INDIANA & MICHIGAN ELECTRIC COMPANY

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

March 22, 1983
AEP:NRC:0781

Donald C. Cook Nuclear Plant Unit Nos. 1 and 2
Docket Nos. 50-315 and 50-316
License Nos. DPR-58 and DPR-74
INSPECTION REPORTS 50-315/82-22 (DPRP)
and NO. 50-316/82-22 (DPRP)

Mr. James G. Keppler
Regional Administrator
Office of Inspection and Enforcement
Region III
799 Roosevelt Road
Glen Ellyn, ILL 60137

Dear Mr. Keppler:

This letter and its Attachments respond to Mr. J. F. Streeter's letter of February 18, 1983 which forwarded to us the subject Inspection Reports. The Notice of Violation attached to Mr. Streeter's letter identified three items of violation. The Attachment to this letter provides the required response to those three items.

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

Very truly yours,

R. S. Hunter
Vice President

RSH:sag

cc: John E. Dolan - Columbus
M. P. Alexich
R. W. Jurgensen
W. G. Smith, Jr. - Bridgman
R. C. Callen
G. Charnoff
NRC Resident Inspector at Cook Plant - Bridgman

ATTACHMENT TO AEP:NRC:0781
RESPONSES TO THE NOTICE OF VIOLATION
ATTACHED TO IE INSPECTION REPORTS NO.50-315/
82-22 (DPRP) AND NO. 50-316/82-22 (DPRP)

ITEM NO. #1

10 CFR 20.408(b) states: "When an individual terminates employment with a licensee, or an individual assigned to work in such a licensee's facility but not employed by the licensee, completes the work assignment in the licensee's facility, the licensee shall furnish to the Commission a report of the individual's exposures to radiation and radioactive material, incurred during the period of employment or work assignment in the licensee's facility. Such report shall be furnished within thirty (30) days after the exposure of the individual has been determined by the licensee or ninety (90) days after the date of termination of employment or work assignment, whichever is earlier." 10 CFR 20.409(b) states: "When a licensee is required pursuant to 20.405 or 20.408 to report to the Commission any exposure of an individual to radiation or radioactive material, the licensee shall also notify the individual. Such notice shall be transmitted at a time not later than the transmittal to the Commission.

Contrary to the above, as of December 13, 1982, the licensee had not provided the required reports to the Commission, or to the individuals involved, for eight (8) personnel who terminated their work assignment before September 12, 1982.

This is a Severity Level V violation (Supplement IV).

RESPONSE TO ITEM NO. #1

Investigation determined that this situation was caused by insufficient controls to insure prompt notification of the final departure of persons from the Plant, and by lack of an arrangement with the TLD contractor for on-demand processing of TLDs.

We have instituted controls to ensure prompt notification of personnel departures, and have a contractual arrangement with the TLD processor to process the badges identified as early readouts and send back the results without waiting for the rest of the badges for that month.

The above changes will be closely monitored for any needed action in order to maintain compliance with the regulation.

Full compliance was achieved on March 3, 1983.

ITEM NO. #2

10 CFR 50, Appendix B, Criterion II, states in part, "The quality assurance program shall provide control over activities affecting the quality of identified structures, systems, and components, to an extent consistent with their importance to safety." 10 CFR 50. Appendix B, Criterion XI, states in part, "A test program shall be established to assure that all testing required to demonstrate that structures, systems and components will perform satisfactorily in service is identified and performed..."

FSAR, Section 1.7, "Operations Quality Assurance Program," commits the licensee to comply with ANS N18.7 (1976). Section 5-2.19.3. of the standard states: "Tests shall be performed following plant modifications or significant changes in operating procedures to confirm that modifications or changes reasonably produce expected results and that the change does not reduce safety of operations."

Contrary to the above, tests were not performed after modifications to a Motor Control Center (MCC) which adequately confirmed that the modification reasonably produced expected results and did not reduce the safety of operations, in that a wiring error in the MCC went undetected causing the affected Unit 1 Auxiliary Feed Pump Exhaust Fan and supply Valve WMO-753 to be inoperable.

This is a Severity Level IV violation (Supplement I).

RESPONSE TO ITEM NO. #2

Licensee Event Report Number 050-315/82-101 has been revised and submitted to the NRC. Attached, please find a copy of the updated LER as a response to this violation.

ITEM NO. #3

Units 1 and 2 Technical Specification 6.5.1.7.b states: "The PNSRC shall render determinations in writing with regard to whether or not each item considered under 6.5.1.6(a) through (e) above constitutes an unreviewed safety question." Item (e) of 6.5.1.6 states in part, "Investigation of all violations of the Technical Specifications..." Contrary to the above, over a period of about the last two years no unreviewed safety question determinations were made in writing by the Plant Nuclear Safety Review Committee on any Technical Specification violations.

This is a Severity Level V violation (Supplement I).

RESPONSE TO ITEM NO. #3

The PNSRC review practices have been amended to include a determination in writing with regard to whether Technical Specification violations constitute an unreviewed safety question as defined in 10 CFR 50.59. The determination will be documented in the PNSRC Meeting Minutes. Full compliance has been achieved.

LICENSEE EVENT REPORT

UPDATED LER-PREVIOUS REPORT DATE 12-03-82

CONTROL BLOCK: | | | | | | | (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | M I D C C 1 | (2) | 0 0 - 0 0 0 0 0 - 0 0 | (3) | 4 1 1 1 1 | (4) | | | (5)

LICENSEE CODE — LICENSE NUMBER — LICENSE TYPE

CON'T 0 1 | REPORT SOURCE | L | (6) | 0 5 0 0 0 3 1 5 | (7) | 1 1 1 2 3 8 2 | (8) | | (9)

DOCKET NUMBER — EVENT DATE — REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | DURING ROUTINE SURVEILLANCE TESTING OF THE ESSENTIAL SERVICE WATER SYSTEM, IT WAS

0 3 | DISCOVERED THAT THE MOTOR OPERATED VALVE (WMO-753) TO THE WEST TURBINE DRIVEN

0 4 | AUXILIARY FEED PUMP WOULD NOT OPEN. THIS EVENT WAS NON-CONSERVATIVE WITH RESPECT

0 5 | TO TECHNICAL SPECIFICATION 3.7.1.2. THE PUBLIC HEALTH AND SAFETY WERE NOT AFFECTED.

0 6 |

0 7 |

0 8 |

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP SUBCODE	VALVE SUBCODE
0 9	H F (11)	D (12)	Z (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 2	—	1 0 1	/	0 1	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	G (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | INVESTIGATION REVEALED THAT WMO-753 AND THE EXHAUST FAN 1-HV-AFP-T2 FOR THE TURBINE

1 1 | DRIVEN AUXILIARY FEED PUMP ROOM WERE OPERATING IN A REVERSED MANNER. THIS RESULTED

1 2 | IN THE VALVE MOTOR BEING DAMAGED. THE MOTOR FOR WMO-753 WAS REPLACED, AND THE

1 3 | PHASING CORRECTED. THE EQUIPMENT WAS TESTED, VERIFIED TO BE OPERATING CORRECTLY AND

1 4 | RETURNED TO SERVICE. (SEE ATTACHED SUPPLEMENT)

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	1 0 0 (29)	NA	B (31)	SURVEILLANCE TEST

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

	ISSUED	DESCRIPTION (45)
2 0	N (44)	NA

dupe 8303280136

NRC USE ONLY

NAME OF PREPARER R. A. PALMER

PHONE 616-465-5901

ATTACHMENT TO LER-82-101/01X-1

SUPPLEMENT TO CAUSE DESCRIPTION

Investigation revealed that the motor operated valve WMO-753 and the exhaust fan 1-HV-AFP-T2 for the turbine driven auxiliary feed pump room were operating in a reversed manner. This resulted in the valve motor being damaged. The cause of the motor and the fan operating backwards was found to be installation error which occurred during the replacement of a feeder cable causing the phasing to be incorrect. This error remained undetected due to the method of subsequent related performance.

The design change coordinator and the electrical field engineer, involved with the cable change were aware of the importance of proper phasing. The electrical field engineer did verify what he thought was the correct rotation on the exhaust fan 1-HV-AFP-T2.

The motor for WMO-753 was replaced, and the phasing corrected. The equipment was tested, verified to be operating correctly and returned to service. To prevent a recurrence, portions of the existing maintenance procedures 12 MHP 5021.082.004 "Cable Replacement" and 12 MHP 5021.062.005 "New Installation of Cables," have been added to the electrical contractor QA/QC manual. This will ensure that the installation procedures of new or existing cable will be uniform between plant personnel and the site contractors.