JUN 26 1986

Docket No. 50-315
Docket No. 50-316

American Electric Power Service
Corporation
Indiana and Michigan Electric Company
ATTN: Mr. John E. Dolan
Vice Chairman
Engineering and Construction
1 Riverside Plaza
Columbus, OH 43216

Gentlemen:

This refers to the routine safety inspection conducted by Mr. J. Foster and others of this office on June 9-11, 1986 of activities at the Donald C. Cook Nuclear Plant, Units 1 and 2 authorized by NRC Operating Licenses No. DPR-58 and No. DPR-74 and to the discussion of our findings with Messrs. M. P. Alexich, W. G. Smith and others of your staff at the conclusion of the inspection.

The enclosed copy of our inspection report identifies areas examined during the inspection. Within these areas, the inspection consisted of a selective examination of procedures and representative records, observations, and interviews with personnel.

No violations of NRC requirements were identified during the course of this inspection. However, weaknesses were identified which will need corrective action by your staff. These weaknesses are summarized in the attached Appendix to this letter. As required by 10 CFR Part 50, Appendix E, IV.F, any weaknesses that are identified must be corrected. Accordingly, please advise us within 45 days of the date of this letter of the corrective action you have taken or plan to take, showing the estimated date of completion with regard to these exercise weaknesses.

In accordance with 10 CFR 2.790 of the Commission's regulations, a copy of this letter, the enclosures, and your response to this letter will be placed in the NRC Public Document Room.

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We will gladly discuss any questions you have concerning this inspection.

Sincerely,

W. D. Shafer, Chief
Emergency Preparedness and
Radiological Protection Branch

Enclosures:
1. Exercise Weaknesses
2. Inspection Reports
   No. 50-315/86016(DRSS);
   No. 50-316/86016(DRSS)

cc w/enclosures:
W. G. Smith, Jr., Plant Manager
DCS/RSB (RIDS)
Licensing Fee Management Branch
Resident Inspector, RIII
Ronald Callen, Michigan
Public Service Commission
EIS Coordinator, USEPA
Region 5 Office
Nuclear Facilities and
Environmental Monitoring
Section

RIII	RIII	RIII	RIII	RIII
Foster/mj 6/24	Kers	Snell	Burgess	Shafer
YES	yes	yes	6/25/86	6-26-86

EXERCISE WEAKNESSES

1. Notification of the completion of plant personnel accountability was not reported to the Site Emergency Coordinator, the Technical Director, nor to the Control Room. It was noted, however, that the Site Emergency Coordinator asked for and received accountability information about 45 minutes after the Site Emergency was declared. (50-315/86016-01; 50-316/86016-01) (Paragraph 5.b.1).

2. The team sent to check operability of the PASS system was unable to get the power supply distribution system working without assistance from the exercise controller. The PASS sample results were not available within the three-hour goal. (50-315/86016-02; 50-316/86016-02) (Paragraph 5.e.1).

3. Communications with the State of Michigan were inadequate. Examples of breakdowns in communication are as follow:

   a. For several hours, the EOF was under the impression that the State had implemented sheltering out to ten miles in all directions. In fact, this was not the case.

   b. The only time the senior licensee officials contacted their counterpart at the State level was when the licensee decided to downgrade from the General Emergency.

   d. PARs for the General Emergency declaration were slow to be provided to the State.

   e. The layout of the notification form for the State has the PARs listed as the twelfth out of fourteen items to be transmitted. This delayed PAR communication.

   (50-315/86016-03; 50-316/86016-03) (Paragraph 5.f.1).

4. Command and control was not transferred to the EOF until two hours after the declaration of a Site Area Emergency. The EOF must be operational within one hour of the Site Area Emergency declaration, and this includes assuming overall command and control of the response to the accident. (50-315/86016-04; 50-316/86016-04) (Paragraph 5.f.2).

5. A number of problems were observed in the area of dose assessment and PARs, as follow:

   a. Dose assessments were conducted using the unit vent effluent monitor, even though there was no flow through this vent.

   b. Actual field data was not used to perform dose assessment until over one hour after it was available.

c. The dose assessment performed at 0930 hours, was used in the PAR flowchart to recommend evacuation out to two miles in all sectors. This conclusion was incorrect.

d. All upgrades in the PARs to include additional sectors were based on actual wind direction changes. A meterological forecast was never obtained to project where the plume would be, to enable PARs to be implemented prior to the plume arrival.

(50-315/86016-05; 50-316/86016-04) (Paragraph 5.f.3).