# INDIANA & MICHIGAN ELECTRIC COMPANY

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

April 4, 1983
AEP:NRC:0791

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 INSPECTION REPORTS NO. 50-315/83-03 (DRMS)
and NO. 50-316/83-03 (DRMS)

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 Attachment respond to Mr. C. J. Paperiello's letter of March 3, 1983 which forwarded to us the subject Inspection Reports. The Notice of Violation attached to Mr. Paperiello's letter identified two items of violation. The Attachment to this letter provides the required response to those two 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:0791

The Notice of Violation attached to IE Inspection Reports No. 50-315/83-03 (DRMS) and No. 50-316/83-03 (DRMS) identifies two violations uncovered during the NRC inspection conducted on February 14-15, 1983.

Quoting from the inspection report they are:

Item 1. "Technical Specification 5.3.1 states, in part, that detailed written procedures shall be prepared and adhered to. Contrary to the above, on February 11, 1983, a chemistry technician failed to operate sampling system valves in accordance with Procedure 12 THP 6020 LAB.038 during collection of a volume control tank gaseous sample. An unplanned airborne release resulted.

This is a Severity Level IV violation (Supplement IV)"

Item 2. "Technical Specification 5.3.3 states, in part, that changes to plant procedures will be reviewed and approved in writing prior to implementation.

Contrary to the above, on February 11, 1983, management allowed the Unit 1 volume control tank to be sampled using changes to Procedure THP 6020 LAB.038 which had not been reviewed and approved in writing.

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

RESPONSE TO ITEMS 1 AND 2

The events giving rise to the two violations detailed above were reported to the NRC in Revision 1 to Licensee Event Report No. 010.* The LER describes the corrective action taken to avoid further noncompliance. Full compliance has been achieved as of the date of this letter. A copy of the LER is attached.

*Unit 1 LER 83-010

LICENSEE EVENT RE[illegible]T UPDATED LER

PREVIOUS REPORT DATE: 02/18/83

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

| | | |
|---|---|---|
| 0 1 | LICENSEE CODE (2) | M I D C C 1 |
| | LICENSE NUMBER (3) | 0 0 - 0 0 0 0 0 - 0 0 |
| | LICENSE TYPE (4) | 4 1 1 1 1 |
| | CAT (5) | |

CON'T

| | | |
|---|---|---|
| 0 1 | REPORT SOURCE (6) | L |
| | DOCKET NUMBER (7) | 0 5 0 0 0 3 1 5 |
| | EVENT DATE (8) | 0 2 1 1 8 3 |
| | REPORT DATE (9) | |

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 ON FEBRUARY 11, 1983, AT 0900 HRS. A PLANNED GAS SAMPLING EVOLUTION WHICH PRODUCED AN

0 3 EXPECTED GAS RELEASE OF UNEXPECTED MAGNITUDE WAS DETECTED BY AN ELEVATED UNIT 1 AND

0 4 UNIT 2 VENT STACK GASEOUS MONITOR (1R-26 AND 2R-26 RESPECTIVELY) READING. THIS EVENT

0 5 CONTINUED UNTIL APPROXIMATELY 1040 HRS. ON FEBRUARY 11, 1983. A SECOND EVENT (UNEXPECT-

0 6 ED, THEREFORE, UNPLANNED) OCCURRED AT 1340 HRS. ON FEBRUARY 11, 1983, WHICH WAS DETECTED

0 7 BY AN ELEVATED UNIT 2 VENT STACK GASEOUS MONITOR (2R-26) READING. THIS EVENT CONTINUED

0 8 UNTIL APPROXIMATELY 1530 HRS. ON FEBRUARY 11, 1983. (SEE ATTACHED SUPPLEMENT)

| 0 9 | SYSTEM CODE (11) | CAUSE CODE (12) | CAUSE SUBCODE (13) | COMPONENT CODE (14) | COMP. SUBCODE (15) | VALVE SUBCODE (16) |
|---|---|---|---|---|---|---|
| | X X | A | X | Z Z Z Z Z Z | Z | Z |

(17) LER/RO REPORT NUMBER

| EVENT YEAR | | SEQUENTIAL REPORT NO. | | OCCURRENCE CODE | REPORT TYPE | | REVISION NO. |
|---|---|---|---|---|---|---|---|
| 8 3 | — | 0 1 0 | / | 0 4 | 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) | Z (19) | Z (20) | Z (21) | 0 0 0 0 0 | Y (23) | N (24) | Z (25) | Z 9 9 9 |

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 DURING SAMPLING OF THE UNIT 1 VOLUME CONTROL TANK (VCT) GAS SPACE, THE SAMPLE LINE

1 1 DRAIN VALVE (NS-186) LOCATED IN THE NUCLEAR SAMPLING ROOM WAS INADVERTENTLY LEFT IN

1 2 THE OPEN POSITION. THIS ALLOWED GAS TO GO FROM NS-186 THROUGH THE CLEAN SUMP TANK TO

1 3 THE WASTE HOLDUP TANKS CONTINUING THROUGH THE AUXILIARY BUILDING VENTILATION SYSTEM TO

1 4 THE UNIT VENT STACKS. (SEE ATTACHED SUPPLEMENT)

| 1 5 | FACILITY STATUS (28) | % POWER (29) | OTHER STATUS (30) | METHOD OF DISCOVERY (31) | DISCOVERY DESCRIPTION (32) |
|---|---|---|---|---|---|
| | E | 1 0 0 | NA | A | RADIATION MONITORING ALARM |

| 1 6 | ACTIVITY RELEASED (33) | CONTENT OF RELEASE (34) | AMOUNT OF ACTIVITY (35) | LOCATION OF RELEASE (36) |
|---|---|---|---|---|
| | G | N | 37.7 Ci Xe-133 | AUXILIARY BUILDING VENT TO ATMOSPHERE |

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

| 1 9 | TYPE (42) | DESCRIPTION |
|---|---|---|
| | Z | NA |

PUBLICITY

Dupe of ~~8304110478~~

| 2 0 | ISSUED (44) | DESCRIPTION (45) | NRC USE ONLY |
|---|---|---|---|
| | Y | PRESS RELEASE TO LOCAL NEWSPAPER 2/12/83 | |

ATTACHMENT TO LER# ______________

SUPPLEMENT TO EVENT DESCRIPTION

ON FEBRUARY 11, 1983, AT 0900 HOURS A PLANNED GAS SAMPLING EVOLUTION WHICH PRODUCED AN EXPECTED GAS RELEASE OF UNEXPECTED MAGNITUDE WAS DETECTED BY AN ELEVATED UNIT 1 AND UNIT 2 VENT STACK GASEOUS MONITOR (1R-26 AND 2R-26 RESPECTIVELY) READING. THIS EVENT CONTINUED UNTIL APPROXIMATELY 1040 HOURS ON FEBRUARY 11, 1983. A SECOND EVENT (UN-EXPECTED, THEREFORE, UNPLANNED) OCCURRED AT 1340 HOURS ON FEBRUARY 11, 1983, WHICH WAS DETECTED BY AN ELEVATED UNIT 2 VENT STACK GASEOUS MONITOR (2R-26) READING. THIS EVENT CONTINUED UNTIL APPROXIMATELY 1530 HOURS ON FEBRUARY 11, 1983. DURING THESE TIME PERIODS, A TOTAL OF 37.7 Ci WAS RELEASED AT A RATE OF 2.86 E-3 Ci/SEC, WHICH IS 4.81% OF TECHNICAL SPECIFICATION APPENDIX B, SECTION 2.1.2.a(1). CONSERVATIVELY ESTIMATING THAT BOTH UNIT'S DETECTORS INDICATED THE MAXIMUM RELEASE RATE SIMULTANEOUSLY, THE MAXIMUM TOTAL RELEASE RATE WAS 5.48 E-2 Ci/SEC WHICH IS 92.39% OF TECHNICAL SPECIFICATION APPENDIX B, SECTION 2.1.3.a(1). THIS OCCURRED WITHOUT THE SAMPLING AND ANALYTICAL REQUIREMENTS OF TECH-NICAL SPECIFICATION APPENDIX B. 2.4.4.E.

SUPPLEMENT TO CAUSE DESCRIPTION

DURING SAMPLING OF THE UNIT 1 VOLUME CONTROL TANK (VCT) GAS SPACE, THE SAMPLE LINE DRAIN VALVE NS-186 LOCATED IN THE NUCLEAR SAMPLING ROOM WAS INADVERTENTLY LEFT IN THE OPEN POSITION, WHEN AT THIS POINT IN THE PROCESS IT WAS PROCEDURALLY REQUIRED TO BE CLOSED. THIS ALLOWED GAS TO GO FROM NS-186 THROUGH THE CLEAN SUMP TANK TO THE WASTE HOLDUP TANKS CONTINUING THROUGH THE AUXILIARY BUILDING VENTILATION SYSTEM TO

ATTACHMENT TO LER# ______________

SUPPLEMENT TO CAUSE DESCRIPTION, CONTINUED

THE UNIT VENT STACK. WHILE VALVING IN THE SAMPLE CONTAINER A PIECE OF PLASTIC TUBING USED TO CONNECT THE SAMPLE CONTAINER WITH THE SAMPLE PIPING SEPARATED AT THE CONNECTION CAUSING ADDITIONAL RADIO-GAS TO BE DISCHARGED TO THE UNIT 1 VENT STACK. THE SAMPLE POINT ROOT VALVE (1-CS-374) WAS CLOSED, TO ISOLATE THE RELEASE. AT APPROXIMATELY 1340 HOURS 1-CS-374 WAS OPENED, THE NORMAL OPERATING POSITION, WHICH CAUSED THE SECOND EVENT TO OCCUR, SINCE NS-186 WAS INADVERTENTLY LEFT IN THE OPEN POSITION. IMMEDIATELY FOLLOWING DETECTION OF THE SECOND EVENT 1-CS-374 WAS RECLOSED. AT APPROXIMATELY 1855 HOUR ON FEBRUARY 11, 1983, NS-186 WAS DISCOVERED OPEN AND PLACED IN THE CLOSED POSTION. VALVE 1-CS-374 WAS THEN REOPENED WITH NO GASEOUS RELEASES BEING DETECTED.

TO PREVENT RECURRENCE OF THIS EVENT, THE FOLLOWING MEASURES HAVE BEEN TAKEN:

1) THE PERSONNEL INVOLVED HAVE BEEN INSTRUCTED IN THE PROPER METHOD OF SAMPLING THE VCT GAS SPACE.

2) ADMINISTRATIVE CONTROLS HAVE BEEN IMPLEMENTED REQUIRING THAT THE PROCEDURE FOR SAMPLING THE VCT GAS SPACE BE IN HAND DURING THE SAMPLING PROCESS.

3) THE CHEMICAL SECTION SAMPLE PROCEDURES WERE REVIEWED TO INSURE THAT EACH PROCEDURE REFLECTED THE CURRENT AND CORRECT METHOD OF SAMPLING.

4) A PRECAUTIONARY NOTE WAS ADDED TO THE SAMPLING PROCEDURE STATING THAT VCT SAMPLES WILL NOT BE TAKEN FOR TESTING OR TRAINING PURPOSES AND THAT THE VCT WILL ONLY BE SAMPLED BY DIRECTION OF THE PLANT CHEMICAL SUPERVISOR.

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SUPPLEMENT TO CAUSE DESCRIPTION, CONTINUED

5) IMPROVING THE GENERAL CONDITION OF THE SAMPLING SYSTEM BY: VERIFYING THAT ALL SAMPLE VALVES IN THE NUCLEAR SAMPLE ROOM HAVE IDENTIFICATION TAGS; AND REPLACING MISSING VALVE HANDLES ON SAMPLE VALVES. VALVE HANDLES ARE CURRENTLY BEING FABRICATED FOR THIS PURPOSE.

ATTACHMENT TO LER

IE INSPECTION REPORT 50-315/83-03, 50-316/83-03, COVERING THE SUBJECT OF THIS LER, LISTED SEVERAL UNRESOLVED ITEMS. THESE ARE DESCRIBED BELOW:

UNRESOLVED ITEM - 315/83-03-01; 316/83-03-01

NO PROCEDURE CHANGE HAD BEEN APPROVED TO REFLECT THE INOPERABLE FLOW MEASURING DEVICE OR USE OF THE MARINELLI SAMPLE VESSEL.

STATUS - SEE PREVENTIVE MEASURE NO.2. THE DEFECTIVE FLOW INSTRUMENT HAS BEEN REPLACED. PROCEDURAL CHANGES HAVE BEEN MADE TO ALLOW THE USE OF THE MARINELLI SAMPLE VESSEL.

UNRESOLVED ITEM - 315/83-03-02; 316/83-03-02

FAILURE TO OPERATE THE SAMPLING SYSTEM VALVES IN ACCORDANCE WITH PROCEDURE 12 THP 6020 LAB.038.

STATUS - SEE PREVENTIVE MEASURE NO.2.

UNRESOLVED ITEM - 315/83-03-03; 316/83-03-03

SEVERAL PROBLEMS WERE NOTED CONCERNING THE METHOD OF CALIBRATION OF 1R-26 AND 2R-26.

STATUS - NO ADDITIONAL ATTEMPTS WILL BE MADE TO CALIBRATE 1R-26 AND 2R-26, OTHER THAN OUR CURRENT METHOD OF USING CAP SOURCES. THESE RADIATION MONITORS ARE CURRENTLY SCHEDULED TO BE REPLACED BY MAY 31, 1983. MR. D.C. PALMER (PLANT RADIATION PROTECTION SUPERVISOR) CONTACTED MR. P.C. LOVENDALE BY PHONE ON 3-18-83. MR. LOVENDALE DID NOT EXPECT THE PLANT TO TAKE FURTHER ACTION AT THIS TIME, ESPECIALLY WITH THE RADIOGAS MONITORS BEING REPLACED.

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UNRESOLVED ITEM - 315/83-03-04; 316/83-03-04

LOSS OF THE UNIT 2 P-250 PRINTOUT COVERING THE PERIOD OF THE RELEASE.

STATUS - WE ARE EXPLORING METHODS OF PREVENTING A RECURRENCE.

UNRESOLVED ITEM - 315/83-03-05; 316/83-03-05

THE FAILURE TO CLASSIFY THE RELEASE AS AN UNUSUAL EVENT AS REQUIRED BY PMP 2080 EPP.001.

STATUS - THIS MATTER STILL REMAINS UNDER REVIEW IN LIGHT OF THE NEW RADIOLOGICAL TECHNICAL SPECIFICATION AMMENDMENTS NO.69 TO UNIT ONE AND NO.51 TO UNIT TWO; AND THE NEW RADIATION MONITORS TO BE IN SERVICE BY MAY 31, 1983. THE OPERATING PERSONNEL HAVE BEEN MADE AWARE THAT ALL RELEASE MONITORS NEED TO BE CONSIDERED WHEN CLASSIFYING A RELEASE IN ACCORDANCE WITH THE CURRENT EMERGENCY PLAN GUIDANCE.

UNRESOLVED ITEM - 315/83-03-06; 316/83-03-06

THE INSPECTORS NOTED SEVERAL PROBLEMS WITH THE GENERAL CONDITION OF THE NUCLEAR SAMPLING SYSTEM.

STATUS - ADDRESSED IN THE BODY OF THE LER

(REFER TO PREVENTIVE MEASURE ITEMS)

UNRESOLVED ITEM - 315/83-03-07; 316/83-03-07

DURING THE RELEASE, AT LEAST TWO CONTINUOUS AIR MONITORS (CAMS) ALARMED. THE GAS ASSOCIATED WITH THIS RELEASE SHOULD HAVE REMAINED CONTAINED IN THE SAMPLING SYSTEM, WASTE DRAIN SYSTEM, AND AUXILIARY BUILDING VENTILATION SYSTEM. A LOSS OF A FLOOR DRAIN LOOP SEAL MAY HAVE BEEN THE SOURCE OF GAS IN THE AUXILIARY BUILDING THAT CAUSED THE CAM ALARMS.

STATUS - THIS MATTER REMAINS UNDER REVIEW