, at 4-5. In addition, two Road Crews were unaware of the procedures for use of dosimetry and maximum exposure allowances. Suffolk Ex. 96, Att. 8, at 6. During the September 17, 1986 drill the distribution of dosimetry was not well controlled, and many LERO workers arrived at the dosimetry briefings near the end of the session and were not afforded the benefit of a complete briefing. Id. at 8. During the October 1, 1986 drill again there were LERO personnel who were unclear as to dose authorization. Suffolk proposed finding 793, at 572 n.538; see Suffolk Ex. 91a, at 7. Finally, during the December 10, 1986 drill it was observed that one member of a two-man Road Crew failed to use his dosimeter. Suffolk Ex. 93c, at 5.

LILCO pointed out in its reply to the proposed findings of the Intervenors and Staff that the LERO badges with the dosimetry information on the back were not provided until

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the December 1986 drills. LILCO reply findings at 181. Further, during the December 10 drill a Field Controller observing two TCPs noted that the LERO workers simulated reading their dosimetry every 15 minutes and that they were aware of the information on the back of their badges. <u>Id</u>.; see Suffolk Ex. 93a, at 6. Moreover, during both the December 2 and 10 drills, Field Controllers observing various locations (Transfer Points and TCPs) reported that LERO workers were reading their dosimeters every 15 minutes and were aware of their usage and limits. Suffolk Ex. 96, Att. 9, at 40.

The NRC Staff, in its proposed findings, noted that LILCO had treated the problems observed during Exercise in responding to road impediments as deficiencies in training for road impediments, rather than as deficiencies in responding generically to unexpected events. Staff proposed finding 487, at 181-82. While the Staff agrees with Suffolk that repeated drills on slightly different road impediment scenarios introduce little in the way of surprise, this kind of repetition was in fact a form of "learning by doing" training that has been emphasized by Suffolk's witnesses. Staff proposed finding 477, at 181; see Suffolk Ex. 95, at 80-89, 93; Tr. 6768-72. Staff believes that this repetition has shown some positive results. It notes that, following the problems in the June 1986 drills, response to the road impediments improved substantially in the September/October

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1986 drills. Staff proposed finding 489, at 182; see Suffolk Ex. 96, Atts. 7, 8. Staff also noted that while LILCO pointed to good responses to impediments during the December 1986 drills, there was a delay in response to one of the four impediments and communication problems on another. Staff proposed finding 489, at 182; see LILCO EX-50 Testimony at 71; Suffolk Ex. 96, Att. 9, at 4. Staff notes that LILCO's observation of Traffic Guide performance during the June, September, and October drills was favorable. Staff proposed finding 490, at 182; see Suffolk Ex. 96, Atts. 7, 8. In the December drills dispatch of Traffic Guides, Bus Drivers, and other field workers appeared to be timely. Suffolk Ex. 96, Att. 9, at 18-26. Finally, remedial "road rallies" of bus drivers continued through the December drills, but they were not evaluated. Id. at 42; see LILCO EX-50 Testimony at 72-73. Staff believes that these apparent improvements lend credence to the correctability of the deficiencies in knowledge exhibited during the Exercise and in the ability to handle road impediments. Staff also believes that the post-Exercise drill evidence tends to show greater emphasis on "learning by doing." Nevertheless, because the drills were observed by neither FEMA nor Suffolk County, but only by LILCO contractors, Staff does not think decisive weight can be accorded the evidence from the post-Exercise drills. Staff proposed finding 491, at 183.

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Staff points out, however, that even LILCO acknowledges that training problems found in the Exercise have persisted. For example, according to LILCO's witness Behr, dispatch problems at staging areas continue to be an area of concern. Staff proposed finding 493, at 183; see Tr. 5786-87. More significantly, LILCO acknowledged that response and communication problems continued in the June, September, and October drills. Staff proposed finding 493, at 183; see Tr. 5758-59, 5769, 5784 (Behr), 5772-73 (Daverio). Staff notes that while the December drill "may have shown improvement," communications problems still occurred in dealing with the brush fire and truck impediments. Staff proposed finding 493, at 184.

Staff concludes by observing that over 1,000 LERO personnel were mobilized for the Exercise, and this was only one of three shifts. Staff proposed finding 494, at 184; see LILCO EX-50 Testimony at 10. Although LILCO's training program conducts quarterly drills, because of the size of LERO, individuals receive training only annually. Staff proposed finding 494, at 184; see Tr. 5725. In addition to the burden of training so many, it is more difficult to train LERO personnel to be emergency response workers for a nuclear accident than it is to train persons who regularly perform emergency response work. Staff proposed finding 494, at 184; see Tr. 4465 (Behr), Tr. 5137 (Mileti). Staff observes, further, that unlike police or fire department

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personnel, who interact as respondents to emergencies on a regular basis, the LERO organization is intermittent in nature, drilling for emergency response only periodically. Staff proposed finding 495, at 184-85; see Suffolk Ex. 95, at 206; Tr. 6425 (Perrow). Staff believes that there is some evidence that LILCO's post-Exercise training efforts have paid dividends. Nevertheless, the FEMA Deficiency findings, and evidence of continuing problems in effective communication and in dealing with the large span of control at the staging areas, particularly in non-routinc situations, have raised substantial doubt in the minds of the Staff about whether LILCO's training program has been intense enough to overcome the burdens placed upon LERO. Staff proposed finding 495, at 185. Because of substantial doubt that LERO personnel have sufficient training to communicate and respond effectively to a major unanticipated problem, plus substantial questions about the timely dispatch of LERO Traffic Guides, Bus Drivers, and other emergency workers and their prompt performance of their tasks, Staff finds that there is not at this time reasonable assurance that adequate protective measures can and will be taken in the event of an emergency at SNPS. Staff proposed finding 496, at 185-86.

Conclusion on Subcontention EX-50I. We agree with the NRC Staff. The evidence before us in this proceeding, while suggesting that there may have been some improvement in LERO's performance since the February 13, 1986 Exercise, generates substantial doubt that LERO personnel have been adequately trained in the areas of communication, responding to unanticipated events, and timely dispatch of and prompt performance of duties by emergency field workers, especially Traffic Guides and Bus Drivers. Although these problems can probably be corrected, we are not convinced that they have indeed been corrected. LILCO's training program, therefore, is fundamentally flawed in teaching emergency communication and the timely dispatch and response of field personnel.

## 14. Overall Conclusion on Contention EX-50

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Deficiencies in the following areas, which are significant to the ability of LERO to implement the LILCO Plan, were found during the Exercise and were not demonstrated to have been compensated for or corrected:

- (1) training for, and execution of internal communications within the LERO command structure and between that structure and field personnel in response to unexpected events;
- basic knowledge of Traffic Guides and Bus Drivers of their assigned functions; and

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3) training for timely and prompt response of Traffic Guides, Bus Drivers, Route Spotters, and Road Crews in the performance of their emergency tasks. These deficiencies in LILCO's training program preclude a finding of reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency at SNPS and therefore constitute a fundamental flaw in the Plan. A finding of reasonable assurance must await further demonstration in a FEMA-graded exercise of those portions of the Plan where deficiencies were found that corrective measures have been adequate.

## III. CONCLUSION

For the reasons indicated above, we have concluded that fundamental flaws were demonstrated by the February 13, 1986 Exercise of the offsite emergency plan for the Shoreham Nuclear Power Station. We summarize those flaws below.

1. Flaws relating to communications were demonstrated:

a. Within the EOC in that the Evacuation Route Coordinator did not inform his superiors or cooworkers of the traffic impediments on receipt of the free play messages, did not include complete information on the impediments in the messages relayed to the route spotters, and did not request the prompt dispatch of one route spotter to verify one impediment;

b. Among field workers in that the plan does not permit such lateral communications;

c. At the ENC in that LERO was unable to furnish timely information on protective action recommendations in

the form of EBS messages to the media and to rumor control, and was unable to accurately respond to questions concerning the traffic impediments and protective action recommendations at news conferences; and

d. In the EBS messages in that they contained some conflicting information concerning protective action recommendations and were, in some respects, confusing in their discussion of doses, releases, and emergency classifications.

2. A flaw was demonstrated in that large numbers of Traffic Control Posts were not staffed untils well after traffic congestion would have occurred.

3. Flaws in the training program were demonstrated in the areas of communications, functions of Traffic Guides and Bus Drivers, and prompt response of field personnel.

In its proposed conclsions of law, Staff urges that:

A finding of reasonable assurance must await further demonstration in a FEMA-graded exercise or drill of those portions of the Plan where deficiencies were found, in order to show the adequacy of corective measures. Staff's proposed findings, p. 187. Staff believes that we should retain jurisdiction until such corrective measures are completed, although it has not elaborated on this position or addressed the Commission's mandate to us contained in CLI-86-11, 23 NRC 577. The other parties have not addressed this question at all. Before reaching a decision on this limited issue, we wish to have the views of

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all the parties. Consequently, we retain jurisdiction in order to decide whether the Commission's mandate requires that we pass on LILCO's efforts to correct the flaws we have found, and direct that the parties, including Staff, furnish us with their views within 15 days following service of this Initial Decision.

In accord with 10 CFR 2.760(a), this Initial Decision will constitute the final action of the Nuclear Regulatory Commission thirty (30) days after its date unless as appeal is taken. In accord with 10 CFR 2.762(a), any party may take an appeal by filing a notice of appeal within ten (10) days after service of this Initial Decision.

THE ATOMIC SAFETY AND LICENSING BOARD

FREDERICK J. SHON ADMINISTRATIVE JUDGE

OSCAF

Bethesda, Maryland February 1, 1988 Separate Opinion of Judge Frye:

While I am in agreement with the bulk of the conclusions reached in this Initial Decision, I find it necessary to note my separate views with regard to the following points.

## COMMUNICATIONS

I must respectfully dissent from one of the conclusions reached with regard to Contention EX-41B. This conclusion concerns the communications breakdown experienced by LERO in its response to the two traffic impediments inserted into the exercise by free play messages. While I concur that such a breakdown did occur and that it amounts to a fundamental flaw, I believe that one of the conclusions reached with respect to that fundamental flaw is not supported by the record. Specifically, I find no support in the record for the conclusion that the exercise demonstrated that the communications structure set up by the plan is itself flawed.

In reaching this conclusion, my colleagues correctly note that the communications system approved in the PID is an administrative one which permits communication vertically only, rather than laterally among field workers. I agree that the endorsement of this system in the PID was less than enthusiastic. However, I part company with my colleagues

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with respect to their conclusion that the exercise demonstrated that lateral communications among field workers are necessary in order to adequately respond to an "emergency-within-an-emergency."

The exercise demonstrated that both lateral and vertical communications within the EOC were flawed. The communications breakdowns all occurred within the EOC. Once the problems which resulted from those breakdowns were overcome, LERO's response to the impediments was adequate. There simply is no indication in this record that the plan requirement that field workers communicate only with their superiors, rather than with each other, in any way hampered the response to the impediments. Indeed, FEMA's deficiency assigned to this matter is carefully limited to communications within the EOC.

While I can readily agree that the plan's vertical communications system is less desirable than a system which permits both lateral and vertical communications, I cannot conclude that the exercise demonstrated that the plan is fundamentally flawed because of its failure to provide for the latter.

Similarly, I must also dissent from my colleagues conclusion on Contention EX-41E. In doing so, I note that all parties to this proceeding appear to agree that the addition of a Traffic Engineer at the EOC has nothing whatever to do with the communications problems revealed by

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the exercise. Moreover, this appears to be so even under the view of those problems adopted by my colleagues. Consequently, Contention EX-41E does not present a dispute which warrants a conclusion.

## TRAINING

In their discussion of Contention EX-50, my colleagues correctly note that the issue of the adequacy of LILCO's training program was a question left open by the prior Licensing Board. In the PID, the Licensing Board tentatively concluded that LILCO's training program met the regulatory standards, but that conclusion was expressly:

made subject to confirmation by a finding, to be made by FEMA after a graded exercise, that the Plan can be satisfactorily implemented with the training program submitted and that LILCO possesses an adequate number of trained LERO workers.

PID, 21 NRC at 756. No such finding was made by FEMA. Tr. 8296-97 (Kowieski); FEMA Ex. 1; SC Ex. 95, at 35, n.16. Intervenors maintain that we must decide whether LILCO's Plan can be satisfactorily implemented with the training program that is part of that Plan. Intervenors' proposed findings, at 494-95. LILCO and Staff believe that this position amounts to a relitigation of planning issues resolved in the PID. LILCO's reply findings, Vol. II, at 153 (reply to Intervenors' proposed finding 678); Staff's proposed findings at 147.

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In my opinion, this proceeding is not concerned with whether the LILCO training program meets each aspect of the regulatory standard. That issue was addressed in the PID, where that program was found to be adequate subject to confirmation by FEMA. The condition imposed in the PID that FEMA verify that the plan can be satisfactorily implemented with the existing training program remains in full force and effect; FEMA's failure to make such a finding does not dictate that we take that responsibility on ourselves.

Rather, in this proceeding, the inquiry is whether there are systemic or pervasive problems in performance, amenable to correction by training, which raise legitimate doubt as to whether there is reasonable assurance that in the event of an emergency, LERO could implement adequate protective measures to protect the public. Existence of such doubt would indicate that the training program was fundamentally flawed.

In their discussion of Contention EX-50, my colleagues appear to have accepted Intervenors' position and reviewed the training program for adequacy. In addition, they have concluded that the exercise demonstrated that LILCO's training program is fundamentally flawed. Their ultimate conclusion is stated as follows:

Overall Conclusion on Contention 50. Deficiencies in the following areas, which are significant to the ability of LERO to implement the LILCO Plan, were found during the Exercise and were not demonstrated to have been compensated for or corrected:

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1) training for, and execution of internal communications within the LERO command structure and between that structure and field personnel in

2) basic knowledge of Traffic Guides and Bus Drivers of their assigned functions; and

response to unexpected events;

3) training for timely and prompt response of Traffic Guides, Bus Drivers, Route Spotters, and Road Crews in the performance of their emergency tasks.

These deficiencies in LILCO's training program preclude a finding of reasonable assurance that adequate protective measures can and will be taken in the event of a radiological emergency at SNPS and therefore constitute a fundamental flaw in the Plan. A finding of reasonable assurance must await further demonstration in a FEMA-graded exercise of those portions of the Flan where deficiencies were found that corrective measures have been adequate.

While I do not concur in all of the conclusions reached with respect to Subcontentions EX-50A through I, I do concur with the ultimate conclusion stated above. I view this conclusion as the definitive statement of the ways in which the training program is fundamentally flawed, and offer the following additional views in its support.<sup>57</sup>

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In my view, the failures which are not encompassed by the above statement are not significant enough to demonstrate fundamental flaws in the training program. Indeed, many of them have been reviewed in connection with

 $^{57}\mathrm{My}$  colleagues concur with these additional supporting views.

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the performance contentions and found not to constitute fundamental flaws.

In their approach to Contention EX-50, Intervenors have viewed virtually every failure which occurred during the exercise as illustrating the need for improved training. They have addressed these failures under the subcontentions, each of which alleges that the training program is flawed in a particular manner. There is, as a result, a considerable amount of redundancy in that particular failures are cited as supporting more than one subcontention. The failures which, in my opinion, rise to the level of indicating a flaw in the training program are summarized by my colleagues' statement quoted above. I do not believe it significant that Intervenors may have cited these failures as support for more than one subcontention.

LILCO's communications problems were highlighted by the exercise. Indeed, all of the fundamental performance flaws revealed by the exercise save one were directly related to communications problems.<sup>58</sup> Accurate communication is essential to an effective emergency response. Clearly LILCO has much to do to remedy its communications problems.

<sup>58</sup>The fundamental flaw not related to communications concerned the staffing of Traffic Control Posts raised by Contention EX-40B.

Whether it can do so will depend upon whether its training program can be significantly improved.

LILCO believes that the flaws found with respect to the basic knowledge of Traffic Guides and Bus Drivers and the promptness of the former as well as Road Crews and Route Spotters in the performance of their tasks are based on matters not explored on the record. It views the flaw related to the delayed dispatch of Traffic Guides, Bus Drivers, Road Crews, and Route Spotters to be based on an inappropriate aggregation of mobilization and response tasks, which, when properly viewed, do not reveal a pattern of failures. It believes that the delays in mobilizing Traffic Guides and Bus Drivers were <u>ad hoc</u> and not a part of a pattern. LILCO's reply findings, Vol. 1, at 63-65.

LILCO may be correct that the promptness of Route Spotters was not extensively discussed in the record. The delay in staffing Traffic Control Points by the Traffic Guides resulted in our finding a fundamental flaw. We considered Road Crew performance under Contention EX-41A and found their response tardy, although we did not conclude that a fundamental flaw was demonstrated. There is evidence in the record concerning the promptness of Bus Drivers. <u>See</u> FEMA Exhibit 1, at 62-63. In these circumstances, LILCO's objection is not well taken. While it may be true that these matters were not discussed under the rubric of a particular subcontention to which LILCO believes they relate, they were discussed. It would be inappropriate to ignore them on the ground that they were mislabeled.

While the evidence with regard to the Road Crews, Bus Drivers, and Route Spotters considered separately is not, in my opinion, sufficient to fault the training program for any particular category of emergency worker, the evidence must be considered as a part of a whole. To consider evidence with regard to each emergency worker category in isolation would create an artificial distinction. There is ample evidence that emergency field workers did not respond promptly to support the finding of a fundamental flaw; improvements in the training program in this regard should not be limited to particular categories of workers.

Similarly in my opinion, LILCO's arguments regarding the inappropriate mixing of mobilization and response tasks also would create an artificial distinction. LILCO may well be correct that such distinctions need to be made in considering specific improvements to the training program. However, they are not appropriate in considering whether that program is flawed. The record demonstrates that the training program needs to be improved; distinctions between mobilization and response tasks can be considered in addressing the details of the improvements.

LILCO concedes that problems were revealed with respect to the Bus Drivers' knowledge of their jobs, but argues that these failures do not fall into a pattern and, in any event, because of the plan's redundant and diverse response mechanisms, do not impact the public health and safety. LILCO's reply findings, Vol. 1, at 66. While redundancy and diversity are useful concepts to mitigate the consequences of such failures, they do not excuse faulty training. A substantial number of the drivers observed failed to adequately perform their tasks; a flaw in their training was demonstrated.

Although it concedes that the Traffic Guides were largely unable to direct evacuees to the Nassau Coliseum, LILCO does not think it appropriate to charge the Traffic Guides with this responsibility. It states that the Guides' procedures have never covered the provision of information to evacuees and that these procedures have never been criticized on this score. LILCO points out that, at most, the Guides are a backup to the EBS system in this respect. Id, at 66.

LILCO may well be correct that Traffic Guides are not considered a source of information for the evacuating public under the plan. Nonetheless, Staff observes that their inability to provide such basic information as the location of the Nassau Coliseum indicates a failure in their training. <u>See</u> Staff's proposed findings at 175. This observation appears to me to be beyond question. Subject to the above exceptions, I fully endorse this Initial Decision.

JOHN H FRYE, III, CHAIRMAN ADMINISTRATIVE JUDGE

Bethesda, Maryland February 1, 1988

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