TU ELECTRIC

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January 8, 1993

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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
RESPONSE TO NRC INSPECTION REPORT NO. 50-445/92-46
AND 50-446/92-46

Gentlemen:

TU Electric has reviewed the NRC's letter dated December 7, 1992, concerning the inspection conducted by the NRC staff during the period November 16-20, 1992. 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 three exercise weaknesses in the emergency preparedness program.

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

Sincerely,

William J. Cahill, Jr.

By: D R Woodlan
D. R. Woodlan
Docket Licensing Manager

CLW/tg
Attachment

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NRC Exercise Weakness 445/9246-01; 446/9246-01:

The inspectors noted unnecessary delays associated with the detection and classification of the initiating conditions for two of the three emergency classifications made during the exercise as follows:

- In the control room, the Emergency Coordinator failed to implement correctly Procedure EPP-201, "Assessment of Emergency Action Levels, Emergency Classification and Plan Activation," Chart 11, "Fire." This chart indicated that a fire inside the protected area lasting greater than 10 minutes for which safety systems were potentially affected by the fire would result in an Alert classification. The Emergency Coordinator failed to declare an Alert 10 minutes after the Diesel Generator 1-01 Day Tank Room fire alarm was received in the control room. Instead, the declaration was made 10 minutes after the existence of the fire was confirmed by an auxiliary operator dispatched to the scene. This resulted in a 6-minute delay in the Alert classification.

  Through player interviews, the inspectors determined that the Emergency Coordinator began the 10-minute countdown at the time when the fire was confirmed by the auxiliary operator. The operator confirmation took 6 minutes from the receipt of the alarm. During this 6 minutes, the fire potentially affected safety systems. Under the conditions of this scenario, following the operator's confirmation of the fire, the Alert classification conditions were met 10 minutes after the receipt of the fire alarm.

- In the Technical Support Center, declaration of the Site Area Emergency following the major steam generator tube rupture and main steam line break was not made promptly following reports of these conditions. At 4:28 a.m., the Technical Support Center staff became aware that the steam generator tube rupture had significantly increased concurrent with reports of an unisolable steam line break outside of containment on the affected steam line. According to the licensee's classification scheme contained in Procedure EPP-201, "Assessment of Emergency Actions Levels, Emergency Classification and Plan Activation," Chart 4, these conditions correspond to a Site Area Emergency. The declaration of the Site Area Emergency was not made by the Technical Support Center until 4:49 am, or 21 minutes following Technical Support Center staff awareness of these conditions. The inspectors noted that a briefing was being started at 4:30 am in the Technical Support Center as information of the main steam line break was received. Rather than take action on this event, the managers took another 5 to 10 minutes to complete the briefing. The control room finally prompted the Technical Support Center concerning the need to upgrade to Site Area Emergency at about 4:47 am.

TU Electric Response

Upon review of the actions taken by the Emergency Coordinator to classify the Alert it was determined that the six minute delay was caused by starting the 10-minute countdown at the confirmation of the fire rather than at the initiating event of receiving the alarm in the Control Room.

The delay in classifying the Site Area Emergency was attributed to the three contributing factors:

1) Personnel in the TSC who evaluate plant conditions relative to emergency action levels were not adequately anticipating what possible events could cause escalation of emergency classification. Consequently, when the report was received in the TSC that an unisolable steam line break had occurred, no one in the TSC was aware that the break would cause escalation to Site Area Emergency.

2) The TSC Manager/Emergency Coordinator wanted to verify the report of the steam line break prior to taking any action with the information.

3) The TSC Manager/Emergency Coordinator had been in the TSC for only a short period of time and elected to continue a briefing rather than evaluate the new information while awaiting verification of this new information.

To address the Alert classification delay, remedial training has been given to the individual who was acting as the Emergency Coordinator and declared the Alert. A random sampling of other licensed Senior Reactor Operators verified that the training in this area was adequate since they all responded with correct answers as to what to do in this scenario. Therefore, this classification delay was determined to be an isolated case and is not believed to be a generic concern. However, this delay will be covered in current events during 1993 annual requalification training for Accident Classification.

To address the Site Area Emergency classification delay, all Emergency Coordinators for the TSC and EOF shall receive training to address the weakness identified above. This corrective action is scheduled to be completed by May 1, 1993.

NRC Exercise Weakness 445/9246-02; 446/9246-02:

Following the declaration of the Site Area Emergency at 4:49 am, the notifications to offsite authorities of the classification were not completed until 25 minutes later at 5:14 am. According to 10CFR50, Appendix E.IV.D.3 and EPP-203, "Notifications," Section 4.1.2.2, notifications are to be made within 15 minutes after declaring the emergency. The licensee's failure to make prompt offsite notifications of the Site Area Emergency was identified as an exercise weakness.

TU Electric Response

Upon review of the player logs and interviews with key players the following is a reconstructed time line of events:

0442 TSC Manager aware of release in progress.
0445 TSC Communicator updated offsite authorities verbally of release and would provide followup information shortly.
0450 Site Area Emergency declared.
0505 Notification Message Form #5 completed and approved.
0505 TSC Communicator commenced notifying offsite authorities verbally of Site Area Emergency.
0515 TSC Communicator transmitted Notification Message Form #5 to offsite authorities.

Based on this time line the completion of the Notification Message Form took up the entire 15 minutes allowed for offsite notification.

To address this weakness the Notification Message Form will be discussed with the State and local governments to determine if the form can be simplified to reduce completion time. This corrective action is scheduled to be completed by June 1, 1993.

The Emergency Coordinators in the TSC and EOF shall receive instruction on the importance of obtaining and providing the information needed for this form to effect notification within the time limit. This corrective action is scheduled to be completed by May 1, 1993.

NRC Exercise Weakness 445/9246-03; 446/9246-03:

The inspection team made the following observations which, in the aggregate, indicated that overall command and control during the exercise was weak:

- The transfer of Emergency Coordinator duties from the control room shift supervisor to the manager in the Technical Support Center was inefficient and confusing and appeared to leave a vacuum of command authority for a period of time.

  The Alert was declared at 3:19 a.m. By 3:36 a.m., there were about four people in the Technical Support Center but with no particular individual in charge. At about 3:42, the Emergency Coordinator's checklist logs indicated that the individual who would eventually become the Emergency Coordinator in the Technical Support Center had relieved the control room shift supervisor of the Emergency Coordinator's duties (while in the simulator). By about 4 a.m., one individual in the Technical Support Center had taken charge of personnel there but did not claim the title of Emergency Coordinator. The Emergency Coordinator arrived in the Technical Support Center from the simulator at about 4:28 a.m. but did not announce that he was the Emergency Coordinator. Status boards in the Technical Support Center continued to show that the control room had command and control. The Technical Support Center Emergency Coordinator log showed that the same individual who had assumed

Emergency Coordinator duties in the simulator again assumed these duties in the Technical Support Center at 4:50 a.m. Because of the distance between the Technical Support Center and the simulator, this exercise included an artificially long period of time (about 10 minutes) to transit between the two facilities. Even giving consideration to the artificiality, it was unclear who was the Emergency Coordinator during the 4:30 to 4:50 a.m. timeframe.

- In the Operational Support Center, the licensee failed to maintain adequate controls over teams dispatched in response to emergency conditions. Between 4 and 6:07 a.m., 16 teams were dispatched from the Operational Support Center. No Emergency Work Permits were completed for 10 of these teams as required by Procedure EPP-116, "Emergency Repair & Damage Control and Immediate Entries", step 4.2.2. Some of these teams were recorded on the Operational Support Center Team Status board and in various logs but no consistent central record was maintained of these teams. In addition, as noted in Section 4.1, early in the exercise it appeared that no individual in the Operational Support Center was clearly responsible for the control of assigning and dispatching repair teams.

- In the Emergency Operations Facility, control of the offsite monitoring teams and utilization of the information developed from them was inadequate. Neither the results of the 5:39 a.m. plume traverse nor the later measurements reported to the Emergency Operations Facility about 6 a.m. that produced above-background readings were recorded on the offsite monitoring status board or reported to the Emergency Operations Facility decision makers. At the termination of the exercise, the Radiation Protection Coordinator and the Emergency Coordinator were unaware of the results of the monitoring team traverse of the plume 3 miles downwind from the plant some 25 minutes before. For an undetermined period of time around 5:53 a.m., the monitoring team communicator's station was abandoned leaving no apparent radio communication or centralized control over the deployed teams during this time period.

- Staffing of the Emergency Response Facilities was at times disorganized, as sometimes several qualified individuals shared (or attempted to fill) the same position. The facility managers were not forceful in directing the excess staff to be released for other duties. There appeared to be no standard practice or procedure for staffing the initial response organization and recording, reassigning or releasing the other personnel who responded. While three different qualified individuals were signed in for, and took part in carrying out the duties of the Emergency Operations Facility Radiation Protection Coordinator position, the Technical Support Center dose projection capability was suffering for a lack of experienced personnel.

TU Electric Response

The transfer of the Emergency Coordinator duties from the Control Room to the Technical Support Center led to an exercise weakness. The Comanche Peak practice in this area has been for a TSC Manager to report to the Control Room and relieve the Shift Supervisor of Emergency Coordinator duties so the Shift Supervisor can concentrate on plant conditions. Once

the TSC is staffed, the TSC Manager/Emergency Coordinator relocates from the Control Room to the TSC and continues Emergency Coordinator duties from the TSC. This practice has worked very well in the past and has proven to be very effective.

In the Operations Support Center (OSC) no single individual was clearly in control of assigning and dispatching teams. Procedure EPP-205, "Activation and Operation of the Operations Support Center" assigns the responsibility of dispatching teams to the OSC Manager, whereas procedure EPP-116, "Emergency Repair and Damage Control and Immediate Entries," assigns the responsibility of dispatching teams to the OSC Manager, OSC Maintenance/ERDC Supervisor, and OSC Radiation Protection Supervisor.

In the Emergency Operations Facility, there was a lack of control of the offsite monitoring teams and use of the information provided by the offsite team. This was attributed to the inexperience of specific individuals filling certain emergency organization positions in the Emergency Operations Facility radiological assessment team.

The last item deals with staffing the Emergency Response Facilities. During the exercise it was observed that some emergency organization positions were filled by several individuals while other positions had a lack of personnel. Currently, there are no written guidelines for the initial staffing of the emergency organization.

The following corrective actions are scheduled to be completed by April 1, 1993.

- The practice of the TSC Manager relieving the Shift Supervisor in the Control Room and then moving to the TSC will be evaluated to determine if this is still the best method of handling this transition.

- To address the issue of control of and dispatching teams in the OSC, procedures EPP-116 and EPP-205 will be evaluated to determine and provide better instructions and directions for team dispatch.

- In the EOF, drills will be conducted to raise the experience level of the Offsite Monitoring Team Communicators and Offsite Monitoring Team Directors.

- Guidelines for initial staffing of the emergency facilities will be re-emphasized to the Emergency Response Organization which outlines management expectations. The emergency planning training program will be updated to provide this information to the Emergency Response Organization.