EXHIBIT E

UNITED STATES OF AMERICA
NUCLEAR REGULATORY COMMISSION

BEFORE THE COMMISSION

In the Matter of	)	Docket Nos. 50-445-OL
	)	50-446-OL
TEXAS UTILITIES ELECTRIC COMPANY, *ET AL.*	)	
	)	Docket No. 50-445-CPA
(Comanche Peak Steam Electric Station, Units 1 and 2)	)	

AFFIDAVIT OF WILLIAM D. JOHNSON REGARDING
THE OCTOBER 6, 1991 EVENT

William D. Johnson, first being duly sworn, deposes and states:

1. My name is William D. Johnson. I am employed by the U.S. Nuclear Regulatory Commission as Chief, Project Section A, in the Division of Reactor Projects, NRC Region IV. Until recently, I was the Senior Resident Inspector for Comanche Peak Steam Electric Station, Unit 1. A statement of my professional qualifications is attached hereto as Attachment 1.

2. As Senior Resident Inspector, I was familiar with the event which occurred on October 6, 1991. The purpose of my affidavit is to describe the event that occurred on October 6, 1991 and to evaluate the safety significance of this event.

3. This event was reported by Texas Utilities Electric Company (Licensee) pursuant to their internal reporting system, and a copy of that report was provided to me, although this event was not required to be reported to the NRC pursuant to the

Commission's regulations. The event occurred as follows: On October 6, 1991, with the unit in cold shutdown, operators were defeating personnel air lock interlocks to open both doors to the containment to facilitate worker entry. With the outer door open, two auxiliary operators defeated the interlock to open the inner door. At the time, the pressure inside containment was 0.2 to 0.3 psig lower than in the adjacent safeguards building. The operators did not consider this pressure differential to be excessive. When the inner door was unlatched, the pressure caused the door to open inward rapidly with a large rush of air. An employee in the air lock was swept into the containment and sustained injuries from impacting piping.

4. The Licensee documented the incident and performed reviews to determine the cause. The Licensee's evaluation determined three root causes: (1) The operating procedure was not followed in that containment purge dampers were not closed prior to defeating the door interlocks as required; (2) Operator training was deficient in that operators did not recognize the existing differential pressure as being excessive; (3) The operating procedure did not include specific instructions and warnings about the danger of high differential pressure across the door. The Licensee's report stated that they provided instructions to operators and revised the procedure to preclude recurrence.

5. This event did not pose a health and safety concern because containment integrity was not required with the unit in cold shutdown. After pressure equalized, one or both of the air lock doors could be closed if necessary. Due to the Licensee's prompt corrective action, no NRC action was required.

6. The matters stated above are true and correct to tne best of my knov.ledge, information and belief.

William D. Johnson

Subscribed and sworn to before
me this 24th day of March, 1992

Constance Marie Spagnoli

Notary Public

My commission expires: 09/02/94