

REGULATOR INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8102100481 DOC. DATE: 81/02/02 NOTARIZED: NO DOCKET #
 FACIL: 50-316 Donald C. Cook Nuclear Power Plant, Unit 2, Indiana & 05000316
 AUTH. NAME: AUTHORITY AFFILIATION
 RISCHLING, J. L. Indiana & Michigan Electric Co.
 RECIP. NAME: RECIPIENT AFFILIATION
 Region 3, Chicago, Office of the Director

SUBJECT: LER 81-001/04T-0: on 810112, there was no flow through radiation monitor R-19 from steam generator 21. Caused by bad diaphragm in roto-meter flow regulator. Design change initiated to modify flow meters.

DISTRIBUTION CODE: A002S COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 143
 TITLE: Incident Reports

NOTES: Send 3 copies of all material to I&E. 05000316

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	A/D SFTY ASSE12		1	1	A/D TECHNOLOG13		1	1
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	I&C SYS BR 29		1	1	I&E 05		2	2
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	REC & RISK A 41		1	1	SFTY PRG EVA42		1	1
	STRUCT ENG BR44		1	1	SYS INTERAC B45		1	1
EXTERNAL:	ACRS	46	16	16	LPDR 03		1	1
	NSIC	05	1	1	TERA DOUG. MAY		1	1

FEB 12 1981

TOTAL NUMBER OF COPIES REQUIRED: LTTR

ENCL

72

72

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1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the organization's finances and for ensuring that all activities are properly documented.

2. The second part of the document outlines the procedures for recording transactions. It details the steps that must be followed to ensure that all information is captured accurately and that the records are kept up to date.

3. The third part of the document discusses the role of the accounting department in maintaining these records. It highlights the importance of the department's work in providing accurate financial information to the management and to the external stakeholders.

4. The fourth part of the document discusses the importance of internal controls in ensuring the accuracy of the records. It outlines the various measures that should be in place to prevent errors and to detect any irregularities.

5. The fifth part of the document discusses the importance of regular audits in verifying the accuracy of the records. It emphasizes that audits are a critical part of the process and that they should be conducted regularly and by independent parties.

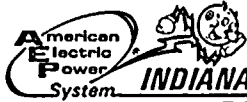
6. The sixth part of the document discusses the importance of training and education in ensuring that all staff are aware of the importance of accurate records and the procedures for maintaining them. It outlines the various training programs that should be in place to ensure that all staff are up to date on the latest practices.

7. The seventh part of the document discusses the importance of communication in ensuring that all staff are aware of the importance of accurate records and the procedures for maintaining them. It outlines the various communication channels that should be used to ensure that all staff are kept informed of any changes or updates.

8. The eighth part of the document discusses the importance of documentation in ensuring that all transactions are properly recorded. It outlines the various documents that should be maintained and the steps that should be followed to ensure that all information is captured accurately.

9. The ninth part of the document discusses the importance of security in ensuring that the records are protected from unauthorized access. It outlines the various security measures that should be in place to ensure that the records are safe and secure.

10. The tenth part of the document discusses the importance of backup and recovery in ensuring that the records are protected from loss. It outlines the various backup and recovery procedures that should be in place to ensure that the records can be restored in the event of a disaster.



INDIANA & MICHIGAN ELECTRIC COMPANY

DONALD C. COOK NUCLEAR PLANT
P.O. Box 458, Bridgman, Michigan 49106
(616) 465-5901

February 2, 1981

Mr. J.G. Keppler, Regional Director
Office of Inspection and Enforcement
United States Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

Operating License DPR-74
Docket No. 50-316

Dear Mr. Keppler:

Pursuant to the requirements of the Appendix B Technical Specifications,
the following report/s are submitted:

AEO 81-001/04T-0.

Sincerely,

D.V. Shaller
Plant Manager

/bab

cc: J.E. Dolan
R.S. Hunter
R.W. Jurgensen
R.F. Kroeger
R.W. Kilburn
E. Swanson/N. DuBry RO:III
R.C. Callen MPSC
G. Charnoff, Esq.
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UNIT

9 1981

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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

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REPORT SOURCE

L	6	0	5	0	0	0	3	1	6	7	0	1	1	2	8	1	8	0	2	0	2	8	1	9		
60	61	DOCKET NUMBER										68	69	EVENT DATE					74	75	REPORT DATE					80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

0 2 DURING NORMAL OPERATION, THE SG BLOWDOWN STARTUP FLASH TANK WAS IN SERVICE TO REDUCE
0 3 SECONDARY SYSTEM CHEMICAL CONTAMINATION FROM CONDENSER IN LEAKAGE. ON JAN. 22 IT WAS
0 4 DETERMINED THAT ON JAN. 12 AT APPROXIMATELY 2200 THERE HAD BEEN NO FLOW THROUGH RAD
0 5 MONITOR R-19 FROM NUMBER 21 S.G. THIS IS NON-CONSERVATIVE IN RESPECT TO APPENDIX "B"
0 6 T.S.2.4.2.G. THIS UNIT IS EXPERIENCING A SMALL PRIMARY TO SECONDARY LEAK. BLOWDOWN
0 7 WAS STOPPED ON JAN. 13, AT 0318 AND AT 0334 BLOWDOWN WAS AGAIN ESTABLISHED THROUGH
0 8 THE NORMAL BLOWDOWN TANK WHERE ADDITIONAL EFFLUENT RADIATION MONITORING WAS POSSIBLE.

7 8 9		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE						COMP. SUBCODE		VALVE SUBCODE	
0 9		M C		E		X		I N S T R U						X		Z	
7 8		9 10		11 12		13 14		15 16 17 18						19 20		21 22	
17 LER/RO REPORT NUMBER		EVENT YEAR		SHUTDOWN METHOD		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.					
8 1		—		0 0 1		/		0 4		T		0					
21 22		23 24		25 26		27 28		29 30		31 32		33 34		35 36		37 38	
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER			
H		F		Z		0 0 0 0		Y		Y		N		B 4 4 0			
33 34		35 36		37 38		39 40		41 42		43 44		45 46		47 48		49 50	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 THE LOSS OF FLOW TO R-19 FROM NUMBER 21 STEAM GENERATOR WAS APPARENTLY DUE TO A BAD

1 1 DIAPHRAM IN THE ROTO-METER'S FLOW REGULATOR, MANUFACTURED BY BROOKS INSTRUMENT

1 2 DIVISION-MODEL NUMBER 1358CC2C1CAA. THE ATTACHED SUPPLEMENT EXPLAINS THIS EVENT

1 3 IN DETAIL.

1	4																	80																																																							
7	8	FACILITY STATUS																		30	METHOD OF DISCOVERY										32	DISCOVERY DESCRIPTION										80																															
1	5	E	28	099										29	N/A										44	B										31	ROUTINE INSPECTION										80																										
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80

ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)
1 6 [M] (33) [M] (34) SEE CAUSE DESCRIPTION
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	000	(37) Z (38)	N/A					

7		8		9		11		12		13			
PERSONNEL INJURIES													
NUMBER						DESCRIPTION (41)							
1	8	0	0	0	(40)	N/A							

7	8	9	11	12			<div style="background-color: black; color: white; padding: 2px;">80</div>
					(43)		
TYPE		DESCRIPTION					
1	9	7	(42)	N/A			

7	8	9	10		80
PUBLICITY	(45)	N/A	NRC USE ONLY		
ISSUED	DESCRIPTION				
1	2	3	4	5	6

NAME OF PREPARER Jack L. Rischling PHONE: 616-465-5901

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PHONE: 616-465-5901

ATTACHMENT TO LER #81-001/04T-0

SUPPLEMENTAL TO CAUSE DESCRIPTION

This incident was reported to Mr. E. Swanson of the NRC on January 22, 1981.

On January 22, 1981, it was determined that on January 12, at approximately 2200, there was no apparent flow through radiation monitor R-19 from number 21 steam generator. During normal operation, the blowdown effluent would also pass through the steam generator blowdown treatment demineralizers where radiation monitor R-24 is located between the second and third demineralizers. However, while investigating the flow meter problem, the steam generator startup blowdown flash tank was in service, thus making R-19 the only radiation monitor that was monitoring the blowdown effluent. The startup blowdown flash tank was in service to reduce secondary system chemical contamination from condenser inleakage.

As Unit 2 has been experiencing a primary to secondary leak, routine daily samples are taken for leak rate determination and effluent release quantification. The activity of the blowdown from the steam generator number 21 was known prior to the incident and the activity levels were lower than had been determined the previous several months. The startup blowdown flash tank was in service for 5 hours and 18 minutes, during which time the blowdown from only number 21 steam generator was unmonitored prior to release to the environment. Flow from the other three steam generators continued to be monitored during this time period. Releases were calculated based on data taken on January 12, 1981, and the following results obtained:

<u>Parameter</u>	<u>Activity</u> (μ Ci/cc)	<u>Release</u> <u>Concentration</u> (μ Ci/cc)	<u>Total Release</u> (m Ci)
Gross beta gamma	1.94×10^{-5}	2.04×10^{-9}	1.75
Tritium	5.62×10^{-6}	6.07×10^{-10}	0.506
Iodine-131	4.82×10^{-7}	5.20×10^{-11}	0.043

These results are considered conservative as the use of the startup blowdown flash tank has a dilution effect on all parameters by discharging larger blowdown volumes and replacing it via a high makeup flow. This is evident by data taken at 0115 hours on January 13, 1981, during the release, which shows all activities had decreased. These samples were part of the plants routine daily analysis program. The results are listed below:

<u>Parameter</u>	<u>Activity(μ Ci/cc) 1-12-81</u>	<u>Activity(μ Ci/cc) 1-13-81</u>
Gross beta-gamma	1.94×10^{-5}	1.33×10^{-5}
Tritium	5.62×10^{-6}	5.37×10^{-6}
Iodine - 131	4.82×10^{-7}	3.13×10^{-7}

During the release, no other alarms or indications of increased primary to secondary leakage were noted. Radiation monitors R-15, steam jet air ejector, and R-33, gland seal exhaust, gave no indication of increased activity.

Estimates of releases were made assuming a constant 500 gallons per day primary to secondary leak rate with coincident 1% failed fuel in the core and using the worst case meteorological data. It was also assumed that all activity remains in solution until reaching the startup blowdown flash tank. Under these hypothetical worst case conditions, the following exposure rates would exist at the site boundary:

8.0×10^{-7} R/hr whole body from noble gases
 3.0×10^{-4} R/hr from iodines with a thyroid dose rate
of 2.5×10^{-4} R/hr.

These estimates would yeild an integrated whole body dose of 0.0047 mR and an integrated thyroid dose of 1 mR. The estimated release under these hypothetical conditions would be 0.023% of technical specifications or noble gases and 13% of technical specifications for radioiodines. The summation of all radioiodines in the liquid release would be 46.5% of technical specifications.

In an effort to prevent reoccurrence of this problem, a design change (RFC#12-1825) was initiated to modify the flow meters to the radiation monitor, R-19, to include a loss of flow alarm. In addition, a departmental standing order, TSO-021, was written to provide accurate responses if the condition were to exist again prior to completion of the design change. This information has been distributed to all plant departments.

Although the incident allowed unmonitored effluent to be released to the environment, sufficient data is available to indicate that during the release the levels of radioactivity were low enough not to pose a threat to the health and safety of the public.

