

A002

REGULATOR INFORMATION DISTRIBUTION SYSTEM

DOCKET NBR: 050-316 Cook-2
RECIPIENT:
ORIGINATOR: Shaller, D.V.
COMPANY NAME: In & MI Pwr
SUBJECT:

DOC DATE: 781020
ACCESSION NBR: 7810310155
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W/enclosed LER#78-073/03L-0. LER#78-074/03L-0 on 780922: while adjusting automatic control of pressurizer pressure, control pressure was reduced below tech spec limit of 2220 PSIA twice, caused by inoper low pressure alarm.

DISTRIBUTION CODE: A002
DISTRIBUTION TITLE:
INCIDENT REPORTS

NOTARIZED

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NOTES: Send 3 cys of all material to I & E.

A04
GP.



INDIANA & MICHIGAN POWER COMPANY

DONALD C. COOK NUCLEAR PLANT
P.O. Box 458, Bridgman, Michigan 49106

REGULATORY DOCKET FILE COPY

October 20, 1978

Mr. J.G. Keppler, Regional Director
Office of Inspection and Enforcement
United States Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

Operating License DPR-74
Docket No. 50-316

Dear Mr. Keppler:

Pursuant to the requirements of the Appendix A Technical Specifications
the following reports are submitted:

RO 78-073/03L-0
RO 78-074/03L-0.

Sincerely,

for D.V. Shaller
Plant Manager

/bab

cc: J.E. Dolan
R.W. Jurgensen
R.F. Kroeger
R. Kilburn
R.J. Vollen BPI
K.R. Baker RO:III
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Dir., IE (30 copies)
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*Approved
5/11*

~~781034~~

LICENSEE EVENT REPORT

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

LICENSEE CODE, LICENSE NUMBER, LICENSE TYPE, CAT 58

REPORT SOURCE, DOCKET NUMBER, EVENT DATE, REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES: WHILE ADJUSTING AUTOMATIC CONTROL OF PRESSURIZER PRESSURE, THE PRESSURE WAS REDUCED BELOW TECH. SPEC. 3.2.5b. LIMIT OF 2220 PSIA TWICE. EACH TIME THE LOW POINT WAS 2200 PSIA WITH 10 MIN. BELOW THE LIMIT ONE TIME AND 2 MIN. THE OTHER. RECOVERY WAS MADE WITHIN THE ALLOWABLE 2 HOURS. NO PROBABLE CONSEQUENCES.

SYSTEM CODE, CAUSE CODE, COMPONENT CODE, COMP. SUBCODE, VALVE SUBCODE, LER/RO REPORT NUMBER, EVENT YEAR, SEQUENTIAL REPORT NO., OCCURRENCE CODE, REPORT TYPE, REVISION NO., ACTION TAKEN, FUTURE ACTION, EFFECT ON PLANT, SHUTDOWN METHOD, HOURS, ATTACHMENT SUBMITTED, NRPD-4 FORM SUB., PRIME COMP. SUPPLIER, COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS: WHEN PRESSURE CONTROL WAS PLACED IN MANUAL AND THE INSTRUMENT CIRCUIT PLACED IN TEST THE LOW PRESSURE ALARM WAS MADE INOPERABLE. THE PRESSURE GRADUALLY DECREASED TO BELOW THE LIMIT PRIOR TO THE OPERATOR REALIZING THE ALARM WAS INOPERABLE AND THEN HE TOOK CORRECTIVE ACTION. THE SECOND EVENT WAS DUE TO CONTROL ADJUSTMENT CAUSING ONE OF THE PRESSURIZER RELIEF (SEE SUPPLEMENT)

ACTIVITY STATUS, % POWER, OTHER STATUS, METHOD OF DISCOVERY, DISCOVERY DESCRIPTION, OPERATOR OBSERVATION, ACTIVITY CONTENT, RELEASED OF RELEASE, AMOUNT OF ACTIVITY, LOCATION OF RELEASE, PERSONNEL EXPOSURES, DESCRIPTION, PERSONNEL INJURIES, DESCRIPTION, LOSS OF OR DAMAGE TO FACILITY, TYPE, DESCRIPTION, PUBLICITY, ISSUED, DESCRIPTION

NAME OF PREPARER: R. S. Lease, PHONE: (616) 465-5901, NRC USE ONLY

SUPPLEMENT TO LER #78 -073/03L-0

(Cause Description Supplement)

VALVES TO OPEN. THIS WAS AN ERROR IN INTERPRETATION OF THE CALIBRATION PROCEDURE. IT WAS ASSUMED THAT THE SECOND BISTABLE REQUIRED TO OPEN THE RELIEF VALVE WOULD NOT ENERGIZE DURING THE PROCEDURE. THE BISTABLE DID ENERGIZE, CAUSING THE VALVE TO OPEN. THE OPERATOR IMMEDIATELY CLOSED THE RELIEF VALVE AND RETURNED THE PRESSURE TO NORMAL. CONTROL ADJUSTMENT WAS STOPPED AND WILL BE ACCOMPLISHED DURING THE NEXT UNIT OUTAGE.

LICENSEE EVENT REPORT

CONTROL BLOCK: [] ①

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0][1] [M][I][D][C][C][2][] ② [0][0][0][0][0][0][0][0][0][0][0][0][0][0][] ③ [4][1][1][1][1][1][] ④ [] ⑤
7 8 9 14 15 25 26 30 57 CAT 58

CON'T
[0][1] REPORT SOURCE [L] ⑥ [0][5][0][0][0][3][1][6] ⑦ [0][9][2][1][7][8] ⑧ [1][0][2][0][7][8] ⑨
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩
[0][2] DURING NORMAL OPERATION, AFTER SUCCESSFULLY TROUBLESHOOTING THE LOOP 1 DELTA-T
[0][3] OVERTEMPERATURE SETPOINT GENERATOR, AND REPLACING A DEFECTIVE MODULE (FOXBORO
[0][4] MODEL 66 RC-OLA SPECIAL), THE SYSTEM WAS RETURNED TO SERVICE WITH THE BISTABLES
[0][5] RETURNED TO NORMAL FROM THE TRIP POSITION. THIS WAS PERFORMED WITHOUT THE DYNAMICS
[0][6] ON THE LEAD-LAG PORTION OF THE UNIT BEING CALIBRATED. THIS IS NON-CONSERVATIVE
[0][7] IN RESPECT TO T.S. TABLE 3.3-1 ITEM 7.

[0][8]
7 8 9

[0][9] SYSTEM CODE [I][A] ⑪ CAUSE CODE [A] ⑫ CAUSE SUBCODE [C] ⑬ COMPONENT CODE [I][N][S][T][R][U] ⑭ [Y] ⑮ VALVE SUBCODE [Z] ⑯
7 8 9 10 11 12 13 18 19 20

⑰ LER RO REPORT NUMBER [7][8] ⑱ EVENT YEAR [] ⑲ SEQUENTIAL REPORT NO. [0][7][4] ⑳ OCCURRENCE CODE [] ㉑ REPORT TYPE [L] ㉒ REVISION NO. [0]
7 8 21 22 23 24 26 27 28 29 30 31 32

ACTION TAKEN [A] ⑲ FUTURE ACTION [H] ⑳ EFFECT ON PLANT [Z] ㉑ SHUTDOWN METHOD [Z] ㉒ HOURS [0][0][0][0] ㉓ ATTACHMENT SUBMITTED [Y] ㉔ NPRD-4 FORM SUB. [N] ㉕ PRIME COMP. SUPPLIER [N] ㉖ COMPONENT MANUFACTURER [F][L][8][0] ㉗
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉘
[1][0] INVESTIGATION REVEALED THAT THE COMPLETE CALIBRATION OF THIS MODULE CONSISTS OF
[1][1] BOTH STATIC AND DYNAMIC GAIN CALIBRATIONS. AFTER REPLACING THE DEFECTIVE MODULE,
[1][2] THE UNIT WAS BEING MONITORED BY NIGHT SHIFT PERSONNEL WITHOUT THE DYNAMIC GAIN
[1][3] SETTING INSERTED, INSURING THE NEW MODULE DID NOT DRIFT. IMPROPER COMMUNICATIONS
[1][4] BETWEEN THE NIGHT AND DAY SHIFTS (SEE SUPPLEMENT)

[1][5] FACILITY STATUS [E] ㉙ % POWER [0][9][7] ㉚ OTHER STATUS [NA] ㉛ METHOD OF DISCOVERY [A] ㉜ DISCOVERY DESCRIPTION [TROUBLESHOOTING FOLLOW UP] ㉝
7 8 9 10 12 13 14 44 45 46 47 80

[1][6] ACTIVITY CONTENT [Z] ㉞ RELEASED OF RELEASE [Z] ㉟ AMOUNT OF ACTIVITY [NA] ㊱ LOCATION OF RELEASE [NA] ㊲
7 8 9 10 11 12 13 44 45 80

[1][7] PERSONNEL EXPOSURES NUMBER [0][0][0] ㊲ TYPE [Z] ㊳ DESCRIPTION [NA] ㊴
7 8 9 11 12 13 44 80

[1][8] PERSONNEL INJURIES NUMBER [0][0][0] ㊵ DESCRIPTION [NA] ㊶
7 8 9 11 12 13 44 80

[1][9] LOSS OF OR DAMAGE TO FACILITY TYPE [Z] ㊷ DESCRIPTION [NA] ㊸
7 8 9 11 12 44 80

[2][0] PUBLICITY ISSUED [N] ㊹ DESCRIPTION [NA] ㊺

781031.0155

NRC USE ONLY

ATTACHMENT TO LER # 78-074/03L-0

SUPPLEMENT TO CAUSE DESCRIPTION

RESULTED IN THE DAY SHIFT PERSONNEL RETURNING THIS SYSTEM TO SERVICE, UNAWARE THAT THE DYNAMIC CALIBRATION WAS INCOMPLETE. TO PREVENT RECURRENCE, THE INSTRUMENT SECTION HAS DEVELOPED A NIGHT SHIFT LOG BOOK TO DOCUMENT THE ACTIVITIES INITIATED BY NIGHT SHIFT PERSONNEL.

