

# ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

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 FACIL: 50-315 Donald C. Cook Nuclear Power Plant, Unit 1, Indiana & 05000315  
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 DAVIS, A.B.      Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 901005 ltr re violations noted in Insp Repts  
 50-315/90-20 & 50-316/90-20.

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AEP:NRC:1125G

Donald C. Cook Nuclear Plant Units 1 and 2  
Docket Nos. 50-315 and 50-316  
License Nos. DPR-58 and DPR-74  
NRC Inspection Report Nos. 50-315/90020 (DRSS)  
and 50-316/90020 (DRSS)  
RESPONSE TO NOTICE OF VIOLATION

U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, D.C. 20555

ATTN: A. B. Davis

November 6, 1990

Dear Mr. Davis:

This letter is in response to Mr. L. R. Greger's letter dated October 5, 1990, which forwarded the report on the routine safety inspection conducted by members of your staff on August 27 through August 31, 1990, at the Cook Nuclear Plant. The Notice of Violation attached to Mr. Greger's letter identified one Severity Level IV violation associated with the performance of radiological and physical hazards evaluations for a test of a chemical and volume control system safety valve. Our response to the Notice of Violation is provided in the attachment to this letter.

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

Sincerely,

A handwritten signature in cursive script, appearing to read 'M. P. Alexich'.

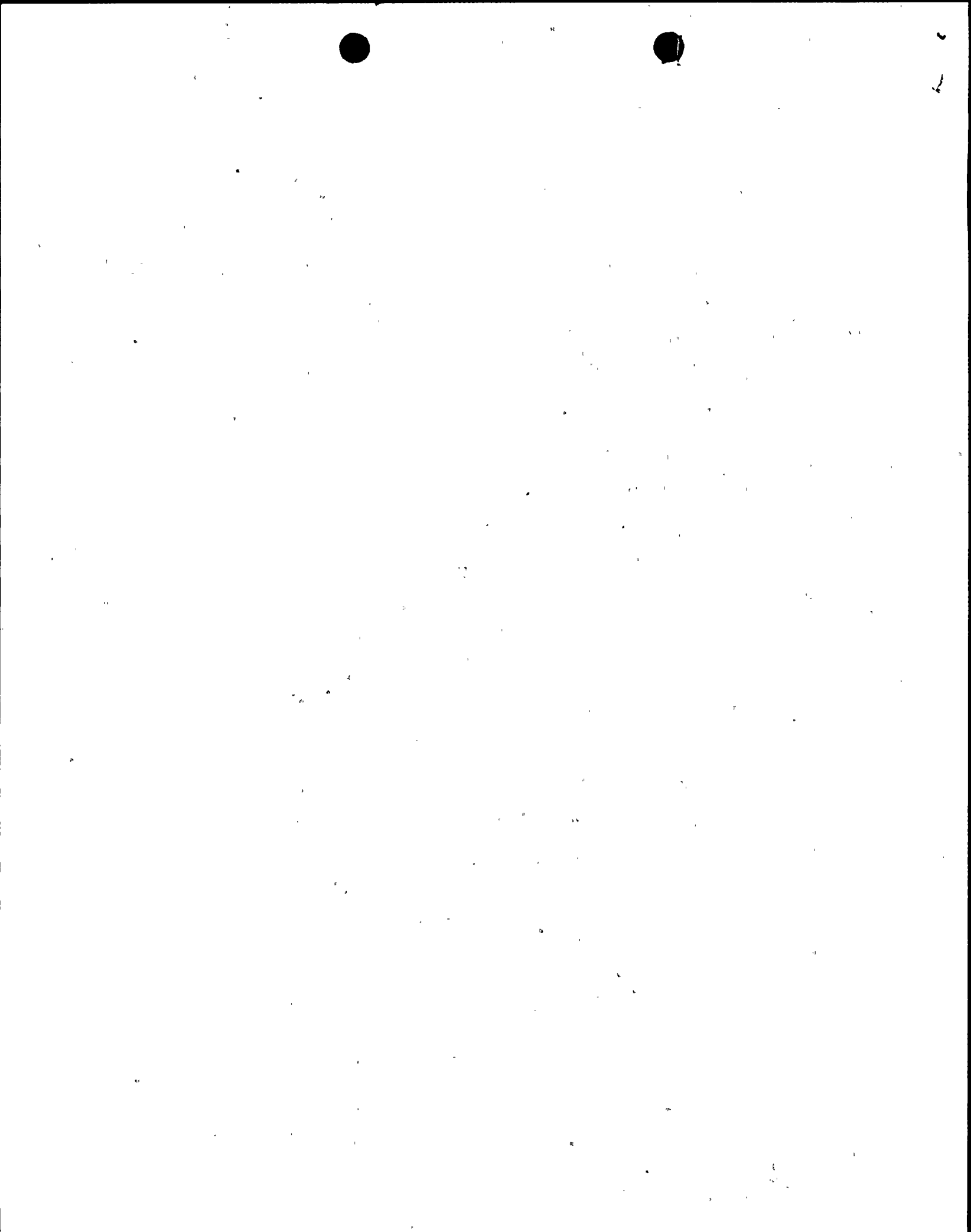
M. P. Alexich  
Vice President

dfw

Attachment

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Mr. A. B. Davis

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AEP:NRC:1125G

cc: D. H. Williams, Jr.  
A. A. Blind  
J. R. Padgett  
G. Charnoff  
NRC Resident Inspector - Bridgman  
NFEM Section Chief

ATTACHMENT TO AEP:NRC:1125G  
RESPONSE TO NOTICE OF VIOLATION

#### NRC Violation

"10CFR20.201(b) requires that each licensee make or cause to be made such surveys as (1) may be necessary for the licensee to comply with the regulations in 10CFR Part 20 and (2) are reasonable under the circumstances to evaluate the extent of the radiation hazards that may be present. 10CFR20.201(a) defines a survey as an evaluation of the radiation hazards incident to the production, use, release, disposal or presence of radioactive materials or other sources of radiation under a specific set of conditions.

Contrary to the above, on July 11, 1990, a test of the operability of a highly contaminated Chemical Volume and Control System safety relief valve was conducted without adequately evaluating the extent of the radiological and physical hazards associated with the new test equipment being used. The test malfunctioned which resulted in an employee receiving an unnecessary radiation exposure and a minor physical injury."

#### Response to Violation

The cited violation involves a contamination event that occurred during performance of a lift check test on a chemical and volume control system (CVCS) safety valve. The test was performed using a newly-acquired test machine which, in order to more closely simulate actual in-service system conditions, provides a larger volume of air to the valve than that applied in prior lift check tests. This was the first test performed using the new test rig on a contaminated valve. Other tests had previously been performed on non-contaminated valves with the new rig, however, use of a HEPA venting system was not required. As a result, the affect of the increased test air volume on the HEPA configuration used in testing the contaminated CVCS safety valve had not been assessed. When the safety valve lifted (at approximately 600 psig), a funnel being used as part of the HEPA venting system was blown from the valve and penetrated a wall of the temporary herculite tent surrounding the test rig. The funnel struck a radiation protection technician standing outside the enclosure, contaminating the technician and the surrounding area with contaminated water and hot particles (although the funnel tore the herculite, it remained inside the tent). A dose evaluation performed after the event concluded that no exposure limits were exceeded as a result of the personnel contamination. Our investigation has concluded that the cause of the event is attributable to the use of a temporary enclosure of insufficient volume to effectively contain the high volume of air produced by the new test rig when the safety valve lifted.

(1) Corrective Action Taken and Results Achieved

After the contamination event, work was immediately stopped and the test rig area (both inside and outside the temporary enclosure) was decontaminated. A "Permacon" enclosure with rigid walls and sufficient volume to contain the test rig discharge from safety valve lift check testing was erected. The Permacon enclosure also incorporates permanent ductwork for HEPA venting of the discharge. The new enclosure has been used successfully in subsequent safety valve tests.

(2) Corrective Action Taken to Prevent Further Violations

Use of the enlarged, rigid wall test enclosure with permanently installed ductwork for HEPA venting the test air discharge volume will more effectively accommodate use of the new safety valve test rig. The test procedure has also been revised to include additional precautions for controlling discharges from the safety valves being tested with the higher capacity tester. In addition, the Cook Nuclear Plant Radiation Protection Section now reviews all maintenance procedures involving work activities where potential radiation hazards exist. This review, performed before the maintenance procedures are submitted to PNSRC for approval, will enable radiation protection personnel to specify any special precautions/controls required to ensure that potential radiation hazards are appropriately addressed in completing future maintenance procedures.

(3) Date When Full Compliance will be Achieved

Full compliance was achieved on July 11, 1990, when the safety valve test was discontinued and the valve restored to a safe configuration. Compliance will be maintained through the actions discussed in (2) above.