



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION IV

511 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

APR 26 1994

Dockets: 50-445
50-446
Licenses: NPF-87
NPF-89

TU Electric
ATTN: W. J. Cahill, Jr., Group Vice President
Nuclear Engineering and Operations
Skyway Tower
400 North Olive Street, L.B. 81
Dallas, Texas 75201

SUBJECT: RESPONSE TO EMERGENCY PREPAREDNESS WEAKNESSES IDENTIFIED IN NRC
INSPECTION REPORT 50-445/94-04; 50-446/94-04

Thank you for your letter dated April 4, 1994, in response to the emergency preparedness weaknesses identified in NRC Inspection Report 50-445/94-04; 50-446/94-04 dated March 2, 1994. We have examined your reply and find it responsive to the concerns raised in our inspection report. We will review the implementation of your corrective actions during a future inspection.

Should you have any questions concerning this letter, please contact Dr. D. Blair Spitzberg of my staff at (817) 860-8191.

Sincerely,

Dwight D. Chamberlain
for Samuel J. Collins, Director
Division of Radiation Safety
and Safeguards

cc:
TU Electric
ATTN: Roger D. Walker, Manager of
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President - CASE
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TU Electric

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Honorable Dale McPherson
County Judge
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Texas Radiation Control Program Director
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Chief, Technological Hazards Branch
FEMA Region 6
Federal Regional Center
800 North Loop 288
Denton, Texas 76201-3698

TU Electric

-3-

bcc to DMB (IE35)

bcc w/copy of licensee's letter dated April 4, 1994:

L. J. Callan
Branch Chief (DRP/B)
MIS System
RIV File
Branch Chief (DRP/TSS)

CPS Resident Inspector (2)
Lisa Shea, RM/ALF, MS: MNBB 4503
DRSS-FIPB
Project Engineer (DRP/B)
D. B. Spitzberg, DRSS

RIV:DRSS <i>DSS</i>	C:FIPB <i>JK</i>	ADD:DRSS <i>DC</i>	D:DRSS <i>DC</i>	
DBSpitzberg:nh	BMurray		SJCollins <i>fn</i>	
4/22/94	<i>JK</i> /94	4/22/94	4/22/94	

TU Electric

-3-

bcc to DMB (IE35)

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RIV:DRSS <i>DRSS</i>	C:FIPB <i>OK</i>	ADD:DRSS <i>DRSS</i>	D:DRSS <i>DRSS</i>	
DBSpitzberg:nh	BMurray		SJCollins <i>for</i>	
4/22/94	<i>DRSS</i> /94	4/22/94	4/22/94	



Log # TXX-94104
File # 10130
Ref. # IR 94-04

April 4, 1994

William J. Cahill, Jr.
Group Vice President

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION (CPSES)
DOCKET NOS. 50-445 AND 50-446
NRC INSPECTION REPORT NOS. 50-445/9404; 50-446/9404
RESPONSE TO IDENTIFIED WEAKNESSES

Gentlemen:

TU Electric has reviewed the NRC's letter dated March 2, 1994, concerning the inspection conducted by the NRC staff during the period of January 31 through February 4, 1994. Identified in the letter were two weaknesses which required response thereto.

TU Electric hereby responds to the identified weaknesses (445/9404-01 and 445/9404-02) in the attachment to this letter.

Sincerely,

William J. Cahill, Jr.

William J. Cahill, Jr.

By:

Roger D. Walker

Roger D. Walker
Regulatory Affairs Manager

NSH:tg

ATTACHMENT

cc: Mr. L. J. Callan, Region IV
Mr. L. A. Yandell, Region IV
Resident Inspectors, CPSES

Attachment to TXX-94104
Page 1 of 3

WEAKNESS I
(445/9404-01; 446/9404-01)

Weakness I: Demonstration of Timely and Accurate Notification of Offsite Authorities.

One crew failed to notify offsite authorities of a Site Area Emergency. The Emergency Coordinator escalated the emergency from an Alert to a Site Area Emergency when the size of the loss of coolant accident increased significantly. A communicator completed the notification message form for the Site Area Emergency and submitted it to the Emergency Coordinator for review and approval. Prior to approving the message, however, plant conditions degraded further and the Emergency Coordinator escalated to a General Emergency. Instead of proceeding with the issuance of the prepared Site Area Emergency notification, the Emergency Coordinator decided to dismiss this notification and to initiate the General Emergency notification process. The General Emergency notification to offsite authorities was complete 24 minutes after the declaration of the Site Area Emergency. The declaration did not meet the 15 minute criteria.

In addition to the above notification failure, the following examples were noted of errors, omissions, or inconsistencies in the content of notification messages communicated to offsite authorities on Notification Message Form EPP-203-B:

- Inconsistent use of Item 6, "Recommended Protective Actions," was noted. One crew indicated that the protective action recommendations were "new" in the Alert notification message when, in fact, they were unchanged. Inconsistency was noted between crews in their completion of Item 6.C.
- Crews were inconsistent in the information that was conveyed in Item 7, "Event Description." Some crews accurately indicated the occurrence of events such as "fire/explosion," "electrical event," "Reactor coolant system breach," or "Radiological event," while others did not.

RESPONSE TO WEAKNESS I
(445/9404-01; 446/9404-01)

Control Room personnel and other Emergency Response Facility personnel responsible for issuing the Notification Message Form have been informed that when an emergency classification is declared, a message updating the State and Counties should be issued for that event classification. If the event classification escalates during this time they have been informed to issue another message as soon as possible after the first message has been sent. It was stressed that regardless of the event classification, a message will be generated and issued within the 15 minutes criteria.

Attachment to TXX-94104
Page 2 of 3

Annual requalification training has been conducted with all crews and specifically stressed the correction of the errors identified.

WEAKNESS II
(445/9404-02; 446/9404-02)

Weakness II: Offsite Dose Projection Performance

Following the General Emergency classifications, the performance of the crews using the licensee's ORCAS program, identified the following problems:

- One crew was unable to calculate dose projections for a period of 34 minutes following the declaration of the General Emergency. The inspectors observed the dose assessor's inability to properly enter input data into the ORCAS program, the inability to alter previously input data, and the inability to move to other menu screens without rebooting the entire program. These problems slowed the issuance of dose projection based protective action recommendations by over 30 minutes.
- The ORCAS dose projection program reports of Protective Action Recommendations incorrectly issued protective action recommendations to affected zones that were upwind of the plant and failed to reference the correct affected zones downwind of the plant. This finding was initially identified by the licensee following the first walkthrough and necessary precautions to prevent use of the erred program were issued.
- One crew failed to issue correct protective action recommendations because an incorrect assumption was entered into the ORCAS program regarding reactor coolant system activity.

RESPONSE TO WEAKNESS II
(445/9404-02; 446/9404-02)

The dose assessor experiencing difficulties operating the dose assessment computer was immediately disqualified, subsequent remedial training was administered, and the dose assessor was returned to the roster. The performance of this dose assessor was considered an isolated case, based on only one of three crews making the error.

The vendor has forwarded the corrected PAR report software. Additional validation efforts are being performed. Installation is expected to occur by April 14, 1994. Prior to installation of the corrected software, cautionary

Attachment to TXX-94104
Page 3 of 3

notes have been placed at each ORCAS terminal to prevent inadvertent use of the erroneous data by Dose Assessors. An EP Bulletin was issued to all personnel identifying the software error and the required compensatory actions to be taken.

The Shift Manager recognized the error of assuming "normal reactor system activity" versus the correct choice of "1% fuel cladding failure" selection criteria immediately following the termination of the drill. This error was considered an isolated case based on only one of three crews making the error.

Both of the above weaknesses were discussed shortly after the inspection by the Emergency Planning Manager with all 5 Shift Managers at a quarterly Shift Manager meeting.

TU Electric will have completed actions as identified in this response by April 30, 1994. Corrective action documentation will be available for review by the NRC during subsequent followup inspections.