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Indiana Michigan Power
Cook Nuclear Plant
One Cook Place
Bridgman, MI 49106
AEP.com

May 11, 2006

AEP:NRC:2573-29

Docket No. 50-316

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Stop O-P1-17
Washington, DC 20555-0001

Donald C. Cook Nuclear Plant Unit 2
LICENSEE EVENT REPORT 316/2006-001-00
FAILURE TO COMPLY WITH TECHNICAL SPECIFICATION 3.6.2,
CONTAINMENT AIR LOCKS

In accordance with the criteria established by 10 CFR 50.73 entitled Licensee Event Report System, the following report is being submitted:

LER 316/2006-001-00: "Failure to Comply with Technical Specification 3.6.2, Containment Air Locks"

Attachment 1 contains the regulatory commitment identified in this submittal.

Should you have any questions, please contact Mr. Michael K. Scarpello, Regulatory Affairs Supervisor, at (269) 466-2649.

Sincerely,

Lawrence J. Weber
Plant Manager

RAM/jen

Attachments

JE22

c: J. L. Caldwell, NRC Region III
K. D. Curry – AEP Ft. Wayne, w/o attachment
J. T. King, MPSC – w/o attachment
MDEQ – WHMD/RPMWS – w/o attachment
NRC Resident Inspector
P. S. Tam, NRC Washington DC

ATTACHMENT 1 TO AEP:NRC:2573-29

REGULATORY COMMITMENTS

The following table identifies those actions committed to by Indiana Michigan Power Company (I&M) in this document. Any other actions discussed in this submittal represent intended or planned actions by I&M. They are described to the Nuclear Regulatory Commission (NRC) for the NRC's information and are not regulatory commitments.

Commitment	Date
I&M will add the information contained in Lessons Learned #40 to the Indoctrination Training given to contractors as they come on site.	06/09/06

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME Donald C. Cook Nuclear Plant Unit 2	2. DOCKET NUMBER 05000-316	3. PAGE 1 of 3
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4. TITLE Failure to Comply with Technical Specification 3.6.2, Containment Air Locks
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5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
03	13	2006	2006	-- 001 --	00	05	11	2006	FACILITY NAME	DOCKET NUMBER

9. OPERATING MODE 1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)									
	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
10. POWER LEVEL 100%	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)						
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)						
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER							
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A							

12. LICENSEE CONTACT FOR THIS LER	
FACILITY NAME Michael Scarpello, Regulatory Affairs	TELEPHONE NUMBER (Include Area Code) (269) 466-2649

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT									
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED				15. EXPECTED SUBMISSION DATE		
YES (If Yes, complete EXPECTED SUBMISSION DATE).	X	NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On March 14, 2006, at approximately 0941 hours, with Donald C. Cook Nuclear Plant (CNP) Unit 2 in MODE 1, Maintenance test technicians performed pressure testing of the Inner and outer Unit 2 Containment Airlock (2-AIRLOCK-C612) door seals. The inner airlock door was the first door to be tested and this surveillance testing was successfully completed. Pressure testing of the outer airlock door seals was not successful and air could be heard escaping during the test. Investigation revealed that on March 13, 2006, contract Maintenance personnel exited the Unit 2 Containment via 2-AIRLOCK-C612 at approximately 1115 hours. These individuals failed to ensure the latch for the outer airlock door was fully engaged. This resulted in the equalizing air valve failing to seat. The cause of this error has been determined to be improper operation of the airlock doors associated with 2-AIRLOCK-C612 by the contract maintenance personnel. Corrective actions included the immediate closure of the outer airlock door, ensuring the responsible personnel were instructed on the proper operation of the airlock doors, issuance of a lessons learned to all maintenance personnel to alert them of the error and to refresh them on the proper operation of the airlock doors associated with 2-AIRLOCK-C612, and the verification that placards are in place at each airlock door for both the upper and lower airlocks in both Unit 1 and Unit 2 to provide guidance on the proper operation of the airlock doors. Operations, Radiation Protection, and Engineering will also complete the lessons learned to ensure these groups understand the proper operation of the airlock doors. During the time period of this event, the inner airlock door was closed and operable and 2-AIRLOCK-C612 was capable of performing its design function. This condition is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B) as an operational condition prohibited by Technical Specification 3.6.2, Containment Air Locks. Specifically, the contract Maintenance personnel did not verify the inner airlock door was closed within one hour of the failure to fully close the outer airlock door.

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17. NARRATIVE (If more space is required, use additional copies of NRC Form (366A))

Conditions Prior to Event

Unit 2 – Mode 1 at 100% power.

Description of Event

On March 14, 2006, at approximately 0941 hours, with Donald C. Cook Nuclear Plant (CNP) Unit 2 in MODE 1, Maintenance test technicians conducted routine operability testing of the inner and outer airlock doors for the Unit 2 Lower Containment Airlock (2-AIRLOCK-C612) [AL]. The inner airlock door was tested first and successfully passed its operability test. The outer airlock door was subsequently tested and audible leakage was detected by test personnel. Indiana Michigan Power Company (I&M) immediately investigated the cause of the excessive leakage and determined that the airlock door latching mechanism was not fully engaged. The lack of full engagement resulted in insufficient seating of the equalizing air valve. Upon discovery, the outer airlock door was immediately sealed closed. Upon obtaining proper closure of the outer airlock door, the outer airlock door was re-tested, resulting in a successful leak rate of 0.0 SCCM.

I&M performed a review of the usage for 2-AIRLOCK-C612 and determined that contract Maintenance personnel last used 2-AIRLOCK-C612 on March 13, 2006, at approximately 1115 hours.

I&M reviewed Technical Specification 3.6.2, Containment Air Locks, and determined that the requirement of Required Action A.1, which for this event required the inner airlock door be verified closed within one hour, was not met. Therefore, this event is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by the plant's technical specifications. During the time period of this event the inner airlock door was closed and operable and 2-AIRLOCK-C612 was capable of performing its design function.

Cause of Event

The cause of this error has been determined to be improper operation of the airlock doors associated with 2-AIRLOCK-C612 by contract maintenance personnel.

Analysis of Event

The configuration of the partially closed outer airlock door meant that the outer airlock door for 2-AIRLOCK-C612 may not have been able to perform its design function. However, the inner airlock door was operable and properly closed and capable of performing its designed safety function. The period of inoperability for the outer airlock door includes the time from the previous opening of the outer door on March 13, 2006, at approximately 1115 hours, and continuing to the successful completion of the operability surveillance test on March 14, 2006, at 1010 hours.

Each air lock door has been designed and tested to certify its ability to withstand pressure in excess of the maximum expected pressure following a Design Basis Accident in containment. As such, closure of a single door supports containment operability. Each of the doors contains double-gasketed seals and local leakage rate

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testing capability to ensure pressure integrity. To affect a leak-tight seal, the air lock design uses pressure-seated doors (i.e., an increase in containment internal pressure results in increased sealing force on each door). Consequently, it is judged that this event would not have resulted in any airlock leakage from containment during an accident, and the airlock remained fully functional during this time because the inner door was in the proper closed position.

Corrective Actions

Actions Taken:

The outer airlock door of 2-AIRLOCK-C612 was immediately sealed closed and successfully leak tested.

The inner airlock door for 2-AIRLOCKC612 and the inner and outer airlock doors for the Unit 2 upper airlock were satisfactorily tested.

Both the inner and outer airlock doors for the upper and lower Unit 1 airlocks were satisfactorily tested.

The individuals who failed to correctly seal closed the outer door of 2-AIRLOCK-C612 were instructed on the proper method of closing and verifying closed the doors associated with 2-AIRLOCK-C612.

I&M issued a lessons learned (required reading) to all Maintenance personnel to alert them of the error and to refresh their knowledge of the proper operation of the airlock doors associated with 2-AIRLOCK-C612.

I&M verified that placards are in place at each airlock door for both the upper and lower airlocks in both Unit 1 and Unit 2 to provide guidance on the proper operation of the airlock doors.

I&M has expanded the distribution of the lessons learned to include all Operations, Radiation Protection, and Engineering personnel.

I&M has provided copies of Lessons Learned #40 to the Work Control Center Senior Reactor Operator and incorporated them into the Unit 1 and Unit 2 Containment Entry Logbooks.

Action To Be Taken:

I&M will add the information contained in Lessons Learned #40 to the Indoctrination Training given to contractors as they come on site.

Previous Similar Events

None.