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UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

Before the Atomic Safety and Licensing Board

In the Matter of	)	
LONG ISLAND LIGHTING COMPANY	)	Docket No. 50-322-OL-3
(Shoreham Nuclear Power Station, Unit 1)	)	(Emergency Planning)

SUPPLEMENTAL TESTIMONY OF DEPUTY INSPECTOR PETER F. COSGROVE AND LIEUTENANT JOHN L. FAKLER ON BEHALF OF SUFFOLK COUNTY REGARDING CONTENTIONS 39, 40, 41, 44, 98, 99 AND 100 - TRAINING OF OFFSITE EMERGENCY RESPONSE WORKERS

Q. Please state your names and occupations.

A. My name is Peter F. Cosgrove. I am a Deputy Inspector in the Suffolk County Police Department and hold the position of Executive Officer of the Third Precinct. Until January 15 of this year, I was the Commanding Officer of the Suffolk County Police Academy.

My name is John L. Fakler. I am a Lieutenant in the Suffolk County Police Department and hold the position of Commanding Officer of Media Services.

add: J. Gorn
OCA

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Our professional qualifications are contained in our previously filed testimony on Contentions 39, 40, 41, 44, 98, 99 and 100.

Q. Since your testimony was filed on April 2, 1984, have you received additional information which bears upon the issues raised in Contentions 39, 40, 41, 44, 98, 99 and 100?

A. Yes. It is our understanding that, subsequent to the filing of our testimony on April 2, 1984, LILCO was ordered by the Licensing Board to produce copies of critique and evaluation forms that had been completed by controllers and observers of four LERO drills and/or exercises. We have been informed that these controller/observer comments were produced by LILCO on or about June 1, 1984, and that such comments represent the only drill/exercise comments by LILCO controllers and/or observers that have been retained by LILCO or its training consultants. Based upon our review of the documents produced, it appears that we have been provided with comments from a training drill held in November, 1983 and another training drill held in January, 1984. We have also been provided comments from two exercises held in February, 1984. We have reviewed these documents and, in our opinion, they raise significant concerns about the adequacy of the LILCO drill and exercise program.

Q. What are these concerns?

A. First, we are concerned about the lack of briefings and the adequacy of the briefings that have been held both prior to and during LILCO's drills and exercises. Such briefings, during an actual emergency at Shoreham, would be of crucial importance and would, for example, provide a way of keeping LERO personnel informed about such matters as the status of the emergency, radiological and meterological conditions, and the general progress of the emergency response. Therefore, it is important that during training drills and exercises, briefings be held and that such briefings be realistic and adequate in scope. Numerous comment sheets, however, noted that briefings were not held and that those which were held were frequently inadequate.

Q. Is it your opinion that emergency workers must be constantly kept advised as to all details of the emergency and the actions taken in response to the emergency?

A. No. However, emergency workers should be kept apprised of the overall status of the emergency and the plant conditions, and they should be knowledgeable about the general progress of the emergency response. In addition, it is essential that emergency workers be kept fully informed about

all emergency conditions that bear upon their particular emergency jobs. For example, radiological monitoring personnel would need to be aware of wind direction and other meterological conditions, just as LILCO's traffic guides would need to be kept advised about traffic conditions.

The importance of timely and adequate briefings of emergency response personnel is emphasized by the LILCO Plan. For example, the LILCO Plan specifies that it is the responsibility of the Staging Area Coordinators to establish and maintain functional staging areas. (See OPIP 2.1.1). It is not possible, however, for the staging areas to function adequately if the emergency workers assigned to the staging areas do not have prompt and accurate information. Such information is provided by briefings; if such briefings are adequate, emergency workers will be better able to perform their tasks effectively and in the manner envisioned by the LILCO training program. For this reason, it is important that training drills and exercises include realistic and adequate briefings of trainees. Without such briefings, drill and exercise participants are precluded from having an opportunity either to interact with other emergency workers or to drill their job skills in a meaningful manner.

From our review of the drill/exercise comments produced by LILCO, it appears that problems in briefing emergency personnel/trainees occurred at every drill and exercise. For example, during the November, 1983 drill, drill controllers/observers commented that "periodic updates were not performed." One observer indicated that training personnel "generally performed below expectations," and that "[t]here were deficiencies of a significant nature." This same observer commented simply as follows: "Not the right info[rmation] at the right time." Similarly, during the January drill, observers noted that some briefings were "slow, late, [and] inaccurate," and also "lacked details." It was also noted that the bus driver dispatcher briefing "did not address current plant status/radiological status."

Briefings continued to be a problem during the two February exercises for which we were provided comments by LILCO. The first exercise, held on February 8, was characterized by numerous comments from observers about the lack of briefings. For example, observers wrote that there was "no general emergency briefing at [the Port Jefferson staging area]", and "[n]o general plant briefings for LERO field workers." In addition, there were comments that "[n]o radiological information was given to people going out to the

field." It was also observed that "people [were] not informed [of the] potential plume path and radiation levels at all." In fact, of the 14 completed critique/evaluation forms commenting on the performance of participants assigned to the LILCO staging areas during the February 8 exercise, seven indicated that personnel going into the field were not properly briefed as to the potential plume path and radiation levels. In addition, six of these forms also noted that field personnel were not properly briefed as to protective action recommendations. Only two of the forms indicated that field personnel had been properly briefed in both areas.

This pattern of problems with briefings continued during the second February exercise, which was held on February 15. As before, observers commented primarily on the lack of briefings. For example, one observer noted that there were "[n]o briefings relative to plant status or radiological conditions," while another observer commented that "[s]taging area personnel (dosimetry) were not briefed regarding emergency status, protective actions, plume travel -- other than status board posting. This is not enough." In addition, it was noted that "[b]riefings as to radiological conditions [were] poor." In fact, the briefings were so poor that one observer noted the following: "Traffic guides were given what meteorological

[and] plant status data . . . displayed on status board . . . but road crews, [route] spotters [and route] alert drivers [were] not given this data in briefings. This is a deficiency." (Emphasis in original.)

From the foregoing, it is clear that problems with briefings have persisted in every drill and exercise held by LILCO. The comments quoted and the critique/evaluation forms from which these comments were taken are appended to this testimony as Attachment 1. In our opinion, it is likely that the consistent failure of LILCO's briefings to provide drill and exercise participants with adequate and accurate information will significantly and adversely effect the ability of LILCO's emergency response personnel to develop an accurate understanding of LILCO's overall emergency response effort. In addition, in our opinion it is likely that the inadequate nature of LILCO's briefings have foreclosed LERO trainees from having an adequate opportunity to practice the particular jobs required of them under the LILCO Plan. This is a serious deficiency of the LILCO training program.

Q. Have the drill/exercise comments reviewed by you revealed any other problems with LILCO's training program?

A. Yes. There are comments and critiques from each of the drills and exercises noting significant problems with radio users being unfamiliar with proper radio language, radio protocol and general communications techniques. These areas are obviously important, since a good command of radio protocal, language and communications techniques would be necessary for there to be adequate communications among emergency response personnel during a Shoreham emergency. In our opinion, the persistent pattern of problems in these areas is therefore of significant concern. A sampling of the problems revealed in the training documents we have reviewed is set forth below and is appended to this testimony as Attachment 2.

During the November 1983 drill, for example, observers noted a "real need for radio training for communicators." One observer, in critiquing two communicators, commented as follows: "poor radio technique in 1 case, fair in the other." Some observers noted that LILCO's communicators were "unfamiliar with radio jargon" and one observer noted that "communicators had varying degrees of expertise with radios . . . more and better radio training [needed]." Similarly, during the

January drill, it was noted that LILCO's "traffic guides need[ed] more exposure" to radios to learn appropriate communication techniques and that the "communicators need[ed] to review [radio] jargon."

These problems continued during the February exercises. For example, during the February 8 exercise, some observers noted that "[b]etter radio protocol practices [were] needed" and that "[g]eneral radio protocol training is needed." In addition, when asked whether radio communications were easily understood, an observer commented as follows: "Not easily. A lot of walkover, some static. Poor radio etiquette." (Emphasis in original.) Radio language, or "jargon," was also a problem in the February 8 exercise. For example, in one case a traffic guide and traffic controller had a simulated "problem" to solve and radioed in for instructions. There were no further communications, and 30 minutes later both the traffic guide and the controller were instructed to come in from the field. After arrival, the traffic controller learned for the first time that the radio room had been trying to reach them in the field with instructions on solving their problem. The controller concluded that this mishap was caused in part by the fact that "no uniform [radio] language [was] being used."

During the February 15 exercise, problems with the use of radios persisted. "Poor radio protocol and etiquette" were observed again, as were examples of exercise participants "joking and laughing around." (This problem had also been noted in the February 8 exercise). For example, one observer commented as follows: "Too many traffic guides were calling the base in rapid succession without waiting for the base to respond to the first caller. This is either lack of courtesy on the air (or fooling around by the drivers) or lack of knowledge in the use of the airways. Perhaps better training in the use of radios is req[uired]."

In our opinion, the problems noted above are symptomatic problems which underscore the inadequate training given to LERO workers in the area of radio communications and usage. As a result, it is likely that the emergency response personnel relied upon by LILCO have not been properly trained to communicate effectively via radios, and therefore cannot be expected to respond to an emergency at Shoreham in the coordinated manner necessary to ensure an adequate and effective emergency response.

Q. Have the training documents reviewed by you revealed any other concerns regarding the communications training provided by LILCO?

A. Yes. In January and February there were problems with the radio equipment used in the training drills and exercises. For example, field personnel were not always provided with the appropriate radio equipment, and in many cases they were not given radios at all. Most of LILCO's emergency personnel do not use radio equipment in their daily jobs, and even those that do use such equipment do not use it under emergency conditions on a day-to-day basis. Therefore, it is important for the LILCO drill and exercise participants to be given some "hands on" experience with the equipment they will be expected to use in an actual emergency at the Shoreham plant. Without such experience, it is unrealistic to expect LILCO's emergency workers to be able to perform adequately during an actual emergency. A sampling of those comments concerning problems with LILCO's radio equipment (including the unavailability of such equipment) is provided below and is appended to this testimony as Attachment 3.

During the January drill, for example, it was noted that LILCO road crews were dispatched from the Riverhead

staging area with "Channel 3 radios, but [Riverhead] can only monitor Channel 10." In addition, observers noted a "lack of radios by field personnel" and a need for "radios for road crews."

During the February 8 exercise, an observer in LILCO's communications room commented that there was "not enough communications equipment in [the] communications room to handle [a] real emergency." Another observer noted that there was probably "not enough radios for the purpose of this exercise." During the February 15 exercise, problems with an insufficient number of radios continued. For example, one observer noted that "road crews [were] supposed to have multi-band radios, which were not available."

Based on the foregoing, it is apparent that segments of the LERO organization have not been provided an opportunity to use and practice with the radio equipment they would be expected to use during an emergency at the Shoreham plant. In our opinion, this is a serious deficiency of the LILCO training program.

Q. Have you discovered any other problems with the LILCO training program from your review of the drill/exercise comments provided by LILCO?

A. Yes. One area of particular concern was revealed by our review of critique/evaluation forms prepared by observers assigned to LILCO's Emergency Worker Decontamination Facility ("EWDF"). The EWDF was activated during the January and February drills and exercises and, during all three training opportunities, there was evidence of "sloppy performance" by the LILCO personnel given responsibility for performing monitoring and decontamination duties under the LILCO Plan. This "sloppy performance" by LILCO's monitoring and decontamination workers is not surprising, since monitoring and decontamination skills are not the kind of job skills performed by LILCO workers on a day-to-day basis. Therefore, LILCO's training program must be of sufficient quality to provide individuals unfamiliar with the tasks of monitoring and decontaminating personnel (and vehicles) with the ability to perform adequately. Based on our review of the training documents provided by LILCO, however, it must be concluded that the training given to LILCO's monitoring and decontamination personnel has failed to teach such personnel their jobs. A sampling of the critique/evaluation comments which lead to this

conclusion is set forth below and appended to this testimony as Attachment 4.

During the January drill, for example, it was noted that "[t]he monitoring personnel were scanning people a little too rapidly and they sometimes neglected to monitor the person's feet . . ." It was not until after a number of persons had been monitored that the monitoring personnel at the EWDF fell into a pattern and scanned more properly "although still a little too rapidly." Even then, however, they "neglected to fully question [a contaminated] person to find out his/her [field] location. Also they neglected to tell the people ajacent [sic] to them that they had a contamination problem."

During the February 8 exercise, it was noted that "[d]osimetry people were acting confused about what to do." The controller therefore had to instruct such persons to read the appropriate sections of LILCO's procedures. In addition, as had happened during the January drill, it was again noted that monitoring and decontamination personnel "monitored too fast." It was also noted that they "rushed the thyroid count." In one instance, an observer commented that the decontamination worker "held the probe too far away;" in another instance, it was noted that "some items were touched but not monitored."

During the February 15 exercise, problems with LILCO's monitoring and decontamination personnel persisted. For example, some observers commented that "monitors were sloppy" and that there was some "sloppy performances." In addition, one observer noted that "[d]econ[tamination] monitors need more training. They were monitoring poorly." This same observer noted that, in one instance, "the Decon[tamination] Coord[inator] sent a person to the hospital . . . without doing decon[tamination]."

In our opinion, this pattern of problems is very significant and raises serious concerns about the adequacy of the LILCO training program. As noted by one observer, "there was the possibility for cross-contamination the way [EWDF workers] were handling monitoring." Taken together, the problems noted during the January and February drills and exercises indicated a significant failure on the part of the LILCO training program to teach adequately the LERO monitoring and decontamination personnel how to perform their emergency jobs.

Q. Have the critique/evaluation comments reviewed by you also indicated problems with drill/exercise participants not checking their personal dosimetry equipment during the drills and exercises?

A. Yes. During the February exercises, many of the participants did not check their dosimetry equipment. Checking dosimetry readings is of obvious importance during a radiological emergency and must be practiced during training drills and exercises so that it becomes "second nature" to each LERO worker's routine.

Notwithstanding the importance of dosimetry checking, there were numerous comments from both the February 8 and the February 15 exercises in which dosimetry checks were not taken by the exercise participants. For example, one observer at the February 8 exercise noted that the participants "did not check their dosimetry." The same observer also commented that he "did see one [participant] check his dosimetry once. The others I did not see check at all during the 2 1/2 hrs [I was] out [at] the transfer point." Another observer at the February 8 exercise noted that "the transfer control point coordinator I was with never checked his dosimeter readings." Similarly, during the February 15 exercise, traffic guides and a transfer point coordinator were observed not to take periodic checks of their dosimetry equipment. At this exercise, another observer noted that "in the field[,] personnel exposures were not checked. This is a habit that should be broken."

The above examples, which are appended to this testimony as Attachment 5, indicate a problem that could have serious consequences for individual workers during an actual emergency involving an offsite release. LILCO must therefore emphasize, during training, the importance of checking dosimeters, so that this practice becomes part of each worker's emergency job routine. Based on the comments reviewed, it must be concluded that LILCO has placed insufficient emphasis and importance on this aspect of each worker's emergency response function.

Q. Have the drill/exercise comments reviewed by you disclosed any other problems with LILCO's training program?

A. Yes. Although there are many other problems that could be discussed, we will conclude this testimony by expressing our concerns about the fact that many of LILCO's own observers/controllers (including those supplied to LILCO by its training consultants) apparently believe that they have not been adequately prepared to be observers/controllers. Obviously, if training drills and exercises are to provide a way to assess the adequacy of a training program (as LILCO claims), it is extremely important that there be enough observers and that they be properly briefed so that they can properly determine if the activity they are observing is being done correctly. In

this regard, LILCO's training program has not met with success. Our opinion with respect to the inadequacy of briefings/preparation of LILCO's observers/controllers are illustrated by the following sampling of comments. These comments are appended to this testimony as Attachment 6.

During the January drill, for example, one observer noted the following:

> For future drills, controllers will need to be better briefed. To prevent the miscommunications which occurred early at the EOC. It is unacceptable to brief fellow controllers at different locations on how events are to occur 15 minutes on the day before the drill. This unfamiliarity caused confusion amongst the participants and also created inconsistencies in procedural useage [sic].

Similarly, during one of the February exercises, an observer commented that "Impel observers (were) not briefed or knowledgeable enough on procedures," while another observer noted that there were "not sufficient observers."

With inadequate briefings and insufficient staffing of observers, it is impossible to determine whether or not all problems with the LILCO training program have been identified. For example, it is possible that observers who were not adequately briefed did not comment on significant problems because

they were not fully cognizant of the procedures and the drill/exercise scenarios. Nevertheless the problems which we have discovered by reviewing the critique/evaluation comments provided by LILCO give rise to serious concerns regarding the adequacy of the LILCO training program and, for this reason, we have prepared this supplemental testimony.

Q. Please summarize your conclusions.

A. The documents provided by LILCO regarding the LILCO drills and exercises conducted to date (and for which LILCO has retained documentation) lead to the following conclusions. First, numerous comments from all drills and exercises demonstrate that there has been a lack of briefings and that briefings that have been held have often been inadequate. Second, there have been significant problems with LILCO's training with respect to radio communications. These problems have included problems in the areas of radio language, etiquette and general radio technique. In addition, not all trainees have had the appropriate radio equipment to practice with during the LILCO drills and exercises. Third, LILCO's EWDF workers have not received sufficient training to perform adequately their monitoring and decontamination responsibilities under the LILCO Plan. Fourth, LILCO's

personnel have not been trained adequately to check their dosimetry equipment. Finally, LILCO's own observers/controllers (including those supplied to LILCO by its training consultants) have not always been adequately prepared to judge the conduct and performance of the trainees under their observation and supervision.

Individually, it could be argued that these concerns may be correctable; similarly, in some cases, it could be asserted that the problems are not that significant. Taken as a whole, however, the concerns and problems discussed in this testimony indicate significant problems with LILCO's training program. While one might expect such problems during early drills, we believe that, by this time, steps should have been taken to correct and remedy them. This has not been the case, however, leading us to conclude that the LILCO training program has failed to recognize and deal adequately with problems. Indeed, in some cases, problems have actually become worse. Drills and exercises should be learning experiences both for the trainees/participants and for those in charge of the training program. It is apparent that, in LILCO's case, those in charge have not learned from their experiences, and, as a result, LILCO has failed to adapt its training program to correct problems either when they first occur, or even over time.

Q. Does this conclude your testimony?

A. Yes.

ATTACHMENT 1

G. Access Control

1. Was an appropriate access control posture established? 5 [✓ 4] 3 2 1 N.O.

2. Was there an identifiable system implemented that effectively identified authroized personnel within the facility? 5 [✓ 4] 3 2 1 N.O.

H. Summary

1. Describe any problems noted by the area being evaluated. Provide a description of the problem, its outcome or effect and any recommended corrective courses of action to alleviate or correct the deficiency. Any of the previously listed areas that receive an evaluation grade of 2 or 1 require a written explanation on this page.

A-4 Group was disorganized and unfamiliar with their procedures at the beginning of the drill causing confusion and little being accomplished. After I spoke to the Transportation Support Coord. about establishing order, the situation improved. Again, a critique with the group is advisable.

B-2) Transportation Support Communicator unfamiliar with equipment.

B-5) periodic updates were not performed, Transportation Support Coord. apprehensive about taking charge.

B-11) Communicator unfamiliar with radio jargon.

D-2) See B-5

[redacted] 11/10/83
Evaluators Signature / Date

E-5) Status Board could be approved. Group had prepared own Status Board. Worked well

Drill Evaluation

Area Evaluated	Monitors Rating
A. Activation and Response	Traf Gen
1. Was the activation/initiation efficient and organized?	[✓ 5] 4 [✓ 3] 2 1 N.O.
2. Were personnel familiar with their responsibilities and respond in a timely manner?	5 [✓ 4] 3 2 1 N.O.
3. Was the person in charge clearly identifiable?	5 4 3 2 1 N.O.
4. Was the transfer of responsibilities accomplished effectively and efficiently?	5 4 3 2 1 N.O. NA
B. Communications	
1. Were all required and specified communications circuits operable?	5 4 3 2 [✓ 1] N.O. Dedicated Lines Still no good Reg phone Good
2. Were personnel familiar with communications available and the intended use of each?	5 [✓ 4] 3 2 1 N.O.
3. Were there sufficient personnel to conduct communications tasks?	5 [✓ 4] 3 2 1 N.O.
4. Was incoming inform- ion effectively and efficiently distributed to appropriate personnel?	5 [✓ 4] 3 2 1 N.O.
5. Were periodic updates made by the senior individual?	5 4 3 [✓ 2] 1 N.O. NOT The Right info @ the Right time
6. Were accurate communication logs kept?	5 4 [✓ 3] 2 1 N.O.
7. Were the status boards properly utilized and updated?	5 4 3 [✓ 2] 1 N.O. Release info not up No Announce
8. Did individuals in charge spend an inordinate amount of time on communications, such that their attention was diverted from the incident? (No = 5, Yes = 1)	[✓ 5] 4 3 2 1 N.O.

Evaluation Standards

"5" Excellent - Personnel and equipment always functioned without error. There were no problems encountered and all personnel and equipment functioned at a superior level.

"4" Good - Personnel and equipment generally performed as expected. Any errors or problems were minor and did not detract from completion of the task.

"3" Satisfactory - Personnel and equipment performed at an acceptable level. Errors noted were not severe and completion of the task was achieved within acceptable limits.

"2" Poor - Personnel and equipment generally performed below expectations. There were deficiencies of a significant nature. The areas ability to carry out its function was diminished.

"1" Failure - Personnel and equipment consistently failed to perform as required. Acceptable completion of the task was not achieved.

N.O. Not Observed

Evaluation Standards

"5" Excellent - Personnel and equipment always functioned without error. There were no problems encountered and all personnel and equipment functioned at a superior level.

"4" Good - Personnel and equipment generally performed as expected. Any errors or problems were minor and did not detract from completion of the task.

"3" Satisfactory - Personnel and equipment performed at an acceptable level. Errors noted were not severe and completion of the task was achieved within acceptable limits.

"2" Poor - Personnel and equipment generally performed below expectations. There were deficiencies of a significant nature. The areas ability to carry out its function was diminished.

"1" Failure - Personnel and equipment consistently failed to perform as required. Acceptable completion of the task was not achieved.

N.O. Not Observed

E-5 Radios for Road Crews
More Bullhorns w/ Batteries for Dosimetry Briefings

C-4 Transfer Pt Coord Dispatch Form in Bus Route Procedure

B-4 Briefings slow, late, inaccurate e.g. 'Site Area Alert'

Area Evaluated	Monitors Rating
2. Did personnel check to ensure that all equipment was available and functional early in the activation process? YES	5 4 3 2 [✓ 1] N.O. NO CHECK W ON TRAFFIC GUIDE RADIOS.
3. If equipment was inoperable or failed in use, were appropriate actions taken to resolve the deficiency? (spares/backup equipment)	5 4 3 [✓ 2] 1 N.O.
4. Were there any situations in which the lack of equipment, or a lack of ability to operate the equipment, prevented personnel from completing their tasks? (No = 5, Yes = 1) If so, please indicate details.	[✓ 5] 4 3 2 1 N.O.
5. Were there any situations in which additional equipment or materials, or different types of equipment could have made the activity more effective? (No = 5, Yes = 1) If so, please indicate details.	5 4 3 2 [✓ 1] N.O. - PA SYSTEM.
6. Could the area support the personnel assigned to it?	5 4 3 2 [✓ 1] N.O.
7. Were there sufficient resource materials readily available to support the conduct of the response? (maps, reference documents, copies of plans and procedures, data sheets, etc.)	5 4 3 2 [✓ 1] N.O.
F. Protective Measures	
1. Were appropriate protective measures implemented for response personnel?	5 4 3 2 [✓ 1] N.O.
2. Did personnel properly wear protective clothing and dosimetry?	5 4 3 2 [✓ 1] N.O.
3. Were appropriate radiological practices observed?	5 4 [✓ 3] 2 1 N.O. BRIEFINGS LACKED DETAILS.
4. Were field personnel kept apprised of radiological conditions?	[✓ 5] 4 3 2 1 N.O.
5. Were response activities conducted with regard for personnel safety, consistent with the need to complete the activity?	5 4 3 2 [✓ 1] N.O.

DRILL COMMENTS

Riverhead Staging Area

Communications:

1. Staging Area radio does not have call letters on set.
2. Riverhead is dispatching raod crews with Channel 3 radios but can only monitor Channel 10.
3. No written mechanism to determine status of traffic control points dispatched vs. manned.
4. Communications links were not fully utilized; a lot of EOC communications were by radio instead of phone. Problem - in Riverhead the radio and dedicated line are next to each other.
5. Problem with EOC overriding the traffic guides on radio.
6. Some traffic guides faint in receiving radio transmissions inadvertently cut off other guides in the process of transmitting.

Bus Drivers:

1. Triumph Bus Company could not be found.
2. Standardize instructions for recording times military vs. regular.
3. Bus Driver Dispatcher briefing (2 minutes) asked for volunteers to drive routes. Briefing did not address current plant status/radiological status.
4. Problem - not all drivers had vehicles.
5. Feedback on maps - the spirals were too small, the maps are coming apart.
6. Map W/Edwards Avenue - Riverhead Warehouse Transfer Point - Scale on map is not consistent. Deceiving in one case an inch is a couple of blocks in another its much longer (3 miles).
7. Route 3P-2 - Reves & Doctor Path is a flood area and may be impassable. Was iced on day of drill 1/28/84.

Transfer Point Coordinator:

1. (Mercy H.S.) Transfer buses were not dispatched to Selden.
   a. No maps to relocation center.

2/8/84

- Command and Control

1. Person was in charge at all areas
   Improvement @ Patchogue good
2. - No General Emergency briefings @ P.J. - [illegible] [illegible] many
   Patch - ok
   - People in SA not familiar with general terminology - i.e. what is a release, class of emergency etc
   - Communication to people ~~[illegible]~~ given but they do not listen
3. No radiological information given to people going out to the field

Dosimetry & Exp. Control

1. 1.5 not enough [illegible]
2. Records O.K.
3. Wait for KI to the SA. - not taken in the SA. - no forms available for KI distribution.
4. Riverhead finished in 45 min. Patch c 1 hour
   Port Jeff > 2 hours

Communications

1. Radios given out at RH prior to the word coming from the EOC. Communication check was good at RH
2. McKay dispatching form for [illegible] Traffic Guide
3. General radio protocol training is needed
4. Port Jeff line - correct message from EOC. - [illegible]
5. Field monitoring teams same freq as Patch ~~[illegible]~~
6. Better use of regular dial phones

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

No general plant briefings for LERO Field workers. It was tough enough getting them briefed for their jobs. Staging Area Coord with assistance of previously mentioned [redacted] did a credible job despite an overabundance of inexperienced people

COMMAND AND CONTROL

- Person was in charge at all areas
  Dispersement @ Patchogue good
- No general emergency briefings @ P.J. - R.H. Island wide / Patch - one
- People in SA not familiar with general terminology - i.e. what is a release, class of emergency etc
- Communication to people ~~not~~ given but they do not listen
  No radiological information given to people going out to the field

DOSIMETRY & EXP. CONTROL

1. 1.5 not enough [illegible]
2. Forms OK.
3. Word for KI to the SA. - not taken in the SA. - no forms available for KI distribution.
4. Briefing finished in 45 min. Patch < 1 hour
   Port Jeff > 2 hours

COMMUNICATIONS

Radio equipment at RH prior to the word coming from the E.O.C. Communication check was good at R.H.
2 Mobile dispatching from for Road Traffic Guide
3 General radio protocol training as needed
4 Port Jeff line - cannot receive from EOC. - [illegible]
5. Field survey team same freq as Patch [illegible]
6 Better use of regular dial phones

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

- ① very apparent evacuation Coord. is in charge because he is the only one who knows anything.

② only the evac. coord. & bus dispatcher are aware of emergy status at all times. This info. is not filtered to other staffs.

③ ~~personnel sent. driver sent~~ checking of dosimeter at 15 min intervals not emphasized to drivers... people out in field, etc. --

people not informed potential plume path & radiation levels at all.

Bus ~~fa~~ drivers not briefed on route or any info. ... if they are to depend only on given maps & routes. This may become a problem when they lose these maps.

Actually bus drivers need not report to staging area when they pick up maps. Why not have them go to bus depot then report to transfer point where transfer point coord. can give him the maps.

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	X			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?	X	X		
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?	X			
- Potential plume path and radiation levels?		X		
- Their particular assignment?	X			

II/2 NOT AS OFTEN AS IT SHOULD HAVE BEEN TO ~~[illegible]~~ ENTIRE GROUP OF COORDINATORS

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	✓			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?	✓			
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?		✓		
- Potential plume path and radiation levels?		✓		
- Their particular assignment?	✓			

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	✓			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?		✓		
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?		✓		
- Potential plume path and radiation levels?		✓		
- Their particular assignment?	✓			

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	X			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?		X		
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?		X		
- Potential plume path and radiation levels?		X		
- Their particular assignment?		X		

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	✓			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?	✓			
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?		✓		
- Potential plume path and radiation levels?		✓		
- Their particular assignment?	✓			

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	✓			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?		✓		
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?		✓		
- Potential plume path and radiation levels?		✓		
- Their particular assignment?		✓		

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	X			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?		X		
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?				X
- Potential plume path and radiation levels?				X
- Their particular assignment?	X			

1. Unfortunately some times it had to be a Controller/Observer

3. For N/O read No

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	✓			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?				✓
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?				✓
- Potential plume path and radiation levels?				✓
- Their particular assignment?	✓			

III. Command and Control

Dosimetry

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?		X		
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?				X
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?				X
- Potential plume path and radiation levels?				X
- Their particular assignment?				X

next page

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	✓			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?				✓
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?				✓
- Potential plume path and radiation levels?				✓
- Their particular assignment?				✓

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	✓			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?	✓			
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?				✓
- Potential plume path and radiation levels?				✓
- Their particular assignment?	✓			

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	X			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?				
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?				
- Potential plume path and radiation levels?				
- Their particular assignment?				

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?				✓
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?	✓			
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?	✓			
- Potential plume path and radiation levels?	✓			
- Their particular assignment?	✓			

III. Command and Control

	Yes	No	N/A	N/O
1. Was it apparent that a senior individual in charge at all times?	✓			
2. Were general briefings given to the Staging Area staff periodically regarding the status of the emergency?	✓			
3. Were personnel going into the field properly briefed as to:				
- Protective action recommendations?	✓			
- Potential plume path and radiation levels?	✓			
- Their particular assignment?	✓			

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION

NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

2/15/84

OBSERVER CONTROLLER LOG SHEET

Name: ______________________

Date: ______________________

Location: ______________________

Summary — Port Jefferson

TIME	OBSERVATION/COMMENT
	Act & Staffing
—	One Xfer pt cmd did not show up - replaced him with someone from another shift
—	All ready to go by ≈ noon
	Fac & Equipment
—	Car stuck in mud at Miller Place. Did not get out until ≈ 6 pm. Word got to Port-
—	One almost got stuck in Norwood.
—	Insufficient maps to Relocation Centers from Port Jeff Xfer pts.
—	A lot of yard vehicles do not have registration to go out on the road.
	Command & Control
—	Xfer drivers at Miller Place asked PJ what to do i.e. go to the Relocation Center. Port Jeff did not know what to do
—	No briefing relative to plant status or radiological conditions.
—	No information to field people on status. Whether there was a [illegible]
—	word from EOC to PJ group on updating ~~the~~ relative to the emergency.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

① The Staging Area Coordinator and function coordinators were in evidence but not that identifiable to the emergency workers. (I knew who they were.)

② Staging Area personnel issue (dosimetry) were not briefed regarding emergency status, protective actions, plume travel — other than status board posting. This is not enough. EWs going out were not so advised except to wear personnel dosimetry and take KI.

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION

NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: ______________________ Date: ____________

Location: ____________________

TIME	OBSERVATION/COMMENT
	Summary Riverhead
—	Very poor information flow ft from EOC to L.H. > 1 hour from time GE declared to time Riverhead knew about it. Need to improve this. ~~[illegible]~~ When Director finds out from EOF he should pass the word to the Staging Areas.
—	Staffing good - All persons who should be there were. Completely staffed by 11:30.
—	Status boards good use. Need blank boards to keep information.
—	Security procedure is unclear. Where get people How many. Responsibilities
—	Briefing as to radiological conditions poor
—	~~[illegible] not~~
—	Information about KI did not get down to the [illegible] Riverhead.
—	3 hours to get Route Alert Drivers out. Part 3 to procedures not in the book.
—	2 of 3 Transfer pt coordinator radios were down. Word was relayed through the traffic guides
—	Traffic guide radios for ≈ 2 hours were receiving a frequency fishing fleet off N.J.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

Item ②: No general briefings regarding status of plant, plume, progress of evacuation etc. given. Status board was helpful, however.

→ Item ③:

a) Lead Traffic guides took responsibility of ensuring that all their groups had gone through dosimetry briefing -- good procedure.

b) Not much radiological or plume data given to or sought by leads. Traffic guides were given what meteorological & plant status ~~data~~ data that was displayed on status board in briefings. This may not be sufficient for actually ~~[illegible]~~ sending people to the EPZ. Also, women traffic guides are supposed to be sent to positions outside EPZ or low rad areas, if possible; no attention given to this matter.

Lead crews are spotters & the alert drivers not given this data in briefings. This is a deficiency.

c) Acceptable as noted.

I would suggest lead traffic guides review OPIP 3.6.3 for their own information, make out a checklist of briefing data as an aid. I strongly suggests - this for last week's group as well.

ATTACHMENT 2

Area Evaluated	Monitors Rating
9. Were the correct private lines used and did non-emergency communications interfere with emergency transmissions? (No = 5, Yes = 1)	[✓ 5] 4 3 2 [✓ 1] N.O.
10. Were logs used effectively by personnel to review past events and to trend data?	5 4 3 2 1 N.O. N.A..
11. Were appropriate communications techniques followed? (Phonetic alphabet, sign-on, sign-off, no abbreviations or acronyms)	5 4 3 2 [✓ 1] N.O. poor radio technique in 1 car Fair in the other real need for radio training for communicators
C. Procedures	
1. Were personnel generally familiar with the relevant procedures?	5 [✓ 4] 3 2 1 N.O.
2. Were procedures followed?	5 [✓ 4] 3 2 1 N.O.
3. Were personnel so overwhelmed with procedural requirements that they were distracted from the appropriate response? NO	5 4 3 2 1 N.O.
4. Were the procedures appropriate? yes & No They were some obvious shortcomings in the traffic procedures.	5 4 3 2 1 N.O.
D. Direction and Control	
1. Could the response be catagorized as a team effort or a group of individual efforts? (Team = 5, Individuals = 1)	[✓ 5] 4 3 2 1 N.O.
2. Was there an effective mechanism for resolving differences of opinion regarding technical issues and actions to be taken?	5 [✓ 4] 3 2 1 N.O.
3. Was there excessive noise and loitering in the response facility? (No = 5, Yes = 1)	[✓ 5] 4 3 2 1 N.O.
E. Material and Equipment	
1. Was all the required material and equipment available? NO=5	[✓ 5] 4 3 2 1 N.O. NO Logbook/Record books Dedicated Lines did not work & other stuff

Area Evaluated	Monitors Rating
G. Access Control	
1. Has an appropriate access control posture established?	5 [✓ 4] 3 2 1 N.O.
2. Was there an identifiable system implemented that effectively identified authroized personnel within the facility?	5 [✓ 4] 3 2 1 N.O.

H. Summary

1. Describe any problems noted by the area being evaluated. Provide a description of the problem, its outcome or effect and any recommended corrective courses of action to alleviate or correct the deficiency. Any of the previously listed areas that receive an evaluation grade of 2 or 1 require a written explanation on this page.

~~[illegible]~~ Group was disorganized and unfamiliar with
A-4 their procedures at the beginning of the drill
causing confusion and little being accomplished.
After I spoke to the Transportation Support Coord,
about establishing order, the situation ~~[illegible]~~ improved. Again,
a critique with the ~~[illegible]~~ group is advisable.

B-2) Transportation Support Communicator unfamiliar with equipment.

B-5) periodic updates were not performed, Transportation Support Coord. apprehensive about taking Charge.

B-11) Communicator unfamiliar with Radio jargon.

D-2) See B-5

[redacted] 11/10/82
Evaluators Signature / Date

E-5) Status Board could be approved. Group had prepared own Status Board. Worked well

Area Evaluated

Monitors Rating

2. Did personnel check to ensure that all equipment was available and functional early in the activation process?

5 4 3 2 [✓ 1] N.O.

Yes = 1

3. If equipment was inoperable or failed in use, were appropriate actions taken to resolve the deficiency? (spares/backup equipment)

5 4 3 2 [✓ 1] N.O.

4. Were there any situations in which the lack of equipment, or a lack of ability to operate the equipment, prevented personnel from completing their tasks? (No = 5, Yes = 1) If so, please indicate details.

5 4 3 2 [✓ 1] N.O.

dedicated line problems necessitated the use of radios & communicators had varying degrees of expertise with radio.

5. Were there any situations in which additional equipment or materials, or different types of equipment could have made the activity more effective? (No = 5, Yes = 1) If so, please indicate details.

5 4 3 2 [✓ 1] N.O.

More & better dedicated lines
More & better maps
More & better radio train...

6. Could the area support the personnel assigned to it?

5 4 3 2 [✓ 1] N.O.

yes = 1

7. Were there sufficient resource materials readily available to support the conduct of the response? (maps, reference documents, copies of plans and procedures, data sheets, etc.)

5 [✓ 4] 3 2 1 N.O.

NO = 5
yes = 1

F. Protective Measures

1. Were appropriate protective measures implemented for response personnel?

5 4 3 2 1 N.O. NA

2. Did personnel properly wear protective clothing and dosimetry?

5 4 3 2 1 N.O. NA

3. Were appropriate radiological practices observed?

5 4 3 2 1 N.O. NA

4. Were field personnel kept apprised of radiological conditions?

5 4 3 2 1 [✓ N.O.]

5. Were response activities conducted with regard for personnel safety, consistent with the need to complete the activity?

5 4 3 2 1 N.O. NA

Area Evaluated	Monitors Rating
9. Were the correct private lines used and did non-emergency communications interfere with emergency transmissions? (No = 5, Yes = 1)	5 4 [✓ 3] 2 1 N.O. RADIO + DEDICATED LINE USED TOO MUCH.
10. Were logs used effectively by personnel to review past events and to trend data?	5 4 3 2 1 [✓ N.O.]
11. Were appropriate communications techniques followed? (Phonetic alphabet, sign-on, sign-off, no abbreviations or acronyms)	5 4 [✓ 3] 2 1 N.O. TRAFFIC GUIDES NEED MORE EXPOSURE.
C. Procedures	
1. Were personnel generally familiar with the relevant procedures?	5 [✓ 4] 3 2 1 N.O.
2. Were procedures followed?	5 [✓ 4] 3 2 1 N.O.
3. Were personnel so overwhelmed with procedural requirements that they were distracted from the appropriate response?	5 4 3 [✓ 2] 1 N.O.
4. Were the procedures appropriate?	5 [✓ 4] 3 2 1 N.O.
D. Direction and Control	
1. Could the response be catagorized as a team effort or a group of individual efforts? (Team = 5, Individuals = 1)	5 [✓ 4] 3 2 1 N.O.
2. Was there an effective mechanism for resolving differences of opinion regarding technical issues and actions to be taken?	5 [✓ 4] 3 2 1 N.O.
3. Was there excessive noise and loitering in the response facility? (No = 5, Yes = 1)	5 [✓ 4] 3 2 1 N.O.
E. Material and Equipment	
1. Was all the required material and equipment available?	5 4 3 2 1 N.O. YES

Area Evaluated	Monitors Rating
G. Access Control	
1. Was an appropriate access control posture established?	5 4 [✓ 3] 2 1 N.O.
2. Was there an identifiable system implemented that effectively identified authroized personnel within the facility?	[✓ 5] 4 3 2 1 N.O.

H. Summary

1. Describe any problems noted by the area being evaluated. Provide a description of the problem, its outcome or effect and any recommended corrective courses of action to alleviate or correct the deficiency. Any of the previously listed areas that receive an evaluation grade of 2 or 1 require a written explanation on this page.

B1 & E5) Pt. Jefferson Direct line inoperable
Other Communication was utilized.
Situation handed over to equipment group.

B4 & B6) Communication messages were in discrepancy
will improve with practice.

B5 & B2) Better control of his people by Section
Coordinator. ~~[illegible]~~ this will be discussed
to improve group organization.

B11) Communicators need to review jargon.

[redacted] / 1/28/79
tors Signature / Date

Overall appraisal:
Good [redacted]

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performances.

Due to the simulation aspects - some of the communication links were not demonstrated

15. High speed telecopy very handy. It's location might be changed to be more readily visible or assign person to monitor the telecopy and distribute messages. Several messages were laying in the machine unobserved.

- The line to Port Jefferson only goes one way - can only receive on line cannot pick up in EOC and ring in Port Jeff

- Rewired the line ring on Patchogue set. (Used to be one set.)

- Better radio protocol practices needed
- Communications in the Rad Health area is left unanswered for extended periods of time.

II Command and Control

1. Person was in charge at all areas
   Improvement @ Patchogue good
2. - No general emergency briefings @ P.J. - R.H. delayed in doing / Patch - [illegible]
   - People in SA not familiar with general terminology - i.e. what is a release, class of emergency etc
   - Communications to people ~~[illegible]~~ given but they do not listen
3. No radiological information given to people going out to the field

Dosimetry & Exp. Control

1. 1.5 not enough [illegible]
2. Records O.K.
3. Word for KI to the SA. - not taken in the SA. - no forms available for KI distribution.
4. Riverhead finished in 45 min. Patch ≈ 1 hour
   Port Jeff > 2 hours

Communications

1. Radios given out at RH prior to the word coming from the EOC. Communications check was good at RH
2. McKay dispatching from for lead Traffic Guide
3. General radio protocol training is needed
4. Port Jeff line - cannot receive from EOC. - need comm. [illegible] line
5. Field monitoring teams same freq as Patch ~~[illegible]~~
6. Better use of regular dial phones

V. Communications

	Yes	No	N/A	N/O
1. For each of the following:				
a. Indicate whether communication was demonstrated (Yes, No, etc.)				
b. Name the communication system used on the dotted line (dedicated land line, two-way radio, commercial phone, etc.)				
- Local EOC/primary ... Dedicated line	✓			
/backup Outside line.	✓			
- Bus Drivers				✓
- Traffic Guides .... Radio	✓			
- Road Crews				✓
- Route Alert Drivers				✓
- Route Spotters				✓
- Transfer Points .... Radio	✓			
2. Were radio communications easily understood, i.e., no static?		X		
3. Was there too much communication traffic on the radio frequency?				
4. In general, were communciations good?	✓			
5. Were messages written down?	✓			
6. Were they retained for future reference?	✓			
7. Were any communications problems rectified?				✓

2. Not EASILY. A lot of walk over some static. Poor Radio Etiquette

3. A lot yes, but too much; I think not

TRAFFIC BLOCKAGE DRILL

TRAFFIC CONTROLLERS AT POINT 35 CONSIDERED SITUATION AND DECIDED TO MOVE CONES TO AID EXISTING TRAFFIC FLOW. AFTER SOME HESITATION INFORMED BASE AND "AWAITING FURTHER INSTRUCTIONS." BASE DID NOT ACKNOWLEDGE AND NO FURTHER COMMUNICATIONS. AFTER 1/2 HOUR GOT PERMISSION TO COME IN

AFTER I GOT IN, I WENT TO RADIO ROOM WHERE THEY WERE TRYING TO GET HOLD OF MY CAR TO GIVE INSTRUCTIONS ON WHAT TO DO ABOUT TRAFFIC STOPPAGE. INDICATES FOLLOWING PROBLEMS

- RADIO ROOM HAS NO WAY TO TRACK STATUS OF TRAFFIC POINTS
- INSUFFICIENT RELAY OF MESSAGES (LEAD TRAFFIC CONTROLLER GOT MESSAGE ABOUT POINT 35, THOUGHT IT WAS SAME MESSAGE AS FROM POINT 63, AND DISREGARDED
- IN ADDITION, RADIO OPERATOR SAYS THAT NO UNIFORM LANGUAGE BEING USED (CB, FIREMEN, LILCO STANDARD

②

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

2/15/84

OBSERVER CONTROLLER LOG SHEET

Name: ____________________ Date: ____________

Location: ____________________

TIME	OBSERVATION/COMMENT
	PORT JEFFERSON
	RAD. CONTROLS
–	PJ got the word on KI
–	Started to run out of dosimeters. Got extra and had them zeroed
	COMMUNICATIONS
–	Poor radio protocol and etiquette - holding mike up to CB radios. Joking and laughing around.
	~~Lack of good communication~~

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION

NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted]

Date: 2-15-84

Location: PORT JEFF COMM

TIME	OBSERVATION/COMMENT
*	NEED PREPRINTED FORM ~~TO~~ BY RADIO NUMBERS IN NUMERICAL ORDER (WITH COLS FOR ~~[illegible]~~ CONTROL PT, INITIAL RADIO CHK, ARRIVAL @ CNTRL PT, DEPARTURE FOR BASE, ARRIVAL @ BASE) TO FACILITATE RADIO COMMUNICATIONS.
2:10	TOO MANY TRAFFIC GUIDES ~~[illegible]~~ WERE CALLING THE BASE IN RAPID SUCCESSION WITHOUT WAITING FOR THE BASE TO RESPOND TO THE FIRST CALLER. THIS IS EITHER LACK OF COURTESY ON THE AIR (OR FOOLING AROUND BY THE DRIVERS) OR LACK OF KNOWLEDGE IN THE USE OF THE AIRWAYS. PERHAPS BETTER TRAINING IN THE USE OF RADIOS IS REQ'D.
2:15	ONE ROUTE DRIVER WAS LOST
	RADIO OPERATORS ARE BEING ASKED QUESTIONS ABOUT DRIVING X-ROUTES TO WHICH THEY HAD NO IDEA WHAT WAS BEING ASKED OF THEM. BETTER BRIEFING OF OPERATORS AS TO THE NATURE OF THE REQUESTS EXPECTED, AND ~~IS NECESSARY~~ WHO TO DIRECT THE REQUEST FOR RESPONSE TO, IS NECESSARY. OPERATORS ~~[illegible]~~ REQUEST A LIST OF WHAT IS CALLER IS ~~[illegible]~~ SUPPOSED TO BE DOING.
*	SUGGEST 2 PEOPLE WORK RADIO WITH HEADSETS AND SPLIT LIST OF RADIOS IN TWO. TOO MANY TRANSMISSIONS IN AN EXTENDED ~~[illegible]~~ TIME FRAME FOR ONE OPERATOR TO HANDLE / NEVER GETS A CHANCE TO "RECOVER"

ATTACHMENT 3

DRILL COMMENTS

Riverhead Staging Area

Communications:

1. Staging Area radio does not have call letters on set.
2. Riverhead is dispatching raod crews with Channel 3 radios but can only monitor Channel 10.
3. No written mechanism to determine status of traffic control points dispatched vs. manned.
4. Communications links were not fully utilized; a lot of EOC communications were by radio instead of phone. Problem - in Riverhead the radio and dedicated line are next to each other.
5. Problem with EOC overriding the traffic guides on radio.
6. Some traffic guides faint in receiving radio transmissions inadvertently cut off other guides in the process of transmitting.

Bus Drivers:

1. Triumph Bus Company could not be found.
2. Standardize instructions for recording times military vs. regular.
3. Bus Driver Dispatcher briefing (2 minutes) asked for volunteers to drive routes. Briefing did not address current plant status/radiological status.
4. Problem - not all drivers had vehicles.
5. Feedback on maps - the spirals were too small, the maps are coming apart.
6. Map W/Edwards Avenue - Riverhead Warehouse Transfer Point - Scale on map is not consistent. Deceiving in one case an inch is a couple of blocks in another its much longer (3 miles).
7. Route 3P-2 - Reves & Doctor Path is a flood area and may be impassable. Was iced on day of drill 1/28/84.

Transfer Point Coordinator:

1. (Mercy H.S.) Transfer buses were not dispatched to Selden.
   a. No maps to relocation center.

Area Evaluated	Monitors Rating
G. Access Control	
1. Was an appropriate access control posture established?	[✓ 5] 4 3 2 1 N.O.
2. Was there an identifiable system implemented that effectively identified authroized personnel within the facility?	5 4 [✓ 3] 2 1 N.O.

SEE LAST COMMENT BELOW

H. Summary

1. Describe any problems noted by the area being evaluated. Provide a description of the problem, its outcome or effect and any recommended corrective courses of action to alleviate or correct the deficiency. Any of the previously listed areas that receive an evaluation grade of 2 or 1 require a written explanation on this page.

(COMMENT TO A-3)

THE PERSON IN CHARGE OF THE TRAFFIC SECTION WAS IDENTIFIABLE ONLY IF YOU KNEW THAT THE "TRAFFIC CONTROL COORDINATOR" HEADS UP THE SECTION. OF COURSE, IF YOU LOOK AT THE SIGN-IN BOARD YOU WOULD THEN KNOW THIS.

PROBLEMS NOTED BY THE TRAFFIC SECTION:

1. PEOPLE USING DIFFERENT REV'S OF THE IMPLEMENTING PROCEDURES.
2. LACK OF RADIOS BY FIELD PERSONNEL
3. INSTRUCTIONS LACK COMPLETENESS (EXACT LOCATIONS OF TANK TRUCKS)
4. INABILITY TO FOLLOW SCENARIO DUE TO PROCEDURAL COVERAGE (NOT ABLE TO CONTACT HELICOPTER).

[redacted] / 1-30-84

Evaluators Signature / Date

COMMENT TO G-2

PEOPLE COULD BE IDENTIFIED BY NAME TAGS OR ARM BANDS BUT SECURITY COULD HAVE BEEN BETTER. IT IS STILL POSSIBLE (SAME AS NOV.) TO ENTER THRU THE REARMOST SIDE DOOR (THRU THE TRUCK STORAGE YARD) AND GO INTO THE EOC UNCHALLENGED AS THEIR IS NO GUARD AT THIS ENTRANCE.

	Area Evaluated	Monitors Rating
2.	Did personnel check to ensure that all equipment was available and functional early in the activation process?	5 [✓ 4] 3 2 1 N.O.
3.	If equipment was inoperable or failed in use, were appropriate actions taken to resolve the deficiency? (spares/ backup equipment)	[✓ 5] 4 3 2 1 N.O.
4.	Were there any situations in which the lack of equipment, or a lack of ability to operate the equipment, prevented personnel from completing their tasks? (No = 5, Yes = 1) If so, please indicate details.	[✓ 5] 4 3 2 1 N.O.
5.	Were there any situations in which additional equipment or materials, or different types of equipment could have made the activity more effective? (No = 5, Yes = 1) If so, please indicate details.	5 4 3 2 [✓ 1] N.O. Radios for Road Crews More active Bullhorns for announcement
6.	Could the area support the personnel assigned to it? Yes	[✓ 5] 4 3 2 1 N.O.
7.	Were there sufficient resource materials readily available to support the conduct of the response? (maps, reference documents, copies of plans and procedures, data sheets, etc.)	5 4 [✓ 3] 2 1 N.O.
F.	Protective Measures	
1.	Were appropriate protective measures implemented for response personnel?	[✓ 5] 4 3 2 1 N.O.
2.	Did personnel properly wear protective clothing and dosimetry?	[✓ 5] 4 3 2 1 N.O.
3.	Were appropriate radiological practices observed?	[✓ 5] 4 3 2 1 N.O.
4.	Were field personnel kept apprised of radiological conditions?	5 4 3 2 1 [✓ N.O.]
5.	Were response activities conducted with regard for personnel safety, consistent with the need to complete the activity?	[✓ 5] 4 3 2 1 N.O.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

① adequate space in turbine deck

space in Communication room not efficient in real emergency, people kept running into each others toes.

not enough meeting room space. bus drivers had to be ~~[illegible]~~ briefed in separate groups.

③ status boards available only to people in communication room.

⑤ not enough meeting space to ~~f~~ brief a lot groups of people (bus drivers) all at once.

⑥ not enough communication equipment in communication room to handle real emergency.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

There were not enough rooms available for simultaneous briefing of different groups. Turbine deck area appeared over crowded. As mentioned before, dosimeters were short. Probably also not enough radios for the purpose of this exercise.

Some logs weren't available, coordinator didn't have a list of personel available.

Additional comments:

Message to send traffic guides was missing 25 of 56 traffic control points, had to add contingency message to maintain progress of exercise.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

Item ⑤:

Some additional briefing space would help. Calls to dispatch various groups come in simultaneously; ~~[illegible] wait for [illegible]~~. dispatch of traffic guides delayed waiting for Room B to ~~[illegible]~~ free up.

→ Item ⑥: ~~Envelopes for traffic guides to traffic control points 37, 95 & 10 missing. Traffic guides could not be sent there.~~ Also, road crews are supposed to have multi-band radios, which were not available.

Items ①-⑤: Acceptable as indicated.

ATTACHMENT 4

1/84

The monitoring personnel were scanning people a little too rapidly and they sometimes neglected to monitor the person's feet but after the first 5 people, each monitor fell into a pattern and the scanning was done more properly although still a little too rapidly. When confronted with a contaminated person, the monitoring personnel remembered to tell the decon leader and knew how to decontaminate the person but they had some trouble filling out the form. They also neglected to fully question the person to find out his/her ~~—~~ locations. Also they neglected to tell the people ajacent to them that they had a contamination problem. When questioned they knew the proper response. It seemed that they were having trouble getting into fully -i.e.- acting out every response.

A problem was observed in the Decon Area. The Decon Leader had no spare people to station at the clean exit from the shower area and workers were using that door to enter and use the bathroom facilities in what was suppose to be a controlled area.

LONG ISLAND LIGHTING COMPANY
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

2/8/84

OBSERVER CONTROLLER LOG SHEET

Date: 2/8/84

Name:

Location: Emergency Worker Decon. Facility

TIME OBSERVATION/COMMENT

10:30 Dosimetry People were acting
confused about what to do. I
made sure they had Rev 3 of the
OPIP 3.9.1 and told them to read the
appropriate sections. OS he said I
would only answer questions after
the drill. S the Decon Leader sent his
people into get their Dosimeters
about 10:50. The Dosimetry
Personnel handled it quite well.

11:15 Decon Leader was anticipating the
arrival of people early in the after-
noon so he sent his people outside
to set up although he had not
recieve word to do so. I OK'd the
move since we were running on a
compressed time schedual.
He also sent 1/2 his crew to lunch

12:30 Dosimetry was distributed. Decon
Coord. called and informed the
Leader that a General Emergency
Had been declared. Decon Leader

1:00 called the Coord. at a 1:00 to inform
him he was ready to recieve people,

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION

NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: ______________________ Date: 2/9/84

Location: Emergency Worker Decon Facility

TIME	OBSERVATION/COMMENT
	a LILCO employee to go try to use the rest room. The guard did deny him access to the Decon Area. I questioned the same guard on his dosimeters. He knew all about it.
~2:30	People arrived from the 3 staging areas, about 24 total. The monitoring personnel performed OK but had some problems. They monitored too fast. One person held the probe too far away. They rushed the thyroid count also. I saw one guy step out of the control area without monitoring. They did handle the contaminated cases OK. They filled in the forms all right. They bagged and tagged contaminated items. One Decon person let the contaminated individual contaminate the sinks & soap and was instructed on what he should have done. The biggest problem was attitude. They didn't want to be serious enough. They were afraid to inconvenience regular employees. I tried to stress that they must play it to the hilt for a graded exercise. (over)

LONG ISLAND LIGHTING CO. ANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION

NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: ______________________ Date: 2/8/84

Location: EOC-Security & Decon

TIME	OBSERVATION/COMMENT
15:05	During monitoring of Traffic Guide 36, [illegible] probe was too far away and moved to fast.
15:20	Second decon subject, Traffic Guide 115, some items were touched but not monitored. All possibly contaminated items should be monitored.

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION 2/15/84
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/15/84

Location: EWOF

TIME	OBSERVATION/COMMENT
1:30	Tables are cluttered. There is a big wad of radiation warning tape on the ground, one end is tied to a door knob, the warning tape is in a controlled area therefore it could become contaminated.
2:30	People arrived from the Staging Area Monitors were surveying. They monitored too fast. People walked over boundaries and weren't stopped. There was the possibility for cross contamination that way. Some handling monitoring. I let them go for about 30 minutes before I stopped them, gave my comments, then let them proceed. They straightened out their acts and improved somewhat. It was as if they were not thinking about what they were doing.
3:30	completed monitoring operations

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION

NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name:

Date:

Location:

TIME | OBSERVATION/COMMENT

SUMMARY

[redacted]

10/05 Message ~~[illegible]~~ relative TCP 35 & 63 wanted to contact Helicopter rather than go thru the S.D.

Emphasize 'this is a Drill' on phones

Could not get any information from SJ relative to TCP's manned. The person on the St would not/or could not get the info.

Very little cooperation with Local Traffic Guide exp at Port Jefferson

Transfer Point at Norwood Ave services K & Q only K should have been evac and he evacuated Q & K - also ran out of buses

[redacted]

Staff performance - several problems.

Signs not properly placed. ~~No clean area~~

clean area sign in a controlled area

No dosimetry worn by people reporting

Lax access control downstairs

Same group as two weeks ago. Like [illegible] night & day. Would not respond to D.B. prompts

Did not use the procedures

LONG ISLAND LIGHTING COMPANY and
LOCAL EMERGENCY RESPONSE ORGANIZATION
NUCLEAR EMERGENCY PREPAREDNESS EXERCISE

OBSERVER CONTROLLER LOG SHEET

Name: [redacted] Date: 2/16/84

Location: Security & Decon

TIME	OBSERVATION/COMMENT
	- Security needs more people. Their procedure call for three people, however, they needed six people.
	- Walkie-Talkies would help the security people do their job
	- Decon. monitors need more training. They were monitoring poorly. If one Decon monitor wears Anti-C they all should.
	- The Decon Coord. sent a person to the hospital for thyroid uptake without doing decon.

ATTACHMENT 5

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

PLAYERS DID NOT CHECK THEIR DOSIMETRY.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

TRANSFER POINT (NORWOOD AVE PROPERTY)

GENERALLY THINGS WENT SURPRISINGLY SMOOTH MY MAIN CONCERN IS THAT AT LEAST THREE TRANFER PT. CORD. WOULD BE REQUIRED IN A REAL EMERG. ONE TO DISPATCH ROUTE PACKETS, ONE TO LOG IN & KEEP TRACK OF BUSES DISPATCHED, AND ONE TO GUIDE THE TRANSFER OF PEOPLE FROM ONE BUS TO ANOTHER.

THERE WAS SOME CONFUSION ABOUT WHAT ORDER (ON THE DISPATCH CHART) SHOULD THE BUS ROUTES BE DISPATCHED. AFTER SOME ANAL. THE BUSES WERE DISPATCHED CORRECTLY.

AT CERTAIN TIMES IT WAS DIFFICULT FOR THE CORD. TO DISPATCH BUSSES & MONITOR THE RADIO TOO.

I DID SEE ONE PLAYER CHECK HIS DOSIMETRY ONCE. THE OTHERS I DID NOT SEE CHECK AT ALL DURING THE 2½ HRS. OUT @ THE TRANSFER POINT.

THERE IS NO LIGHTING PROVIDED @ THE TRANSFER PT.

A FEW BUS DRIVERS (4 OUT OF 80) COMPLAINED OF INACCURACIES IN THEIR MAPS (WRONG STREET NAMES, ONE MAP WAS MISSING 3 PAGES) ALL DRIVERS WERE ABLE TO COMPLETE THEIR ROUTES THOUGH.

(CONT. ON BACK)

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

· Most of the dosimetry specifics was not my assignment, therefore I did not observe most of these actions. However, the transfer control point coordinator I was with never checked his dosimeter readings.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

E.

3. TRAFF GUIDES AND TR POINT COORD OBSERVED NOT TO DO - PERIODIC CHECK.

5. FORMS FOR KI GIVEN OUT BUT NOT ORDER FROM EOC TO DISBURSE KI GIVEN.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

Dosimetry went very smooth in the staging area. However, in the field personal exposures were not checked. This is a habit that should be broken.

ATTACHMENT 6

GENERAL COMMENTS ON 1/28/84

Overall, events at the EOC went smoothly. The Communications group was disorganized as were messages handled by this group. This was largely due to the group being re-organized with five communicators rather than 3 as before. The group will function better after a few more drills.

[For future drills, controllers will need to be better briefed. To prevent the miscommunications which occurred early at the EOC. It is unacceptable to ~~[illegible]~~ brief fellow controllers at different locations on how the events are to occur for 15 minutes on the day before the drill. This unfamiliarity caused confusion amongst the participants and also created inconsistencies in procedural usage.]

VI. Scenario

Summary

Comment on the adequacy of the scenario. Did it provide enough activity? Was it realistic? Did it test areas of earlier deficiency?

INPAL OBSERVERS NOT BRIEFED OR KNOWLEDGEABLE ENOUGH ON PROCEDURES.

Summary

In your own words, describe and evaluate the demonstrated activities, capabilities and resources, or lack thereof, covered by this section. Put the facts recorded in the "yes/no" questions in perspective. Explain the deficiencies, and also note the exceptionally good performance.

1. OF THE 3 DOSIMETRY PERSONNEL AT DRILL ONLY ONE PARTICIPATED IN PREVIOUS DRILLS. HE WAS AT ONE TIME UNSURE OF SEQUENCE IN EMERGENCY CLASSIFICATIONS. 400 DOSIMETERS WERE ZEROED IN 1 1/2 HOURS AND DISTRIBUTED IN 45 MINUTES. THIS VERY QUICK AND SATISFACTORY DISTRIBUTION TIME IS DUE TO THE DOSIMETRY GROUP TRAVELING TO EACH ROOM OF SEATED PERSONNEL. EXPECT EVEN BETTER TIMES WHEN ALL THREE RECORD KEEPERS ARE FULLY DRILL EXPERIENCED AND INDEPENDANT.
2. RECORDS, COPIES AND THEIR HANDLING AND DELIVERY TO THE EOC WAS VERY EFFICIENT.
3. NOT SUFFICIENT OBSERVERS
4. SCENARIO CALLED FOR PEGGING ONE TRAFFIC GUIDES 0-200 MR DOSIMETER. WHEN RELAYED TO THE LEAD TRAFFIC GUIDES HE TOOK NO ACTIONS. FINALLY A PROMPT WAS GIVEN TO NOTIFY THE EOC. REASSIGNMENT OF WOMEN WAS NOT OBSERVED. NOTE OPIP 3&3 DOES NOT SAY TO CALL EOC WHEN FIELD MEMBER REPORTS HIGH READING > 200 MR ON DOSIMETER (0-200). ROUTE ALERT DRIVERS WERE SENT OUT WITHOUT KI BECAUSE IT HAD NOT BEEN ANNOUNCED UNTIL 12:45 - WELL AFTER THE SIRENS SOUNDED FOR THE SITE AREA EMERGENCY.