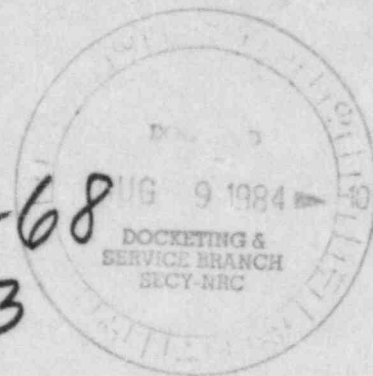


50-322 04-3

SC EP68

I - SC-68
11/83



DOCKET NUMBER 50-322 04-3

NOVEMBER, 1983

NUCLEAR REGULATORY COMMISSION

Docket No. 50-322-04 Official Exh. No. SCEP68
In the matter of Shoreham - Emergency Planning

Staff	IDENTIFIED
Applicant	RECEIVED
Intervenor	REJECTED
Cont'g Off'r	
Contractor	DATE <u>6/15/84</u>
Other	Witness
Reporter	<u>R. Eyster</u>

8408170251 840615
PDR ADOCK 05000322
Q PDR


Area EvaluatedMonitors RatingG. Access Control

1. Was an appropriate access control posture established? 5 4 3 2 (1) N.O. *Yes=1*
2. Was there an identifiable system implemented that effectively identified authorized personnel within the facility? (5) 4 3 2 1 N.O. *Yes=1*

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.

One of the key participants in the traffic group did not show. One of the two communicators was reassigned to cover the Traffic Control Point Coordinators which made things tough for the sole remaining communicator.


Evaluators Signature / 11/15/03
Date
Drill
Date

Area EvaluatedMonitors RatingG. 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 authorized personnel within the facility? | 5 | 4 | 3 | 2 | 1 | N.O. |

I. 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.

Procedures

4. Home Coordinator's call out tasks include:

- o Contacting Invalids (ORIP 5.12 d)
- o Alerting Hospitals of arrival (ORIP 5.12 e)
- o ~~Contacting Ambulances~~ Verifying Lists (ORIP 5.12 e)

This is too much for one coordinator.
Material & Equipment

5. Needed some more Suffolk Cty. Hagstroms.

Evaluators Signature

Date

11/16/83

JANUARY 24, 1984

Area EvaluatedMonitors RatingE. 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 authorized 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.

- ONE WAY TRAFFIC FLOW CONCEPTS/PAPERWORK NEEDS CLOSE REVIEW (C.4)
- 56 TRAFFIC POSTS TO BE MANNED, ONLY 50 T.G.'S ASSIGNED
- ATTACHMENT 9 TO OPIF 36.4 ED. 2 IS INCOMPLETE, NOT USABLE AT T.P.'S (C.4)
- SA COORDS. SHOULD BE GIVEN NECESSARY KEYS AT THIS POINT
- T.P. COORD. BOXES TOO LARGE & EASY TO TAKE INTO FIELD.
- LEASE AGREEMENTS / CO. CARS IS A BIG PROBLEM
- DEVELOP RADIO * LISTING IN ADVANCE FOR RADIO OP. USE (TRAFFIC GUIDE DISPATCH LOG)

Evaluators Signature

Date

/ 1/28/84

Problems: The biggest problem area was the controlled parking lot. The problems stemmed from both lack of equipment and from lack of personnel. The monitoring decon personnel used the available plastic traffic cones and the radiation area warning tape (plastic ribbons). The barrier was ~~not~~ very visible being only two feet off the ground. The wind was blowing the traffic cones over. The tape and cones were lost from view once cars were parked beside them. The Decon Leader had only one (1) person to assign to park the arriving vehicles. The arriving traffic guides ignored the monitoring person's directions. Some went into the cafeteria for coffee before going down stairs to be monitored. Others entered the facility by other than the marked path way ignoring the requests from the monitoring person. Part of the problem was that he was not clearly identifiable as a member of the Decontamination Facility.

Inside the facility the operation went better. The traffic guides waited in a controlled holding area until a monitor was free.

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 ~~to~~ location. Also they neglected to tell the people adjacent to them that they had a contamination problem. When questioned - were given the proper response. It seemed that they were having trouble getting into fully, fully-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.

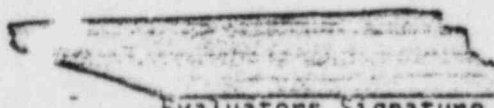
Area EvaluatedMonitors RatingG. Access Control

- | | | | | | | |
|---|---|---|---|---|---|------|
| 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 authorized 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.

1. Another individual should be assigned to ensure that minute-by-minute duties of the dose assessment staff are performed. Much of the RHC's time is taken with the decision-making process and overall direction. This comment was also made by several participants.
2. The offsite dose rate table should be relocated in the dose assessment area.
3. All players should be educated in the role of the controller and how the players should or should not play their roles.
4. Phone numbers for the dosimetry contacts at the staging areas should be available


Evaluators Signature X Date

FEBRUARY 8, 1984

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.

Principle subject of observation was Traffic control. As noted, the lead traffic guides had no advance preparation training or information about tasks. (They were normally just traffic guides in prior drills.)

This was a serious error on the part of those responsible for coordinating effort. Insufficient training and preparation, and ^{lack of} knowledge of the operation of non-traffic guide tasks led to unacceptable delays and omissions of data. The three leads deserve an A+ for effort in dealing with an unfamiliar and complicated task; an actual lead traffic guide probably would have performed better. ~~But the results in general were not good enough for FEMA in this observer's opinion.~~

Refer to controller log sheets for specific details.

The lack of enough dosimeters prevented all the TCP's from being manned. That could flunk the exercise probably.

The staging area also didn't have enough route spotters (~~most~~ only one showed up!).

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

OBSERVER CONTROLLER LOG SHEET

Name:

Date:

Location:

TIME

OBSERVATION/COMMENT

of Ld Traffic Controller
Observer

10:00

None of the lead traffic guides
were trained or prepared for their
tasks! { ~~_____~~ ^{govern}
~~_____~~ ^{ph}

Traffic Guide logs not available
for leads. List of personnel not avail.
Overhead Bus ~~Dispatch~~ ash "What's EPZ stand for."

10:15

Notification of alert, declared
at 9:07 am. No synchronization
of watches.

10:20

~~_____~~ ^{ph} suggests installing speakers
for communications as an aside.

10:30
to 11:00

Three lead traffic guides attempt to familiarize
with their tasks. It should be recognized
that they have had no training. ¹⁸ ~~Begin~~
~~writing briefing info~~ on boards (phones, reminder
to state that ~~overwrite~~ "This is a drill"
in messages, etc.)

Dispatch logs for Road Crews and
Evacuation Route Spotters not available.
Had to be improvised from other logs

11:15

Communications delegated to ~~_____~~
~~_____~~ prepared for briefings.

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.

Overall Grade - 'A' for effort,
Probable FEMA Grade Between 'C' & 'D'. ^{For easy} graders.
Numerous key functions were being performed by people who had never done it before in a drill and some had never even seen the procedures before - especially the Lead Traffic Guides who had never been other than traffic guides before. Also the Dosimetry Record Keepers (only 2 out of 3 showed) were 'virgins' and needed a lot of direction by their Controller/Observer to even get the drill to function. **VERY POOR STAFFING SCHEDULING** for a drill that was to be a 'hands off' Observer drill. Especially with regard to some of the sophisticated message tricks, key controller observers were wasted in the field waiting for messages to arrive to provide a contingency message reply. I strongly suggest this aspect of these drills be skipped for the other two replays.

STAGING AREA MODULE

I. Activation and Staffing

- | | Yes | No | N/A | N/O |
|--|-----------------------------|-------------|---------------------|-------------|
| 1. Which Staging Area were you assigned to? | <u>Port Jefferson</u> | | | |
| 2. Were mobilization and notification procedures demonstrated (as opposed to pre-positioning)? | <u>TRAFFIC CONTROL</u> | | | |
| | <u>✓</u> | <u> </u> | <u> </u> | <u> </u> |
| 3. If so what time was staffing complete for: | | | | |
| - Group II? | <u>not observed</u> | | | |
| - Group III? | <u> </u> | | | |
| 4. Was a full complement of staff present according to the plan? | <u>see note(1) below</u> | | | |
| 5. Did the Staging Area personnel in general, display adequate training and knowledge? | <u> </u> | <u>✓</u> | <u>see note (2)</u> | <u> </u> |
| 6. Was 24 hour staffing capability demonstrated? | <u> </u> | <u> </u> | <u> </u> | <u>✓</u> |

Notes :

- (1) Full staff probably present for most functions. However, lack of sufficient number of dosimeters prevented full participation and implementation of plan.
- (2) The three lead traffic guides were not trained or prepared for their tasks, and had not been informed of their positions before arriving at staging area.

2/8/84

Port Jefferson Staging Area Critique

I Activation & Staffing

REALISTIC ATTEMPT AT TRAFFIC IN
WAS COMPLICATED BY MANY
BUT ~~KEY~~ FUNCTIONS
BEING PERFORMED BY PEOPLE WHO
HAD NEVER DONE THESE TASKS
IN A DRILL SCENARIO BEFORE
ESPECIALLY LEAD TRAFFIC GUIDES
WHO HAD ONLY BEEN TRAFFIC
GUIDES BEFORE & DISMETER
RECORD/DISTRIBUTION PEOPLE WHO
HAD NEVER CARRIED THE BALL
IN A DRILL BEFORE AS
WELL AS ADMIN ASSTS.

II Facilities and Equip

1. DESK WITH 5 PHONES & A RADIO
ON IT. IT NEEDS MORE SPACE
THE STATUS BOARDS COULD HAVE
BEEN USED TO GREATER
ADVANTAGE. PEOPLE IN MANY
CASES WERE WORKING WITH
PROCEDURES THEY HAD NEVER
SEEN BEFORE AND HAD NO
PERSONAL COPIES OF SAME TO REVIEW
AND RECALL

SOME DIFFICULTIES WITH THE LAYOUT
AT PORT JEFF. ~~NEEDS~~ A
PERMANENT PA SYSTEM WITH MULTIPLE
SPEAKERS ON TURBINE DECK. THE LARGER
BRIEFING ROOM COULD HANDLE NO
MORE THAN 50 AT A TIME WHICH
MEANS 25 SEPARATE STAGGERED BRIEFS
HAD TO BE HELD FOR JUST THE BUS
DRIVERS & TRAFFIC GUIDES ON THE
WAY OUT NOT TO MENTION THE
SMALLER GROUPS. COMMUNICATIONS
AREA HAD 5 PEOPLE ~~AROUND~~

III Command & Control

To specific Briefing & Dismeter
Briefings were OK. But there was
little in the way of general
plant briefings or radiobased
condition briefing for the troops.

THE Coordinator did a
credible job especially in light
of the inexperienced people he
had to depend on. Unfortunately
the Drill Controller/Observer had
to direct some actions to facilitate
the running of the drill. Good
use was made of an experienced
admin. asst on the Turbine Deck
who acted as the S.A. Coord rep.

IV Dismetering & Exposure Control

well as ~~the~~ Dismetering and Kepters with insufficient DRILL experience
for a drill like this one was supposed to be, a hands
off ~~critically~~ observed scenario. THIS WAS ONE AREA
that required a lot of control & direction by the specific
controller and ~~observers~~ ~~parted~~ the ability of the staging area
to dispatch manpower efficiently

Problems encountered
included insufficient
resources available as

V Communications

physically
~~was~~ Communications pretty good in
and out of the staging area but needs improvement
within the staging area itself - as mentioned the need for
a P.A. system on the Turbine Deck ~~was~~ a portable bullhorn
was insufficient. THERE WAS SOME CONCERN IN
EVIDENCE WITH REGARD TO OFFICIAL & UNOFFICIAL
LITCO COMMUNICATIONS ~~WAS~~ AVAILABLE DURING
DRILL

VI Scenario Drill

OVERALL - 'A' BASED ON ~~THE~~
NOT HIGHER THAN 'C' BY FEW
& MAYBE LESS
STDS

SUPPOSED TO BE A HANDS OFF OBSERVER
DRILL BUT THE SITUATION AS IT DEVEL-
OPED REQUIRED ~~THE~~ CONTROLING and hence unable to critically observe

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.

2. REPORTING WAS PREPLANNED WITH PRIOR NOTIFICATION. SOME STAFF ARRIVED EARLY. ROSTERS OF PERSONNEL WERE PROVIDED BY DRILL CONTROLLER - THEY SHOULD BE MADE AVAILABLE BY OTHER MEANS. STAGING AREA COORDINATOR DID NOT KNOW HOW MANY PEOPLE WERE REQUIRED FOR FULL STAFFING AS HE COULD NOT JUDGE WHEN CENTER WAS ACTIVATED FOR GROUP III.
4. ONE OF THREE LEAD TRAFFIC GUIDES DID NOT SHOW UP.
5. SEVERAL PEOPLE FROM EACH GROUP IN GROUP II DID NOT HAVE PREVIOUS DRILL EXPERIENCE. THEY WERE HELPED/TRAINED BY 'OBSERVERS' FROM CILCO WHO HAD THE EXPERIENCE FROM PREVIOUS DRILLS. THESE 'OBSERVERS' TOOK ACTIVE ROLES ON SEVERAL OCCASIONS DESPITE CONTROLLER INSTRUCTIONS AT DRILL COMMENCEMENT. THESE OCCASIONS WERE:

1. CALLING THE EOC FOR THE LEAD TRAFFIC GUIDE TO REPORT A DOSIMETER READING OF A TRAFFIC GUIDE (200 MR).
2. MAINTAINING SIGN IN POST AND ASSOCIATED ROSTERS.
3. TAKING AN ACTIVE ROLE IN RESOLVING A MISSING TRANSFER POINT COORDINATOR BOX.
4. PROVIDING VARIOUS INSTRUCTIONS AND/OR ADVICE.
5. 2 PEOPLE HELPED BUS DISPATCHER DISPATCH DRIVERS.

STAFF GENERALLY UNFAMILIAR WITH TERMS SUCH AS 'PROTECTIVE ACTIONS', 'RELEASE STATUS' OR PLANT EVENTS REPORTED BY EOC WHICH ARE CAUSES OF PARTICULAR EMERGENCY CLASSES.

- 7 BUSES NOT AVAILABLE DUE TO LACK OF VEHICLES/LEASES.
- 20 BUS DRIVERS NEVER WENT OUT. 6th ROUTE/TRANSFER DRIVERS WERE AVAILABLE TO FILL 75 SLOTS NEEDED. IF ALL ROUTES WERE REQUIRED, 32 BUSES WOULD BE UNAVAILABLE.
- 3 TRAFFIC POINTS WERE NOT MANNEQUIN OUT OF 30 REQUIRED.

5 of 9

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

OBSERVER CONTROLLER LOG SHEET

Name: [REDACTED]

Date: 2/6/84

Location: Port Jeff

TIME

OBSERVATION/COMMENT

** But TCP at outside perimeter of EOE chosen in recognition of radiation damage.

	was relayed to Patchogue, message returns to send crew there anyway. Will take action after traffic guides sent out.
1:32	Running short of traffic guides to fill out list due to 2 man crews. why *
1:35	Female driver (only one present with dosimeter) sent to TCP #51. Radiological data not sought or given*. Last traffic guide sent out 1:38. * due to shortage of dosimeters.
1:40	Road crews briefed. some confusion over where destinations are due to lack of experience on part of leads. Martin Callery has worked out confusion over pt. #35 satisfactorily. First crew leaves 1:49.
1:52	Supplementary message IV-59 given. No crews had radios, so no crew dispatched for this message.

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

OBSERVER CONTROLLER LOG SHEET

Name: [REDACTED]

Date: 2/3/84

Location: Port Jeff

TIME

OBSERVATION/COMMENT

2:00

Only one of two route spotters shown
were going to fill in with traffic
guides but none had dosimeters

Not all the traffic ~~guides~~ control
points were able to be manned.

The following were manned:

141	4	56	40	119	97
43	140	57	121	58	99
147	6	41	95	145	100
1	5	120	50	61	101
49	38	122	52	59	102
98		137	144	60	94
51		139			93

37

TOTAL = 39 OF 50

The following were missing from the
1:00 message:

141	118	117	49	95
142	1	44	55	57
43	104	74	48	96
147	103	105	60	
146	133	96	98	
42		47		

TOTAL = 25 OF 50

and his
no radio

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 TRANSFER PT. COORD. 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 COORD. TO DISPATCH BUSES & MONITOR THE RADIO TOO.

I DID SEE ONE PLAYER CHECK HIS DOSIMETRY ONCE. THE OTHERS I DID NOT SEE CHECK AT ALL DURING THE 2 1/2 HRS. OUT @ THE TRANSFER POINT.

THERE IS NO LIGHTING PROVIDED @ THE TRANSFER PT.

A FEW BUS DRIVERS (4 OUT OF 30) COMPLAINED OF INACCURACIES IN THEIR MAPS (WRONG STREET NAMES, ONE MAP WAS MISSING 3 PAGES) ALL DRIVERS WERE ABLE TO COMPLETE THEIR ROUTES THOUGH.

V. Scenario

Summary

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

- ACTIVITY ^{WAS} ~~WAS~~ SUGGESTED TAKING THE START OF DRILL.
- IT PICKED UP WHEN PACKETS WERE DISTRIBUTED
- 2 MEN PER BUS WAS SEEN TO BE MORE EFFICIENT - 1 TO READ MAP & 1 TO DRIVE.
- DOSIMETRY WAS SUFFICIENT BUT NOT USED.

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

OBSERVER CONTROLLER LOG SHEET

Name: ~~██████████~~

Date: FEB. 8, 1984

Location: PORT JEFFERSON

MILLER PLACE RD. T.P.

TIME

OBSERVATION/COMMENT

14:49

EVERY ROUTE HAS BEEN COVERED
M. RUSSO (T.P.C.) HAS CALLED IN
TO P.J.P.S. TO UPDATE STATUS.

NO DOSIMETRY CHECKS

3 MEN:

~~██████████~~
~~██████████~~
~~██████████~~

3 MEN MINIMUM PER.

TRANSFER POINT IN REAL
SITUATION

SEE OVER →

DOSIMETRY ONLY

Yes No N/A N/D

- Port Jefferson

Was advised that personnel
were pre-informed of drill

One man shot at 3 men
Dosim Record Keeping crew

Estimate of the effect of the intervention on the outcome	Estimate of the effect of the intervention on the outcome	Estimate of the effect of the intervention on the outcome	Estimate of the effect of the intervention on the outcome
---	---	---	---

_____ X _____

 X X

FEBRUARY 15, 1984

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

OBSERVER CONTROLLER LOG SHEET

Name: [redacted]

Date: 2/16/81

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.

① of ④

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

OBSERVER CONTROLLER LOG SHEET

Name:

[REDACTED]

Date:

2/15/83

Location:

PORT JEFFERSON

TIME

OBSERVATION/COMMENT

10:00

Informed that 63 of 75 traffic guides were signed in at main staging area. Lead traffic guides have organized in preparation of dispatching various crews.

~~10:30~~
10:30

Staging area status board set up ~~to~~ on main turbine deck noting alert level wind speed & direction & reactor data -- good. (none available last week)

11:00

Lead traffic guide updating list of arriving personnel -- good procedure.

11:03

Lead traffic guides collect traffic guides for their dosimetry briefing.

11:14

Message re: boy scouts. dispatched one route alert driver at 11:17 ^{to evacuate them.} Man will call back when he gets to position. Note that at this time status board still indicates "Alert" level.

11:45

Last of traffic guides to arrive receive dosimetry briefing. Two guides have medical problems which would prevent them from using the potassium-iodide tablets. Alternative job tasks have to be assigned. At this time 6 road crews & 66 traffic guides have signed in, as tabulated by lead traffic guides.

(2) of (4)

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 1, A
091

TIME

OBSERVATION/COMMENT

11:50	Status board update to Site Area Emergency, and note that no release of radiation occurred.
12:00	Lead traffic guides well on top of count of no-shows, etc. Reported data to traffic coordinator.
12:04	Rte alert driver sends message that Boy Scouts were evacuated at 11:55. Coordinator notified promptly.
12:05	At time, 66 of 76 traffic guides { 3 of 60 + 6 of 60 7 of 10 road crews { in red 1 of 2 route spotters 20 of 22 route alert * 1 reassign have signed in. The rest are no-shows.
12:50	2 more TG. showed up, but 2 went home sick.
1:00	Message: prepare to evacuate zones: A, B, C, D, E, G, & H Traffic control points: (32 pts of 56) 4 140 6 5 38 40 139 41 121 120 122 137 37 57 56 144 50 145 58 119 61 59 60 97 52 95 99 100 101 102 93 94 (No indication of no. in per T.C.P.)

(3) of (4)

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

OBSERVER CONTROLLER LOG SHEET

Name: _____

Date: _____

Location: _____

TIME

OBSERVATION/COMMENT

1:03

Call for Rte spotters to
1001, 1003, 1006

(note: only one rte spotter available)

1:05

Message for Road Crews (4) to
77, 70, 126, 30

Lead traffic guides split up, each taking
one of the groups.

1:13

First Road crew out. Last crew out by
1:16. No data re: weather, plume, etc
given.

1:16

Dispatch of traffic guides in progress.

1:20

Rte spotter out -- informed re KI

1:24

message to change road crew
destinations. Controller gives out
contingency message IV-52 to send
traffic guides to whatever remaining
TCP's not given with 1:00 message

1:25

They can fill up remaining people
Route alert drivers to: (message)
56A, 3k, 53F, 26F

Good briefing re weather, plume & reactor
status given to traffic guides.

5 of 6

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 ~~FR~~ BY RADIO NUMBERS IN NUMERICAL ORDER (WITH COLS FOR ~~CONTROL~~ CONTROL PT, INITIAL RADIO CKE, ARRIVAL @ CTRLPNT, DEPARTURE FOR BASE, ARRIVAL @ BASE) TO FACILITATE RADIO COMMUNICATIONS.

2:10

TOO MANY ^{TRAFFIC GUIDES} ~~WERE~~ 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 (A TOOLING 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, ~~IS NECESSARY~~ ^{AND} WHO TO DIRECT THE REQUEST FOR RESPONSE TO, IS NECESSARY. OPERATORS ^{REQUEST} ~~ARE~~ A LIST OF ^{WHAT IS CALLER IS} ~~WHAT IS CALLER IS~~ SUPPOSED TO BE DOING.

*

SUGGEST 2 PEOPLE WORK RADIO WITH HEADSETS AND SPLIT LIST OF RADIOS IN TWO. TOO MANY TRANSMISSIONS IN ^{AN EXTENDED} ~~TOO SHORT A~~ TIME ^{FRAME} FOR ONE OPERATOR TO HANDLE / NEVER GETS A CHANCE TO ^{RECOVER} ~~RECOVER~~

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. E.O.C. NOT GIVING TITLE ; SOURCE UNKNOWN
2. # 55 , # 63 TRAFFIC GUIDES
3. a. CORAN TR. 6 out of 60
 - b. TRAFFIC GUIDES 16 NOT INITIALLY MANNED.
 - c. ROUTE ALERT : 5 @ 11:30-12:00
6 @ 2:30
 - d. BUS DISPATCHER : PRE-STAGE THEN MARCHING ORDERS
(1:00 AM.) (LATER)
4. 1 HR 05 MINUTES. G.E.
ANNOUNCEMENT.

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 ④:

There were a number of no-shows as indicated in comment/observation sheets, specifically

- a. 8-traffic guides fail to come and 2 extremely late & 2 went home sick; also 3 have real-life medical problems that would prohibit them from taking the KI tablets, thus they cannot be used in a real emergency.
- b. ~~3 Road crew~~, 1 Rte spotter & 2 Rte alert drivers no-show.

Item - ②:

Lead traffic guides performed well in response to the messages received. However, without knowing the background information, it appears from the traffic control standpoint that communications from the EOC is not good.

The lead traffic guides were prompt in notifying coordinator of actions taken.

Item ③: Lead traffic ~~control~~ guides were responsive and well-prepared. A review of OPIP 3:42:3 (by them) is suggested.

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.

THE THREE TRANSFER POINT CORD. RAN THE DISPATCHING OF BUSES VERY EFFICIENTLY & SMOOTHLY. IT WAS CLEAR THAT THESE PEOPLE HAD BEEN THRU THIS BEFORE.

BEFORE BEING DISPATCHED TO TRANS. PT. THERE WAS CONFUSION ON WHERE TO WAIT FOR INFO. FROM BUS DISPATCHER. A BUS DISPATCHER MIGHT HAVE TROUBLE FINDING THE T. P. C(S). A FORMAL T.P.C. MEETING RM. IS REQD.

BUSES WERE DISPATCHED IN THE CORRECT MANNER. THEY HAD BEEN TOLD TO DISPATCH BUSES IN SEQUENCE WITH THE CHART. THIS WAS DONE.

5 BUSES WERE DISPATCHED TO RELOCATION CENTER. NO MAPS WERE PROVIDED IN ENVELOPES.

DOSIMETRY WAS CHECKED BY MOST PERSONNEL QUOTE OFTEN. ONE BUS DRIVER WAS OBSERVED TO HAVE LEFT HIS DOSIMETRY IN HIS CAR. T.P.C. TOLD HIM TO PUT HIS INSTR. ON & REMINDED EVERYONE TO PERIODICALLY CHECK THEIR DOSIMETRY.

GIVING BUS ROUTE STATUS OVER THE RADIO WAS DIFFICULT, TIME CONSUMING, AND TAKING UP VALUABLE RADIO TIME. SUGGEST USE OF A PHONE (ADDED TO T.P.C. KIT) TO COMPLETE THIS TASK. A PHONE LEAD WOULD BE REQD. AT THE TRANSFER POINT.

ONE THING I WOULD LIKE TO POINT OUT, A TRANSFER POINT CORD. ~~ALONE~~ COULD NOT RUN THE TRANSFER POINT ALONE. AT LEAST THREE ARE REQD. MIN! ONE T.P.C. TO ~~LOG~~ LOG IN BUS ROUTES, ONE TO

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 Staging Area

TIME

OBSERVATION/COMMENT

9:50	In meeting room with lead traffic guides. It was reported that 63 traffic guides on list. A lead traffic guide commented that 75 traffic guides are needed for this staging area for 56 TCP'S.
9:30	In turbine level area the "Staging area Status Board" calls an alert at 9:00
11:02	Lead Traffic guides assembling traffic guides for dosimetry in turbine area.
11:14	1st message received to lead Senior Traffic guide to dispatch Route alert driver to warn Boy Scout troupe to evacuate. dispatched 11:17, 1 person.
11:45	66 traffic guides have reported and as they arrive are giving dosimetry info.
11:51	Site area emergency entered on the Status Board
12:04	Route alert driver called in and evacuation Complete at 11:55.

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. Staging Area

TIME

OBSERVATION/COMMENT

1:00	In meeting room A with lead Traffic guides - just received a message from EOC to send Traffic guides to TCP's - Total of 32 guides
1:04	Message to send out route spotters (3) but only one available
1:07	Message to send out 4 road crews
1:10	All traffic guides assembled in meeting room B
1:20	TCP #6 package handed to traffic guide Left to pick up radio
1:25	Took bus to parking area
1:30	Called in and heading to TCP #6
2:00	Arrived at TCP #6 and called in.
3:20	Called in and returning to Staging Area
3:45	Arrived at staging area and called in

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.

3. THE FOLLOWING DID NOT SHOW UP:

4 BUS DRIVER ~~1111~~ 111

ROUTE / LEFT DRIVER 11

TRAFFIC GUIDE 111

83 45

27 PEOPLE REMAINED AT STAGING AREA AFTER DISPATCHING. ONLY A HANDFUL WENT TO BRENTWOOD. REMAINING EITHER CAR POOLED OR HAD NO LEAVES.

5. LEAD TRAFFIC GUIDES UNSURE OF MEANING OR IMPACT OF EMERGENCY CLASSES. GUESTS AT EMERGENCY CLASS AND JS BRIEFED ROAD CREWS
A TRANSFER POINT COORDINATOR WAS UNSURE OF WHAT A RS TRANSFER BUS WAS.
A BUS DRIVER WENT TO JCCC FIRST INSTEAD OF TRANSFER PC.

13. Responding to requests from public/commitments made.

- a. Home Coord told individual that addition oxygen would be supplied by LERO with responding ambulance @ 1312, at 1415 action was finally initiated by Ambulance coord
- b. Rumor Control told a mother of a missing child that a car would pick her up to take her to each relocation center to look for her missing child. however no steps were taken to dispatch a vehicle (see comment on missing person procedure)

14. Staffing

During initial contacting of schools / facilities / invalid individuals there is a need for additional personnel. Some personnel not busy at the early stages of the emergency should be identified to support this relatively short lived activities (initial contact)

(2)

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

OBSERVER CONTROLLER LOG SHEET

Name: _____

Date: _____

Location: _____

TIME

OBSERVATION/COMMENT

—	Group the radios out early worked very well - rather than waiting for dispatching orders.
—	R.H. had enough people to man 2. x P's but could not man 4 if required.
—	R.H. tries to run the show by themselves and do not communicate with other S.P.'s or the EOC. Symptomatic - different from the way their everyday jobs are done.
—	Time to dispatch people will be increased quite a bit if all equipment has to be taken out i.e. cones, etc.

(3)

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

OBSERVER CONTROLLER LOG SHEET

Name: _____

Date: _____

Location: _____

TIME

OBSERVATION/COMMENT

Summary

—	Security procedure calls for 3 people named 6 people. Including me for EVO's
—	Security checks for no too many heavy loads for motivation on EVO's.
—	Some people should all show up on anti-C's rather than some.
—	Worker with contamination on the neck area was assumed to be thyroid uptake and was sent to the hospital. Should have washed him and then checked for thyroid uptake. <u>EVO's 1st</u>
—	Pub Demand (Security Control) trying to do a good job but has not been told his responsibilities and what to do at the Delegation Center.
—	Need listing of names and addresses of all schools not just school districts.
—	Need listing of fully commodities needed during a drill.
—	Delegation procedure does not address notification of the A.R.C.
—	_____

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

(4)

OBSERVER CONTROLLER LOG SHEET

Name: [redacted]

Date: 2/15/84

Location: Port Jervis Staging Area

TIME

OBSERVATION/COMMENT

Obviously, a breakdown occurred @ the ECC/
Port Jervis line. While waiting, the base
station informed us they were in touch to the
EOC and were awaiting further information.

- What is the difference between a
black and white cone symbol on
the traffic guide intersection maps?
My guides did not know that.
- Suggest wording messages
better - ours was confusing and
interpreted two ways.
- Suggest 2 traffic guides per
intersection in all stages.