GULF STATES UTILITIES COMPANY

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Gentlemen:

River Bend Station - Unit 1
Docket No. 50-458/Report 93-01

This letter provides Gulf States Utilities Company's (GSU) response to the exercise weaknesses noted in NRC Inspection Report No. 50-458/93-01. This letter describes GSU's corrective actions regarding the weaknesses observed during our annual emergency planning exercise conducted on February 24, 1993.

Should you have any questions, please contact Mr. L.A. England at (504) 381-4145.

Sincerely,

J. E. Booker

J.E. Booker
Manager - Oversight
River Bend Nuclear Group

LAE/DNL/JWC/WMS/lc

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ATTACHMENT 1

Response to Weakness 50-458/9301-01

REFERENCE

Letter - L.J. Callan to P.D. Graham, dated March 11, 1993

DESCRIPTION

The inspectors observed that the licensee's accident mitigation efforts were weak following the initial radiological release. At about 12 p.m., the Emergency Director (ED) was away from his normal position in the Technical Support Center (TSC) and was involved in a telephone dialogue about the protective action recommendations with state and local agencies. This telephone discussion took place in the communications room of the TSC and lasted between 5 to 7 minutes. In addition, during this time, the TSC Manager was away from his normal position to conduct a relief turnover briefing. During the period when both the ED and TSC Manager were away from the command table, the initial radiological release began.

The absence of these two key personnel from the main TSC command and control area contributed to confusion about the release. Subsequent events required a vent of the reactor vessel at about 12:23 p.m. which masked the first release; however, the ED has been informed of the 12 p.m. release at about 12:09 p.m. Also, during this time, the ED was in the process of being relieved which may have contributed to the incomplete understanding of the radiological release. Following the initiation of the release at 12 p.m., no action was taken to locate and stop the source of this release. Failure to take prompt action to mitigate a radiological release was identified as an exercise weakness.

GULF STATES UTILITIES COMPANY'S RESPONSE

The ED was in the communications room on the hotline with the state and local governments confirming protective action recommendations. It should not be necessary for the ED to leave the area for this purpose. A hotline has been placed on the command and control area table for this purpose. The TSC Manager was also not available during this period because of conducting a relief turnover briefing. There must always be someone designated to be in charge at the command and control area. If the ED has a need to be away from the area he should announce that the TSC Manager is in charge and the TSC Manager should remain in the area until the ED returns and an announcement made that the ED is again in charge. This will be emphasized in training for these positions.

Had the initial release not coincided with the time of absence of these two key personnel, actions to mitigate the release would have occurred and it would not have been masked by the venting of the reactor vessel. It is therefore not necessary to take any corrective action on the failure to locate and stop the source of the release.

ATTACHMENT 2

Response to Weakness 50-458/9301-02

REFERENCE

Letter - L.J. Callan to P.D. Graham, dated March 11, 1993

DESCRIPTION

One of the objectives of the exercise was to collect and analyze a sample using the Post-Accident Sampling System (PASS). Before the exercise, the inspection team was advised that the small volume liquid sampler of PASS was inoperative. A decision was made to collect and analyze a containment air sample to satisfy the exercise objective. A team consisting of a radiation technician and two chemistry technicians was dispatched from the Operational Support Center to collect the PASS air sample. The team received an adequate briefing necessary to accomplish the task in a safe manner. The inspectors noted several actions by the PASS team which caused unnecessary delays as follow:

- One team member had to shave so that he could wear the self-contained breathing apparatus required for entry into radiological controlled area.

- One team member had to be excessively coached by the radiation protection technician on proper dress-out procedures.

- A defective radio had to be exchanged before entry into the radiological controlled area.

- The inspectors noted that the volume and weight of the equipment the team carried to get an air sample was excessive and inhibited the progress of the team to the sampling area.

- Upon arriving at the PASS facility, the team discovered they did not have the required wrench to tighten a connection from the compressed nitrogen gas bottle to the postaccident sampling system purge system. Thirteen minutes elapsed before a wrench was obtained.

- The switch on the portable air sampler was found to be defective and 15 minutes were expended in replacing the air sampler.

- In attempting to collect the PASS air sample, a vacuum on the system could not be drawn and, subsequently, the system had to be purged with nitrogen. This procedure took about 15 minutes. Two attempts were made in collecting the PASS air sample before an inspection of the PASS air sampling equipment revealed that the sample injection needle was bent. After considerable effort, the needle was straightened before finally being removed and replaced.

Approximately 4 hours were expended in collecting and analyzing the PASS air sample. This is in excess of the 3 hour time frame for collecting and analyzing PASS specified in EIP-2-015, "PASS Operations," and NUREG-0737, "Clarification of TMI Action Plan Requirements." The

failure to collect and analyze a PASS sample in an efficient and timely manner was identified as an exercise weakness.

GULF STATES UTILITIES COMPANY'S RESPONSE

A team has been formed to evaluate the delays in obtaining a PASS containment air sample. Additional surveillances, on-the-job-training, maintenance, and panel modifications will be performed, as necessary, to enhance PASS performance such that a sample can be obtained and analyzed in the prescribed time. The ability to collect and analyze this PASS sample will be satisfactorily demonstrated to NRC inspectors during an inspection scheduled for River Bend Station for the week of May 10, 1993.

ATTACHMENT 3

Response to Weakness 50-458/9301-03

REFERENCE

Letter - L.J. Callan to P.D. Graham, dated March 1[illegible] 1993

DESCRIPTION

During the collection of the Post-Accident Sampling System (PASS) sample, the inspectors identified several improper radiological practices as follows:

- The PASS sampling team removed their self-contained breathing apparatus equipment before the area air sample results were known.

- No provisions were made for respiratory protection for the PASS team beyond the 30-40 minute air supply provided by the initial self-contained breathing apparatus air tanks carried by the team to the postaccident sampling system facility.

- The PASS sample team did not read their direct reading dosimeters during the first 30 minutes of their activities.

- During the air sampling in the PASS facility, the inspectors noted that one of the air sample filters had a hole in it. This would have resulted in a significant underestimation of the airborne radioactivity.

The failure to implement proper radiological controls for in-plant response teams was identified as an exercise weakness.

GULF STATES UTILITIES COMPANY'S RESPONSE

The Radiation Protection department will take the steps necessary to emphasize that the Radiation Protection Technician sent with the PASS team ensures that proper radiological practices are performed during PASS samples. This will be accomplished through training on proper use of the self-contained breathing apparatus (SCBA) (i.e., when they may be removed, provisions for respiratory protection beyond the 30-40 minute air supply provided by the SCBA), reading of their dosimeters frequently, and ensuring that the air sampler is functional and that the sample filters are not damaged. Proper radiological practices will be satisfactorily demonstrated to NRC inspectors during an inspection scheduled for River Bend Station for the week of May 10, 1993.

ATTACHMENT 4

Response to Weakness 50-458/9301-04

REFERENCE

Letter - L.J. Callan to P.D. Graham, dated March 11, 1993

DESCRIPTION

Some notifications to offsite authorities made during the exercise contained conflicting information. For example, Notification Message 5 issued from the Technical Support Center at 11:05 a.m., indicated protective action recommendations of evacuation for Sector 1 and shelter for Sectors 4, 9, and 16 (Scenario 16). In the next Notification Message 6 issued from the Technical Support Center at 11:50 a.m., Item 5, "Protective Action Recommendations" gave conflicting information. The item was checked to indicate that previously issued protective action recommendations remained "unchanged". The specific protective action recommendations listed, however, were changed from those previously issued. The new protective action recommendations were to evacuate Sectors 1, 4, 9, and 16, and Shelter Sectors 2, 3, and 8 (Scenario 26). This same message gave further conflicting information in Item 9, "Release Information." This item was marked to indicate that the release information provided was "new" information, yet the message information continued to show "no release" as indicated in previous messages. Since the licensee was recommending that offsite populations be evacuated, Item 9 should have been marked to indicate "potential for release."

A notification message was not promptly issued by the Emergency Operations Facility following a significant change in plant conditions when the initial radiological release began. Beginning about 12:06 p.m., when the radiological release was recognized, notification to offsite authorities of this significant change in plant conditions was not made until about 46 minutes later at 12:52 p.m. This notification, contained in Message 7, indicated a release was in progress which had started at 12:06 p.m. The incident conditions and comment Section 6 of this message did not contain any amplifying information about the release, regarding its significance or cause. Emergency Implementing Procedure EIP-2-006, "Notifications," specifies that during a declared emergency, prompt update notification messages will be issued to offsite authorities whenever there is a significant change in plant conditions.

The licensee's failure to promptly notify offsite authorities of a significant change in plant conditions, and the issuance of notification messages with conflicting information was identified as an exercise weakness (458/9301-04).

GULF STATES UTILITIES COMPANY'S RESPONSE

Procedure EIP-2-006, "Notifications", Revision 16, section 5.3 states that "Follow-up notifications to offsite agencies are accomplished approximately every 60 minutes following the initial notification or more often if emergency conditions change significantly". A release of radioactivity is a significant change in emergency conditions and should have been reported on a notification message form (NMF). Training will be used to emphasize the need to update the

NMF when significant changes in the emergency condition warrant and to fill out the form properly without conflicting information. Procedures will be reviewed to locate any possible problem area or area that could be used to better direct issuing a NMF when significant changes in the emergency condition warrant.

Part of the problem with conflicting information on the NMF is that the present software for the NMF computer will not always let you change from "new" to "unchanged" information or from "unchanged" to "new". This software problem has been corrected and will be installed as soon as training has been completed on the new software.