

INDIANA & MICHIGAN ELECTRIC COMPANY

P.O. BOX 16631
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February 10, 1984

AEP:NRC:0866

Donald C. Cook Nuclear Plant Unit Nos. 1 and 2
Docket Nos. 50-315 and 50-316
License Nos. DPR-58 and DPR-74
NRC Inspection Report No. 50-315/83-19 (DPRP);
50-316/83-20 (DPRP)

Mr. James G. Keppler
U.S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Dear Mr. Keppler:

This letter is in response to Mr. W. D. Shafer's letter dated December 28, 1983, which forwarded the subject Inspection Report of the routine safety inspection conducted by your staff at the Donald C. Cook Nuclear Plant during the period of October 21 through December 10, 1983. The Notice of Violation attached to Mr. Shafer's letter identified five items of noncompliance. The Notice of Violation stated that no reply was required for Item 4. Therefore, we are providing responses to Item 1, 2, 3, and 5 only. On January 27, 1984, Mr. D. Boyd of your staff granted us an extension to February 10, 1984 to provide our responses. Our responses to these items are presented below:

Item 1 (Unit 1)

Unit 1 Technical Specification 6.8.1 requires implementation of written procedures. Procedure THP 6030 IMP.033 states: "7.3 Following restoration of the instrument to normal service verify the associated valves are returned to their correct positions."

Contrary to the above, on May 16, 1983, the upper isolation valve (DF-123A) for the Unit 1 AB Diesel Generator fuel oil transfer pump magnatrol column was isolated for calibration and not returned to its required open position.

Response to Item 1

1. Corrective Actions Taken and Results Achieved

The valve was restored to the proper position immediately upon discovery of the error. This action returned the magnatrol column to an operable condition.

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The Control and Instrument (C&I) Section Head re-emphasized to the C&I Section the importance of verifying and documenting that equipment/components, addressed in Instrument Maintenance Procedures (IMPs), have been properly returned to service.

2. Corrective Action Taken to Avoid Further Noncompliance

On January 24, 1984, the Plant Manager issued a Standing Order (PMSO.077, effective date February 1, 1984) regarding Independent Verification. The objective of this order is to ensure that Technical Specification, safety related, important to safety*, and sphere of jeopardy** equipment is removed and returned to service properly; that proper actions have been performed on the intended component(s); and that neither redundant nor other like equipment in the opposite Unit is mistakenly operated without being detected.

If two-person teams are needed to perform the initial action, the independent verification action shall be performed by a person or persons acting independently of the initial team. Additionally, where practical, this independent verification is to be performed using independent means (e.g. redundant indication, operability test observations, etc.) from those used by the initial person(s).

As an enhancement to equipment removal and return activities, an ongoing program has been established to uniquely label (unique identification numbering) additional components, such as small valves which were previously not labeled. This ongoing program should provide for more effective control of equipment removal and return activities. Instructions have been issued to require that the unique identification numbers be recorded on procedure-data sheets when performing IMPs or surveillance tests.

3. Date When Full Compliance Was Achieved

Full compliance was achieved on February 1, 1984, commensurate with the effective date of the Independent Verification Program. The enhanced labeling activities are not necessary for achieving full compliance.

Item 2 (Unit 2)

Unit 2 Technical Specification 3.3.3.10.6 requires that with less than one operable Condenser Evacuation System radiation monitor". . . effluent releases via this pathway may continue for up to 30 days provided grab samples are taken at least once per eight hours and these samples are analyzed for gross activity within 24 hours."

*As defined in PMSO.077.

**Sphere of jeopardy equipment includes equipment which could directly or indirectly cause a turbine, generator, or reactor trip.

Contrary to the above, on October 3, 1983 the radiation monitor for the turbine Condenser Evacuation System (SRA-2905) was inoperable due to the sample pump's feed breaker being tripped open for eight hours and forty-one minutes without a grab sample being taken.

Response to Item 2

1. Corrective Action Taken and Results Achieved

The sample pump was restored to service after the eight hour and forty-one minute period, which brought radiation monitor SRA-2905 back into service.

2. Corrective Action Taken to Avoid Further Noncompliance

The apparent cause of the violation was the failure to recognize the audible alarm which sounded when the radiation monitor SRA-2905 became inoperable. The audible alarm has a duration of one second.

An administrative memorandum has been written instructing our Shift Supervisors to assure that all console alarms are reviewed every four hours to determine monitor status. Based upon this review, a determination of the operability of the system will be made and documented, along with any subsequent actions that may be required.

3. Date When Full Compliance Will be Achieved

Full compliance has been achieved.

Item 3 (Units 1 and 2)

Units 1 and 2 Technical Specification 3.11.2.5 specifies limits on explosive gas mixtures in the waste gas holdup system. Action Item b. specifies: "With the concentration of oxygen in the waste gas holdup system or tank $>4\%$ by volume and $>4\%$ hydrogen by volume without delay suspend all additions of waste gases to the system or tank and reduce the concentration of oxygen to $\leq 3\%$ or the concentration of hydrogen to $\leq 4\%$ within 96 hours in the system or tank."

Contrary to the above, on November 3, 1983 at 1400 hours, samples of the No. 3 Gas Decay Tank showed greater than 4% by volume of both oxygen and hydrogen, and the tank was not isolated until 0615 hours on November 4, 1983.

Response to Item 31. Corrective Action Taken and Results Achieved

The No. 3 Gas Decay Tank was sampled at approximately 8:05 a.m. on November 4, 1983 and found to be within radiological limits for release to the atmosphere. The No. 3 Tank was released to atmosphere at approximately 7:42 p.m. on November 4, 1983. The release reduced the oxygen/hydrogen concentration in GDT No. 3 below the Technical Specification limits.

2. Corrective Action Taken to Avoid Further Noncompliance

The excessive oxygen/hydrogen concentration in the No. 3 Gas Decay Tank (GDT) resulted when the oxygenated gas space in the Volume Control Tank (VCT) was vented to the Waste Gas Holdup System. The GDT was discovered to be out of specification both by alarm and by sample results. The Technical Specification Action Statement which required suspension of all additions of waste gases to the tank, was not complied with because of inadequate communications procedures. Specifically, no formal interface was established to assure that an identified out-of-specification GDT was communicated to the appropriate personnel for initiation of the respective Action Statement.

To resolve this inadequacy, a written communications agreement (Operation/Chemistry Interface Agreement) was established on December 2, 1983 to assure proper response to oxygen alarms and out of specification oxygen conditions in Gaseous Rad Waste Systems. This agreement defines interface responsibilities between the respective departments. These responsibilities include such actions as the chemistry laboratory notifying the Unit Supervisor and the Waste Disposal System Operator of the results of oxygen/hydrogen concentration sample analysis, and the Unit Supervisor taking the necessary steps to insure that Technical Specification Action Statements are fulfilled.

Two Operations Departmental procedures were also revised with Temporary Procedure (TP) changes. Procedure No. 2 - OHP 4021.003.004, revision 2 (TP-1) was revised to add steps to instruct an operator on how to vent the VCT to prevent excessive amounts of oxygen from being added to the waste gas system. Procedure 1-OHP 4024.128.001-.050, revision 1 (change sheet No. 4) was revised to reflect proper requirements for responding to Waste Gas System alarms.

3. Date When Full Compliance Was Achieved

Full compliance was achieved on January 4, 1984, when Change Sheet No. 4 to Procedure 1-OHP 4024.128.001-050, revision 1 became effective.

Item 5 (Unit 1 and 2)

10 CFR 50 Appendix B Criterion XVI "Corrective Action" states in part: "... measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition . . ."

AEPSC General Procedure 2.2; Nonconformance/Noncompliance and Corrective Action, Section 4.2.1 states: "Conditions adverse to quality (such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances) shall be promptly identified, as soon as practical, by measures which are established and documented."

Section 4.2.4 states: "Measures shall be established to include followup actions for corrective action that cannot be immediately completed to assure; timely resolution, and/or completion of the planned corrective action activity."

PMI-7030, Condition Reports, stated in part: "It is a requirement for the safe and efficient operation of the plant that as something is known or suspected to be noncompliant . . . or inconsistent with the design of physical components, systems and structures, that the condition be promptly identified, and resolved through the use of a Condition Report."

Contrary to the above, in a letter dated December 7, 1981, the licensee stated that the root cause for the discrepancy between the containment ventilation isolation system construction and the way it was functionally understood to work on both units (as reflected in the Technical Specifications and correspondence to the NRC) was due to the use of incorrect functional logic diagrams. Neither a Nonconformance Report or a Condition Report was issued. The logic diagrams have not been corrected and are still in use. None of the licensee's corrective action systems were effective in ensuring the timely resolution of the discrepant drawings.

Response to Item 51. Corrective Actions Taken and Results Achieved

On February 8, 1984 the AEPSC Electrical Generation Department (EGD) issued a letter to all recipients of functional logic diagrams. The letter instructed the recipients that the diagrams are not up-to-date and are therefore not to be used in any safety related activities, unless the accuracy is otherwise confirmed.

Effective February 1, 1984 all functional logic diagrams had been removed from the D. C. Cook Nuclear Plant Control Rooms. The diagrams will only be returned to the Control Rooms after they are updated.

The AEPSC Manager of Quality Assurance issued a Noncompliance Report on January 16, 1984. The Report documents and initiates the resolution to the failure to previously document and control the out-of-date functional logic diagrams.

2. Corrective Action Taken to Avoid Further Noncompliance

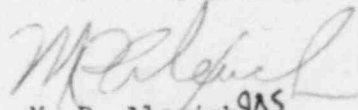
Subsequent to the time of the cited incident, the AEPSC Quality Assurance Department conducted training sessions on Noncompliance Reporting for the individuals involved with the Donald C. Cook Nuclear Plant.

3. Date When Full Compliance Will Be Achieved

Full compliance will be achieved when the February 8, 1984 letter from EGD is effected (approximately February 15, 1984).

This document was prepared following Corporate procedures which incorporate a reasonable set of controls to insure its accuracy and completeness prior to signature by the undersigned.

Very truly yours,


M. P. Alexich
Vice President

MPA/pab

cc: John E. Dolan
W. G. Smith, Jr. - Bridgman
R. C. Callen
G. Charnoff
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