

APPENDIX

U.S. NUCLEAR REGULATORY COMMISSION  
REGION IV

Inspection Report: 50-445/92-46  
50-446/92-46

Operating License: NPF-87

Construction Permit: CPPR-127

Licensee: TU Electric  
Skyway Tower  
400 North Olive Street, L.B. 81  
Dallas, Texas 75201

Facility Name: Comanche Peak Steam Electric Station

Inspection At: Glen Rose, Texas

Inspection Conducted: November 16 through 20, 1992

Inspectors: D. Blair Spitzberg, Ph.D., Emergency Preparedness Analyst,  
Team Leader  
K. M. Kennedy, Project Engineer  
D. Barss, Emergency Preparedness Specialist, Office of Nuclear  
Reactor Regulation (NRR)

Accompanying  
Personnel: J. D. Jamison, Senior Staff Scientist, Battelle Laboratories  
G. W. Bethke, Comex Corporation  
R. Emch, Section Chief, Emergency Preparedness Branch, NRR  
M. L. Thomas, Radiation Specialist, Office of Nuclear Regulatory  
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Approved: Blaine Murray  
Blaine Murray, Chief, Facilities  
Inspection Programs Section

12/3/92  
Date

Inspection Summary

Areas Inspected: Routine, announced inspection of the licensee's performance and capabilities during an annual exercise of the emergency plan and implementing procedures. The team observed activities in the control room (simulator), Technical Support Center, Operational Support Center, and the Emergency Operations Facility.

Results:

- The control room staff performance was strong during the exercise (Section 2).
- The Technical Support Center was staffed and activated promptly (Section 3).
- An exercise weakness was identified for delays in detecting and classifying two emergency classes (Section 3.1).
- An exercise weakness was identified for failure to make prompt notifications to offsite authorities of an emergency classification (Section 3.1).
- The Operational Support Center was staffed and activated promptly. Information flow within the Operational Support Center and between the Operational Support Center and other facilities was good. Repair teams followed proper safety controls and were well briefed (Section 4).
- The Emergency Operations Facility was staffed and activated promptly, and personnel were proficient in carrying out their assigned duties. The press conference did not clearly convey essential information which was available at the time to the media (Section 5).
- An exercise weakness was identified for several examples of weak emergency command and control (Section 6.1).
- The scenario and exercise preparation provided sufficient challenge to demonstrate the exercise objectives (Section 7).
- The licensee's self-critique process was excellent in identifying areas in need of corrective action (Section 8).

Summary of Inspection Findings:

- Exercise Weakness 445/9246-01; 446/9246-01 was opened (Section 3.1).
- Exercise Weakness 445/9246-02; 446/9246-02 was opened (Section 3.1).
- Exercise Weakness 445/9246-03; 446/9246-03 was opened (Section 6.1).

Attachment:

Attachment 1 - Persons Contacted and Exit Meeting

## DETAILS

### 1 PROGRAM AREAS INSPECTED (82301)

The licensee's annual emergency preparedness exercise began at 2 a.m. on November 18, 1992. The exercise start time had been withheld from exercise participants. The exercise did not involve participation by offsite agencies.

Initial conditions for the exercise included full power operations in Unit 1 with Diesel Generator 2 removed from service. Unit 2 was undergoing pre-operational testing, and its equipment and systems were unavailable for use during the exercise. The exercise began with a small steam generator tube rupture meeting the conditions for a Notification of Unusual Event. A short time later, a fire alarm was received in the control room (simulator) indicating a fire in the Emergency Diesel Generator 1-01 Day Tank Room. This would lead to conditions corresponding to an Alert classification. Following several subsequent minor events, the scenario presented a significant increase in the size of the steam generator tube rupture concurrent with an unisolable steam break outside of containment on the affected steam generator. These events led to conditions corresponding to a Site Area Emergency, with activity in the primary coolant being released to the environment. About 40 minutes later, the final significant event occurred with the rupture of a waste gas decay tank drain line. The scenario called for the emergency to be terminated while in the Site Area Emergency classification with two offsite release pathways. The releases were not of a magnitude to cause offsite dose projections to exceed Environmental Protection Agency protective action guidelines.

The inspection team identified various concerns during the course of the exercise; however, none were of the significance of a deficiency as defined in 10 CFR 50.54(s)(2)(ii). Each observed concern is characterized as an exercise weakness or as an area recommended for improvement. An exercise weakness is a finding that a licensee's demonstrated level of preparedness could have precluded effective implementation of the emergency plan in the event of an actual emergency. An exercise weakness is a finding that needs licensee corrective action. Other observations are documented which did not have a significant negative impact on overall performance during the exercise but still should be evaluated and corrected as appropriate by the licensee.

### 2 CONTROL ROOM (82301-03.02.b.1)

The inspection team observed and evaluated the control room staff as they performed tasks in response to the exercise. These tasks included detection and classification of events, analysis of plant conditions, implementation of corrective measures, notifications of offsite authorities, and adherence to the emergency plan and implementing procedures.

#### 2.1 Discussion

The control room simulator was used to initiate the exercise. Dynamic simulation of the exercise was accomplished throughout the exercise.

Overall, the control room staff performance was observed to be strong during the exercise. The crew successfully detected abnormal events, analyzed plant conditions, and aggressively pursued corrective actions and alternate success paths. Augmentation of the control room staff by offsite personnel assigned to Emergency Organization positions occurred within 1 hour following the Alert declaration. The Notice of Unusual Event and the Alert classifications were both made from the control room during the exercise. The inspectors observed that the classification of the Alert was delayed by the control room crew after confirming that a fire in the protected area which lasted more than 10 minutes was potentially affecting a safety system. This observation is discussed in detail in Section 3.1 as part of an exercise weakness in detection and classification. Notifications to offsite authorities from the control room were timely and accurate. The inspection team noted that the control room crew performed prompt and appropriate offsite dose projections based on the small steam generator tube leak.

The following observations made in the control room did not significantly detract from the overall effectiveness of the licensee's response and are identified as potential areas for improvement:

- Following the declaration of a Notification of Unusual Event and the subsequent activation of the pager system, the control room received numerous phone calls requesting information from offsite personnel with pagers. These phone calls were handled by the two control room communicators and the Emergency Coordinator which caused a distraction to the performance of their duties.
- Control room logs were not maintained during the late stages of the exercise between 5:09 a.m. and the termination of the exercise at 6:09 a.m. During this time period, events which were not logged by the control room included the rupture of a waste gas decay tank and the loss of an offsite power distribution line.

## 2.2 Conclusions

The performance of the control room staff was observed to be strong during the exercise. A delay in the classification of the Alert contributed to an exercise weakness in detection and classification (Section 3.1).

## 3 TECHNICAL SUPPORT CENTER (82301-03.02.b.2)

The inspectors observed the operation of the Technical Support Center from activation through termination of the exercise. The inspectors evaluated staffing, command and control, technical assessment and support of operations, classifications and notifications, dose assessment, formulation of protective action recommendations, and adherence to the emergency plan and implementing procedures.

### 3.1 Discussion

The Technical Support Center was staffed and activated promptly within 1 hour of the Alert declaration. The transition of emergency command from the

control room to the Emergency Coordinator in the Technical Support Center was noted to be inefficient and confusing. Inspector observations related to the transfer of Emergency Coordinator duties to the Technical Support Center are discussed in further detail in Section 6.1 as part of an exercise weakness in emergency command and control.

Technical Support Center briefings were held approximately every half hour. These briefings included a presentation by each major technical area coordinator and served to keep all Technical Support Center personnel apprised of plant conditions and priorities. The classification and declaration of the Site Area Emergency was made from the Technical Support Center approximately 18 minutes following this facility's activation. The inspectors noted unnecessary delays associated with the detection and classification of the initiating conditions for two of the three emergency classifications made during the exercise as follows:

- In the control room, the Emergency Coordinator failed to implement correctly Procedure EPP-201, "Assessment of Emergency Action Levels, Emergency Classification and Plan Activation," Chart 11, "Fire." This chart indicated that a fire inside the protected area lasting greater than 10 minutes for which safety systems were potentially affected by the fire would result in an Alert classification. The Emergency Coordinator failed to declare an Alert 10 minutes after the Diesel Generator 1-01 Day Tank Room fire alarm was received in the control room. Instead, the declaration was made 10 minutes after the existence of the fire was confirmed by an auxiliary operator dispatched to the scene. This resulted in a 6-minute delay in the Alert classification.

Through player interviews, the inspectors determined that the Emergency Coordinator began the 10-minute countdown at the time when the fire was confirmed by the auxiliary operator. The operator confirmation took 6 minutes from the receipt of the alarm. During this 6 minutes, the fire potentially affected safety systems. Under the conditions of this scenario, following the operator's confirmation of the fire, the Alert classification conditions were met 10 minutes after the receipt of the fire alarm.

- In the Technical Support Center, declaration of the Site Area Emergency following the major steam generator tube rupture and main steam line break was not made promptly following reports of these conditions. At 4:28 a.m., the Technical Support Center staff became aware that the steam generator tube rupture had significantly increased concurrent with reports of an unisolable steam line break outside of containment on the affected steam line. According to the licensee's classification scheme contained in Procedure EPP-201, "Assessment of Emergency Action Levels, Emergency Classification and Plan Activation," Chart 4, these conditions correspond to a Site Area Emergency. The declaration of the Site Area Emergency was not made by the Technical Support Center until 4:49 a.m., or 21 minutes following Technical Support Center staff awareness of these conditions. The inspectors noted that a briefing was being started at 4:30 a.m. in the Technical Support Center as information of the main steam line break was received. Rather than take action on this



event, the managers took another 5 to 10 minutes to complete the briefing. The control room finally prompted the Technical Support Center concerning the need to upgrade to Site Area Emergency at about 4:47 a.m.

Delays in detecting and classifying emergency conditions were identified as an exercise weakness (445/9246-01; 446/9246-01).

Following the declaration of the Site Area Emergency at 4:49 a.m., the notifications to offsite authorities of this classification were not completed until 25 minutes later at 5:14 a.m. According to 10 CFR 50, Appendix E.IV.D.3 and EPP-203, "Notifications," Section 4.1.2.2, notifications are to be made within 15 minutes after declaring the emergency. The licensee's failure to make prompt offsite notifications of the Site Area Emergency was identified as an exercise weakness (445/9246-02; 446/9246-02).

The inspectors made the following observations from the Technical Support Center which were determined not to have significantly detracted from the overall effectiveness of the licensee's response and are identified as areas for improvement:

- Status boards in the Technical Support Center were often late in being updated or were never annotated in sections pertinent to the exercise scenario data. Specific examples include:
  - At 3:55 a.m., the Sequence of Events status board attributed the ALERT to "Primary to Secondary Leakage" versus the actual cause which was the Train "A" diesel day tank fire.
  - At 4:17 a.m., the Sequence of Events status board did not indicate that the Operational Support Center and Technical Support Center were activated.
  - The Radiological status board was never updated to reflect offsite monitoring team data or the results of dose projections made.
- The inspectors noted difficulties in the Technical Support Center associated with use of the "Offsite Release Consequence Assessment System" (ORCAS). Fifteen minutes following activation of the Technical Support Center, there was still no operator available for the ORCAS computer system. Because of this, the Technical Support Center Onsite Radiological Assessment Coordinator decided that he would have to operate the ORCAS instead of occupying his position at the management table. At about 4:30 a.m., a newly arrived individual was assigned to the ORCAS but this individual stated that he had only operated ORCAS once before.

Throughout the exercise, the Technical Support Center ORCAS was operated under only one accident scenario assumption, "Steam Generator Tube Rupture." All dose projections performed used data from the main steam line radiation monitors. These monitors are installed on the steam

lines between the relief valves and the main steam isolation valves. For the exercise scenario, the inspectors found that these monitors could have been unrepresentative of release concentration because of such conditions as being positioned downstream of the break, because of damage by high temperature and humidity, or because of being subjected to physical damage caused by pipe whip, etc.

Scenario selections are not available on the ORCAS computer program for releases via the condenser offgas stack or for ground level releases created by main steam line breaks with a steam generator tube rupture.

- Several personnel in the Technical Support Center stated that the Gaitronics/All Page system was unreliable or would not work from the Technical Support Center. This was explained by the licensee as being a drill artificiality caused by the additional load on the system of the remote simulator facility. The inspectors noted that the loading problem did not appear to affect transmission from the simulator to the plant speaker systems; therefore, the problem may not be one of system over-loading.

### 3.2 Conclusions

The Technical Support Center was staffed and activated promptly. An exercise weakness was identified for delays in detecting and classifying two emergency classes. Another exercise weakness was identified for failure to make prompt notifications to offsite authorities of an emergency classification. The transition of emergency command from the control room to the Emergency Coordinator in the Technical Support Center contributed to an exercise weakness discussed in Section 6.1 in the area of emergency command and control.

## 4 OPERATIONAL SUPPORT CENTER (82301-03.02.b.4)

The inspectors evaluated the performance of the Operational Support Center staff as they performed tasks in response to the exercise to determine whether the Operational Support Center would be effective in providing emergency support to operations.

### 4.1 Discussion

The inspectors observed the activation and operation of the Operational Support Center and repair teams dispatched to in-plant locations. The Operational Support Center was initially staffed by personnel who were on site at the time the Alert was declared, and the facility was operational with minimum staffing 12 minutes after the declaration of the alert. The Operational Support Center was officially declared operational 33 minutes after the Alert declaration.

Personnel appeared generally to be acquainted with their responsibilities and duties. Procedural guidance was available and used by individuals in the Operational Support Center. The inspectors noted that on one occasion an auxiliary operator who was dispatched to investigate the fire alarm, needed to

be instructed in immediate entry procedures at the access control point. Radios, telephones, and plant page systems were effectively used to maintain communication between emergency response facilities and teams dispatched to in-plant and onsite locations.

Key emergency responders kept logs of ongoing activities. A status board for plant events was maintained. The inspectors noted that reports of in-plant radiation monitors were posted on a dry erase board while another status board specifically provided for this information was not utilized. Also, results of radiological surveys were not posted on plant maps provided in the Operational Support Center.

The command and control of the Operational Support Center was fragmented and somewhat uncoordinated. Early in the exercise, it appeared that no single individual was clearly in control of assigning and dispatching teams. The licensee did manage to dispatch teams needed to respond to emergency events in a timely manner; however, it was not done in an orderly fashion. For example, the licensee failed to maintain adequate administrative controls over teams dispatched in response to emergency conditions as specified in Procedure EPP-16, "Emergency Repair & Damage Control and Immediate Entries." This finding is discussed in Section 6.1 as part of the exercise weakness in emergency command and control.

Repair team priorities were frequently discussed by the Operational Support Center Manager with Technical Support Center management. These priorities were clearly posted on a status board in the Operational Support Center. Briefings of emergency response damage control teams were good. Team members were adequately informed of existing or expected radiological conditions. Appropriate radiological controls were prescribed and good radiological practices were followed by team members. Team tasks were clearly explained.

#### 4.2 Conclusions

The Operational Support Center was staffed and activated promptly. Information flow within the Operational Support Center and between the Operational Support Center and other facilities was good. Repair teams followed proper safety controls and were well briefed. Failure of the Operational Support Center to exercise specified administrative controls over repair teams is discussed in Section 6.1 as part of a weakness identified in the area of emergency command and control.

### 5 EMERGENCY OPERATIONS FACILITY (82301-03.02.b.3)

The inspection team observed the Emergency Operations Facility staff as they performed tasks in response to the exercise. These tasks included activation of the Emergency Operations Facility, accident assessment and classification, offsite dose assessment, protective action decisionmaking, notifications, and interactions with offsite field monitoring teams.



## 5.1 Discussion

The Emergency Operations Facility staff arrived promptly and the Emergency Operations Facility was declared activated 72 minutes following the Alert declaration. Some minor security access delays were observed in the Emergency Operations Facility. It was noted that the authorized access list for the Emergency Operations Facility was dated September 10, 1992. The first two responders to the Emergency Operations Facility were not on the list and the guard responsible for Emergency Operations Facility access control had to obtain authorization by telephone before admitting them. Later, for the same reason, the driver assigned to field monitoring team No. 1 was prevented from accessing the area where survey team equipment was stored, causing a short delay in the deployment of the team.

The inspection team noted that Emergency Operations Facility staff appeared to be trained and proficient in carrying out their response duties. The operational status and event sequence status board was kept current and complete throughout the exercise. It provided a very useful and accurate summary of plant conditions for ready reference by all the Emergency Operations Facility staff. Written logs, however, were not as well maintained. For example, logs kept by key Emergency Operations Facility players were in loose-leaf format instead of bound log books. Many interpersonal and inter-station communications were recorded using scraps of paper or informal notes. These practices would make event reconstruction from the records very difficult and legally tenuous.

Control of the offsite monitoring teams and dissemination of the measurement results they collected were weak. These observations are discussed in further detail in Section 6.1 as part of the exercise weakness in emergency command and control. In addition, offsite monitoring team measurement results of the plume traverse reported as background by the team at 5:39 a.m. were not logged in the field team communicator log, nor were these, or the later above-background readings reported about 6 a.m. recorded on the offsite monitoring status board.

The inspection team observed the licensee's exercise press conference conducted in the auditorium adjacent to the Emergency Operations Facility. The press conference did not clearly convey basic information that was available at the time and that both the media and public would need to understand. For example, the press briefing apprised the media of a radiological release in progress but failed to convey any clear information as to the offsite hazards associated with the release. In fact, before the press conference was held, the licensee's response staff had conducted onsite monitoring surveys of the release and had performed detailed dose projections, both of which indicated that the offsite hazards associated with the release were minor. In the absence of such information being conveyed, the media was left to report only that licensee personnel had been evacuated from the site but as for the general population, county authorities were working to formulate offsite protective actions. Further, the press conference did little to describe the licensee's response efforts in progress at the time. No definition was given for the Site Area Emergency which had been declared, nor was it differentiated from the other emergency classes. No perspective

was conveyed relative to whether the emergency was stabilizing or whether conditions were still degrading.

## 5.2 Conclusions

The Emergency Operations Facility was staffed and activated promptly and personnel were proficient in carrying out their assigned duties. Control of offsite monitoring teams and the information they returned to the Emergency Operations Facility was part of an exercise weakness discussed in Section 6.1 in the area of emergency command and control. The press conference did not clearly convey essential information to the media which was available at the time.

## 6 EMERGENCY COMMAND AND CONTROL (82301)

The inspection team evaluated the emergency command and control exercised in each emergency response facility to determine whether clear chains of command were in place for effective emergency management, and whether the emergency response organization was issued appropriate directives by key decisionmakers.

### 6.1 Discussion

The Emergency Coordinator position (a.k.a. Emergency Director) was transferred twice during the exercise. Between the Alert declaration and the Site Area Emergency, the Emergency Coordinator position shifted from the control room to the Technical Support Center. About 30 minutes after the Site Area Emergency declaration, the Emergency Coordinator responsibilities were transferred to the Emergency Operations Facility. The inspection team made the following observations which, in the aggregate, indicated that overall command and control during the exercise was weak:

- The transfer of Emergency Coordinator duties from the control room shift supervisor to the manager in the Technical Support Center was inefficient and confusing and appeared to leave a vacuum of command authority for a period of time.

The Alert was declared at 3:19 a.m. By 3:36 a.m., there were about four people in the Technical Support Center but with no particular individual in charge. At about 3:42, the Emergency Coordinator's checklist logs indicated that the individual who would eventually become the Emergency Coordinator in the Technical Support Center had relieved the control room shift supervisor of the Emergency Coordinator's duties (while in the simulator). By about 4 a.m., one individual in the Technical Support Center had taken charge of personnel there but did not claim the title of Emergency Coordinator. The Emergency Coordinator arrived in the Technical Support Center from the simulator at about 4:28 a.m. but did not announce that he was the Emergency Coordinator. Status boards in the Technical Support Center continued to show that the control room had command and control. The Technical Support Center Emergency Coordinator log showed that the same individual who had assumed Emergency Coordinator duties in the simulator again assumed these duties in the Technical Support Center at 4:50 a.m.

Because of the distance between the Technical Support Center and the simulator, this exercise included an artificially long period of time (about 10 minutes) to transit between the two facilities. Even giving consideration to this artificiality, it was unclear who was the Emergency Coordinator during the 4:30 to 4:50 a.m. timeframe.

- In the Operational Support Center, the licensee failed to maintain adequate controls over teams dispatched in response to emergency conditions. Between 4 and 6:07 a.m., 16 teams were dispatched from the Operational Support Center. No Emergency Work Permits were completed for 10 of these teams as required by Procedure EPP-116, "Emergency Repair & Damage Control and Immediate Entries," step 4.2.2. Some of these teams were recorded on the Operational Support Center Team Status board and in various logs but no consistent central record was maintained of these teams. In addition, as noted in Section 4.1, early in the exercise it appeared that no individual in the Operational Support Center was clearly responsible for the control of assigning and dispatching repair teams.
- In the Emergency Operations Facility, control of the offsite monitoring teams and utilization of the information developed from them was inadequate. Neither the results of the 5:39 a.m. plume traverse nor the later measurements reported to the Emergency Operations Facility about 6 a.m. that produced above-background readings were recorded on the offsite monitoring status board or reported to the Emergency Operations Facility decisionmakers. At the termination of the exercise, the Radiation Protection Coordinator and the Emergency Coordinator were unaware of the results of the monitoring team traverse of the plume 3 miles downwind from the plant some 25 minutes before. For an undetermined period of time around 5:53 a.m., the monitoring team communicator's station was abandoned leaving no apparent radio communication or centralized control over the deployed teams during this time period.
- Staffing of the Emergency Response Facilities was at times disorganized, as sometimes several qualified individuals shared (or attempted to fill) the same position. The facility managers were not forceful in directing the excess staff to be released for other duties. There appeared to be no standard practice or procedure for staffing the initial response organization and recording, reassigning or releasing the other personnel who responded. While three different qualified individuals were signed in for, and took part in carrying out the duties of the Emergency Operations Facility Radiation Protection Coordinator position, the Technical Support Center dose projection capability was suffering for a lack of experienced personnel.

Emergency command and control was identified as an exercise weakness (445/9246-03; 446/9246-03).

## 6.2 Conclusions

Several examples of weak emergency command and control were identified in emergency response facilities.

## 7 SCENARIO AND EXERCISE CONDUCT (82301)

The inspection team made observations during the exercise to assess the challenge and realism of the scenario and to evaluate the conduct of the exercise.

### 7.1 Discussion

The inspection team determined that the scenario provided sufficient challenge to exercise response activities in each of the exercise objectives. Realism was enhanced by utilizing the control room simulator in the dynamic mode to model the accident sequence.

The following observations related to the scenario and to the conduct of the exercise did not significantly detract from the exercise and are discussed as potential areas for improvement:

- The exercise data for the RM-11 was inaccurate for the Steam Generator Sample (SES 164) and the Steam Generator Blowdown Process Monitors (SGB 173). The exercise data for the steam generator blowdown monitor indicated that the channel would be at the alert level at  $2.164\text{E-}4 \mu\text{Ci/cc}$  and the alarm level at  $4.272\text{E-}4 \mu\text{Ci/cc}$ , and the steam generator sample monitor would be in alert at  $2.524\text{E-}4 \mu\text{Ci/cc}$  and in alarm at  $3.779\text{E-}4 \mu\text{Ci/cc}$ . The actual plant setpoints for these monitors are different than those provided in the scenario. In addition, the exercise data did not reflect the isolation of the steam generator blowdown or sample lines when these respective monitors reached the alarm setpoint.
- Scenario data for the liquid primary coolant sample and the No. 3 steam generator was inconsistent. At times (e.g., 2:30 to 2:45 a.m.) the steam generator noble gas and iodine levels were a factor of 3 to 5 times greater than the coolant activity values, a condition which is a physical impossibility.
- In-plant survey teams simulated the posting of radiological controlled areas. This was contrary to information presented in the pre-exercise discussions with the inspection team which indicated that posting would not be simulated.
- The scenario and exercise control did not provide for realistic feedback to the Emergency Operations Facility regarding the status of implementation of the offsite protective actions. County officials would be expected to report (or be responsive to queries) on what they were doing in response to the licensee's recommendations, and licensee personnel would be expected to take that feedback into account when making further recommendations.



## 7.2 Conclusions

The scenario and exercise preparation provided sufficient challenge to demonstrate the exercise objectives.

### 8 LICENSEE SELF-CRITIQUE (82301-03.02.b.12)

The inspectors observed and evaluated the licensee's formal self-critique on November 20, 1992, to determine whether the process would identify and characterize weak or deficient areas in need of corrective action.

#### 8.1 Discussion

The licensee gave a presentation of its critique findings as well as a documented summary. The licensee used terminology identical to that used by the NRC to characterize its findings. The licensee identified the following 2 weaknesses:

- Notification was not timely.
- Command and control was unsatisfactory in some areas.

In addition to the two weaknesses identified, the licensee characterized five improvement items and a list of proficiencies. Among the improvement items were the identification of delays in assessing and classifying conditions of the Alert and Site Area Emergency as well as other observations noted by the NRC inspection team. The licensee's self-critique process involved appropriate levels of management review and was determined to be a strength.

#### 8.2 Conclusions

The licensee's self-critique process was excellent in identifying areas in need of corrective action.

## ATTACHMENT 1

### 1 PERSONS CONTACTED

#### 1.1 Licensee Personnel

- \*J. Ardizzoni, Supervisor, Administrative Security
- \*D. Barham, Emergency Planner
- \*R. Belockis, Senior Emergency Planner
- \*G. Bell, Supervisor, Emergency Planning
- \*M. R. Blevins, Director, Nuclear Overview
- \*T. A. Carder, Emergency Planner
- \*D. Davis, Manager, Plant Analysis
- \*J. Ellard, Senior Emergency Planner
- \*J. R. Gallman, Manager, Trend Analysis
- \*W. G. Guldemono, Manager, Independent Safety Engineering Group
- \*N. Harris, Licensing Engineer
- \*N. Hood, Manager, Emergency Preparedness
- \*T. Hope, Manager, Site Licensing
- \*B. T. Lancaster, Manager, Plant Support
- \*P. E. Mills, Senior Quality Assurance Specialist
- \*D. Moore, Manager, Unit 2 Nuclear Operations Transition Organization
- \*S. Palme, Stipulation Manager
- \*A. Saunders, Assessment Manager
- \*A. J. Scogin, Jr., Manager, Security
- \*E. A. Sirois, Senior Engineer
- \*W. Stengar, Senior Emergency Planner

#### 1.2 NRC Personnel

- \*V. G. Gaddy, Reactor Inspector (Intern)
- \*D. N. Graves, Senior Resident Inspector
- \*T. P. Gwynn, Deputy Director, Division of Reactor Projects
- \*B. E. Holian, Project Manager, NRR
- \*L. A. Yandell, Chief, Project Section B

#### 1.3 Other Personnel

- \*O. L. Thero, Consultant, Citizens for Sound Energy
- \*T. Mayberry, Senior Staff Consultant, Houston Lighting and Power

\*Denotes those present at the exit interview

### 2 EXIT MEETING

The inspection team met with the licensee representatives and other personnel indicated in Section 1 of this attachment on November 20, 1992, and summarized the scope and findings of the inspection as presented in this report. The licensee did not identify as proprietary any of the materials provided to, or reviewed by, the inspection team during the inspection.