

INDIANA & MICHIGAN POWER COMPANY

P. O. BOX 18
BOWLING GREEN STATION
NEW YORK, N. Y. 10004

July 24, 1979
AEP:NRC:00232

Donald C. Cook Nuclear Plant Units 1 and 2
Docket Nos. 50-315 and 50-316
License Nos. DPR-58 and DPR-74

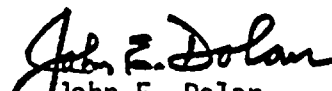
Mr. James G. Keppler, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Dear Mr. Keppler:

This letter responds to Mr. A. B. Davis's letter of June 25, 1979 received June 28, 1979 and which transmitted IE Report No. 50-315/79-14 and No. 50-316/79-11.

The attachment to this letter contains the explanation and corrective actions taken in response to the two infractions which appear to be in non-compliance with NRC regulations.

Very truly yours,


John E. Dolan
Vice President

JED/emc
Attachment

cc: R. C. Callen
G. Charnoff
R. W. Jurgensen
D. V. Shaller - Bridgman
R. S. Hunter

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RESPONSE TO IE INSPECTION REPORT 50-315/79-14 AND 50-316/79-11INFRACTION 1

The analyses of all whole body counts taken at Cook Plant are made by a contractor located in California, the collected data being transferred to him by telephone. Normally the results of the analyses are mailed to the plant. However, when more immediate results are desired, a telephone request can be made and the analysis is reported by telephone. This was done for the count in question. The telephone results (not appearing on the later written report) were that external contamination might be involved as well as activity in the gut region (as opposed the more critical lung region). The 300.MPC-hr exposure cited in the report, is based on all insoluble material being deposited in the lungs, the most critical situation.

In as much as the individual had already left the site, it was not possible to perform follow-up counting as normally done under such circumstances. No efforts were made to request follow-up data to be provided through the individual's employer, although the individual was contacted by telephone and requested to return to the site.

An investigation of the most likely time and cause of exposure was conducted at the time of the incident. The only time the individual was working alone in a situation that might have produced unexpected high airborne levels was when replacing the cofferdam between the reactor cavity and refueling cavity. That particular task was performed on or about 24 May, the day previous to the high count. Note that the date of 13 May specified in the inspection report was the date of the initial count on the individual when he arrived at the site. The date of the terminating count which was high was on 24 May.

As a result of this incident and investigation, verbal instructions were given to all Radiation Protection Supervisors to:

- a) Assure that assembly of the cofferdam will always be performed by individuals wearing respiratory protective equipment.
- b) Air sampling shall accompany all future movements of the cofferdam pieces.

Since that time, a memo was written to all Radiation Protection Supervisors stating these instructions and reemphasizing their importance.

In order to help assure adequate identification of those exposures requiring investigation and to facilitate the subsequent investigations, the following actions will be taken:

- 1) A new procedure will be written and approved prior to the Unit 2 refueling outage, giving guidelines for the initiation of an investigation based on the results of whole body counting.
- 2) When an individual is not available for recount, efforts are now made to obtain the necessary follow-up information through the cooperation of the individual's employer.

INFRACTION 2

The examples of inadequate evaluation cited in this infraction all stem from two interrelated conditions:

- 1) The reporting of analytical results by the Chemistry Section who performed certain analyses for the Radiation Protection Section was not all inclusive, and
- 2) Sampling performed by the Radiation Protection Section was not comprehensive enough to allow both qualitative and quantitative analysis of airborne radioiodine hazards.

Both conditions may be traced to a number of causes. Previous samples had not shown the presence of iodine when it was sampled. Due to the lack of earlier signs of iodine and the extensive time required to perform the analysis, it was decided to do only periodic iodine sampling. Iodine appearing on particulate samples was not reported to Radiation Protection; and the backup iodine samples which would have been taken because of the results, were not taken.

In order to avoid a recurrence of this type of event, the following actions are being taken:

- 1) A new method of reporting the results of laboratory analyses of all types of air samples has been developed and placed into effect which facilitates the transfer of information between the Chemistry and Radiation Protection Sections.

This method consisted of instructing all responsible Chemistry Section technical personnel by memo of the



need to be cognizant of transmitting all data from the Chemical Section to the Radiation Protection Section by using, for record purposes, the form .013 data sheet.

- 2) Additional training will be given within 30 days to all Radiation Protection Section technical personnel which emphasizes the sampling for and control of radioiodine in air including potential sources and recommendations on ways to recognize the need for special sampling.