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SUBJECT: Forwards response to SALP 10 Board rept. Actions initiated to improve engineering/technical support & maint programs during reporting period. EOPs improved & responsibility re compensatory fire protection actions transferred.

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Donald C. Cook Nuclear Plant Units 1 and 2
Docket Nos. 50-315 and 50-316
License Nos. DPR-58 and DPR-74
RESPONSE TO SYSTEMATIC ASSESSMENT OF LICENSEE
PERFORMANCE (SALP) 10 BOARD REPORT

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Attn: A. B. Davis

April 21, 1992

Dear Mr. Davis:

Thank you for the opportunity to discuss the initial SALP 10 report for the Donald C. Cook Nuclear Plant with your representatives during the public meeting held at the plant on March 26, 1992, and the opportunity to provide our comments to you in writing. This letter provides general comments and the attachment provides more specific comments regarding this report.

While we believe the report is generally an accurate reflection of our performance at Cook Nuclear Plant over the 16-month SALP period, we believe we performed better than your rating indicates in the area of radiological controls. A review of our performance over the past several SALP periods demonstrates that we have made notable improvements in key areas such as collective dose, radioactive waste volume reduction, and the number of personnel contamination events. We believe our 1991 performance is among the best in the industry in these areas. These improvements, as well as others, are cited in the report. We therefore request consideration be given in the final SALP 10 report to changing our rating in this functional area from a Category 2 to a Category 2 improving.

During the period covered by the SALP 9 report, we initiated actions to improve our engineering/technical support and maintenance programs. We remain committed to implementation of these initiatives, which were expanded during the SALP 10 period. Your recognition of our improvements in these areas is appreciated. Although some of our more recent initiatives in the engineering/technical support area are in the early stages of implementation, significant benefits are already evident. We view effective engineering/technical support and maintenance programs as strategic elements to safe and reliable plant operation. As

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such, the continued improvement of Cook Nuclear Plant programs and performance in these areas will remain a high priority for us.

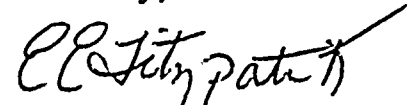
While we are disappointed that our operations rating declined, we intend to address aggressively the challenges you identified and fully expect that our performance in the current SALP period will earn back our previous Category 1 rating. We note in the initial SALP report cover letter and in the summary of results section that the words operator inattentiveness are used. Lack of complete operator awareness of status of equipment is discussed in the plant operations section of the report, but nothing that carries the implication of operator inattentiveness. In addition, we are not aware of any situations where we would conclude that our operators were inattentive. We respectfully request that you reconsider the use of the words operator inattentiveness in the final report to avoid any misunderstanding or misinterpretation that could be attributed to these words.

The report cites, in several functional areas, that root cause analysis is in need of improvement. We recognize and agree with this. In response, we have developed a revision to our corrective action system, including a unique approach to root cause determinations. As we discussed on March 26, 1992, we would like to include this item on the agenda for our next quarterly meeting, tentatively scheduled for June 2, 1992, so that we may brief you regarding our approach. As discussed between D. H. Williams, Senior Executive Vice President, Engineering and Construction (AEPSC) and C. J. Paperiello, Deputy Regional Administrator, following the March 26, 1992 meeting, we believe these periodic meetings with Region management have been very beneficial and we therefore recommend continuing them on a frequency of about once per quarter.

Finally, while we do not have any specific comments regarding the functional areas of emergency preparedness and security, we want to assure you that we will continue to provide the necessary resources and management attention needed to maintain our excellent level of performance in these areas.

This document has been prepared following corporate procedures that incorporate a reasonable set of controls to ensure its accuracy and completeness prior to signature by the undersigned.

Sincerely,



E. E. Fitzpatrick
Vice President

rdh



Mr. A. B. Davis

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AEP:NRC:0973L

Attachment

cc: D. H. Williams, Jr.
A. A. Blind - Bridgman
J. R. Padgett
G. Charnoff
NFEM Section Chief
NRC Resident Inspector - Bridgman



ATTACHMENT TO AEP:NRG:0973L
RESPONSE TO SPECIFIC ITEMS
IN THE DONALD C. COOK NUCLEAR PLANT
SALP 10 BOARD REPORT



Functional Area: Plant Operations

Item 1: Implementation of Emergency Operating Procedures (SALP Report Section III.A.1. pg.5)

SALP Report Text

"There were some problems experienced in transient evolutions that may have shown some weaknesses in training. The results of the licensed operator examinations were usually acceptable, although they showed some weaknesses in knowledge of emergency operating procedures."

Response

During the annual requalification process we identified a need to improve emergency operating procedure (EOP) knowledge. The annual requalification plan for the next training cycle emphasizes the EOPs.

In addition, actions are being taken to strengthen the control room crew performance while responding to simulated emergency conditions. A review of the crew assignments for simulator training determined that the crew composition does not reflect the actual control room team, resulting in less than optimum team training. Hence, the training crew composition has been augmented with additional licensed personnel to more closely simulate the actual control room team and improve training effectiveness.

Simulator training standards for determining acceptable overall program performance are being reviewed. A process for trending individual operator performance during requalification training has already been established. Annual exam and continuing training results will be trended to identify opportunities for individual performance improvements. Periodic reports will be issued to individual operators and management that will summarize progress during the year. As a result of this trending, supplementary simulator-based training emphasizing EOP implementation will be provided as needed.

We believe that emphasizing the EOPs during our annual requalification training, combined with a more realistic training crew composition and the addition of trending training results, will strengthen this area.

Item 2: Fire protection requirements (SALP Report Section III.A.1, pg. 4)

SALP Report Text

"Some of the personnel errors described in the LERs were related to fire protection requirements not being adhered to - an issue identified in the last SALP period that showed little improvement into the current period."

Response

The events that are being referred to occurred early in the SALP period and consisted primarily of incorrect posting of fire watches. To address this problem we transferred the responsibility for determining compensatory fire protection actions from the operations department to the safety and assessment department. The safety and assessment department is now responsible for implementation of both our fire protection and 10 CFR 50, Appendix R continuing compliance programs. We consider this change to be effective since there has not been a recurrence of this problem following implementation.

Item 3: Operator performance during reactor startup (SALP Report Section III.A.1, pg. 4)

SALP Report Text

"Operator performance was somewhat weaker during reactor startup. On two occasions during startup testing in October 1990, steam generator water level inadvertently reached the hi-hi set point. In May 1991 a water hammer occurred in the feedwater system, partly due to a lack of complete operator awareness of the status of secondary plant equipment."

Response

The primary contributor to the events cited was the failure of the operating crew to realize the status of the plant systems or other evolutions occurring at the time of startup. This issue was addressed at the time of each event through critiques and dissemination of lessons-learned information. Lessons-learned are also incorporated into requalification training material. Through strengthening our clearance process, addressing these events in our requalification training, and continuing management involvement in operator performance, we expect to improve the performance of our operators. A strong start-up lessons learned program will be in place prior to the start-up of Unit 2 following the current refueling outage.

Functional Area: Radiological Controls

Item 1: Effluent monitors inoperable and compensatory grab samples (SALP Report Section III.B.1, pg. 6)

SALP Report Text

"Management was less effective in addressing operability problems with effluent monitors and, on a few occasions, compensatory grab samples were missed."

Response

It is our understanding that this statement refers to the failures of liquid monitor RRS-1000. At issue is the event in which the monitor failed during a batch release, which resulted in the failure of an isolation valve in the discharge line to automatically trip. Consequently, until the operator identified the situation and manually terminated the liquid release, the release continued unmonitored.

We recognize the importance of this issue and accordingly have initiated a task force to address concerns identified within the radiation monitoring system. The specific goals of the task force include implementation of design changes to the system to improve signal communication reliability and overall system performance. Full implementation of these design changes is expected by the end of 1993.

As a point of information, we would like to note that the compensatory grab samples from the steam jet air ejector radiation monitoring system were not "missed" due to personnel error or management oversight. Samples could not physically be obtained due to water in the lines in certain reactor modes. The design change referred to above addresses this issue as well.

Item 2: Access control (SALP Report Section III.B.1, pg. 6)

SALP Report Text

"The licensee was . . . slow to remedy access control weaknesses at one of two points of egress from the RCA."

Response

The egress control issue stems from a recurrent issue with personnel alarming the whole body frisker and subsequently taking measures to decontaminate themselves rather than contacting radiation protection (RP) personnel as required by procedure. Approximately two years ago we increased posting of the RP phone extension at the RCA egress points and provided an explanation of



the requirement to call RP personnel if a whole body frisker alarms. Despite our efforts, another incident of this type occurred in September 1991.

In response to this repeat incident, the decision was made to prohibit egress from the RCA through the turbine building exit during non-outage periods, leaving only one exit from the RCA. This exit is at the RP access control area, which is continuously staffed by RP personnel. This significantly improves control of personnel egress practices. Since implementing this change we have had no recurrence of personnel failing to comply with egress procedures. During outages, when egress through the turbine building exit is permitted, RP personnel man the exit. We believe that these actions will minimize the potential for future violations of egress procedures. Should we revert to multiple egress points during non-outage periods in the future, we will only do so if each point is manned.

Item 3: Reconsideration of Category 2 rating to Category 2
improving trend (SALP Report Section III.B.2, pg. 7)

SALP Report Text

"Performance is rated Category 2 in this area."

Response

We believe we performed at better than a 2 rating in this functional area. Over the past several SALP periods we have made improvements in key areas such as personnel contaminations, site dose, amount of contaminated area, and volume of radioactive waste generated.

We are especially proud of our efforts in reducing total site dose. In 1991, of the 2,141 people requiring exposure monitoring at Cook Nuclear Plant, 1,326 had no measurable exposure, 805 had exposures between 100 mR and 500 mR, and the remaining 10 individuals all had exposures of less than 1 rem. The total site dose for 1991 was 69.087 rem, which is the lowest level in the plant's operating lifetime.

In the SALP 10 report, the NRC recognizes as strengths many parts of our program. The results of our radiological measurements compared to those of the NRC were qualified as being "excellent"; of 93 comparisons there were 93 agreements. Total station dose and the number of personal contamination events (PCEs) were cited as low, about 410 person-rem and 190 PCEs, respectively, over the 16-month assessment period, which included a refueling outage. In addition, improvements in the radiation work permit system, completion of the high radiation door modification program, and

initiation of aggressive programs for hot particle control, contamination control, waste reduction, and reductions in leaking containment devices in the auxiliary building were noted as accomplishments.

Additionally, our aggressive action of purchasing a robot to use to reduce the source term in the CVCS holdup tank rooms and, thereby, be able to further decontaminate one of the few remaining contaminated areas in the plant is a positive indication of our attitude and our continuing strong desire to achieve excellence in this area.

Consequently, we believe that our SALP rating in this functional area should be a 2 with an improving trend. We request that you reconsider your rating of this functional area in the final SALP 10 report.

Functional Area: Maintenance/Surveillance

Item 1: Large number of non-outage corrective job orders (SALP Report Section III.C.1, pg. 8)

SALP Report Text

"Management appeared committed to long-term improvements, but the effectiveness of these programmatic improvements was not yet evident. A few programmatic issues identified in the last assessment period, such as the large number of non-outage corrective job orders, remained."

Response

Due to the method we employed to categorize our maintenance items, the number of backlogged job orders, as well as the ratio of corrective to preventive maintenance job orders, is misleading. Hence, the corrective to preventive maintenance ratio evaluated for the SALP 10 period may not be truly reflective of our actual performance. We have taken action that will make our categorization more consistent with the industry definitions for corrective and preventive maintenance job orders. In addition, we will continue to prioritize our outstanding maintenance work and will continue to stress early completion of safety-related work.

Item 2: Procedure availability and usability (SALP Report Section III.C.1, pg. 8)

SALP Report Text

". . . written procedures were not always provided for performing maintenance on safety-related equipment resulting in some rework."

Response

We are investing a major effort in improving procedure quality at the Cook Nuclear Plant. As procedure quality improves, we anticipate that procedure availability and utilization will increase, resulting in improved adherence. These efforts, in conjunction with an increased management focus on this issue, will result in measurable improvement in this area.

Item 3: Adequacy of root cause analysis (SALP Report Section III.C.1, pg. 8)

SALP Report Text

"The quality of corrective maintenance varied, and was somewhat dependent on root cause analyses. The adequacy of root cause analyses varied with the extent of management involvement."

Response

Root cause analysis has been the subject of considerable attention from AEP nuclear organization management, as evidenced by the revision of the corrective action system, which we are concurrently implementing. The corrective action system is being revised to implement a graded application of root cause analysis that will be based on the amount of risk and uncertainty associated with the conditions being investigated. When our revised system is fully implemented, condition report subjects and their root causes will be trended in a computerized database. In addition, we are instituting a formal training program for all personnel that may be potentially involved in root cause analysis activities. We anticipate that these initiatives, combined with strong management involvement, will significantly improve our performance in this area.

Item 4: Continued improvement of Cook Nuclear Plant programs and performance in the area of maintenance/surveillance (SALP Report Section III.C.1, pg. 7)

SALP Report Text

"Overall, implementation of the maintenance program had improved since the last assessment period."

Response

During the SALP report period we undertook numerous initiatives, reliability-centered maintenance for example, to improve our maintenance program. We are beginning to realize benefits from

these initiatives and appreciate your acknowledgment of our efforts. We realize the importance of an effective maintenance program and will remain committed to its improvement.

Functional Area: Engineering and Technical Support

Item 1: Content of modification packages (SALP Report Section III.F.1, pg. 12)

SALP Report Text

"... a lack of attention to detail was noted in some design reviews, in documentation of postmodification testing, and in control of the quality and content of modification packages."

Response

The issue of adequacy of documentation in modification packages is the subject of continued management attention. As deficiencies in this area are identified, our governing procedures are critically examined and revised as necessary. Through critical self-assessment we expect to achieve a system that consistently produces modification packages that are well documented and of high quality.

Item 2: Pass rate for initial operator training (SALP Report Section III.F.1, pg. 13)

SALP Report Text

"... the operator initial licensing examinations had a low pass rate, which had declined from the previous assessment period (i.e., from 75 percent to 67 percent). In addition, one senior reactor operator failed three NRC-administered requalification examinations. Two failures followed remediation by the licensee."

Response

Following the examinations conducted early in the SALP 10 period, increased focus was brought to this area to determine what adjustments in our training/requalification programs were needed. We believe our efforts have resulted in improvement as evidenced by the results of the most recently administered examinations (requalification and initial retakes), in which all individuals and crews passed.

Item 3: Root cause analysis (SALP Report Section III.F.1.
pg. 13)

SALP Report Text

"On the negative side, there were some examples of weak root cause analysis."

Response

As discussed previously in this attachment in Item 3 under the functional area of maintenance/surveillance, root cause analysis is an area receiving considerable attention from AEP nuclear organization management. We recognize that this issue crosses several functional areas (it is also mentioned in the functional area of safety assessment/quality verification in the SALP 10 report) and may impact the safe and reliable operation of our units. As such, improvement in this area is considered a management priority.

Functional Area: Safety Assessment/Quality Verification

Item 1: Implementation of 10 CFR 50.59 (SALP Report Section
III.G.1, pg. 14)

SALP Report Text

". . . The other violation concerned activities related to implementation of 10 CFR 50.59 and appeared to be programmatic in nature. Multiple examples were identified of failure to properly evaluate modifications and procedure changes to determine whether an unreviewed safety question existed."

Response

The response to the above-stated challenge requires a brief description of the AEPSC design change safety review process. The design change safety review process, which is performed pursuant to 10 CFR 50.59, consists of two discreet steps, the first being a "screening test" to see if 10 CFR 50.59(a)(2) applies to the change request, and the second being a determination as to whether the proposed change constitutes an unreviewed safety question. Depending upon the outcome of the first step, the unreviewed safety question determination may not be necessary. In the case of Requests-for-Change, however, AEPSC management has recently opted to perform the unreviewed safety question determination regardless of the response to the 50.59(a)(1) screening questions. Nevertheless, the screening review will continue to be performed for Requests-for-Change to review the impact on the UFSAR, which must be noted in the safety review memorandum.



In addition, as we stated in our February 27, 1992 submittal, AEP:NRC:1148F, we are taking two specific actions with respect to this violation. The first involves training and the second involves auditing.

With respect to training, the 10CFR50.59 training at AEPSC has previously consisted of annual classroom training, which could be substituted for by completing a reading assignment. As a result of the Notice of Violation, 10CFR50.59 training at AEPSC will now consist of mandatory annual classroom training that will include a written examination.

Second, prior to the NRC inspection, an audit of the safety review process had been scheduled for the second quarter of 1992. The audit, to be conducted by the Quality Assurance Division, will include a general review of the safety review process and an increased focus on the 10CFR50.59(a)(1) screening performed in safety reviews. Depending on the results of this audit, additional audits will be scheduled as necessary.

The above actions, mandatory classroom training and QA audits of the safety review process, will minimize the potential for similar, future violations.

In addition, sampling of safety reviews for design changes that were approved prior to the incorporation of NSAC-125 and that have not yet been installed will be conducted. The purpose of this review is to ensure that the conclusions in those safety reviews are consistent with the conclusions that would be reached using our present process.

Item 2: Root cause analysis (SALP Report Section
 III.G.1. pg. 14)

SALP Report Text

"Root cause analyses focused on the most likely causes and all possible contributing factors were not always considered."

Response

As previously discussed in Item 3 under maintenance/surveillance and Item 3 under engineering and technical support, we recognize the need for improvement in this area. Since root cause analysis may potentially impact every aspect of safe plant operations, improvement in this area is a management priority. As such, we have developed a revision to our corrective action system, which includes a unique approach to root cause determinations. In addition, we are instituting a formal training program on root cause analysis. We anticipate that these measures will significantly improve our performance in this area.