

DMB

JAN 13 1983

Docket No. 50-282  
Docket No. 50-306

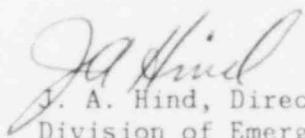
Northern States Power Company  
ATTN: Mr. C. E. Larson  
Director of Nuclear  
Generation  
414 Nicollet Mall  
Minneapolis, MN 55401

Gentlemen:

Thank you for your letter dated December 29, 1982, in reply to our letter of December 2, 1982, requesting a response to two items identified as weaknesses in the emergency exercise conducted on October 14, 1982. We have reviewed your response and schedules for correcting these weaknesses by April 1, 1983.

We will examine your corrective actions during a subsequent exercise or inspection.

Sincerely,



J. A. Hind, Director  
Division of Emergency Preparedness  
and Operational Support

cc: E. L. Watzl, Plant Manager

cc w/ltr dtd 12/29/82:  
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Northern States Power Company

414 Nicollet Mall  
Minneapolis, Minnesota 55401  
Telephone (612) 330-5500

December 29, 1982

Mr. J. A. Hind, Director  
Division of Emergency Preparedness and  
Operational Support  
Region III  
U. S. Nuclear Regulatory Commission  
799 Roosevelt Road  
Glen Ellyn, IL 60137

Dear Mr. Hind:

PRAIRIE ISLAND NUCLEAR GENERATING PLANT  
DOCKET NOS. 50-282    LICENSE NOS. DPR-42  
                  50-306                    DPR-60

Your letter of December 2nd, transmitting Inspection Reports 50-282/82-18 and 50-306/82-18, requested that we submit a written statement describing our planned actions for improving the two items identified in the letter Appendix. Following is our response:

Weakness

Based on plant data including containment pressure, two out of four containment fan coils being inoperable, one out of two containment spray pumps inoperable, both diesel generators out of service, high radiation levels in containment and primary coolant activity greater than 300  $\mu\text{Ci/cc}$ , a General Emergency should have been declared at 11:00 A.M. Instead a General Emergency was not declared until 11:30 A.M.

Thus, by the earlier General Emergency declaration, more time would have been available to notify State and Local governmental agencies who in turn could have begun evacuation and/or sheltering of the general public, earlier than actually occurred during scenario conditions.

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Response

At 11:00 A.M., two of the three fission product barriers were breached. The minimum required containment suppression equipment (2 out of 4 Fan Coil Units and 1 out of 2 spray pumps) were operating to provide sufficient cooling to reduce containment pressure during the Design Basis Accident, as specified in the Technical Specifications. With this suppression equipment in service, containment pressure was trending down and had already declined 10 psi (from 40 to 30 psig).

Loss of the third or potential loss of the third fission product barrier was not immediately evident at 11:00 a.m., as was a deliberate scenario development. The scenario allowed for escalation to a General Emergency at 11:30 A.M. to allow State & Local Authorities sufficient time in the Site Area Emergency classification in order for them to adequately demonstrate various capabilities.

At 11:00 A.M., the Control Room received indication, via the Control Room Controller, that the Containment Purge Valve Close Light (#44104B9) went out. It is felt that the Technical Support Center (TSC) personnel did not hesitate, at this time, to escalate to a General Emergency, but that they were attempting to substantiate the validity of the release path potential as indicated by the loss of the Purge Valve Damper Close Light. The Purge Valve Damper Close Light going out was not adequate and should not be adequate indication to predict actual or potential release paths without backup indication. Verification of a release should have been indicated by loss of the Purge Valve Damper Light in conjunction with an onscale indication from the Shield Building Stack High Range Monitor, 1R-50. The Shield Building stack low range monitor, at this time, was pegged high due to elevated background radiation levels.

When the Radiation Emergency Coordinator (REC) requested 1R-50 readings, he was instructed that 1R-50 was erratic. The scenario contained both a table of the radiation monitor readings, which listed 1R-50 simply as erratic, and also radiation monitor graphs, which depicted 1R-50 bouncing erratically at a high level. If the REC had been given the range of the erratic readings, as depicted on the 1R-50 graph versus the word erratic from the radiation monitor table, the REC would have immediately recommended to the Emergency Director that a General Emergency be declared. However, since the REC, at this point, had no concept as to what 1R-50 was actually doing, an inplant survey team was dispatched to investigate the erratic response of 1R-50 (still with no indication of range from the controller).

When confirmation of the release was received, the TSC personnel recommended escalation to a General Emergency at 11:21 A.M.; however, the lead controller held off the notification until 11:30 A.M. for the benefit of State and Local Authorities.

The emergency classification procedure, F3-2, and the scenario have been reviewed. The following changes are recommended:

- (1) The loss of 2 of 3 fission product barrier Emergency Action Level (EAL) should be changed to include other key parameters as indicators for loss of the third fission product barrier rather than simply loss of the minimum required pressure suppression equipment.
- (2) The Emergency Director and REC training should include the importance of prompt emergency classification and the necessity of timely Protective Action Recommendations during a General Emergency.
- (3) Future scenarios should be developed to clarify the radiation monitor readings, i.e., if a radiation monitor indicates erratic, give the range that the monitor is erratic instead of simply stating that the monitor is erratic.

We expect this to be completed by April 1, 1983.

#### Weakness

An apparent (simulated) overexposure occurred about 10:40 A.M. when an equipment operator was sent to the Auxiliary Building to check the two containment fan coil breakers as a response to Message 10A in the scenario. This equipment operator did not start from the Operations Support Center (OSC) and consequently he had no Health Physics representative to monitor his pathway for radiation levels. He passed through a high radiation area without being aware. This indicates inadequate access control of plant personnel during an emergency.

#### Response

At approximately 10:40 A.M., a plant evacuation was ordered. The Auxiliary Building Equipment Operator remained at his watch station, which had been normal past practice. (In most of the past emergency plan drills, the auxiliary operators were not involved and were told to stay at their routine work station which is what this individual did during the exercise.) When requested by the Control Room, who contacted him by paging him, the Auxiliary Building Equipment Operator proceeded to check the Containment Fan Coil Breakers. In doing so, he passed through simulated high radiation areas, unknowingly, since he was not accompanied by a drill controller. When the Control Room Operator learned the Auxiliary Operator had not gone through the OSC for entry he requested the individual to report to the OSC.

Mr. J. A. Hind  
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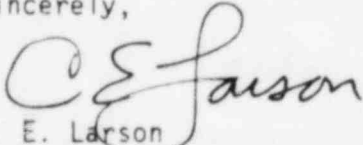
Based on radiation levels in the scenario, the route the operator used while checking the breakers, and the time he spent in the area, an apparent (simulated) overexposure did not result. Exposure was estimated at 165-250 mRem.

To improve the exposure control of the Auxiliary Building Operators, specific evacuation criteria for the Auxiliary Building Operators will be added to F3-9, "Emergency Evacuation".

This also shall be incorporated as part of the operator training cycle.

We expect this to be completed by April 1, 1983.

Sincerely,



C. E. Larson  
Director, Nuclear Generation

cc: Messrs. G. Charnoff  
C. Feierabend