



Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

June 19, 1992

U.S. Nuclear Regulatory Commission
Washington, DC 20555

Attention: Document Control Desk

Subject: Quad Cities Nuclear Power Station Units 1 and 2
Response to Exercise Weaknesses
Inspection Report Nos. 50-254/92004; 50-265/92004
NRC Docket Nos. 50-254 and 50-265

Reference: C. Norelius letter to Cordell Reed dated May 20, 1992
transmitting NRC Inspection Report 50-254/92004;
50-265/92004

Enclosed is the Commonwealth Edison Company (CECo) response to three identified Exercise Weaknesses which were transmitted with the reference letter and Inspection Report.

If your staff has any questions or comments concerning this transmittal, please refer them to Jim Watson, Compliance Engineer at (708) 515-7205.

Sincerely,

T.J. Kovach
Nuclear Licensing Manager

Attachment

cc: A.B. Davis, Regional Administrator - Region III
L. Olshan, Project Manager, NRR
T. Taylor, Senior Resident Inspector

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RESPONSE TO IDENTIFIED WEAKNESSES

NRC Inspection Report Nos.
50-254/92004; 50-265/92004

Weakness: (254(265)/92004-01)

Control room simulator staff did not initially notify State officials of the Unusual Event and the Alert declarations in a timely manner.

Weakness: (254(265)/92004-03)

Technical Support Center staff did not initially notify State officials of the Site Area emergency declaration in a timely manner.

Discussion:

CECo agrees that the weaknesses identified existed during the exercise. Both of the above exercise weaknesses dealt with the untimely notification of state officials regarding emergency conditions. The following response will address both weaknesses.

Corrective Actions:

A meeting was held with NRC Region III on May 22, 1992 where these weaknesses were addressed. Several actions were discussed and have already taken place with further corrective measures in progress.

The Nuclear Accident Reporting System (NARS) failure experienced in the control room simulator (CRS) is believed to have resulted from a faulty circuit board unique to the CRS NARS installation. This circuit board has been removed and sent to TELLABS for repair. A spare circuit board has been ordered from TELLABS.

The Technical Support Center (TSC) NARS failure was identified and corrected during the April 29, 1992 exercise. The failure was caused by a loose wire found in the Public Branch Exchange (PBX) room located in the Station Service Building.

Several enhancements to CECo telephone equipment have been completed which provides easier notification to state officials if the NARS communication equipment fails. Two telephone extensions in the control room and one in the TSC have been assigned priority status to allow more reliable access to outside lines. These extensions have been programmed to permit speed dialing to agencies that must be notified, in accordance with the Quad Cities Generating Station Emergency Plan. Verification that the correct numbers were programmed has been completed. Instructions for using the speed dial feature have been posted in the control room, CRS, and TSC. The instructions also list the order established for contacting the state agencies.

RESPONSE TO IDENTIFIED WEAKNESSES

NRC Inspection Report Nos.
50-254/92004; 50-265/92004

Corrective Actions (continued):

Procedure QEP 300-1, "Notifications For GSEP Emergencies", is being revised to.

- Add a provision on who to call (Illinois Emergency Management Agency) if the NARS link is inoperable.
- Provide more specific guidance on alternate methods of making notifications if the NARS link is inoperable.
- Consider utilization of extra personnel, if available, when making notifications with the NARS link inoperable.

Individuals with state agency notification responsibilities will be given instructions on the telephone equipment and procedure enhancements to ensure familiarity with the alternate method provided. The procedure revisions and user instruction will be completed by June 30, 1992.

A review was completed of recent actual events which identified no concerns relative to notification timeliness.

RESPONSE TO IDENTIFIED WEAKNESSES

NRC Inspection Report Nos.
50-254/92004; 50-265/92004

Weakness: (254(265)/92004-02)

The shift engineer failed to assess degraded plant conditions warranting an Alert declaration in a timely manner and later failed to obtain information from the accident scene in order to determine the potential for emergency reclassification.

Discussion:

CECo agrees with the above weakness. This weakness dealt with the Shift Engineer (SE) not promptly recognizing that the Unit 2 turbine casing failure was classifiable as an Alert per Emergency Action Level (EAL) 6.t, "Main turbine failure causing casing penetration." Instead, the SE declared an Unusual Event (UE) per EAL 9.a, "A condition that warrants increased awareness on the part of state and/or local offsite officials."

The classification was subsequently corrected based on input from another senior reactor operator (SRO). However, directions to the communicators to not make the UE notifications were not provided. This contributed to the late notifications already described.

CRS personnel did not pursue information from the accident scene dealing with the generator hydrogen leak and the injured individual in that area. An apparent assumption was made that the victim was injured by turbine debris when the actual scenario was that the victim's injury was due to a toxic (hydrogen) atmosphere. This led to no consideration of the Site Emergency EAL 7.g, "Uncontrolled release of toxic or flammable gas at life threatening levels is confirmed within vital areas."

Corrective Actions:

Briefings of all SEs will be completed by June 30, 1992. The briefings will stress aggressive pursuit of information from the scene during all plant events and the necessity of a questioning attitude to acquire the most complete information for making accurate assessments of conditions.

A review of this segment of the exercise is in progress and will be developed into a case study. Lessons learned from the case study will be provided to applicable departments. The lessons learned will also be incorporated into appropriate training modules. The case study will be completed by June 30, 1992.

RESPONSE TO IDENTIFIED WEAKNESSES

NRC Inspection Report Nos.
50-254/92004; 50-265/92004

Corrective Actions (continued):

Nuclear Services Emergency Preparedness (NSEP) is drafting guidance that will address how to resolve misclassification events once they have occurred. This guidance then will be incorporated into the appropriate procedures.

Mini-scenarios have been developed and distributed to key GSEP personnel that are an aid to reviewing interim EALs which are scheduled to be implemented in June 1992. The mini-scenarios were a part of distributed packages that included the interim EALs, the associated philosophy document, and portions of material used in presenting the interim EALs to the NRC and state officials. This is considered an effective training tool for reviewing the interim EALs.

Other training efforts aimed at EAL familiarization include:

- Licensed operator classroom training will target event based EALs that are less routine and will include completion of NARs information and protective action recommendations.
- Several new scenarios that are broader in scope and involve less routine EALs will be developed for licensed operator training.

This training will begin on July 20, 1992 and continue through October 10, 1992.

A long term plan to improve EAL recognition and assessment of plant conditions will be the implementation of NUMARC EALs. These EALs are under development and two of the key goals include:

- The target user is the SE and SCRE.
- The format will be developed to prevent both missed classifications and misclassifications.

The NUMARC EALs are currently scheduled for use by January 1994.