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 JAMISON,J.D. Battelle Memorial Institute, Pacific Northwest Laboratory
 RECIP.NAME RECIPIENT AFFILIATION
 GOOD,G.M. Region 5, Ofc of the Director

SUBJECT: Forwards final rept of G Wehmann of PNL participation in
 870912-13 emergency preparedness exercise.

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September 29, 1988

Ms. G. M. Good
U. S. Nuclear Regulatory Commission
Region V
1450 Maria Lane
Suite 210
Walnut Creek, CA 94596

Dear Gail:

WNP-2 EXERCISE, SEPTEMBER 12-13, 1987

Enclosed is the final report of George Wehmann who was the Pacific Northwest Laboratory (PNL) participant during the subject exercise. Only minor changes have been made to the draft given to you prior to his leaving the site. The areas covered by Mr. Wehmann included the Operational Support Center (OSC) and the Field Team #2.

If you have any questions regarding this report, please contact me on FTS (509) 375-3782.

Sincerely,

J. D. Jamison, Project Manager
Operational Health Physics
Occupational & Environmental Protection Section
HEALTH PHYSICS DEPARTMENT

JDJ/chb

Enclosure

cc: WD Travers, w/enclosure
LC Ruth, w/enclosure

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WNP-2 EMERGENCY PREPAREDNESS EXERCISE

September 12-13, 1987

- A. Name: George Wehmann
- B. Assignment: Operational Support Center (OSC), Field Team #2
- C. Site Personnel Contacted: D. Anderson, Safety Marshall; L. Sharp, Principal Engineer; J. Fulfer, Maintenance Engineer; R. Tanska, Senior Trainer; J. Kleam, Shop Coordinator, Electrical Maintenance; F. Bartel, BPA Oversight Team; C. Eggen, Principal Fire Protection Engineer; J. Massey, Senior Technical Engineer; and T. Hull, Senior Training Specialist.
- D. Positive Findings
- The organization and implementation of the re-entry team program permitted the OSC to carry out this function in an efficient and timely manner.
- E. Negative Findings
- The OSC failed to notify other ERFs of carbon filter failure.
 - Security took 20 minutes to deliver requested computer printouts and visitor logs to OSC, reducing OSC's time to perform accountability check to 15 minutes.
 - The method of notifying OSC workers to take KI (simulated) was inadequate. Two verbal announcements by the OSC Director cannot be considered to be a positive method of notification to all OSC staff members.
 - Security officers responding to unlock Building 17 at about 12:30 pm did not wear anti-C's nor did they have a radiological technician with them.

Role of these officers is not clear but it was assumed they were players.

- Field team survey techniques would have contaminated instrument probes during ground level radiation survey since the probe made contact with various types of vegetation.
- Some simulations that were not identified in the scenario were utilized by players. For example; 1) re-entry teams did not remove outer clothing when suiting up; 2) the lobby of service building was 3 R/hr by scenario but was apparently exempted to allow teams to suit out in this area.

F. Chronology

<u>Time</u>	<u>Observation</u>
Day 1	
0630	Arrived at OSC.
0636	Public address announcement (PA) exercise has started.
0654	PA: NUE due to high winds.
0719	PA: "Alert" due to >100 mph winds.
0730	OSC Director asks everyone to sign in.
0731	Computer printout requested from security by OSC accountability staff.
0736	OSC Director announced that OSC is operational.
0751	Printout received from security.
0805	Accountability reported complete.
0838	Site Area Emergency declared. Protected Area controlled evacuation ordered.
0843	PA all evacuees report to OSC.

<u>Time</u>	<u>Observation</u>
0901	OSC Director provides instructions to evacuees on what gate to take. Only one problem -- no evacuees.
0951	OSC Director - first announcement to take KI tablets.
1111	Radiation survey of OSC - 100 mR/hr at window, 5 mR/hr at door. Re-entry team personnel move to near nurses station.
1135	Finally posted high radiation area near windows.
1231	Radiation survey - 3 R/hr at window 15 mR/hr at door - didn't move radiation barrier.
1245	Finally moved one end of barrier 3 feet for increase of 100 mR/hr to 3 R/hr.
1251	Team dress-out in an area of 3 R/hr observed. Controller had to tell Radiation Technician the dose level. Still little concern.
1309	Another team dressing out in 3 R/hr field.
1315	OSC Lead Controller informs me that suit-up area is exempt from 3 R/hr area.

Day 2

0915 Leave EOF with field team 2.
1340 Returned from field.

G. Follow-up on Previous Inspection Findings Inspection Report 92701:

Open Item 87-20-03:

The ability of the licensee to perform the accountability process within their stated time constraint (30 minutes after OSC becomes operational) remains questionable. Present procedures allow Security 30 minutes to deliver the computer printouts and visitor logs to OSC, thus, it is conceivable that OSC would not be able to meet their time line.

SUPPLEMENT TO SECTION E. NEGATIVE FINDINGS

Due to the scenario for this exercise, it was anticipated that the radiological impact upon the OSC would be significant. As a result, considerable emphasis was placed upon observing the licensee's radiological responses. The evaluator noted that a number of health physics procedures and/or practices were not followed. Each of these, by itself, would not have precluded effective implementation of this portion of the emergency plan. However, when taken collectively, they indicate a weakness that could seriously affect the licensee's response to an actual emergency. The following examples are symptomatic of the overall problem:

- 1) Radiological members of two different re-entry teams did not follow suit-up procedures.
- 2) It took 24 minutes to post the High Radiation Area in the OSC (near windows) after the radiation survey was made.
- 3) The Radiation Technician accompanying one re-entry team did not demonstrate the proper use of a survey instrument.
- 4) No smears or air samples were taken in the OSC following the release of radioactive material into the plant or environs.
- 5) OSC staff remaining within the OSC were never reminded to check their dosimeter, even when the dose rate at one end of the room was 3 R/hr.
- 6) Racks of spare dosimeters were left within 10-15 feet of the 3 R/hr area.
- 7) A number of the routine radiation surveys were made with a "ho-hum" attitude.
- 8) Two women were allowed to continue to sit within 15-18 feet of the 3 R/hr area.

- 9) Contamination control points were not established at the Service Building and the OSC entrance.
- 10) The HP Technician in OSC made no attempt to perform a detailed radiation survey after being told the dose rate at the window was 3 R/hr and 15 mR/hr. Professional health physics practices would dictate a more comprehensive survey within the room.
- 11) Once aware of the 3 R/hr dose rate near the window, the HP Technician did not make any effort to determine the source of the radiation, i.e., was it due to sky shine, ground deposition or airborne material.