INDIANA & MICHIGAN ELECTRIC COMPANY

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

July 31, 1981
AEP:NRC:0595

Donald C. Cook Nuclear Plant.Unit Nos. 1 and 2
Docket Nos. 50-315 and 50-316
License Nos. DPR-58 and DPR-74
IE REPORTS NO. 50-315/81-05 AND NO. 50-316/81-05

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

Dear Mr. Keppler:

The attachment to this letter provides our response to the Notice of Violation contained in IE Inspection Reports No. 50-315/81-05 and No. 50-316/81-05.

Very truly yours,

R. S. Hunter
Vice President

RSH/os

Attachment

cc: John E. Dolan - Columbus
R. C. Callen
G. Charnoff
R. W. Jurgensen
D. V. Shaller - Bridgman
Joe Williams, Jr.
Region III Resident Inspector - Bridgman

AUG 4 1981

STATE OF NEW YORK)
COUNTY OF NEW YORK)

R. S. Hunter, being duly sworn, deposes and says that he is the Vice President of Licensee Indiana & Michigan Electric Company, that he has read the foregoing response to the Notice of Violation contained in IE Inspection Report Nos. 50-315/81-05 and 50-316/81-05 and knows the contents thereof; and that said contents are true to the best of his knowledge and belief.

R. S. Hunter

Subscribed and sworn to before me this 31st day of July, 19 81.

Kathleen Barry
Notary Public

KATHLEEN BARRY
NOTARY PUBLIC, State of New York
No. 41-4606792
Qualified in Queens County
Certificate filed in New York County
Commission Expires March 30, 1983

Response to Item 1 of Appendix A

The primary reason for the failure to report this event to the NRC Operational Center via the direct line within the required one hour was due to the nature of the event itself. The event involved a decrease in the #3 Gas Decay Tank (GDT) pressure from 97 psig on February 3, 1981 when the tank was isolated, to 53 psig on March 13, 1981 on which date a request was submitted for a release of the GDT to repair the two valves suspected of causing the leak. When the leak was discovered,it was not known if the gas had leaked into the radioactive vent gas system and was therefore contained in the CVCS holdup system or if it had escaped to the atmosphere. An investigation was immediately initiated to determine the leakage path but its results were inconclusive. That investigation checked the waste gas inventory records, which did not reveal any gas leak, and also reviewed the effluent gas monitor recorder , which did not indicate that a leak had occurred. It was therefore concluded that the gas had leaked from one of the GDT isolation valves into the room and then through the auxiliary building ventilation system to the atmosphere.

During the repair of the valves suspected of causing this leak, indentations in the valve diaphragm were present, which may have provided the leakage path for the gas. Conservative release calculations show the release of noble gases to be 1.23×10^{-3}% of Technical Specification limits, and I-131 to be 1.85×10^{-5}% of Technical Specification limits.

Because of the circumstances surrounding the discovery of the event and the time required to arrive at the conclusion that there had been a release, the need for prompt reporting included in 10.CFR.50.72 never occurred to Plant Management Staff. This event, however, differs from the previous event referenced in IE Report 81-05, Item 11.f in that the Shift Operating Engineers were not involved in deciding the reporting requirements.

This event has been discussed thoroughly in meetings between Corporate and Plant Management and in the Plant Manager's Staff Meetings. In the future, if there is any possibility that an event might fall within the requirements of 10 CFR 50.72, "Notification of Significant Events", the notification to the NRC Operations Center will be made. A memo re-emphasizing this management directive was sent to the Shift Operating Engineers on July 22, 1981.

Response to Item 2 of Appendix A

On March 31, 1981, the Unit 2 Spray Additive Tank was found to have a volume below the minimum required by Technical Specification 3.6.2.2. This situation was discovered during a routine scheduled surveillance of the Unit 2 Spray Additive Tank level magnetrol. This event was properly reported under Licensee Event Report No. RO 81-005/01T-1. On April 4, 1981 the Spray Additive Tank volume was returned to its proper level.

The Technical Specification verification of level had been performed by verifying the absence of the low level alarm which had been set to alarm at approximately 4,190 gallons in the tank. During this verification, the low level alarm was found to have been wired backwards, precluding the low level alarm from annunciating. The incorrect wiring was in agreement with the then current wiring drawing.

A thorough review of all appropriate logs, data sheets, and plant records indicate that the loss of sodium hydroxide occurred on or about December 21, 1979. It has been verified that the sodium hydroxide from the tank entered the Waste Disposal System. Records indicate that at the time of the previous surveillance performed on September 29, 1979, the tank level was within the Technical Specification limit and the low level alarm was apparently wired properly. Following that surveillance, the high level of construction activity taking place in the Spray Additive Tank Room is suspected to have resulted in the de-termination of the low level alarm wiring to allow design changes to be made. Reconnection of the level alarm was made according to the existing wiring drawings (which were in error) and resulted in preventing the loss of the sodium hydroxide to be detected by the low level alarm.

An evaluation of this event concluded that of the 1,654 gallons of sodium hydroxide remaining in the tank, 1,155 gallons were available for injection due to the lo-lo level cut-out leaving 499 gallons remaining in the tank. Further, calculations performed using the 1,155 gallon volume indicate that this amount of sodium hydroxide was sufficient to assure that if a design basis accident were to occur, there would have been no adverse effect on the health and safety of the public. This analysis was previously submitted to Region III headquarters in a letter from Mr. D. V. Shaller to Mr. J. Keppler dated April 8, 1981.

In order to avoid a recurrence of this event, the responsibility for the level verification of the Spray Additive Tank has been assigned to the Technical Department Chemical Section. In addition to the alarm, applicable plant procedures were changed to incorporate a level verification

using a tygon hose at the Spray Additive Tank. Operations Department procedures have also been changed to include a Sign-off by the Chemical Section indicating that this surveillance is current prior to the plant changing modes during startup. In addition, a design change is presently in progress to correct the errors on the applicable electrical drawings. All tank drain valves have been locked and chained shut as per Operations Procedures STP.035, 'Valve Position Logging'. All applicable annunciator response procedures and sampling procedures have been reviewed with the responsible plant personnel. Since the occurrence, routine surveillance checks of both Units' Spray Additive Tank levels have been performed satisfactorily. Full compliance with Technical Specification 3/4 6.2.2 was achieved on April 4, 1981.