



Log # TXX-91048  
File # 10130 (IR 90-44)  
10013 clo  
Ref. # 10CFR2.201

William J. Cahill, Jr.  
Executive Vice President

February 7, 1991

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  
RESPONSE TO NRC INSPECTION REPORT NO. 50-445/90-44  
AND 50-446/90-44

Gentlemen:

TU Electric has reviewed the NRC's letter dated December 28, 1990, concerning the inspection conducted by the NRC staff during the period November 12-15, 1990. This inspection covered activities authorized by NRC Facility Operating License NPF-87 and Construction Permit CPPR-127 for CPSES Unit 1 and 2, respectively. The inspection report identified six exercise weaknesses in the emergency preparedness program.

This response was scheduled to be submitted on January 30, 1991; however, TU Electric requested and received an extension until February 8, 1991, in providing this response in a telephone conversation between Mr. Dwight Chamberlain and Mr. R. D. Walker.

The TU Electric responses to these findings are provided in the attachment to this letter.

Sincerely,

William J. Cahill, Jr.

By:   
Roger D. Walker  
Manager of Nuclear Licensing

GLB/grp  
Attachment

c - Mr. R. D. Martin, Region IV  
Resident Inspectors, CPSES (3)  
Mr. J. W. Clifford, NRR  
Mr. D. D. Chamberlain, RIV

9102140035 910207  
PDR ADOCK 05000445  
Q PDR

400 North Olive Street L.B. 81 Dallas, Texas 75201

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RESPONSE TO NRC INSPECTION REPORT  
50-445/90-44 AND 50-446/90-44

NRC Finding 50-445/9044-01:

The performance of the CR [Control Room] staff was observed to be adequate during the exercise. However, the inspection team identified instances where CR personnel failed to demonstrate adequate proficiency in the performance of their assigned emergency response duties. On one occasion, the CR staff made a conscious decision to deviate from Emergency Operating Procedure (EOP) 3.0A without regard for the radiological hazards of doing so. On another occasion, the CR operators failed to follow the correct sequence of steps in EOP 3.0A, "Steam Generator Tube Rupture," and did not know when to implement Associate Procedure ECA 3.1A, "Steam Generator Tube Rupture With Loss of Reactor Coolant."

TU Electric Response:

The TU Electric Nuclear Training Department has expanded the instruction concerning EOP 3.0A and ECA 3.1A in the licensed operator requalification training program; therefore, the corrective action is complete.

NRC Finding 50-445/9044-02:

Further observations by the inspection team in the CR determined information flow discrepancies as follows:

- At 9:49 a.m. the CR staff recommended to the TSC staff to declare a general emergency (GE) based on existing plant condition, such as: indications of failed fuel, a faulted SG, and a SG tube rupture greater than 50 gpm. These conditions should have resulted in the declaration of a GE. However, the TSC staff incorrectly declared a site area emergency (SAE) at 9:52 a.m. It was not until about 9 minutes later (10:03 a.m.) that the GE was declared by the EOF staff. From this sequence of events, the inspection team concluded that there was poor information flow between or within one or more of the emergency response facilities (ERFs) involved in this decisionmaking process.

TU Electric Response:

The EP training program will be updated to stress to Emergency Response Facility personnel, the importance of information exchange and flow, especially the emergency classification. This corrective action will be completed by February 28, 1991. The EP training program is repeated annually.

NRC Finding 50-445/9044-03:

It was noted in the CR that Form EPP-203-B, "Notification Message Form," was not complete at times in that the names of individuals contacted from the offsite agencies were not recorded on the form at the time of notification. This was observed to occur on three different occasions. In addition, the inspection team noted that the communicator in the CR was not always accurate in sending the message as written. When message No. 2 was generated, the statement "No fuel damage exists," was added to Block 6 of the notification form. However, the communicator told offsite agencies that there was no

change from Message 1. Finally, the clock of the telefax machine indicated Daylight savings time instead of standard time.

TU Electric Response:

Changes to the Emergency Planning training materials have been made to further stress the need to be accurate and provide correct communications to Offsite agencies. The observed problem regarding the clock on the telecopier has been corrected. Also, two entries have been added to the EP tracking list to ensure the telecopiers are updated at the appropriate times during the year. The training material update and the addition of the tracking items will be completed by February 28, 1991.

NRC Finding 50-445/9044-04:

The inspection team noted that the staff performed well during the exercise. However, the NRC team observed some instances of inadequate information flow within and between ERFs. In particular, information flow inadequacies were identified within the TSC which resulted in delays in classification, uncertain interpretation of plant conditions, and uncertainties pertaining to the significance and extent of core damage. Other information flow inadequacies between the CR and TSC resulted in unnecessary delay of repair activities. [Specific examples of inadequate information flow are enumerated in the inspection report.]

TU Electric Response:

See TU Electric response to NRC finding 50-445/9044-02 and 50-445/9044-03.

NRC Finding 50-445/9044-05:

The inspection team observed and evaluated the OSC staff's performance during the exercise. Items observed included activation of the OSC, personnel staffing, and support to the control room, technical support center, and emergency operations facility.

The inspection team noted that the activation of the OSC was performed quickly and orderly. The overall performance of the OSC staff appeared to be good.

Improvements were noted in the licensee's tracking of emergency repair and damage control teams. Information concerning the team number, member names, dispatch time, work location, and return items were posted on a status board in the OSC.

Even though improvements were noted in the licensee's performance in the OSC, [three observations were noted which were determined to indicate lack of adequate radiological controls.]

TU Electric Response:

After investigating the observation, it was determined that a Radiation Protection (RP) technician was dispatched and stopped the Auxiliary Operator (AO) from entering the MSIV room. However, recognizing a weakness, the AOs will receive instruction directed at the importance of having appropriate RP coverage to reenter plant environs during emergency situations. This corrective action is expected to be completed by February 28, 1991.

Concerning the second observation, the radiation protection portion of Emergency Response Training will be updated to stress the importance of continuous radiological coverage, particularly the taking of air samples, during emergency conditions. The updates to this training program are expected to be complete by February 28, 1991.

Regarding the third observation, the results of an investigation revealed that a state of confusion existed between the RP technician and the controller. As a result of that confusion, accurate area radiation levels were not communicated to the RP technician. The controller issue is addressed in the response to 50-445/9044-06.

This confusion also appears to have led to the conclusion of inadequate RP coverage. The RP technician provided coverage which consisted of periodic radiation surveys every 10 - 20 minutes and floor smears and checking pocket in chambers every 10-25 minutes. As erroneous controller information appears to have contributed to the observation, no additional actions are prescribed for the Radiation Protection personnel.

NRC Finding 50-445/9044-06:

Several observations made in different ERFs indicated that controllers' actions were not always appropriate to the conduct of the exercise and that more training of controllers may be needed prior to the next annual exercise. Some of the controllers' actions could possibly be remedied by more careful planning and anticipation by scenario developers. For example, controllers were not observed to be adequately sensitized to prevent actions on their part that could result in inadvertent or involuntary prompting of players. Simulation announcement messages were not prepared beforehand to prevent confusion and delays. In addition, in some instances exercise controllers fed emergency responders incorrect data or incomplete information such as: expected radiation readings in plant areas like the residual heat removal (RHR) pump room, and lack of written initiating conditions for control room players. [Several specific examples follow in the Inspection Report.]

TU Electric Response:

The controller training program will be revised to include instruction on the importance of providing correct and accurate information and on actions which could inadvertently prompt the exercise participants. This program will be revised by February 28, 1991. In addition, the scenario development personnel have been counseled regarding the preparation of detailed messages concerning initial conditions. No further corrective actions are expected.