



Results: Within the emergency response areas inspected, no violations or deviations were identified. There were nine deficiencies identified by NRC and contractor inspectors.

DETAILS1. Persons ContactedTexas Utilities Generating Company

- \*J. R. Gallman, Lead Engineer
- \*T. L. Gosdin, Support Services Superintendent
- \*R. W. Haskover, Nuclear Licensing Engineer
- \*R. A. Jones, Manager, Plant Operations
- \*R. T. Jenkins, Operations Support Superintendent
- \*J. C. Kuykendall, Vice President
- \*G. J. Laughlin, Emergency Planning Supervisor

\*Denotes those present at the exit interview.

The NRC inspectors also contacted other licensee employees during the course of the emergency exercise. They included chemistry and health physics technicians, reactor and auxiliary operators, members of the security force, and other members of their emergency response organization.

2. Exercise Scenario

The exercise scenario was reviewed to determine if provisions had been made for the required level of participation by state and local agencies, and that all the major elements of emergency response would be exercised in accordance with the requirements of 10 CFR Part 50 and the guidance in NUREG 0654, Section 11.n. The review included the evaluation of the technical adequacy of both operational and radiological aspects of the scenario. In addition, a review of the internal consistency and thoroughness of information provided to participants, observers, controllers and evaluators was made. The licensee provided the scenario to the NRC on a timely basis and results of the NRC review were incorporated in the scenario.

No violations or deviations were identified.

3. Control Room

Initial conditions were provided to the control room staff assigned to respond to the simulated emergency at 8:00 a.m. Among significant initial conditions were the following:

1. The reactor was operating at full power in its first fuel cycle with 250 Effective Full Power Days utilization of core.

2. Several plant components were out of service for maintenance including one Startup Transformer.

The scenario was based upon two independent accident events. The initiating event for the scenario was a failure of the seal in a gas decay tank valve, which forced the contents into a valve room in the auxiliary building. When an operator was sent to investigate a "hissing" sound coming from the valve room, he suffered a personal injury and became contaminated. The radioactive gases in the decay tank were exhausted to the environment via the plant vent stacks. This release caused the plant ventilation stack monitors to alarm. A raise in radiation levels in excess of 10 times alarm set point required an ALERT classification. Eventually, the contents of the decay gas tank were dissipated into the environment. Forty-five minutes later, a steam generator primary to secondary leak had increased to 400 gpm, and in addition, a loss of offsite power resulted from the failure of a breaker. The emergency was upgraded to a Site Area classification. Releases of radioactivity due to the accident scenario were moderate and never in excess of EPA Protective Action Guides.

The NRC inspectors in the control room observed the appropriate use of critical safety function status trees, emergency operating procedures and emergency implementing procedures. With isolated exceptions, the control room staff was well directed and functioned as an integrated team.

The NRC inspectors observed the following deficiencies:

The licensee did not comply with 10 CFR 50.72(a)(3) which requires that notification of the NRC should follow immediately after notification of states and local authorities. After the first Alert classification was declared from the control room, 28 minutes elapsed before NRC was notified. A similar situation occurred in the Technical Support Center after the declaration of a Site Area emergency (445/8515-01; 446/8512-01).

The transfer of data from the control room to other emergency response facilities during the loss of power event did not contain a collection time-tag. As a result, it was not always clear which set of data corresponded to specific times. In addition, responsibility for manual data collection was not assigned (445/8515-02; 446/8512-02).

No violations or deviations were identified.

4. Technical Support Center (TSC)

The NRC inspectors observed that the manning and activation of the TSC took place in a prompt and orderly manner. Briefings made by the TSC manager to his staff were frequent and informative. Space limitations in the TSC were compensated by well controlled noise levels.

The transfer of emergency direction and coordination responsibilities and authorities from the shift supervisor to the TSC manager and to the Manager, Nuclear Operations in the Emergency Operations Facility were formal, positive and clearly announced. TSC personnel kept neat and comprehensive records of activities as required by procedures.

The NRC inspectors observed the following deficiencies:

The TSC manager failed to relieve the shift supervisor as emergency coordinator until 53 minutes after the Alert classification (445/8515-03; 446/8512-03).

The licensee did not include the town of Glen Rose in the sheltering recommendation to 5 miles, although Glen Rose had the greatest population density in the geographical sector affected by the radioactive plume in the scenario. This omission was not corrected until one hour later (445/8515-04; 446/8512-04).

There were no steam suits available to allow operators to closely diagnose and take remedial actions on incidents involving steam hazards (445/8515-05; 446/8512-05).

No violations or deviations were identified.

5. Search, Rescue and Medical Scenario

The NRC inspectors noted that during the medical scenario, players were proficient in radiological control procedures.

The NRC inspectors observed the following deficiency:

The techniques used for medical attention, handling and transportation of the injured person were inadequate, e.g., the rescue team dragged the victim by lifting his feet disregarding a potential neck injury and deep laceration on the head; they failed to provide oxygen to the patient; failed to check vital signs; ignored the possibility of the victim suffering from potential shock; failed to stabilize the head on the stretcher; and failed to recognize that the stretcher could be folded into a chair to facilitate transportation of the victim down the stairs (445/8515-06; 446/8512-06).

No violations or deviations were identified.

6. Radiological Controls

The NRC inspectors observed the following deficiency:

Onsite monitoring teams took air samples near building walls, and failed to properly label and retain samples. In addition, the NRC

inspectors noted that both access control and contamination control of personnel returning from potentially contaminated areas to the Operations Support Center were inadequate (445/8515-07; 446/8512-07).

No violations or deviations were identified.

7. Communications Hardware

The NRC inspectors observed the following deficiency:

Radio communications with offsite monitoring teams was on occasion garbled and intermittent. In addition, during the loss of offsite power, radio communications between the teams and the EOF were inadequate (445/8515-08; 446/8512-08).

No violations or deviations were identified.

8. Exercise Critique

The NRC inspectors attended the post-exercise critique conducted by the licensee staff on October 31, 1985, to evaluate the licensee's identification of deficiencies and weaknesses as required by 10 CFR 50.47(b)(14) and Appendix E of Part 50, paragraph IV.F.5. The licensee staff identified and properly characterized the deficiencies listed below:

- The TSC staff failed to inform control room personnel that the release of radioactivity to the environment was caused by a relief valve which failed in the open position.
- The staff of the TSC continuously monitored the failed fuel monitor throughout the exercise. This was inappropriate since this monitor was isolated once safety injection was initiated.
- An offsite survey team was not sent to measure the radiological consequences of gas decay tank release after the vent monitor alarmed due to high radiation.
- The controller coached the main steam safety valve repair team by informing them that the power operated relief valve was leaking.
- Procedure EPP-203 was found not to be consistent with the requirements of 10 CFR 50.72(a)(3).

The NRC inspectors observed the following deficiency:

The licensee's critique did not identify and properly characterize several deficiencies. The critique emphasized positive findings while

attempting to minimize the importance of negative ones. The NRC inspection team concluded that the licensee did not demonstrate the ability to adequately portray important findings, such as the inadequacy of the medical procedures used by the rescue team, and the failure to include the population of Glen Rose in their protective actions (445/8515-09; 446/8512-09).

No violations or deviations were identified.

9. Exit Interview and NRC Critique

The NRC team met with licensee representatives identified in paragraph 1 above. The NRC team leader summarized the deficiencies observed during the exercise and stated that the licensee's corrective actions to these deficiencies will be reviewed in the near future.