

U. S. NUCLEAR REGULATORY COMMISSION

REGION I

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License No: DPR-26

Report No: 050000247/99012

Licensee: Consolidated Edison Company of New York, Inc.

Facility: Indian Point Nuclear Generating Station, Unit II

Dates: September 21 - October 7, 1999
November 22, 1999 (In-Office Inspection End Date)
December 22, 1999 (Final Exit Meeting)

Inspectors: N. McNamara, Emergency Preparedness Inspector, RI
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EXECUTIVE SUMMARY

Indian Point Nuclear Generating Station, Unit II
Emergency Preparedness Exercise Evaluation
September 22, 1999
Inspection Report Number 050000247/99012

During the June 1998 biennial full-participation exercise, the NRC observed several exercise deficiencies and an exercise weakness which were discussed in NRC Inspection Report No. 50-247/98-07. In August 1999, an actual event occurred that resulted in the licensee not declaring an Unusual Event (UE) based on the Emergency Action Level (EAL) scheme not containing all the adequate information for determining that the conditions of an UE had been met. Based on these two issues, the NRC conducted a team inspection to review and assess the licensee's performance during its off-year annual exercise. The inspection results are based primarily on the exercise observations, except where noted.

The shift manager (SM) maintained an appropriate oversight of the central control room (CCR) staff, and the CCR Supervisor directed operator activities based on emergency and abnormal operating procedures. However, an EAL training problem was noted when the SM did not properly implement the EALs for the Alert classification when sufficient information was available.

Several repeat training and communication deficiencies were noted resulting in a poor technical support center (TSC) performance, some of which included: (1) repair teams were not prioritized; (2) the staff failed to provide needed support for event mitigation; and (3) there were instances where the staffs' expertise were not fully utilized. In addition, procedure implementation problems were noted in which both the TSC Manager (TSCM) and the plant operations manager (POM) did not fulfill their responsibilities as described in their pertinent emergency procedures. Also, the procedures describing the POM's role were confusing because the POM's attention is needed in support of two facilities simultaneously. Based on these identified problems, overall performance in the TSC was considered an exercise weakness. **(IFI 50-247/99-12-01)**

Several repeat training and communication deficiencies were noted which resulted in a poor operations support center (OSC) performance. Also, a repeat exercise weakness from the 1998 and 1994 exercises was identified with respect to a repair team dispatched during a radiological release. Specifically, procedural implementation problems identified were: (1) some repair teams were dispatched without a means to communicate; (2) teams were not selected based on expertise; (3) the OSC manager did not keep OSC personnel informed of the emergency classifications or the progression of the mitigating activities; and (4) there was an inadequate demonstration of the use of repair teams. Based on these identified problems, overall performance in the OSC was considered an exercise weakness. **(IFI 50-247/99-12-02)**

The emergency operations facility (EOF) was activated and operated in accordance with the emergency plan (E-Plan) and its implementing procedures. However, the emergency director (ED) prematurely declared a Site Area Emergency based on: 1) an incorrect assessment of plant conditions; and 2) not utilizing the expertise of the TSC staff to review all the information available for meeting the classification.

Overall, several performance, communication, training and procedural deficiencies were noted during the exercise. There were two repeat findings in the TSC (paragraph b.2) and two repeat findings and a repeat exercise weakness in the OSC (paragraph b.3), along with repeat findings with respect to inadequate critiques (paragraph b.5) from previous NRC-evaluated exercises. Based on these findings, the inspectors determined, collectively, that the licensee did not adequately identify and correct weak or deficient conditions. This Severity Level IV violation is being treated as a NCV. **(NCV 50-247/99-12-03)**

During the inspection, it was identified that ERO qualifications had lapsed for one individual in a key ERO position listed on the E-Plan's current emergency responders list. The licensee immediately removed the individual from the list and has entered this concern in their corrective action system. **(IFI 50-247/99-12-04)**

During the August 31, 1999, Loss of Offsite Power event, the licensee's EAL scheme for this type of event did not contain the adequate information for declaring an unusual event (UE), and the shift manager did not review the available technical basis document from which to make a proper classification. As a result, the licensee failed to declare a UE when offsite power was lost to the 480V safety buses. This Severity Level IV violation is being treated as an NCV **(NCV 50-247/99-12-05)**. A similar problem was observed during the exercise in September 1999.

Report Details

P4 Staff Knowledge and Performance

a. Exercise Evaluation Scope (92904 and 82301)

During this inspection, the inspectors observed and evaluated the licensee's annual exercise in the CCR, TSC, OSC, and the EOF. The inspectors assessed ERO recognition of abnormal plant conditions, classification of emergency conditions, notification of offsite agencies, development of protective action recommendations (PARs), command and control, communications, utilization of repair and field monitoring teams, and the overall implementation of the emergency plan (E-Plan) and its procedures. In addition, the inspectors observed the post exercise critique to evaluate the licensee's self-assessment of the exercise.

b. Observations and Findings

b.1 CCR

The SM maintained an appropriate oversight of the CCR staff and the CCR Supervisor directed operator activities based on emergency and abnormal operating procedures. However, there were two controller prompts that were necessary for the Alert and the Site Area Emergency (SAE) (see paragraph b.4 for details of the SAE). The SM had sufficient information to make the Alert declaration and had to be prompted by the controller to make the classification. At 0855, analytical results from a reactor coolant sample indicated that reactor coolant "dose equivalent Iodine-131" was $312\mu\text{Ci/cc}$. The SM did not make an Alert declaration because EAL 2.1.2, stated that an Alert must be declared when the "coolant activity $>300\text{ uCi/cc I-131 equivalent}$ ". Despite the terminology difference, the SM could have made the Alert declaration based on the available information.

The SM stated that EAL 2.1.2 specifically referred to "I-131 equivalent" rather than the terminology that was used by the chemistry technician of "dose equivalent iodine". The SM asked specifically for the I-131 concentration which was $180\mu\text{Ci/cc}$. Based on this information, the SM did not declare the Alert. The definition of "dose equivalent I-131" is, "that concentration of I-131 which alone would produce the same thyroid dose as the quantity and isotopic mixture of I-131, I-132, I-133, I-134 and I-135 actually present". Therefore, it would be inaccurate to look at only the I-131 result when the dose equivalent I-131 is used to determine the emergency declaration. The inspectors noted that the EAL does not use the word "dose" when referring to I-131 equivalent and it did not contain all the descriptive terms expected for meeting the technical basis. However, the bases document was clear on proper terminology and this document was available to the SM and other ERO staff members for use. This problem was identified in the licensee's critique and entered into their corrective action system for follow-up.

The SM not declaring an Alert was indicative of a training problem in understanding the basis of the EAL. On an actual event, the delay in the Alert declaration could have impeded the licensee from activating the emergency facilities from mitigating the consequences of the event.

b.2 TSC

The TSC was activated within the required time period after the Alert declaration. Discussions focused on mitigation strategies, EAL status, plant status, and actions within the emergency operating procedures. Plant status boards were properly maintained. However, the inspectors observed that the TSCM and the POM did not fulfill their responsibilities as described in their pertinent emergency procedures. Also, several training deficiencies were noted resulting in repetitive exercise findings from the previous two exercises. (NRC Inspection Report 50-247/98-07 and Report 50-247/94-06).

Emergency Procedures IAP-13, "POM," and IP-1023 "OSC," described generally the POM's role once the Emergency Director (ED's) responsibilities were shifted to the EOF. Although the POM is physically located in the TSC, the OSC procedure clearly delineates the POM as having oversight of dispatching maintenance repair teams. In many of the instances, the POM was observed in the TSC as assuming the role of the TSCM resulting in the POM having little involvement with the OSC activities as described in IP-1023. This resulted in: (1) the POM giving tasks conflicting with the TSCM; (2) apparent confusion in the TSC as to who was in command and control; and (3) the POM did not ensure maintenance team briefings were adequate and work priorities were not maintained or changed accordingly as described in the IP-1023, OSC. This issue was also identified by the licensee at the exercise critique.

The inspectors also noted that the POM did not establish work priorities to the repair teams who were briefed and dispatched out of the TSC. Repair teams are to be dispatched as soon as possible for the purposes of gathering information that would be insightful for diagnosing the problem or making a repair to stop event escalation. During the exercise, direction of the repair teams was based upon available resources and position in line for the briefings. A consequence of this problem was in the postponement of the acquisition of a steam generator sample which could have assisted the licensee in determining escalation to the SAE.

Overall, training and communication deficiencies were noted with respect to the performance and operations of the TSC. IP-1035 clearly described the duties of the TSCM, some of which were not properly implemented. Contrary to the procedure, the TSCM did not keep the TSC staff informed of all the emergency classifications and the ED and POM were not routinely updated as specified in the procedure. Also, in certain instances, the TSCM did not provide direction to the technical staff to pursue mitigation strategies. In addition, the POM and the TSCM did not fully utilize the expertise of the TSC staff, as evidenced by the POM and the ED concluding that an SAE was warranted based on an assumption that the reactor coolant system (RCS) leak had increased (see Paragraph b.4). The TSC staff had not been tasked with calculating an RCS leak rate which would have provided the key information for not escalating the classification.

Several instances were observed in which the TSC staff failed to provide needed support for mitigation of the event. Examples of this were they: (1) did not provide input into the potential escalation of the EALs when requested or monitoring plant conditions (e.g., early SAE declaration); (2) did not follow-up on the definition of "ruptured" generator in relationship to the EALs; (3) failed to evaluate the use of the main condenser for storage of RCS leakage in the turbine building; and (4) did not pursue the loss of water inventory within the turbine building which impacted long-term recirculation capability.

Overall, the inspectors concluded that the problems noted in the TSC were due to weak proficiency in procedure implementation and inconsistent E-Plan procedures. The above performance problems on the effectiveness of the TSC E-Plan reflect an exercise weakness (**IFI 50-247/99-12-01**). Licensee corrective actions are being followed by Condition Report (CR) No. 1999-07448.

Further, the inspectors determined that there were two repeat findings from the June 1998 exercise: (1) not prioritizing maintenance repair teams, and (2) the TSCM not performing the responsibilities as described in the pertinent emergency procedure. These repetitive findings constitute the first set of examples of a violation of the licensee's E-Plan and NRC regulations 10 CFR 50.54(q), 50.47(b)(14) and (15), and Appendix E (Section IV.F.2.g) for failure to identify and correct weak or deficient conditions (Section b.5-**NCV 50-247/99-12-03, in part**).

b.3 OSC

Conduct and operation of the OSC is described in emergency procedure IP-1023. The OSC was utilized as a waiting area for individuals to report to the TSC for repair assignments. The facility was activated and staffed in a timely manner, personnel exposure limits were tracked, facility habitability was periodically assessed and teams were dispatched to the TSC for their assignments. However, inspectors observed several discrepancies with respect to procedural implementation, communications and training.

When assigning individuals to teams, the licensee did not utilize the associated supervisors (maintenance, health physics and I&C) for assigning tasks to individuals who maintained qualifications specific to the repair. Not having proper staff assigned for repairs could potentially delay the mitigation of the event. However, no specific consequence of this issue could be cited, because all exercise play for the repair teams was simulated. Repair teams were told by controllers what to fix, how to fix it and what tools would be appropriate. The inspectors spoke with a few of the players who stated that in the last three years, team repairs had always been simulated. The inspectors noted this to be "negative" training, in that repair team simulation does not independently demonstrate the knowledge or capability of the ERO staff for ensuring that the proper tool was selected, repair alternatives were discussed, and the repair was completed in a timely manner. This issue was also noted by the NRC during the licensee's 1994 full-participation graded exercise.

Several examples of not meeting IP-1023 included: (1) a repair team was not aware of the general emergency (GE) declaration because the radio address system didn't work in that area; (2) two teams were dispatched without a means to communicate; (3) pagers didn't properly function for some ERO responders; (4) the OSC and TSC staff were not cognizant of the status of a repair team due to poor tracking; and (5) the OSC manager did not keep OSC personnel informed of the emergency classifications, general plant status or the progression of the mitigating events.

In the previous exercise (June 1998), the licensee exhibited an exercise weakness (IFI 50-247/98-07-01) for dispatching repair teams to the field while a release was in progress without a means of communication. This was a repeat finding from the previous exercise conducted in June 1994. In accordance with IP-1023, the licensee committed to "keeping field teams apprised of plant conditions and emergency classifications via portable radios". During the 1999 exercise, this was not conducted as evidenced by two repair teams were in the plant without communication while a release was in progress. Even though the teams were escorted by health physics technicians, forewarning teams of existing hazards is prudent.

Insufficient communications and inadequate training appeared to be a contributing factor for not meeting specific requirements of IP-1023. The above performance problems on the effectiveness of the OSC reflect an exercise weakness (IFI 50-247/99-12-02). Licensee's corrective actions are being followed by CR 1999-07448.

Further, the inspectors determined that the failure to keep field teams apprised while a release was in progress is a repeat exercise weakness from the June 1998 exercise. Also, there were two repeat findings, in that: (1) some in-plant beepers or pager systems did not activate, and (2) inadequate demonstration of the use of repair team were repetitive findings from the 1998 and 1994 exercises. These repetitive findings are the second set of examples of a violation of licensee's E-Plan and NRC regulations 10 CFR 50.54(q), 50.47(b)(14) and (15), and Appendix E (IV.F.2.g) for failure to identify and correct weak or deficient conditions (Section b.5-NCV 50-247/99-12-03, in part).

b.4 EOF

The ED and the POM demonstrated a very good turnover at the CCR. The ED activated the EOF in a timely manner, the EOF staff exhibited very good teamwork, overall, and the offsite notifications were timely.

The CCR controller had to stop the premature escalation of the SAE by the ED based on the players' assessment of plant conditions. Control room operators had initiated a plant cooldown and depressurization in response to a 30 gpm RCS leak. At approximately 1500 psig primary system pressure, safety injection pumps began to inject into the RCS, making up inventory losses in the pressurizer (PZR). The technical staff in the EOF observed 300 gpm safety injection flow and incorrectly concluded the leak had become more severe. An SAE was declared based on EAL 2.1.3, "primary system leakage exceeding capacity >75 gpm of singled charging pump".

The inspectors reviewed this action and determined that had the licensee assessed all the plant information, they would have determined that the leak rate had not increased and they did not meet the specifications of the EAL. In fact, plant parameters indicated that the containment sump fill rate had not increased. Based on a misdiagnosed leak rate, the licensee entered EAL 2.1.3 correctly. However, this was another example in which the expertise in the TSC was not fully utilized and consequentially led to misclassifying the event based on actual conditions.

Following the GE classification, the ED gave a briefing to the State and County agencies. The briefing was not adequate because it did not contain correct radiological information, the basis for the PAR and the ED did not refer to the dose assessment staff for correctly answering the state's questions. Based on discussions with the ED, the inspectors determined that this was a player simulation problem that appeared to be isolated to that one briefing. This issue was captured in the licensee's post-critique and entered into their corrective action system.

The dose assessment team correctly assessed and integrated information from multiple sources to properly define the magnitude and location of the offsite impact of the simulated radiological release in support of the PAR development. The field teams were properly prepared and verified that radiological instrumentation was operational and calibrated.

b.5 Licensee Exercise Evaluation and Critique Processes

The inspectors observed that immediately following the exercise termination, the licensee conducted facility debriefs with the players to solicit their input for feedback regarding the facilities, equipment, procedures, and ERO performance. A formal critique was conducted on September 23, 1999. The NRC's observations were that Con Edison's critique of the TSC and OSC was not sufficiently self-critical and many of the findings discussed in this report were not found except as noted herein. In the last two emergency exercises, the licensee was assessed as conducting poor exercise critiques. This repetitive finding is the third example of a violation of licensee's E-Plan, Section 8.4, and NRC regulations 10 CFR 50.54(q), 50.47(b)(14) and (15), and Appendix E (IV.F.2.g) for failure to identify and correct weak or deficient conditions and critiques were not adequate (**NCV 50-247/99-12-03**). Licensee's corrective actions are being followed by CR 1999-07448.

c. Overall Exercise Conclusions

The SM maintained an appropriate oversight of the CCR staff, and the CCR Supervisor directed operator activities based on emergency and abnormal operating procedures. However, an EAL training problem was noted when the SM did not properly implement the EALs for the Alert classification when sufficient information was available.

Several repeat training and communication deficiencies were noted resulting in a poor TSC performance, some of which included: (1) repair teams were not prioritized; (2) the staff failed to provide needed support for event mitigation; and (3) there were instances where the staffs' expertise were not fully utilized. In addition, procedure implementation problems were noted in which both the TSCM and the POM did not fulfill their responsibilities as described in their pertinent emergency procedures. Also, the procedures describing the POM's role were confusing because the POM's attention is needed in support of two facilities simultaneously. Based on these identified problems, overall performance in the TSC was considered an exercise weakness. **(IFI 50-247/99-12-01)**

Several repeat training and communication deficiencies were noted which resulted in a poor OSC performance. Also, a repeat exercise weakness from the 1998 and 1994 exercises was identified with respect to a repair team dispatched during a radiological release. Specifically, procedural implementation problems identified were: (1) some repair teams were dispatched without a means to communicate; (2) teams were not selected based on expertise; (3) the OSC manager did not keep OSC personnel informed of the emergency classifications or the progression of the mitigating activities; and (4) there was an inadequate demonstration of the use of repair teams. Based on these identified problems, overall, performance in the OSC was considered an exercise weakness. **(IFI 50-247/99-12-02)**

The EOF was activated and operated in accordance with the E-Plan and its implementing procedures. However, the ED prematurely declared a SAE based on: 1) an incorrect assessment of plant conditions; and 2) not utilizing the expertise of the TSC staff to review all the information available for meeting the classification.

Overall, several performance, communication, training and procedural deficiencies were noted during the exercise. There were two repeat findings in the TSC (paragraph b.2) and two repeat findings and a repeat exercise weakness in the OSC (paragraph b.3), along with repeat findings with respect to inadequate critiques (paragraph b.5) from previous NRC-evaluated exercises. Based on these findings, the inspectors determined, collectively, that the licensee did not adequately identify and correct weak or deficient conditions. This Severity Level IV violation is being treated as a NCV. **(NCV 50-247/99-12-03)**

P5 Staff Training and Qualification in EP**a. Scope (82301 and 82700)**

The inspectors reviewed EP training records, training procedures and the E-Plan's training requirements to determine if all individual's who participated in the exercise had maintained their ERO qualifications current.

b. Observations and Findings

Following the exercise, the inspectors requested the licensee to confirm that ERO qualifications were current in accordance with the E-Plan's responders list dated September 14, 1999. The licensee found one individual in a key ERO position (radiation protection coordinator) that was not qualified. This type of finding was also identified during a previous NRC program inspection (50-247/96-07). Licensee representatives acknowledged weak administrative controls in this area and documented this issue in CR's 1999-06868 and 07449. **(IFI 50-247/99-12-04)**

However, this repetitive finding is a fourth example of a violation of licensee's E-Plan and NRC regulations 10 CFR 50.54(q), 50-47(b)(14) and Appendix E (Section IV.F.2.g) for failure to identify and correct weak or deficient conditions. **(NCV 50-247/99-12-03)**

c. Conclusions

It was identified that ERO qualifications had lapsed for one individual in a key ERO position listed on the E-Plan's current emergency responders list. The licensee immediately removed the individual from the list and has entered this concern in their corrective action system **(IFI 50-247/99-12-04)**. This is a fourth example contributing to NCV 50-247/99-12-03.

P8 Miscellaneous EP - August 31, 1999, Event Resulting in Not Declaring an Unusual Event**a. Scope (92904)**

On August 31, 1999, an NRC Augmented Inspection Team (AIT) reviewed the causes of a reactor trip which resulted in a loss-of-offsite power to all four vital 480 volt buses. This resulted in the loss of emergency power and loss of the emergency diesel generator to one of the four vital buses. The licensee did not declare an UE based on the specific wording of the EAL. The AIT concluded that the EAL was deficient because it did not contain the adequate information for describing when offsite power was unavailable to the 480 Vital buses. The inspectors reviewed the circumstances and the corrective actions related to the event.

b. Observations and Findings

The inspectors reviewed the licensee's action reports, EAL 6.1.1 and held discussions with the EP staff to determine the adequacy of their proposed corrective actions. Although plant conditions did not exactly correlate with the wording of EAL 6.1.1, the SM had available the technical basis document which clearly described that the plant conditions during the event met an UE. Discussions held with the EP Manager determined that the SM is expected to review the bases document for clarity on a specific EAL. Additionally, the option exists to use EAL 9.1.1, which is based on discretion, if the SM believes that plant conditions were degraded.

The inspectors determined that EAL 6.1.1 did not contain the adequate information for declaring an UE; and the operators did not review the available technical basis document for clarity of the guidance. This is considered a violation of 10 CFR 50.47(b)(4) for failure to use the EAL 6.1.1 and its bases. This Severity Level IV violation is being treated as a NCV consistent with VII.B.1.a of the NRC Enforcement Policy. This violation is in Con Edison's corrective action system as CR Nos. 1999-06798 and 06868 (**NCV 50-247/99-12-05**). A similar problem was observed during the exercise (paragraph b.1).

The inspectors found the licensee's specific corrective actions and extent of condition review to be acceptable for resolving this issue. The licensee determined that EAL 6.1.1 needed to be revised to reflect its plant specific technical basis and issued a Standing Order to plant operators that contained the technical basis interpretation of the EAL.

Although the licensee determined this to be an enhancement to the EAL, they submitted the correction for NRC review and approval which was pending at the completion of this inspection. The licensee submitted a long term action plan which included evaluation of all EALs for consistency and the retraining of the operators on EALs and its technical basis document. The NRC found these actions to be acceptable for resolving this issue.

Overall, the licensee's proposed corrective actions for the August 1999 event included the revision of the appropriate EAL, issued a Standing Order as an interim measure, reviewed all EALs for accuracy and clarity and retrained operators on understanding the technical basis of EALs.

c. Conclusions

During the August 31, 1999, Loss of Offsite Power event, the licensee's EAL scheme for this type of event did not contain the adequate information for declaring an UE, and the shift manager did not review the available technical basis document from which to make a proper classification. As a result, the licensee failed to declare an UE when offsite power was lost to the 480V safety buses. This Severity Level IV violation is being treated as an NCV (**NCV 50-247/99-12-05**). A similar problem was observed during the exercise in September 1999.

V. Management Meetings

X1 Exit Meeting

The inspectors presented the inspection results to members of licensee management via telephone on October 5, 1999.

A management meeting was held at the licensee's facility on October 7, 1999 with Mr. Blind, and others to discuss: 1) the licensee's assessment and views of the significance of the exercise weaknesses; and 2) the proposed corrective actions (both short and long term) to address the exercise weaknesses. The meeting commenced with the understanding that the NRC found the proposed short term corrective actions to be adequate with the understanding that the long term goals will be completed by March 2000 (see Enclosure 2). The short term actions included: (1) reviewing EALs for any anomalies; (2) immediately retraining team leaders and facility managers with respect to their roles and responsibilities; (3) ensuring senior management oversight of the program; and (4) indicating their intent to conduct another exercise for NRC evaluation by June 2000.

A final exit meeting was conducted by telephone on December 22, 1999 between Messrs. B. Holian and R. Conte, NRC, and Mr. McGrath, ConEd, and other representatives. Two exercise weaknesses were discussed. An exercise weakness is a finding that the licensee's demonstrated level of preparedness could have precluded effective implementation of the E-Plan in the event of an actual emergency (re: 10 CFR 50 Appendix E, Section IV.F.2.g)

PARTIAL LIST OF PERSONS CONTACTED

Licensee

A. Alan Blind, Vice President - Nuclear Power
 T. Ferraro, E-Planner
 K. Walker, Emergency Preparedness Consultant, Duke
 R. Burns, E-Planner

NRC

B. Holian, Deputy Director, Division of Reactor Safety, Region I
 R. Conte, Human Performance and Emergency Preparedness Branch, DRS, RI

NRC INSPECTION PROCEDURE USED

92904 Followup - Plant Support

ITEMS OPENED, CLOSED, AND DISCUSSED

Open

50-247/99-12-01	IFI	Exercise weakness due to overall poor performance in the TSC
50-247/99-12-02	IFI	Exercise weakness due to overall poor performance in the OSC
50-247/99-12-03	NCV	Inadequate corrective actions and inadequate exercise critique
50-247/99-12-04	IFI	Lapse of ERO qualifications
50-247/99-12-05	NCV	Failure to use the EAL technical basis document during the August 31, 1999 event and not declaring a UE.

Closed

50-247/98-07-01	IFI	Exercise weakness due to dispatching a repair team with a simulated release in progress without the team's knowledge. (Closed for Administratively purposes since inspector follow-up occurred in this inspection based on another exercise scenario.)
50-247/98-07-02	IFI	Various Program Control Weaknesses. (Closed for administratively purposes since inspector follow-up occurred in this inspection based on another exercise scenario.)

Discussed

None

LIST OF ACRONYMS USED

TSC	Technical Support
CCR	Central Control Room
OSC	Operations Support Center
EOF	Emergency Operations Facility
ED	Emergency Director
ERO	Emergency Response Organization
ORAD	offsite radiological assessment director (ORAD)
PAR	Protective Action Recommendation
GE	General Emergency
SAE	Site Area Emergency
UE	Unusual Event
EAL	Emergency Action Level
PZR	Pressurizer
RCS	Reactor Coolant System
POM	Plant Operations Manager
TSCM	Technical Support Manager
NRC	Nuclear Regulatory Commission
CFR	Code of Federal Regulations

EMERGENCY PLANNING

- DRILLS/EXERCISES
- TSC/OSC ISSUES
- CRITIQUES
- EMERGENCY ACTION LEVELS

DRILLS/EXERCISES

- DRILL EACH WATCH CREW-START NOV.1-TOTAL OF 7 DRILLS
- 3 OF THE 7 DRILLS WILL INVOLVE OTHER FACILITIES-OSC,TSC,EOF
- UTILIZE OUTSIDE MENTORS TO ASSIST IN CRITIQUING DRILLS

TSC/OSC ISSUES

- COMMAND & CONTROL-FACILITY TRAINING FOR TSC/OSC MANAGERS, COORDINATORS, POM
- JOB PRIORITIZATION-TSC STATUS BOARDS TO SHOW PRIORITIES
- TEAM EXPERTISE-OSC SUPERVISORS TO DETERMINE MEMBER QUALS

TSC/OSC ISSUES

- TEAM DISPATCH & CONTROL-ISSUE PAGERS TO TEAMS-TEAMS TO CALL BACK TSC FOR UPDATES
- TSC/OSC PROCEDURES TO BE REVISED TO REFLECT CHANGES

CRITIQUES

- CONTINUE FACILITY DEBRIEFS AT END OF DRILLS
- FACILITY CONTROLLERS & OBSERVERS REMAIN AFTERWARDS TO ESTABLISH FACTS & TIMELINE
- UTILIZE INDUSTRY MENTORS TO ASSIST IN EVALUATIONS

CRITIQUES

- INTERACTIVE CRITIQUE TO INCORPORATE OTHER COMMENTS
- TABLETOPS IN EACH FACILITY TO REVIEW CRITIQUE, PAST DRILLS & OTHER ISSUES

EMERGENCY ACTION LEVELS

- AUG. 31, 1999-REVISIONS MADE AND PLAN & PROCEDURES CHANGED-SNSC REVIEW AND THEN NRC PRE-APPROVAL & STATE/COUNTY REVIEW NEXT
- INTERIM GUIDANCE ON ABOVE EALS IN WATCH STANDING ORDER

EMERGENCY ACTION LEVELS

- SEPT. 22, 1999 EXERCISE
 - ALERT DECLARATION
 - SITE AREA DECLARATION