ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket Nos.:	50-498 50-499
License Nos.:	NPF-76 NPF-80
Report No.:	50-498/96-23 50-499/96-23
Licensee:	Houston Lighting & Power Company
Facility:	South Texas Project Electric Generating Station, Units 1 and 2
Location:	FM 521 - 8 miles west of Wadsworth Wadsworth, Texas
Dates:	October 29 through November 1, 1996
Team Leader:	Gail M. Good, Senior Emergency Preparedness Analyst
Inspectors:	Howard F. Bundy, Reactor Engineer Edwin F. Fox, Jr., Senior Emergency Preparedness Specialist Wayne C. Sifre, Resident Inspector
Approved By:	Blaine Murray, Chief, Plant Support Branch Division of Reactor Safety

Attachment: Supplemental Information

EXECUTIVE SUMMARY

South Texas Project Electric Generating Station, Units 1 and 2
NRC Inspection Report 50-498/96-23; 50-499/96-23

Routine, announced inspection of the licensee's performance and capabilities during the full-scale, biennial exercise of the emergency plan and implementing procedures. The inspection team observed activities in the control room simulator, technical support center, operations support center, and emergency operations facility.

Plant Support

- Overall, control room staff performance was very good. Communications were effective and the quality of periodic status briefings was excellent. The control room communicated effectively with the technical support center and used its expertise advantageously in resolving technical issues. The control room staff was particularly effective in tracking plant parameters which could satisfy emergency action levels. Emergency classifications and offsite agency notifications were timely and correct. The control room staff encountered difficulty in implementing two emergency operating procedures (Section P4.2).

- Overall, the technical support center staff's performance was very good. The technical support center manager exercised excellent command and control and maintained facility team focus on safety and providing support to other facilities (Section P4.3).

- The overall performance of the operations support center was very good. The operations support center coordinator exercised strong command and control of center activities, inplant repair teams, and information flow. Team priorities were closely coordinated and verified with the technical support center. Methods used to brief and prepare teams expedited team dispatch and repair activities. Health physics briefings and coverage for inplant teams was strong (Section P4.4).

- Overall, the emergency operations facility staff's performance was very good. Facility personnel worked well as a team to promptly classify emergency events, make timely offsite agency notifications, and develop appropriate public protective action recommendations. Facility command, control, and management were identified as a strength. An exercise weakness was identified for failure to communicate protective measures to offsite utility field team members in a timely manner. The licensee questioned the characterization of the exercise weakness during a followup discussion on November 12, 1996 (Section P4.5).

- The inspectors determined that the scenario was sufficiently challenging to test emergency response capabilities and demonstrate onsite exercise objectives. Use of a mock NRC team and control of the fire brigade response were identified as strengths (Section P4.6).

- The licensee's self-critique process effectively identified areas for corrective action. The management critique was thorough and professionally conducted. Offsite response agency participation in the management critique was identified as a program strength (Section P4.7).

IV. Plant Support

P4 Staff Knowledge and Performance in Emergency Preparedness

P4.1 Program Areas Inspected (82301)

The licensee conducted a full-scale, biennial exercise on October 30, 1996. The exercise was conducted to test major portions of the onsite (licensee) and offsite emergency response capabilities. The licensee activated its emergency response organization and all emergency response facilities. The Federal Emergency Management Agency evaluated the offsite response capabilities of the State of Texas and Matagorda county. The Federal Emergency Management Agency will issue a separate report.

The exercise scenario was run using the Unit 1 control room simulator in a dynamic mode. The exercise began at 6:45 a.m. with the plant operating at 100 percent power. When the operating crew assumed the watch at 6:57 a.m., a containment high pressure alarm existed. Operators immediately began a purge to reduce pressure. The operators noted that the inboard supplemental purge isolation valve failed to close when they secured the purge at 7:13 a.m. At 7:14 a.m., the plant operators determined that a reactor coolant system leak of 11 gallons per minute existed which resulted in the shift supervisor declaring a notification of unusual event at 7:19 a.m. At 7:30 a.m., the Number 11 steam generator feed pump turbine tripped and underwent a mechanical failure resulting in flying parts. The flying parts damaged the Number 12 steam generator feed pump turbine and caused it to trip. The operators manually tripped the reactor at 7:31 a.m. when a low steam generator level trip appeared imminent. Operators noted that one control rod failed to insert.

At 7:50 a.m., lightening struck the "B" essential safety feature transformer, thereby, damaging the bus and causing a ground condition. The standby diesel generator started but failed to load on the deenergized bus. The operators secured the diesel generator at 7:51 a.m. At 7:55 a.m., a fire was reported in the E1B switchgear room. The shift supervisor dispatched the fire brigade to the room and declared an alert at 8:06 a.m. The fire was reported out shortly thereafter. The shift supervisor remained in the alert condition because of increasing radiation levels in containment. Emergency director responsibilities and authorities were transferred to the technical support center at 8:45 a.m. and then to the emergency operations facility at 9:10 a.m.

The emergency operations facility director declared a site area emergency at 9:12 a.m. due to high radiation levels in containment (loss of two fission product barriers). The control rod drive housing on the control rod that failed to insert ruptured at 11 a.m. resulting in a rod ejection and a large unisolable leak. Containment pressure increased and the outboard supplementary purge valve failed open, which initiated an offsite radiological release. The emergency operations

facility director declared a general emergency at 11:08 a.m. due to loss of all three fission product barriers. The release was terminated at 1:30 p.m. after the outboard supplementary purge valve was repaired. Controllers terminated the exercise at 2:15 p.m.

P4.2 Control Room

a. Inspection Scope (82301-03.02)

The inspectors observed and evaluated the control room simulator staff as they performed tasks in response to the exercise scenario conditions. These tasks included detection and classification of events, analysis of plant conditions, notification of offsite authorities, and adherence to the emergency plan and implementing procedures. The inspectors reviewed applicable emergency plan implementing procedures, logs, checklists, and notification forms generated during the exercise.

b. Observations and Findings

The control room staff performed very well in mitigating the effects of the simulated plant and equipment failures. The control room staff was particularly effective in tracking plant parameters which could satisfy emergency action levels. The control room staff was also proactive in attempting to control these parameters to avoid emergency action levels. The control room staff appropriately classified the unusual event due to reactor coolant system leak rate in excess of 10 gallons per minute and the alert based on fire in a vital area affecting safe shutdown or decay heat removal. The control room staff also appropriately continued the alert due to increasing radiation levels in containment. The inspectors concluded that the crew was both cautious and expeditious in classifying the events. The shift supervisor, unit supervisor, and shift technical advisor all had appropriate input in arriving at the correct classifications. Corresponding offsite agency notifications were timely and correct.

Internal and external control room communications were effective. The periodic status briefings conducted by the shift supervisor were very strong. While brief and concise, appropriate input was solicited from all crew members. Any inattentiveness to the briefing was promptly corrected by the shift supervisor. The control room communicated effectively with the technical support center and used its expertise advantageously in resolving technical issues, such as the reactivity status of the reactor and problems in implementing emergency operating procedures.

The control room staff experienced the following problems using two emergency operating procedures:

- Step 18 of Procedure 0POP05-EO-E010, "Loss of Reactor or Secondary Coolant," Revision 5, required a return to Step 1 if the reactor coolant system pressure was not controlled or decreasing, which was the situation. After failing to satisfy this step twice, the management staff determined that they needed to exit this loop to proceed with reactor coolant system cooldown and depressurization in accordance with Procedure 0POP05-EO-ES12, "Post LOCA Cooldown and Depressurization," Revision 4, as directed by Step 21 of Procedure 0POP05-EO-E010. After consultation with the technical support center, the decision was made to deviate from the requirements of Step 18.

- Step 27 of Procedure 0POP05-EO-ES12 was deficient in requiring the reactor coolant pump to be stopped if the Number 1 seal leakoff flow was less than 0.9 gallons per minute. Procedure 0POP04-RC-0002, "Reactor Coolant Pump Off Normal," Revision 7, Addendum 2, indicated a Number 1 seal leakoff flow range of 0.2 to 1 gallons per minute was acceptable. After consultation with the technical support center, the decision was made to deviate from the requirements of Step 27.

The inspectors observed that the shift supervisor properly approved and logged the above procedure deviations in accordance with Procedure 0POP01-ZA-0018, "Emergency Operating Procedure User's Guide," Revision 8. Although these procedural problems did not result in exacerbating plant safety, they delayed placing the plant in a depressurized condition.

Although the overall adverse effect on performance was minimal, fatigue appeared to contribute to a decrease in attentiveness and intensity of the control room staff during the last 2 hours of the exercise. The inspectors observed the following minor performance lapses during this period:

- One of the board operators stated that he wanted to start a safety injection pump and then was distracted by an annunciator on another panel. The unit supervisor directed the operator to start the pump twice before he responded.

- Another board operator inadvertently stated that he had started an auxiliary feedwater pump which was powered by a deenergized bus.

- The frequency of the otherwise excellent briefings decreased. It was not apparent that all crew members were as aware of plant status as they had been earlier.

c. Conclusions

Overall, control room staff performance was very good. Communications were effective and the quality of periodic status briefings was excellent. The control room communicated effectively with the technical support center and used its expertise advantageously in resolving technical issues. The control room staff was particularly effective in tracking plant parameters which could satisfy emergency action levels. Emergency classifications and offsite agency notifications were timely and correct. The control room staff encountered difficulty in implementing two emergency operating procedures.

P4.3 Technical Support Center

a. Inspection Scope (82301-03.03)

The inspectors observed and evaluated the technical support center staff as they performed tasks necessary to respond to the exercise scenario conditions. These tasks included staffing and activation, facility management and control, accident assessment, onsite protective action decisionmaking and implementation, communications, assistance and support to the control room, and prioritization of mitigating actions. The inspectors reviewed applicable emergency plan implementing procedures and logs.

b. Observations and Findings

The technical support center had the minimum required staff within 15 minutes after the 8:09 a.m. alert public address announcement. At 8:32 a.m., the facility manager announced that the technical support center was activated for plant assessment and mitigation functions. The technical support center was activated in a coordinated and efficient manner and was staffed with a sufficient number of individuals who demonstrated the appropriate expertise for their various positions.

Communications were promptly established with the control room simulator, operations support center, and emergency operations facility. There were an adequate number of communicators available in the technical support center, and status boards were maintained current. The inspectors identified an area for improvement in that three-point communications were seldom observed within the technical support center. The facility manager stated that this did not meet management's expectations. Three-point communications involve: (1) information communication by provider, (2) information restatement by receiver, and (3) information confirmation by provider.

The technical support center manager exercised excellent command and control. Distractions were kept to a minimum, and the team maintained their focus on safety and support for the control room and other organizations. Facility management team meetings were initially conducted about every 30 minutes to update plant

status and technical support center priorities. As the exercise progressed, the facility manager determined that the meetings were too frequent and becoming a distraction. The meetings were changed to every 45 minutes. The technical support center manager conducted a short facility update briefing after each meeting. Appropriate log-keeping was observed, and the technical support center staff exhibited good team work and coordination.

Plant conditions were appropriately analyzed and evaluated in a timely manner. The technical team was persistent in their efforts to stop the supplemental containment purge system flow. Several innovative options were considered, including use of a blind flange, crushing the piping, and connecting alternative power sources to the stuck open valve.

Technical support center habitability was properly monitored throughout the exercise. However, changes in facility habitability were not always communicated to the staff in a timely manner. This resulted in some confusion about when the consumption of food or drinks was permitted. The inspectors identified this as an area for improvement.

c. Conclusions

Overall, the technical support center staff's performance was very good. The technical support center manager exercised excellent command and control and maintained facility team focus on safety and providing support to other facilities.

P4.4 Operations Support Center

a. Inspection Scope (82301-03.05)

The inspectors observed and evaluated the operations support center staff as they performed tasks in response to the scenario conditions. These tasks included the fire brigade response, functional staffing, and inplant emergency response team dispatch and coordination in support of control room and technical support center requests. The inspectors reviewed applicable emergency plan implementing procedures, logs, checklists, and forms generated during the exercise.

b. Observations and Findings

The fire brigade's response was efficient and effective. Personnel arriving at the fire brigade staging area rapidly donned fire fighting clothing, assembled equipment, and assumed prescribed duties. The fire brigade leader provided good command and control of the response activities. The most rapid ingress route to the affected

area was determined. The route required coordination with security to ensure rapid entry to the fire (located in a vital area). The fire brigade applied appropriate fire fighting strategies (e.g., using carbon dioxide then waiting until the bus was deenergized before applying water). The fire brigade leader properly kept the control room informed of the status of the fire and its effects on the bus.

The operations support center was promptly activated after the alert declaration. Teams dispatched from the simulator control room and teams designated by the operations support center were properly logged on the team tracking board. However, some inplant teams were dispatched without the necessary equipment to effect repairs. For example, two teams were not provided keys to allow them to either enter an area to do work or to obtain necessary tools.

The operations support center coordinator exerted effective command, control, and leadership by using three-point communications, conducting comprehensive briefings, and focusing on priority tasks. Status briefings were informative, timely, and presented clearly and loudly to facility staff. Briefings were provided by the operations support center coordinator and functional area supervisors. Internal and external information flow effectively supported timely inplant team formation and dispatch.

The operations support center was efficiently arranged with key facility personnel in a horseshoe configuration facing status and team dispatching boards. Team briefings were conducted in a separate room to eliminate distractions. Personnel available for team assignments were organized on a team resources status board and grouped by discipline.

A pool of craft personnel was initially assembled in the machine shop. When radiological conditions changed, the operations support center coordinator and radiological coordinator properly decided to relocate the craft personnel to the welding shop (north of the release pathway). Radio communications were maintained by a radio communicator.

Sufficient supplies were available to support center activities. Radiation protection equipment, including alarming dosimeters and survey equipment were available and properly issued to team members prior to leaving the health physics area.

Teams were formed, briefed, and dispatched in a timely manner with minimal delays observed. Over 30 teams were dispatched during the exercise. The operations support center used a special team to obtain parts for inplant teams. The inspectors concluded that this practice was a unique and effective method to expedite team dispatch. The teams maintained continuous contact with the operations support center through the radio communicator. Teams were given periodic plant condition updates and informed of emergency classification changes.

The habitability of the operations support center was properly monitored during the exercise. Facility habitability was initially determined and continuously monitored thereafter. Following routine surveys and air sampling, habitability status was posted on status boards. When the status of habitability was uncertain, eating, smoking, and drinking were not permitted.

Inplant radiation levels reported by the teams were appropriately posted on building layout maps in the operations support center. Team priorities were based on the critical nature of the assignment. The operations support center coordinator and support staff continually reassessed team priority assignments and adjusted the ranking when conditions changed.

Health physics coverage and team briefings were very thorough and conscientiously accomplished. Inplant teams received necessary health physics information and equipment prior to entering the radiological controlled area. Health physics personnel also ensured that team members were aware of methods to keep doses as low as reasonably achievable, given the simulated plant conditions. Moreover, health physics personnel who accompanied inplant teams were knowledgeable and took personal responsibility for the team's safety.

c. Conclusions

The overall performance of the operations support center was very good. The operations support center coordinator exercised strong command and control of center activities, inplant repair teams, and information flow. Team priorities were closely coordinated and verified with the technical support center. Methods used to brief and prepare teams expedited team dispatch and repair activities. Health physics briefings and coverage for inplant teams was strong.

P4.5 Emergency Operations Facility

a. Inspection Scope (82301-03.04)

The inspectors observed the emergency operations facility's staff as they performed tasks in response to the exercise. These tasks included facility activation, event classification, notification of state and local response agencies, development and issuance of protective action recommendations, dose assessment and coordination of field monitoring teams, analysis of plant conditions, and direct interactions with offsite agency response teams.

b. Observations and Findings

The emergency operations facility was promptly and systematically activated following the 8:06 a.m. alert declaration. Full facility staffing was present at about 8:30 a.m., and the emergency operations facility was activated at 8:43 a.m. Upon arrival, facility personnel signed-in on the emergency operations facility staffing

board and obtained position-specific alert checklists. Prior to facility activation, the emergency operations facility director ensured that facility clocks were synchronized, contacted the technical support center manager, established initial facility priorities, and polled facility directors for activation obstacles.

The emergency operations facility director assumed emergency director responsibilities and authorities at 9:10 a.m. The transfer was very systematic and thorough. Prerequisites outlined in the emergency director turnover checklist (Emergency Procedure 0ERP01-ZV-EF01, "Emergency Operations Facility Director," Revision 8, Data Sheet 6) were strictly followed. The emergency operations facility promptly made a public address announcement to inform the other emergency response facilities of the authority transfer.

At 9:12 a.m., 2 minutes after assuming the responsibility, the emergency operations facility director correctly classified the site area emergency based on the loss of two fission product barriers. Offsite protective action recommendations were deemed appropriate. The corresponding offsite agency notifications were timely and completed in accordance with Emergency Procedure 0ERP01-ZV-IN02, "Notifications to Offsite Agencies," Revision 6. Facility personnel, including the technical and radiological directors and their staffs, and the engineering assistant, displayed exceptional teamwork during this sequence.

During the next couple of hours, facility staff closely monitored changing plant conditions, including radiological conditions in containment, and anticipated possible event escalation paths. At 11:08 a.m., the emergency operations facility director correctly declared a general emergency due to rapidly degrading conditions and indications of a radiological release (loss of the third barrier). The offsite agency notification form was completed and transmitted within 12 minutes, with close coordination between the engineering assistant, technical/radiological/emergency operations facility directors, and the offsite agency communicator.

Since a 5-mile radius evacuation was recommended at the site area emergency declaration, additional protective action recommendations were not required at the general emergency declaration; however, due to changing radiological conditions (trending upward), protective action recommendations were expanded at 11:29 a.m. to include evacuation in Zones 7 and 8 (downwind to 10 miles). The expanded protective action recommendations were communicated to offsite authorities in a timely manner.

Dose assessment, radiation protection activities, and field monitoring team control were generally performed well during the exercise. Numerous dose projections were calculated and used to support protective action recommendations. Habitability of the emergency operations facility was appropriately monitored. Prior to the radiological release, the emergency operations facility emergency ventilation system was switched to the recirculation mode, and thermoluminescent dosimeters were distributed to facility personnel.

Two issues involving offsite field team control were identified. First, the recommendation for offsite field team members to take potassium iodide was not communicated in a timely manner and could have affected personnel safety and the ability to obtain timely field measurements and samples (used to validate dose projections and protective action recommendations).

Following the radiological director's recommendation, the emergency operations facility director authorized the use of potassium iodide for offsite field team members at 11:50 a.m. The recommendation was not communicated to Team 2 and the "rad van" until 12:45 p.m. and 1:02 p.m., respectively (55 and 72 minutes). When the recommendation was made, the projected offsite iodine dose was about 28 rem thyroid committed dose equivalent at 2 miles (field teams were located at about 3.5 miles). The inspectors observed that there was a lack of procedural guidance concerning the process for communicating/logging potassium iodide recommendations to offsite field team members and that involved staff appeared somewhat unfamiliar with the process. The failure to communicate timely protective measures to offsite field teams was identified as an exercise weakness (498/9623-01;499/9623-01).

In response, the licensee stated that potassium iodide was still 90-95 percent effective up to 2 hours after exposure and that rescuing Team 1 (simulated jeep malfunction) was considered a priority. The inspectors acknowledged the former point but did not consider it to be a valid justification for delaying the recommendation. Regarding the latter point, the inspectors noted that there was sufficient staff to perform the field team communication/rescue actions simultaneously. The licensee questioned the characterization of the exercise weakness during a followup discussion on November 12, 1996.

Second, although no problems with field team location tracking were observed, discussions concerning team positions could have been more explicit. Narrative descriptions were used instead of visual methods, such as maps, to show utility and state field team positions. There were times when it appeared that utility and offsite field team trackers were not fully aware of the others' team locations.

Throughout the exercise, the emergency operations facility director exercised very effective command, control, and management practices. For example, the emergency operations facility director conducted frequent, comprehensive, structured, and concise briefings, encouraged clear communications through the use of three-point communications and understandable terms, developed and ensured that facility priorities were completed, and inspired a team spirit. This aspect of the response effort was identified as a strength.

Public address announcements were regularly used to communicate changing plant conditions an response updates. The inspectors determined that the effectiveness of the facility public address briefings could have been improved; announcements were barely audible in the dose assessment/technical area.

Interactions with offsite response teams in the emergency operations facility (state and mock NRC) were effective. Both teams received status briefings upon arrival and then were quickly incorporated into the response effort. Emergency operations facility personnel closely monitored offsite protective action decisionmaking and implementation status. State and mock NRC representatives were included in facility briefings; however, the value and emphasis of the state's input to the facility briefings was lessened because a briefing microphone was not passed to the representative at the horseshoe table. Only utility personnel used the microphones.

c. Conclusions

Overall, the emergency operations facility staff's performance was very good. Facility personnel worked well as a team to promptly classify emergency events, make timely offsite agency notifications, and develop appropriate public protective action recommendations. Facility command, control, and management were identified as a strength. An exercise weakness was identified for failure to communicate protective measures to offsite utility field team members in a timely manner. The licensee questioned the characterization of the exercise weakness during a followup discussion on November 12, 1996.

P4.6 Scenario and Exercise Control

a. Inspection Scope (82301)

The inspectors made observations during the exercise to assess the challenge and realism of the scenario and to evaluate the control of the exercise.

b. Observations and Findings

The inspectors did not identify any issues concerning the exercise scenario. The scenario was sufficiently challenging to test emergency response capabilities and demonstrate onsite exercise objectives. The licensee appropriately prepared hardcopy data to use if the control room simulator failed during the exercise. The inspectors observed that the RM-11 radiation monitor simulator in the technical support center was not providing reliable data. This forced the health physics team to rely on data provided by telephone from the emergency operations facility. As a result, some analyses were slightly delayed.

The inspectors identified two strengths concerning exercise control. First, the use of a mock NRC team added realism and stimulated exercise response activities. Second, the fire brigade response was controlled very well; cloudy face covers were used to simulate smoke, care was taken to ensure personnel and plant safety, and equipment was not allowed to operate until proper steps were taken.

c. Conclusions

The inspectors determined that the scenario was sufficiently challenging to test emergency response capabilities and demonstrate onsite exercise objectives. Use of a mock NRC team and control of the fire brigade response were identified as strengths.

P4.7 Licensee Self-Critique

a. Inspection Scope (82301-03.13)

The inspectors observed and evaluated the licensee's post-exercise facility critiques and the formal management critique on November 1, 1996, to determine whether the process would identify and characterize weak or deficient areas in need of corrective action.

b. Observations and Findings

The inspectors determined that the post-exercise critiques were generally thorough, open, and self-critical. With the exception of the emergency operations facility, critiques included input from all controllers, evaluators, and participants. In the emergency operations facility, participant input was limited to facility directors. In other facilities, the facility managers/coordinators met with their staffs prior to the critique to obtain their input. The radiological and technical directors in the emergency operations facility did not meet with their staffs prior to the critique.

In addition to the verbal, post-exercise critiques, participants were encouraged to complete comment sheets. The sheets included specific questions concerning the scenario, training, facility critique, strengths, minor problems, weaknesses, deficiencies, and procedural guidance. The inspectors concluded that the questions on the comment sheet facilitated the critique process.

The management critique was conducted in a professional and serious manner. A handout was distributed to enhance the presentation. The management critique included a summary of the exercise scenario timeline and comments from each of the lead controllers and facility management. Offsite emergency response agency representatives also participated in the management critique. The inspectors concluded that this unique element highlighted the integral nature of the response team effort.

The issues identified by the licensee's team (controllers, evaluators, and participants) were generally consistent with those identified by the NRC inspection team. The licensee's team identified that all facility objectives were met; most objectives were met satisfactorily, some were met with strengths, and some were met with minor problems. No weaknesses or deficiencies were identified.

c. Conclusions

The licensee's self-critique process effectively identified areas for corrective action. The management critique was thorough and professionally conducted. Offsite response agency participation in the management critique was identified as a program strength.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on November 1, 1996. The licensee acknowledged the findings presented. No proprietary information was identified. The licensee questioned the characterization of the exercise weakness during a followup discussion on November 12, 1996.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

H. Butterworth, Manager, Plant Operations, Unit 2
T. Cloninger, Vice President, Nuclear Engineering
T. Frawley, Shift Supervisor
J. Groth, Vice President, Nuclear Generation
K. Keyes, Staff Specialist
J. Ledgerwood, Manager, Instrument and Control
C. Lunsford, Supervisor, Maintenance Programs
L. Martin, General Manager, Nuclear Assurance & Licensing
R. Masse, Plant Manager, Unit 2
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G. Parkey, Plant Manager, Unit 1
F. Puleo, Supervisor, Onsite Emergency Response
K. Richards, Manager, Work Control
C. Sayko, Manager, Plant Projects & Programs
P. Serra, Manager, Emergency Response

LIST OF INSPECTION PROCEDURES USED

IP 82301 Evaluation of Exercises at Power Reactors

LIST OF ITEMS OPENED

Opened

50-498/96023-01 50-499/96023-01	IFI	Exercise weakness - Failure to communicate timely protective measures to offsite field teams (Section P4.5)

LIST OF DOCUMENTS REVIEWED

Emergency Plan Implementing Procedures

0ERP01-ZV-EF01	Emergency Operations Facility Director	Revision 8
0ERP01-ZV-EF02	Deputy Emergency Operations Facility Director	Revision 5
0ERP01-ZV-EF03	Radiological Director	Revision 2
0ERP01-ZV-EF04	Technical Director	Revision 3
0ERP01-ZV-EF10	Offsite Field Team Supervisor	Revision 3
0ERP01-ZV-EF15	Dose Assessment Specialist	Revision 1
0ERP01-ZV-IN07	Offsite Protective Action Recommendations	Revision 4
0ERP01-ZV-IN01	Emergency Classification	Revision 3
0ERP01-ZV-IN02	Notifications to Offsite Agencies	Revision 6

0ERP01-ZV-OS01	Operations Support Center Coordinator	Revision 1
0ERP01-ZV-OS02	Assistant Operations Support Center Coordinator	Revision 1
0ERP01-ZV-OS03	Radiological Coordinator	Revision 2
0ERP01-ZV-OS04	Security Coordinator	Revision 2
0ERP01-ZV-OS05	Materials Handler	Revision 2
0ERP01-ZV-OS06	Emergency Teams	Revision 4
0ERP01-ZV-SH01	Shift Supervisor	Revision 10
0ERP01-ZV-TP02	Offsite Field Teams	Revision 6
0ERP01-ZV-TS01	Technical Support Center Manager	Revision 7
0ERP01-ZV-TS03	Operations Manager	Revision 3
0ERP01-ZV-TS04	Radiological Manager	Revision 2
0ERP01-ZV-TS07	Technical Manager	Revision 3

Emergency Operating Procedures

0POP01-ZA-0018	Emergency Operating Procedure User's Guide	Revision 8
0POP05-EO-EO10	Loss of Reactor or Secondary Coolant	Revision 5
0POP05-EO-ES12	Post LOCA Cooldown and Depressurization	Revision 4

Other Documents

South Texas Project Electric Generating Station Emergency Plan
Management Critique Handout