

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-266; 50-301
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Report Nos: 50-266/98020(DRS); 50-301/98020(DRS)

Licensee: Wisconsin Electric Power Company

Facility: Point Beach Nuclear Plant, Units 1 & 2

Location: 6610 Nuclear Road
Two Rivers, WI 54241

Dates: November 2-6, 1998

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EXECUTIVE SUMMARY

Point Beach Nuclear Power Plant, Units 1 & 2
NRC Inspection Reports 50-266/98020; 50-301/98020

This inspection consisted of evaluation of the licensee's performance during the plant's biennial exercise of the Emergency Plan. It was conducted by four regional emergency preparedness inspectors and two resident inspectors. No violations of NRC requirements were identified.

Plant Support

- Overall performance during the 1998 Emergency Preparedness exercise was effective and demonstrated that emergency plan implementation activities met regulatory requirements. (Section P4.1.c).
- Exercise performance in the Control Room Simulator was exceptionally effective. Appropriate procedures, including abnormal operating procedures and emergency operating procedures were effectively used. "Repeat back" communications were consistently used by the crew. Close and effective command and control of the operators was consistently displayed by the Duty Operating Supervisor. (Section P4.1.c)
- Overall, the Technical Support Center's staff's performance was adequate. Staff teamwork was apparent and communications with offsite authorities and between the emergency response facilities' staffs were effective. (Section P4.1.c)
- An inappropriate decision was made to tie a non-safety electrical bus to a safety-related electrical bus in order to enable providing reactor makeup water to Unit 2. (Section P4.1.c)
- Operations Support Center (OSC) staff performance was satisfactory. OSC teams were generally assembled, briefed and deployed in a timely manner. Returning teams were adequately debriefed. (Section P4.1.c)
- The Emergency Operations Facility (EOF) staff's overall performance was effective and in accordance with the Emergency Plan. The Emergency Director declared a Site Area Emergency and a General Emergency in a correct and timely manner as plant conditions worsened. (Section P4.1.c)
- A field monitoring team followed their procedures very well. Sampling procedures and equipment needed enhancement. (Section P4.1.c)
- Self-critiques following termination of the exercise were generally thorough, self-critical, and controllers effectively solicited verbal and written inputs from exercise participants. (Section P4.1.c)

Report Details

IV. Plant Support

P3 Emergency Preparedness Procedures and Documentation

P3.1 Review of Exercise Objectives and Scenario (82302)

The inspectors reviewed the 1998 exercise objectives and scenario and determined that they acceptably exercised major elements of the licensee's onsite emergency plan. The scenario provided a challenging framework to support demonstration of the licensee's capabilities to implement its emergency plan. The scenario included a radiological release, and several equipment failures.

P4 Staff Knowledge and Performance in Emergency Preparedness

P4.1 1998 Evaluated Biennial Emergency Preparedness Exercise

a. Inspection Scope (82301)

On November 3, 1998, the licensee conducted a biennial exercise involving full participation by the State of Wisconsin and the counties of Manitowoc and Kewaunee. This exercise was conducted to test major portions of the licensee's onsite and offsite emergency response capabilities. Onsite and offsite emergency response organizations and emergency response facilities were activated.

The inspectors evaluated performance in the following emergency response facilities:

- Control Room Simulator (CRS)
- Technical Support Center (TSC)
- Operations Support Center (OSC)
- Emergency Operations Facility (EOF)

The inspectors assessed the licensee's recognition of abnormal plant conditions, classification of emergency conditions, notification of offsite agencies, development of protective action recommendations, command-and-control, the transfer of emergency responsibilities between facilities, communications, and the overall implementation of the Emergency Plan. In addition, the inspectors attended the post-exercise critiques in each of the above facilities to evaluate the licensee's initial self-assessment of exercise performance.

b. Emergency Response Facility Observations and Findings

b.1 Control Room Simulator (CRS)

Exercise performance in the Control Room Simulator was exceptional. Appropriate procedures, including abnormal operating procedures and emergency operating procedures were effectively used. "Repeat back" communications were consistently used by the crew. Close and effective command and control of the operators was consistently displayed by the Duty Operating Supervisor (DOS).

Periodic, effective briefings kept operations personnel aware of current conditions and clear desired goals and priorities. Operators closely monitored conditions and attempted to anticipate trends and maintain control of the plant rather than simply responding to malfunctions. These operator actions indicated a detailed understanding of developing plant conditions.

Control Room shift personnel properly diagnosed reactor events at the Alert emergency level. Event notification forms and verbal notifications to State and local officials and the NRC were completed in a detailed and timely manner.

Transfer of command and control of emergency responsibilities from the CRS Duty Shift Superintendent (DSS), to the EOF Emergency Director (ED) was orderly and timely. Prior to the transfer, the DSS effectively communicated via telephone with the ED on current plant conditions.

Communications with staff in other emergency response facilities were frequent and detailed. The CRS communicator was effective in keeping TSC and EOF counterparts informed of changing plant conditions, priorities and actions taken by the CRS crew. Radio communication difficulties were troublesome for the operators in the CRS and for operators in the plant. Discussion indicated radio system upgrades are planned.

Additionally, the simulator operating crew and controllers smoothly handled the real time loss of the U2 reactor operator (RO), due to a personnel emergency. A controller temporarily acted in the capacity of the RO until the DSS could request and receive a replacement through the OSC. The teamwork displayed by the exercise participants and controllers resulted in no adverse impact on the exercise scenario.

Reactor operators provided relevant reactor information to the DOS as needed without the need for prompting. The two reactor operators responding to the Unit 1 conditions displayed good teamwork between each other and with the DOS.

The DSS, once understanding and assessing the situation with Unit 1, began to notify needed personnel. There were indications that the DSS was maintaining overall understanding of the sequence of events and actions taken on Unit 1.

The operators initiated a manual reactor trip. The reactor trip and safety injection, while coming earlier than expected by the exercise scenario developers, was a conservative decision. The opening of the "A" atmospheric dump valve once the steam generator

was isolated created an unmonitored release which was apparently not anticipated during scenario development, as a later reactor trip would not have actuated the "A" atmospheric dump valve.

CRS personnel were not issued dosimetry. Discussion indicated that the real Control Room has a supply of dosimetry, but issuance of dosimetry to Control Room personnel under emergency conditions had not been proceduralized. The safety significance of this item is low; the Control Room is designed with shielding, instrumentation and ventilation systems to ensure radiological habitability under most postulated conditions. This will be tracked as an Inspection Follow-up Item (IFI 50-266/98020-01; 50-301/98020-01(DRS)).

b.2 Technical Support Center (TSC)

Overall, the TSC's staff's performance was adequate. Staff teamwork was apparent. Communications with the NRC and between the emergency response facilities' staffs were effective.

The staff started arriving within minutes after the Alert announcement, signed in the staffing status board, and proceeded to their stations where they opened their response procedures and activated communications and data acquisition equipment. Activation of the facility was appropriately aided by the Engineering Coordinator when he provided an initial briefing to the staff prior to the arrival of the TSC Manager. The TSC did not declare the facility operability until approximately 50 minutes after the Alert declaration. The TSC Manager stated that he was waiting for the OSC before he activated the TSC. This delayed activation of the TSC, however, the facility was declared operable within the one hour requirement.

Plant personnel accountability was completed within 20 minutes of the accountability announcement. Accountability was accomplished well within the required 30 minutes. The Emergency Response Data System (ERDS) was rapidly simulated as activated within approximately 15 minutes after the Alert declaration, which was well within the one hour requirement.

Command and control of the facility by the TSC Manager was adequate. Periodic staff briefings provided the opportunity for all the facility coordinators to provide comments. Frequently changing priorities were discussed and clearly identified during these briefings. Some briefers did not effectively summarize certain emergency conditions such as the high priority assigned to energizing the B01/B02 busses, protective actions recommended to the State and protective actions taken, and plant or field monitoring radiological levels. Also, very little of that information was included in the briefings regarding the charcoal bed fire and related activities. On the other hand, some of that information, not included in the TSC's briefings, appeared to be understood by most of the personnel in the facility.

Briefings from the TSC, using a remote microphone system, were audible throughout the TSC/OSC complex. However, loud feedback frequently disrupted discussions and communications in the TSC and OSC. Eventually, one of the facility coordinators

requested the system be shut off when not in use. Finally, late in the day, the system functionality was improved when new batteries were used in the microphone. Despite these problems, briefings were completed.

Communications on the Emergency Notification System (ENS) phone line were excellent. An open line was maintained by the ENS Communicator with the NRC in order to update simulated NRC staff as plant conditions changed. Communications within the facility were good, with the exception that fire response activities (fire fighting status) and some equipment repair activities (why energizing the B01 and B02 busses was a high priority) were not communicated.

The staff members who needed plant radiation data were able to obtain the information from the Radiation/Chemistry Monitors, who aggressively reviewed the plant radiation monitor system data via the Plant Process Computer System. The Radiation/Chemistry Coordinator was continually apprised of the current plant radiological conditions by the monitors.

Facility status boards were well maintained and continuously updated during the simulated emergency response. The inspectors noted that the "Protective Action Recommendations" (PAR) and "State Protective Actions" taken blanks were not used after the General Emergency was declared and the offsite notifications sent. Even though the PARs were not displayed on the status board, the ENS Communicator effectively completed the Event Notification Worksheet and correctly communicated protective actions to simulated NRC responders.

Plant equipment problems and other emergency issues were proactively tracked on a status board. The status board keepers were challenged on several occasions in the TSC and OSC when they attempted to keep up with frequent priority changes. Maintaining the OSC priorities similar to the TSC priorities was delayed occasionally due to these periods of rapidly changing priorities.

Initially, the Operations Coordinator in the TSC did not effectively review the procedure containing the Emergency Action Levels (EALs). At the time personnel in the EOF (who had lead classification responsibility) declared the Site Area Emergency, the TSC's Operations Coordinator had not identified that an EAL was met or exceeded. However, following the Site Area Emergency declaration, the Operations Coordinator was proactive in reviewing the EALs and emergency plant conditions.

An inappropriate decision was made to tie a non-safety electrical bus to a safety-related electrical bus in order to enable providing reactor makeup water to Unit 2. The demineralized water storage tank low level tank interlock electrical source comes from the non-safety related electrical bus planned to be energized. Unit 2 would have to shut down if this makeup water was not available. However, if a fault occurred in the non-safety related electrical bus, it would have then disabled the safety-related electrical bus. This action would not have been justified under 10 CFR 50.54(x) as it was not a necessary action to protect the public health and safety. Discussion with licensee personnel indicated agreement that the decision was inappropriate and would be reviewed.

Recovery was initiated in the TSC, however, the exercise was terminated prior to any Recovery phase discussions.

b.3 Operational Support Center (OSC)

OSC staff performance was satisfactory. Inplant teams were generally assembled, briefed and deployed in a timely manner. Returning teams were adequately debriefed.

Radiation protection equipment inspected was in current calibration and in good working condition. Simulated self-reading dosimeters were appropriately provided to OSC/TSC personnel and contamination control zones (Step Off Pads) were established. Habitability of the facility was periodically checked by a Radiation Protection Technician (RPT).

The Priority status board in the OSC, at times, did not match the priority board in the TSC. This was partly due to the rapidity with which priorities were being changed in the TSC. Lag times of up to 25 minutes were noted. This did not appear to have any affect on OSC staff's performance, as they were generally aware when priorities changed.

In-plant response team "Aux Feed" was accompanied into the plant. The entry briefing was thorough and team members were given clear instructions as to what needed to be done and contingencies. The team exhibited good "drillmanship" and no controller prompting was noted. In fact, the controller provided only limited information, requiring the players to become more involved and think out their actions. Communications with the OSC staff were maintained and verified during the entry.

An inspector accompanied the fire brigade assembled to engage the fire in the Primary Auxiliary Building (PAB). The pre-job briefing was given by the fire brigade leader and RP personnel briefed the crew on dose rates in the area and provided the crew with a "turn back" dose rate limit. The brigade donned fire fighting gear and entered the PAB about 15 minutes after completing the briefing.

The fire brigade members donned self-contained breathing apparatus devices and actually activated and used the breathing air. The RPTs accompanying the fire brigade provided good support and took dose rate measurements ahead of the brigade. When the "turn back" dose rate was exceeded at the base of the stairs on the 8' elevation of the PAB, the team returned to the Health Physics station. The entry team was then identified as being contaminated and decontamination efforts followed. The controllers exercised excellent "drill" awareness by requesting the fire brigade to return all the equipment to the proper storage locations for use in case of an actual fire at the plant.

OSC procedures addressed "rapid response teams", where the desire was to quickly assemble, brief, and dispatch teams which were assigned time-critical essential tasks. However, two "rapid response teams" took a lengthy amount of time to get released (approximately 15 minutes). This will be tracked as an Inspection Follow-up Item (IFI 50-266/98020-02; 50-301/98020-02(DRS)).

The radiation survey board in the OSC contained some early dose rate information without a date or time entered for reference. Later in the exercise, updated information was added and the date and time were present.

b.4 Emergency Operations Facility (EOF)

The EOF staff's overall performance was effective and in accordance with the Emergency Plan.

The near site EOF was activated following the Alert declaration. Incoming personnel efficiently prepared to perform their duties and established communications with counterparts in other response facilities. Liaisons to the counties' emergency response facilities were promptly deployed following an initial briefing.

The EOF's Emergency Director (ED) assumed overall command of the licensee's event response within an hour after the Alert declaration. The transfer of command and control to the ED was smoothly accomplished once the ED was assured that EOF staff were ready to assume their responsibilities and after he provided a well detailed initial briefing to EOF personnel.

Two offsite radiological monitoring teams were formed and deployed from the EOF in a timely manner following the Alert declaration. Their initial deployment strategy and subsequent movements allowed them to provide early confirmation of the eventual airborne release due to a fire in a charcoal bed. Survey reports from licensee and State offsite radiological survey teams were shared.

The EOF Manager coordinated short briefings to the EOF staff at roughly 30 minute intervals. The Plant Status Monitor and the Dose/PAR Coordinator were the principal spokespersons during these briefings. The ED participated in these briefings as he deemed necessary. Questions from EOF staff were encouraged and were particularly valuable on several occasions, as indicated by these examples:

The bases for the Site Area Emergency and General Emergency declarations were not clearly communicated to EOF staff until briefers were asked for these important details by staff assigned to communicate with persons in other response facilities; and

It was unclear whether puff releases through a cycling atmospheric relief valve continued following another degradation in plant conditions.

The effectiveness and quality of the periodic briefings varied. The times that the TSC, OSC and Joint Public Information Center (JPIC) became fully operational were not mentioned. Current higher priorities determined by the TSC Manager were not always summarized. In contrast, the changing status of Unit 2 was well communicated to the staff. It was incorrectly stated that representatives from a local fire department had reached the site using a southerly route, rather than the northerly route that was taken to avoid the simulated plume. On one occasion, the EOF Manager's concern to begin a

periodic briefing on schedule momentarily disrupted the ED's important discussion regarding a potential emergency reclassification.

The EOF's status boards were acceptably maintained with accurate information with a few exceptions that were corrected within several minutes. Although TSC priorities were posted and updated, this important information was displayed at about waist level on a status board that was not readily visible to everyone within the EOF's main room. The times that the TSC, OSC, and JPIC became fully operational were not posted.

Key EOF staff demonstrated proper concern for the potential need to reclassify the emergency following continued worsening plant conditions. The ED declared a Site Area Emergency and a General Emergency in a correct and timely manner as plant conditions worsened. However, the EAL procedure did not appear to be organized in a user friendly manner, as indicated by the time needed to identify the appropriate EAL. The EAL procedure also did not clearly focus attention on the status of the three fission product barriers, as evident by several discussions that were needed to decide whether the Unit 1 containment should be considered to be intact, threatened, or breached. Discussion with licensee personnel indicated that the EALs were under review for revision and restructuring. This will be tracked as an Inspection Follow-up Item (IFI 50-266/98020-03; 50-301/98020-03(DRS)).

The Dose/PAR Coordinator effectively directed his staff in assessing abnormal inplant radiation levels, reviewing radiation monitors' data for indications of a release, closely monitoring current and forecast meteorological conditions, directing the movements of the licensee's offsite radiological survey teams, performing offsite dose projections, and continuously assessing the EOF's habitability. With one exception, offsite dose projections' assumptions were reasonable. This single exception, which was associated with an incorrect understanding that the core had been uncovered, was quickly identified by EOF management and properly discarded before any actions were initiated based on this incorrectly based dose projection.

A procedurally correct offsite PAR was quickly formulated and communicated to State and county officials following the General Emergency declaration. The PAR was promptly revised and communicated following a sufficient change in wind direction. Key EOF staff remained acceptably aware of what protective actions were chosen for implementation by offsite officials. The Emergency Planning Zone map included only sector nomenclature, not the pre-planned geographic subareas indicated in the State's and counties' emergency plans. This reduced the EOF staff's ability to readily understand which geographic areas were affected by protective actions being implemented by offsite officials. This will be tracked as an Inspection Follow-up Item (IFI 50-266/98020-04; 50-301/98020-04(DRS)).

The Health Physics Network/ State Radiological Coordinator (HPN/SRC) Communicator was tasked with maintaining communications with the SRC in Madison, Wisconsin, and simulated NRC officials. It was unlikely that one communicator could satisfy the information needs of the SRC and remotely located NRC officials in a timely manner if either party requested continuous communications, or if NRC's computerized Emergency Response Data System became inoperable.

Another communicator was tasked with notifying corporate staff and NRC's Project Manager (PM). Notification of the NRC PM was not a regulatory requirement. The value of notifying the PM was limited. The PM would become a member of NRC Headquarters' incident response organization and would not be available in his or her office to receive emergency-related notifications from licensee staff.

The ED authorized members of the licensee's offsite radiological survey teams to ingest potassium iodide (KI) in accordance with procedural guidance. A communicator notified a State official of this decision. Following reports of very high radiation levels in the vicinity of the charcoal bed fire, key EOF staff appropriately weighed the potential radiation exposures to the plant's fire brigade if they fought the fire versus the potential offsite radiological consequences if the fire was allowed to burn itself out. However, a final decision on this situation was not announced within the EOF before the exercise transitioned to the onsite Recovery phase.

The ED and EOF Manager became involved in a brief onsite Recovery discussion. Interaction with TSC counterparts was not apparent. The results of the ED's and EOF Manager's onsite Recovery conversation were not shared with EOF staff.

b.5 Field Monitoring Team

An inspector accompanied the "second shift" of Mobile Survey Team 2, dispatched after 1:00 p.m. The team was properly briefed as to their tasks, route, and expected hazards. Team members simulated taking potassium iodide tablets. Survey and air sampler equipment had stickers indicating current calibration. The team traversed the plume, detected the plume centerline, and determined the proper location to take ambient radiation, air, soil and vegetation samples.

Team members consistently referred to their procedures, and kept in communication with personnel in the EOF. Team members checked the readings of self-reading dosimeters belonging to security guards, as requested.

The team took soil and vegetation samples according to procedure 7.3.1, "Offsite Airborne Radiation Sampling And Direct Dose Survey Guidelines", Revision 18, October 28, 1998, sections 6.6.3 - 6.6.4. However, supplied equipment for taking the soil sample was a small trowel and two inch petri dish. The selected location for the soil sample was at the bottom of an already existing small hole, and appeared unrepresentative of the general area soil. The procedure refers to the soil sample and vegetation comprising 100 centimeters². It was not apparent that the obtained sample approached 100 centimeters² for either the soil or vegetation sample. Procedures and supplied equipment were insufficient to assure adequate sampling. This will be tracked as an Inspection Follow-up Item (IFI 50-266/98020-05; 50-301/98020-05(DRS)).

b.6 Scenario and Exercise Control

The inspectors assessed the challenge of the scenario and evaluated the licensee's control of the exercise. The scenario was challenging, and exercised the majority of the

licensee's emergency response capabilities. The scenario was appropriate to test basic emergency capabilities and to demonstrate the licensee's exercise objectives.

Noteworthy challenging aspects of the scenario included degraded Unit 1 conditions that warranted a General Emergency declaration without an associated radiological release from containment and a subsequent radiological release due to a fire in a charcoal bed.

b.7 Licensee Critiques

The inspectors attended the licensee's critiques in the CRS, TSC, OSC, and EOF which occurred immediately after the exercise. Exercise controllers solicited verbal and written inputs from the participants in addition to providing the participants with the controllers' initial assessments of personnel performance. The inspectors concluded that these initial critiques were thorough and in close agreement with the majority of inspectors' observations.

The control room critique was conducted in a relatively quick manner. Ten minutes was allowed for the completion of player critique forms and the overview took only about 15 additional minutes. Only three of four comments were voiced by the crew. The TSC critique immediately following the exercise termination was quite self-critical and all participants were provided an opportunity to identify issues. The initial critique involving EOF staff was conducted by the ED and was extremely detailed. All EOF staff were expected to contribute to the discussion.

c. Overall Conclusions

The exercise was a competent demonstration of the licensee's capabilities to implement its emergency plans and procedures.

- Overall performance during the 1998 Emergency Preparedness exercise was effective and demonstrated that emergency plan implementation activities met regulatory requirements. (Section P4.1.b)
- Exercise performance in the control room simulator was exceptionally effective. Appropriate procedures, including abnormal operating procedures and emergency operating procedures were effectively used. "Repeat back" communications were consistently used by the crew. Close and effective command and control of the operators was consistently displayed by the Duty Operating Supervisor. (Section P4.1.b.1)
- Overall, the TSC's staff's performance was adequate. Staff teamwork was apparent and communications with offsite authorities and between the emergency response facilities' staffs were effective. (Section P4.1.b.2)
- An inappropriate decision was made to tie a non-safety electrical bus to a safety-related electrical bus in order to enable providing reactor makeup water to Unit 2. (Section P4.1.b.2)

- OSC staff performance was satisfactory. OSC teams were generally assembled, briefed and deployed in a timely manner. Returning teams were adequately debriefed. (Section P4.1.b.3)
- The EOF staff's overall performance was effective and in accordance with the Emergency Plan. The ED declared a Site Area Emergency and a General Emergency in a correct and timely manner as plant conditions worsened. (Section P4.1.b.4)
- A field monitoring team followed their procedures very well. Sampling procedures and equipment needed enhancement. (Section P4.1b.5)
- Critiques following termination of the exercise were critical and included inputs from controllers and exercise participants. (Section P4.1.b.7)

P8 Miscellaneous EP Issues

- P8.1 (Closed) Inspection Follow up Item No. 50-266/96006-05; 50-301/96006-05: During the 1996 evaluated exercise, Control Room Simulator personnel were not consulted regarding declaring a General Emergency based upon plant conditions. During this exercise, communication and coordination with the shift crew in the Control Room Simulator was adequate. This item is closed.
- P8.2 (Closed) Inspection Follow up Item No. 50-266/96009-06; 50-301/96006-06: During the 1996 evaluated exercise, an offsite team arrived to work in the switchyard, but was not tracked by OSC personnel nor issued dosimetry, although they were working in an area affected by the scenario release plume. A portion of the 1998 exercise scenario was specifically written to address this item. An individual responded to the site, representing an offsite volunteer fire department "team." This "team" was brought to the TSC/OSC late in the exercise, and not dispatched, due to indications that the scenario fire was self-extinguishing. The "team" was, however, brought to the TSC/OSC, controlled, and procedures were in place to track the team and provided needed dosimetry and radiological briefings. This item is closed.

V. Management Meetings

X.1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on November 5, 1998. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

J. Anderson, Operations Manager
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NRC

F. Brown, Senior, Resident Inspector
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INSPECTION PROCEDURES USED

IP 82301 Evaluation of Exercises for Power Reactors
IP 82302 Review of Exercise Objectives and Scenarios for Power Reactors

ITEMS OPENED AND CLOSED

Opened

- | | | |
|---------------------|-----|--|
| 50-266/301/98020-01 | IFI | Issuance of dosimetry to Control Room personnel under emergency conditions was not proceduralized. |
| 50-266/301/98020-02 | IFI | Two "rapid response teams" took a lengthy amount of time to be assembled and dispatched. |
| 50-266/301/98020-03 | IFI | EALs to be revised and restructured. |
| 50-266/301/98020-04 | IFI | Need for state geographic subarea map in the EOF. |
| 50-266/301/98020-05 | IFI | Soil and vegetation sample procedure and equipment in need of revision. |

Closed

- | | | |
|---------------------|-----|---|
| 50-266/301/96006-05 | IFI | Control Room Simulator personnel not consulted regarding declaring a General Emergency based upon plant conditions. |
| 50-266/301/96006-06 | IFI | Offsite switchyard team not tracked by OSC personnel nor issued dosimetry. |

LIST OF ACRONYMS USED

CFR	Code of Federal Regulations
CRS	Control Room Simulator
DOS	Duty Operations Supervisor
DPR	Demonstration Power Reactor
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
DSS	Duty Shift Superintendent
ED	Emergency Director
EAL	Emergency Action Level
EOF	Emergency Operations Facility
EP	Emergency Preparedness
ENS	Emergency Notification System
EPZ	Emergency Planning Zone
ERDS	Emergency Response Data System
ERF	Emergency Response Facilities
IFI	Inspection Follow up Item
IP	Inspection Procedure
JPIC	Joint Public Information Center
KI	Potassium Iodide
NRC	Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
OSC	Operations Support Center
PAB	Primary Auxiliary Building
PAR	Protective Action Recommendation
PDR	NRC Public Document Room
PM	Project Manager
PRR	Public Reading Room
RO	Reactor Operator
RP	Radiation Protection
RPT	Radiation Protection Technician
SAE	Site Area Emergency
SRC	State Radiological Coordinator
TSC	Technical Support Center
TSS	Technical Support Staff