

November 22, 1996

RIM
PER

Mr. D. R. Gipson
Senior Vice President
Nuclear Generation
The Detroit Edison Company
6400 North Dixie Highway
Newport, MI 48166

SUBJECT: NRC INSPECTION REPORT NO. 50-341/96007

Dear Mr. Gipson:

On September 13, 1996, the NRC completed an inspection at the Fermi 2 reactor facility. The enclosed report presents the results of that inspection.

During this 6-week inspection period, your staff demonstrated a good safety focus in response to an emergency diesel generator trip by promptly testing the other three diesels to assure that the potential for common mode failure did not exist. In addition, your actions to identify and assess problems encountered during safety system outages were prompt and aggressive. However, as reflected in the five examples of violations described below, problems with modification implementation, work control, procedural compliance, and post maintenance restoration persist and needs to be addressed.

Based on the results of this inspection, the NRC has determined that several violations of NRC requirements occurred. These violations are cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding them are described in detail in the subject inspection report.

The first violation concerned a modification that was made to a safety service water system in a manner contrary to explicit instructions in the 10 CFR 50.59 Safety Evaluation. While it was subsequently determined that the impact was minor, your staff violated a process critical to maintaining the plant within its licensing basis. It is a concern to us that the oversight by your staff was not sufficient to identify this condition.

The second violation concerned inadequate online maintenance controls. During previous inspections, we have expressed concerns with coordination problems associated with planning and conducting online maintenance. This specific online maintenance to the Reactor Core Isolation Cooling System was performed with existing system in-leakage that was not properly evaluated. As a result, this important safety system was unintentionally rendered inoperable.

D. R. Gipson

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The third violation concerned adherence to procedures. We cited two examples, one pertaining to inadequate control of scaffolding. Scaffolding was built and used without the required reviews, including required radiation surveys. As a result, the impact on plant operations were not known. The other example pertained to changes to a work package being performed in violation of your work control instructions.

The fourth violation pertained to the continuing problem with procedure adequacy. During several previous inspections, we have raised the concern with procedure inadequacies. Your corrective actions have not been effective in resolving this issue. The current violation addresses inadequacies with the System Operating Procedure for Emergency Diesel Generator switchgear room ventilation. The procedure was inadequate in that it failed to provide instructions for damper restoration. This contributed to a failure to restore a damper following maintenance.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. The NRC will use your response, in part, to determine whether further enforcement action is necessary to ensure compliance with regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures, and your response will be placed in the NRC Public Document Room (PDR).

Sincerely,

Original signed by:
John A. Grobe, Acting Deputy Director
James L. Caldwell, Acting Director
Division of Reactor Projects

Docket No.: 50-341
License No.: NPF-43

Enclosures:

1. Notice of Violation
2. Inspection Report
No. 50-341/96-07

cc w/encl: N. Peterson,
Supervisor of Compliance
P. A. Marquardt, Corporate
Legal Department
James R. Padgett, Michigan Public
Service Commission
Michigan Department of
Public Health
Monroe County, Emergency
Management Division

(See attached continued distribution)

D. R. Gipson

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NOTICE OF VIOLATION

Detroit Edison Company
Fermi 2

Docket No. 050-341
License No. NPF-43

During an NRC inspection conducted on August 2 through September 13, 1996, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG 1600, the violations are listed below:

1. 10 CFR Part 50.59, requires in part, that changes to a utilization facility as described in the safety analysis report shall be reviewed to ensure that the change does not involve an unreviewed safety question.

Contrary to the above, inspectors identified that on September 10 and 11, 1996, a modification to the Division 1 Residual Heat Removal Service Water System (RHRWS) drain lines was performed without a review to ensure that the modification did not involve an unreviewed safety question in that both RHRWS lines in Division 1 were worked simultaneously which had not been analyzed.

This is a Severity Level IV Violation (Supplement I).

2. Technical Specification 6.8.1 requires, in part, that written procedures be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Item 9.e of Appendix A of Regulatory Guide 1.33, Revision 2, requires general procedures for the control of maintenance.

Operations Conduct Manual (MOP) 05, "Control of Equipment," Revision 5, Section 2.2.1, requires that operations evaluate the consequences of removal of equipment from service, including technical specification (TS) limiting conditions for operations (LCO) actions which might require an action statement to be carried out, expected time for restoration, and other systems which may be affected.

Contrary to the above, on September 9, 1996, operators failed to adequately evaluate the consequences of removing the Reactor Core Isolation Cooling Barometric Condenser Condensate Pump from service. Removal of the pump from service rendered the Reactor Core Isolation Cooling system inoperable and required an entry into Technical Specification LCO actions.

This is a Severity Level IV Violation (Supplement I).

3. 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawing," requires in part, that activities affecting quality shall be accomplished in accordance with procedures appropriate to the circumstances.

- a. Fermi 2 Maintenance Conduct Manual, Chapter 8, "Scaffolding," Section 3.12, states in part, that scaffolds erected in the Auxiliary Building be inspected by a senior reactor operator or reactor operator to ensure that the operability of safety related equipment is not compromised.

Contrary to the above, on August 21, 1996, four scaffolds erected in the Auxiliary Building were not inspected by a senior reactor operator or reactor operator.

- b. Fermi 2 Work Control Conduct Manual, Chapter 2, "Work Control," Section 3.7, stated in part, that a general supervisor must clearly initial and date a minor revision to a work instruction.

Contrary to the above, on August 3, 1996, a general supervisor failed to initial and date a change in step sequence, a minor revision to Work Instruction 000Z964041 that required performance of steps in sequence.

This is a Severity Level IV Violation (Supplement I).

4. 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawing," requires in part, that activities affecting quality shall be accomplished in accordance with procedures appropriate to the circumstances.

Contrary to the above, on September 5, 1996, System Operating Procedure 23.420, Revision 18, "Residual Heat Removal Complex Heating and Ventilation," a procedure prescribing an activity affecting quality, was not appropriate to the circumstances. Specifically, the procedure was inadequate in that it failed to ensure that a temporary blocking device was removed from Emergency Diesel Generator 11 Switchgear Room Damper X4103-F109.

This is a Severity Level IV Violation (Supplement I).

Pursuant to the provisions of 10 CFR 2.201, the Detroit Edison Company is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region III, and a copy to the NRC Resident Inspector at the facility that is subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately

addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that

identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (e.g. explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.790(b) to support a request for withholding confidential commercial or financial information). If safeguards information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

Dated at Lisle, Illinois,
this 22nd day of Nov, 1996.

U.S. NUCLEAR REGULATORY COMMISSION

REGION 3

Docket No: 50-341
License No: NPF-43

Report No: 50-341/96-07

Licensee: Detroit Edison Company (DECo)

Facility: Enrico Fermi, Unit 2

Location: 6400 N. Dixie Hwy.
Newport, MI 48166

Dates: August 2, through September 13, 1996

Inspectors: A. Vogel, Senior Resident Inspector
C. O'Keefe, Resident Inspector
A. Kugler, Project Manager, NRR

Approved by: M. Jordan, Chief, Branch 5
Division of Reactor Projects

EXECUTIVE SUMMARY

Enrico Fermi, Unit 2 NRC Inspection Report 50-341/96-07

This inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a 6-week period of resident inspection; in addition, it includes the results of inspections by the NRR Project Manager and a regional projects inspector.

Operations

- Licensee identified inadequate restoration from emergency diesel generator switchgear room maintenance resulted in a damper being left in the wrong configuration. This was an additional example of a continuing concern with inadequate configuration control on restoration from maintenance activities. (O4.1)
- The lack of operator understanding of the design function of the Reactor Core Isolation Cooling (RCIC) barometric condenser while the system was in standby, and an inadequate alarm response procedures contributed to the delayed recognition that the system was inoperable. (M4.1)

Maintenance

- Poor control of test equipment and inadequate documentation resulted in not removing a test device from the output breaker for Combustion Turbine Generator 11-1 during vendor refurbishment. This caused damage to breaker support equipment while attempting to rack the breaker. (M1.2)
- A series of existing equipment deficiencies in a reactor building equipment drain sump went unidentified until a new equipment leak began increasing the input to the sump. (M2.1)
- Maintenance, Engineering, and Operations response to an emergency diesel generator trip was prompt and well coordinated. The potential for common mode failure was effectively addressed. (M2.3)
- Inadequate administrative control of scaffolding was identified by inspectors. (M3.1)
- Inadequate work documentation for reactor building equipment drain sump was identified by inspectors. (M3.2)
- Reactor Core Isolation Cooling System (RCIC) rendered unexpectedly inoperable during online maintenance because system inleakage was not adequately considered during work planning. (M4.1)
- Safety system outage critiques were effective in identifying and assessing problems. (M7.1)

Engineering

- Inspectors identified that safety system service water modification was performed in manner contrary to the applicable 10 CFR 50.59 safety evaluation. (E1.1)
- RCIC leak at a hose connection was not reported to operations or radiation protection. Contaminated leakage was not collected or posted as a result. (E2.1)
- Failure mode for control room recorders was identified by the licensee during preparation for a plant modification. Prompt investigation and corrective actions were taken. (E7.1)
- System engineering did not adequately assess the impact of removing the barometric condenser condensate pump from service with the RCIC steam inlet valve leaking. As a result, the operability of the RCIC system and the control room staff were unnecessarily challenged. (M4.1)

Plant Support

- Licensee identified several instances of eating and drinking in the radiologically restricted area. Prompt corrective measures were taken. (R1.1)

Report Details

Summary of Plant Status

Unit 2 operated between 84 and 89 percent power throughout this inspection period. Periodically, reactor power was lowered to reduce the number of nuisance main turbine vibration alarms.

I. Operations

01 Conduct of Operations

01.1 General Comments (71707)

Using Inspection Procedure 71707, the inspectors assessed plant operations. The conduct of plant operations was professional and safety-conscious; specific events and noteworthy observations are detailed in the sections below.

02 Operational Status of Facilities and Equipment

02.1 Engineered Safety Feature System Walkdowns (71707)

The inspectors used Inspection Procedure 71707 to walk down accessible portions of the following systems:

- High Pressure Coolant Injection System
- Reactor Core Isolation Cooling (RCIC) System
- Emergency Diesel Generators (EDGs) 11, 12, 13 and 14
- Residual Heat Removal Service Water (RHRSW) System
- Standby Gas Treatment (SBGT) System
- Reactor Protection System Power
- Hydrogen Recombiner System

Equipment operability, material condition, and housekeeping were acceptable in all cases. Several minor discrepancies were brought to the licensee's attention and were corrected.

The inspectors identified brass nuts on steel studs fastening the heater covers on both divisions of SBGT filter housings. System engineering investigated the material and determined that the operability of the system was not affected because the system operated at a low pressure, therefore not challenging the strength of the fasteners. In addition, due to the electrical potential of the material being similar and low humidity in the SBGT room, the potential for galvanic corrosion was minimal.

As discussed in detail in Section M3.1, the inspectors identified numerous scaffold problems. In one case, on September 13, the inspectors identified that a scaffold was erected such that a cross bar was within one inch of an alternate rod injection solenoid valve. With such a small clearance between the valve and the scaffolding, the inspectors were concerned that the scaffolding could potentially impact the solenoid valve, thereby affecting the ability of the valve to perform its safety function. The scaffold tag indicated that operations had previously inspected and accepted the scaffold. The inspectors discussed the questionable configuration with operations personnel and management. Based on these discussions, the inspectors determined that no specific guidance was given to operators on how to determine the adequacy of scaffolding installation with respect to clearances around safety related equipment. One licensed operator stated that if the scaffold could be jiggled without touching safety related equipment, it was acceptable. Operations management had the scaffold in question moved and was reviewing the issue of acceptance criteria for scaffold near safety related equipment to ensure the equipment would remain operable. This will be tracked as an inspection followup item (IFI) (50-341/96-07-01).

02.2 Main Turbine Low Pressure Intercept Valve Closure

a. Inspection Scope (71707)

Inspectors reviewed licensee action in response to an unexpected closure of the Numbers 4 and 5 Main Turbine Low Pressure Intercept Valves (LPIV). The inspectors reviewed licensee documentation, including Deviation Event Report (DER) 96-0904 that documented event occurrence, and discussed the cause for the event with operations and engineering personnel.

b. Observations and Findings

On August 7, with the plant operating at 84 percent power, the No. 4 (N3021F0310) and No. 5 (N3021F013E) LPIVs closed unexpectedly. Expected control room annunciators were received including "Unitized Actuator Intercept Valve Fault" alarm. No appreciable change in reactor parameters occurred as a result of the transient. Licensee investigation determined that the cause for valve closure was a blown power supply fuse (FS-39). Both power supply fuses were replaced and the LPIVs were restored to service. Licensee inspection of the blown fuse determined that an overcurrent condition caused the fuse to open. However, no specific cause for the overcurrent condition was identified. The licensee identified that fuse FS-39 had previously failed in December 1989, and March 1990. The root cause for these failures was not determined. Since the failure in 1990, no other problems have been encountered with the fuse.

c. Conclusions

The licensee concluded that the cause for the overcurrent condition and resultant fuse failure was indeterminate. However, the licensee planned to replace the hydraulic actuators for LPIV's No. 4 and 5 during the upcoming refueling outage. The inspectors concluded that licensee investigation of the fuse failure was adequate.

04. Operator Knowledge and Performance

04.1 Emergency Diesel Generator No. 11 Ventilation Damper Configuration Control Inadequacies

a. Inspection Scope (71707)

Inspectors reviewed the circumstances that led to EDG 11 Switchgear Room Damper X4103-F109 being left blocked after the completion of maintenance activities. This damper was required to be operable by Technical Specifications. The inspectors discussed the event with operations staff and management and attended a lessons learned meeting for operators, maintenance technicians, and engineering staff on September 16. The inspectors also reviewed licensee documentation related to the event, including DER 96-1090 and System Operating Procedure (SOP) 23.420, Revision 18, "RHR Complex Heating and Ventilation."

b. Observations and Findings

On July 12, EDG 11 switchgear room return air damper X4103-F104 was found open, when it should have been shut. With the damper inoperable, Technical Specifications 3.8.1.1 and 3.8.3.1 for an inoperable diesel generator were entered and actions were initiated. The EDG 11 switchgear room dampers were blocked open in accordance to SOP 23.420 and the TS action statements were exited. Section 7.0, "Operation with Inoperable Dampers," of SOP 23.420 directed that with the X4103-F104 damper inoperable, all other dampers for the EDG 11 switchgear room also be declared inoperable and be blocked open to predetermined positions with clamps. Tracking LCO 96-0396 was initiated to track manual positioning of dampers. On September 5, maintenance completed work on damper X4103-F104 and were directed by control room operators to "unblock and return all the EDG 11 switchgear room dampers to service." Later, maintenance personnel reported to the control room that the dampers were unblocked. A licensed operator then conducted a walkdown of the dampers, verifying that the dampers were restored to normal and tracking LCO 96-0396 was exited. On September 6, a non-licensed operator reported to the control room that the EDG 11 exhaust air damper X4103-F109 was blocked. The damper was unblocked and returned to service. Deviation Event Report (DER) 96-1090 was initiated to document event occurrence and track corrective actions.

SOP 23.420, Section 7.2.2.4.b stated "Track all manually positioned dampers as inoperable on the LCO log. Tracking should be done as a group so that each group is entirely returned to service." However, the

inspectors noted there is no procedure for restoring dampers to service. The inspectors noted that LCO 96-0396 referred only to damper X401-F104, but indicated that dampers were blocked per SOP 23.420. The licensee stated that the latter notation was equivalent to tracking the dampers as a group.

Licensee investigation of the event determined that the cause for the event was the lack of configuration control of switchgear room dampers. Specifically, there was not a structured process for the operators to follow to ensure that the dampers were returned to service, following maintenance activities.

c. Conclusion

The inspectors concluded that due to the lack of a restoration procedure, non-specific direction to restore the dampers, and a lack of attention to detail by the operator performing the independent verification, damper X4103-F109 was not restored to service and the LCO was improperly cleared.

Based on inspector observation of licensee immediate corrective actions in progress at the end of the inspection period, licensee investigation and review of the event were thorough. However, the inspectors were concerned by continued recurrence of events caused by poor equipment configuration control during post maintenance restoration. As documented in Inspection Reports 96002 and 96004, several events had occurred previously due to inadequate restoration of equipment. For example, on February 23, following the completion of maintenance activities, operators did not restore the starting air system for EDG 14 while returning it to a standby lineup. On April 11, the Division 1 Emergency Equipment Cooling Water Pump Motor Breaker was not restored adequately following maintenance. On April 16, a control rod drive hydraulic control unit valve was not restored following maintenance. Based on the continued occurrence of configuration control problems, the corrective actions taken for previous events have not been effective.

Though the safety consequences of the mispositioned damper was minor, the continued recurrence of problems with restoration of equipment following maintenance was a concern. Since licensee corrective actions for previous events could reasonably have prevented this event, mitigation of enforcement sanctions was not warranted per Section VIIB of "General Statement of Policy and Procedure for NRC Enforcement Actions," (NUREG 1600). Consequently, the failure of the licensee to ensure that procedure SOP 23.420 was adequate to ensure EDG switchgear room damper configuration was a violation of 10 CFR Part 50, Appendix B, Criterion V (50-341/96-07-02).

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments

a. Inspection Scope (62703)

The inspectors observed all or portions of the following work activities:

- Emergency Diesel Generator No. 12 Starting Air Compressor Repair
- Emergency Diesel Generator No. 12 Fast Start
- New Fuel Receipt Inspection
- New Station Air Compressor SOE Testing
- MLO Cooler Cleaning
- Load Shed Agastat Replacement for Bus 72E
- RHR Room Cooler Fan Motor Replacement
- RHR System Fill and Vent Surveillance
- Combustion Turbine Generator (CTG) 11-1 Refurbishment and Testing
- Sump D073 Repairs and Troubleshooting

b. Observations and Findings

The inspectors found the work performed under these activities to be well controlled. All work observed was performed with the work package present and in active use. Technicians were knowledgeable of their assigned tasks. When applicable, appropriate radiation exposure control measures were in place. Specific discussions of maintenance observed are listed below.

On September 10 while observing installation of new drain lines in the return lines to the Division 1 Mechanical Draft Cooling Towers, the inspectors observed questionable foreign materials exclusion control practices. During performance of the work, the inspectors observed that at times the floor drains were not covered. The floor drains in question, drained to the Ultimate Heat Sink (UHS). Though no debris appeared to have fallen into the UHS and the drains were subsequently covered, controls at times were weak.

M1.2 Failure to Remove Breaker Test Device (62703)

The inspectors observed functional testing of CTG 11-1 during refurbishment. When an operator attempted to rack in the generator output breaker, the elevator motor failed. An inspector identified that a test device was jammed between the breaker and the cubicle. Licensee personnel were unaware of the presence of the test device and had planned to attempt to rack the breaker in with a replacement motor. Deviation Event Report (DER) 96-1033 was written to document the event and track corrective action.

The breaker and cubicle were undamaged, but the elevator motor burned out. The licensee's investigation found that a contractor had installed the test device during work without documentation and did not remove it. The CTG was still under contractor control at the time of the event, but site operators were required to perform all component operations and were performing breaker racking. Neither organization performed a sufficient visual inspection to identify that the test gear was still installed before attempting to rack in the breaker.

This event demonstrated a lack of control over the breaker test equipment and inattention to detail. The licensee missed an opportunity to avoid this event when the operator correctly removed another piece of test equipment from the breaker but did not remove the breaker closure test device before he attempted to rack it into the cubicle. The inspector reviewed the corrective actions taken by the licensee and they appeared appropriate.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Emergency Core Cooling System (ECCS) Room Equipment Drain Sump D073 Material Condition Problems

a. Inspection Scope (62703)

Through observation of daily plant activities, attendance at morning status meetings and discussions with licensee staff, inspectors monitored licensee actions in response to material condition problems with reactor building equipment drain sump D073. In addition, inspectors observed maintenance activities related to the sump repair and reviewed licensee documentation of the work. Assessment of the work documentation is discussed in Section M3.2 of this report.

b. Observations and Findings

In June 1996, the water input to sump D073 increased. Sump D073, located in the Division 1 RHR Pump Room, collected equipment drainage from inside secondary containment. The hot water being collected was identified as mainly leakage from the reactor water cleanup system. The level detector for sump D073 had a known problem with calibration drift such that indicated level was higher than actual due to contaminants coating the detector over time. It was cleaned without significantly improving the level error. This level error caused operators to briefly enter emergency operating procedures several times with normal actual sump levels. Instrumentation and Control technicians made calibration adjustments to the sump level detector instrument to correct an indicated error that had grown to 11 inches higher than actual.

Coincident with the increased leakage of hot water into sump D073, sump high temperature alarms were periodically received. The sump was designed to recirculate water when a high temperature condition existed. However, operators realized that the sump was actually being pumped down instead. This was determined to be caused by G11-F021, the sump pump

outlet valve not shutting fully due to air operator misalignment. The temperature of the sump was not sufficient to cause damage in the liquid radwaste system when water was inadvertently being sent to radwaste instead of being recirculated and cooled. When the F021 problem was corrected, it was realized that recirculation was still not cooling the sump. Further investigation revealed plugging in the recirculation line by sediment. This was corrected by replacing a section of the pipe.

After the inspection period, sump D073 was functioning normally. Troubleshooting to determine the cause of the sump level instrument calibration shift continued; the level error was suspected to be caused by the elevated temperature in the sump.

c. Conclusions

The safety significance of this sequence of events was minor. However, the inspectors were concerned by several aspects of this issue. The instrumentation providing sump level developed an error sufficient to force operators to enter emergency operating procedures more than once when sump level was actually normal. A moderate amount of plant leakage was required to bring to the licensee's attention, a string of existing material deficiencies that were not previously identified. The licensee was slow to identify that hot water was being pumped to the liquid radwaste system. Fortunately, the temperature of the sump waste was not sufficient to cause damage in the liquid radwaste system. Individually, these deficiencies were minor, but the simultaneous existence of all these unidentified deficiencies challenging the ability to keep plant leakage away from ECCS equipment was of concern. Additionally, it is a concern that operators were required to enter their emergency operating procedures on several occasions without initiating corrective actions. This is an unresolved inspection item until the inspector can review the conditions surrounding the operators entry into emergency procedures (50-341/96-07-03).

M2.3 EDG 12 Trip on Failure of Generator Field

On August 15, during a slow start of EDG 12 per Surveillance 24.307.015, EDG 12 engine tripped on a generator field failure when the local output breaker control switch was taken to the close position. DER 96-0969 was written to document occurrence and track corrective action.

Troubleshooting was conducted and the potential for a common mode failure was identified. The licensee proceeded to successfully test all remaining EDGs. Cards were replaced in the EDG 12 automatic voltage regulator, and the engine was started to perform a post maintenance test. The engine speed could not be raised above 500 rpm. Further troubleshooting identified that the Woodward Governor Actuator Speed Control Dial had slipped when it was dialed down for initial EDG 12 troubleshooting. The licensee determined that the speed dial slippage would not have impacted the ability of the EDG to perform its safety function. DER 96-0986 was written to document the problem and track corrective actions. This problem was corrected, but additional testing

was delayed several hours when a cylinder drain valve broke during pre-start checks. With the valve repaired, EDG 12 was successfully tested.

Overall licensee response to this event was coordinated and proper. The potential for common mode failures were appropriately addressed, and repairs were made in a deliberate manner. Licensee investigation of the cause for the failure of the circuit card in the automatic voltage regulator was in progress at the end of this inspection period. Pending inspector review of the cause of the card failure, this item will remain open (IFI) (50-341/96-07-04).

M3 Maintenance Procedures and Documentation

M3.1 Scaffold Problems

a. Inspection Scope (62703)

During routine inspection of the auxiliary building, inspectors identified several examples of scaffolding installed and being used without proper administrative approval. The inspectors reviewed licensee documentation related to scaffolding control, including Maintenance Conduct Manual, Chapter 8, "Scaffolding," and DER's 96-0117 96-1014. In addition the inspectors discussed scaffolding control with the Modifications and Projects Supervisor, maintenance workers, and plant operators.

b. Observations and Findings

On August 21 and August 27, inspectors identified that several scaffolds erected in the Auxiliary and Turbine Building were not inspected by operations personnel as required by site procedures. Maintenance Conduct Manual, Chapter 8, "Scaffolding," Revision 1, Section 3.12, stated: "All scaffolds erected in the Auxiliary Building, Reactor Building, and RHR Complex shall be inspected by a senior reactor operator (SRO) or reactor operator (RO). The inspection shall ensure the operability of safety related equipment is not compromised. The SRO or RO should sign and date the back side of the Scaffolding Identification Tag."

The inspectors observed that four scaffolds in the Auxiliary Building were not inspected by operators as evidenced by a lack of a signature and date on the back of the Scaffolding Identification Tag. The scaffolds erected in late July and early August were located in the Division 1 and 2 Standby Gas Treatment Rooms and near control room ventilation ducting. The inspectors notified licensee personnel of the discrepancy.

Licensee immediate corrective actions included the conduct of a walkdown by operators and modifications and projects supervision of the Auxiliary Building. Licensee personnel agreed that the operator inspections discussed above had not been completed, and identified additional examples where the scaffolding was not properly inspected. Based on

licensee walkdowns and subsequent inspector observations, the scaffolds in question were built according to procedural guidelines. All scaffolds in the plant were inspected by plant operators. Long term corrective actions planned by the license included review of the current scaffolding procedure for enhancements.

c. Conclusions

The inspectors considered licensee immediate corrective actions in response to the scaffolding problems to be prompt and aggressive. Though the safety consequence of the scaffolding control weaknesses was minimal, the occurrence of the event was another example of maintenance personnel not following site procedures and poor coordination with operations. The continued inspector identification of maintenance procedure compliance problems was of concern. As discussed in Inspection Report 96006 and in the subsequent section of this report, maintenance procedure compliance remains a problem. The failure to follow the requirements of Maintenance Conduct Manual, Chapter 8, "Scaffolding," in that the scaffolding in the Auxiliary Building was not inspected by operators, was a violation of 10 CFR Part 50, Appendix B, Criterion V (50-341/96-07-05).

M3.2 Poor Documentation of Maintenance Activities Related to Equipment Drain Sump D073

As discussed in Section M2.1, maintenance personnel performed corrective maintenance on sump D073 components. The maintenance activities on the sump pump outlet valve (G11-F021) were performed under Work Request 0002964041 and were completed on August 13. On September 11, during review of the work request, inspectors identified several questionable entries, including changes in step sequences without proper documentation and several steps not signed off when accomplished.

The licensee initiated DER 96-1134 to document the potential problems. Subsequent licensee review concurred with the inspectors initial assessment of the work documentation, in that the overall documentation was poor. Though the maintenance task was apparently performed according to the specific work request and the corrective maintenance on the valve was effective, the presence of the administrative errors reflected on poor adherence to site work control procedures. Specifically, on page 8 of the work request, a note was added on August 1, stating that, "steps in this procedure may not be worked out of sequence after step 8." The inspectors noted that the sequence of steps 14, 15, and 16 were changed without initials or a date. Subsequently, the licensee determined that the step sequence was changed on August 3, by a work group supervisor.

The Fermi 2 Work Conduct Manual, Chapter 2, "Work Control," Section 3.7, "Minor Revisions to Work Instructions," stated in part that during performance of a job a work group supervisor may make minor revisions to work instructions, including step sequence changes, however, the general supervisor must clearly initial and date the revision. The failure of

the work group supervisor to date and initial the step sequence change was a violation of the Work Conduct Manual. Though the safety consequences of the missed initial and date was minimal, the continued inspector identification of maintenance personnel not following site procedures remained an area of concern. The failure to follow the requirements of the Fermi 2 Work Conduct Manual, was a violation of 10 CFR 50, Appendix B, Criterion V (50-341/96-07-06).

M4 Maintenance Staff Knowledge and Performance

M4.1 RCIC Online Maintenance Resulted in Unintentionally Rendering the System Inoperable

a. Inspection Scope (62703)

On September 10, the RCIC system was unexpectedly rendered inoperable due to online maintenance and poor material condition. The inspectors reviewed preventive maintenance event W311, "Inspect and Test 260V DC Motor Control Center Load Compartment," control room operator logs, DER 96-1103, and system documentation. In addition, inspectors interviewed system engineers, operators, and licensee management.

b. Observations and Findings

As previously discussed in Inspection Report 96004, the licensee had experienced problems with seat leakage past the RCIC Turbine Steam Inlet Valve (E5150-F045). Based on observations of a small leak on a braided hose on the gland seal line on September 4, the inspectors questioned the impact of continued steam leakage past the E5150-F045 valve on the operability of the RCIC turbine. The inspectors were concerned that water could build up in the turbine and cause a potential water hammer in the exhaust line when the turbine was started. The gland seal line leak is further discussed in Section E2.1 of this report.

Based on discussions with system engineers, the operability of the RCIC Turbine was not affected by the leakage since the barometric condenser was collecting the leakage and not allowing water to build up in the turbine.

At 9:00 am, on September 10, the RCIC system barometric condenser condensate pump was tagged out for preventive maintenance event W311 on the motor and breaker. The expected duration of work, during which the barometric condenser could not be pumped down, was three hours. However, anomalous behavior of a relay discovered during testing, significantly delayed the completion of this work.

At 2:55 pm, the RCIC barometric condenser high water level alarm was received in the control room, just as shift turnover began. Following turnover, the shift discussed draining the barometric condenser by opening the drain plug, but decided not to do this because it was decided that this would render RCIC inoperable. The operating shift then attempted to get maintenance to restore the condensate pump to

service. The barometric condenser sight glass was not checked to determine level because operators were not aware one existed.

At 9:15 pm, a non-licensed operator reported water leaking from the RCIC system such that it appeared possible that the RCIC turbine was half full of water. The Nuclear Shift Supervisor (NSS) discussed with the system engineer this possibility based on the available indications. RCIC was subsequently declared inoperable because the possibility could not be quickly refuted, though the system engineer did not agree.

At approximately 10:39 pm, the barometric condenser condensate pump was restored to service. On September 11, at 3:35 am, the RCIC system was declared operable following verification that the turbine oil moisture content was satisfactory. The vendor was consulted on the impact of water in the casing and for recommended corrective actions. The system was run satisfactorily on September 14.

DER 96-1103 was written to document the event and track corrective actions. The DER was discussed at the September 11, morning managers meeting and assigned a Level 3 priority, the lowest significance level. The significance was considered low because the system was thought at that time to have been functional throughout the event. Following discussions with inspectors, the DER was raised to a higher (Level 2) classification.

The inspectors determined that the decision to perform this preventive maintenance on line, without declaring the system inoperable, was related to vendor documentation with which all people interviewed had only a general knowledge. The document was reviewed by the inspectors, and it indicated that the barometric condenser condensate and vacuum pumps were not required to be environmentally qualified equipment because failure of these pumps during operation would not prevent the RCIC system from performing its safety function. However, the document did not discuss the impact of the condensate pump not being available when the RCIC turbine was in standby.

The inspectors determined that with the RCIC system in standby, the barometric condenser was required to function to prevent existing seat leakage past the RCIC Steam Admission Valve (E51-F045) from condensing and backing up into the turbine. After reviewing the event, operations management and system engineering agreed with this assessment. Per the vendor, the consequences of water in the turbine casing during a start was likely to result in a turbine trip on high exhaust pressure.

The inspectors determined that system engineering, planning, and work control personnel did not evaluate the impact of existing seat leakage past E51-F045 on system operability when planning this work to be performed online. The NSS raised questions in this regard, but was apparently satisfied by the system engineer's response that the barometric condenser condensate pump was not required for RCIC system operability.

Operations management told the inspectors that operators had performed according to their expectations during this event, both in response time and decision-making. However, they stated that RCIC should have conservatively been declared inoperable when water level was above the barometric condenser sight glass; this was issued as a policy statement in a night order dated September 13.

In addition, the inspectors determined that the operators were unable to perform any of the steps in Alarm Response Procedure 1D63, "RCIC Condenser Vacuum Tank Level High." At the time the annunciator was received, the steps in the alarm procedure could not be performed because the condensate pump was out of service and the procedure did not address supplementary actions for this condition when the RCIC system was in standby.

Operations Conduct Manual (MOP) 05, "Control of Equipment," Revision 5, Section 2.2.1, requires that operations evaluate the consequences of removal of equipment from service, including technical specification (TS) limiting conditions for operations (LCO) actions that might require an action statement to be carried out, expected time for restoration, and other systems which may be affected.

c. Conclusions

The inspectors determined that during this event, RCIC should have been declared inoperable no later than when water level was above the barometric condenser sight glass. Contributing to the occurrence of this event was inadequate work planning and assessment of plant conditions by operations and system engineering prior to removing the barometric condenser condensate pump from service.

Operators and system engineering did not adequately understand the design function of the barometric condenser and gland exhaust function while the system was in standby, and as a result misapplied vendor information. As a result, operators were slow to declare the system inoperable and take action to restore the system and pump down the water. Also as a result, management initially underestimated the significance of this event during the DER screening process.

The existing condition of seat leakage past E51-F045 was not quantified, either before or after the event to support work planning or event assessment. Operators, work control personnel, system engineers, planners and schedulers did not adequately evaluate the impact of this existing condition on the operability of a safety related system as it related to performing Preventive Maintenance Event W311. This was a violation of Operations Conduct Manual MOP05 that requires in part that operators review the consequences of removing equipment from service. (50-341/96-07-07)

M7 Quality Assurance in Maintenance

M7.1 Safety System Outage Self-Assessments

a. Inspection Scope (40500)

The inspectors reviewed and assessed a number of safety system outage critique reports for outages performed during the period June through August 1996. The assessments reviewed included Divisions 1 and 2 of RHR, Division 2 Core Spray System, Division 1 Hydrogen Recombiner System, Non-Interruptible Air System, and Division 2 Primary Containment Monitoring System (PCMS). The results of the various outages and critiques were discussed with licensee senior management. Inspectors also attended the critique meeting for the Division 1 RHR outage.

b. Findings and Observations

The licensee instituted a policy to include a critique session and report as part of each safety system outage. The first 6 critiques were reviewed. The inspectors noted a great diversity in the detail and assessment in these reports; the reports ranged from 4 sentences up to 9 pages.

A number of common problems were identified in these reports:

- Late assignment of outage managers (as late as the day prior to the start of the outage) hampered coordination planning and fixing of outage scope.
- Scope reductions during or immediately prior to the outage due to inadequate planning (lack of parts, job time longer than outage goal, initial conditions not met, ALARA review).
- Safety tagging problems (last minute changes, delays in hanging or clearing tags).
- Although noted to be improving, work packages not getting to all parties in time for proper review (this caused the PCMS outage to be delayed more than a month).
- Coordination of qualified personnel and test equipment for testing.
- Incomplete or inaccurate Engineering Design Package (EDP) information complicated installation and testing.

The inspectors considered the PCMS and Hydrogen Recombiner critiques to be excellent. Each was detailed in assessing strengths and problems encountered, and included specific recommendations for improvements. Among the findings of these critiques was a lack of clear policy on the handling of safety system outages and the duties and qualifications of outage managers. Also, while a checklist for preparation for safety system outages existed, it was not always completed according to schedule, in part due to late assignment of outage manager and late planning of work.

Among recommended improvements were:

- Perform bench tests of new parts prior to the outage to reduce time equipment is out of service.
- Walk down tagouts prior to the outage to identify conflicts and administrative problems.
- Assign maintenance personnel to jobs sufficiently in advance so the same workers would perform the pre-job reviews/walkdowns and do the work.

c. Conclusions

On average, the self-assessments reviewed provided a good, candid assessment of problems encountered. These critiques were conducted immediately following the outage, while the events were still fresh, and included representatives of all involved groups. The inspectors considered that a number of the above critiques fell short of providing information useful for preparation for future outages of the same system, primarily through lack of detail. It appeared that coordination meetings prior to outages were becoming more effective, based on fewer coordination problems cited in later reports.

III. Engineering

E1 Conduct of Engineering

E1.1 Modification Fails to Comply with Conditions Set Forth in 50.59 Safety Evaluation

a. Inspection Scope (37551)

The inspectors observed a plant modification to move drain lines in safety related service water lines. Following the observation, the inspectors reviewed the safety evaluation for the plant modification. The inspectors identified a disparity between the safety evaluation and implementation and brought the problem to the attention of the licensee, then monitored corrective actions.

b. Observations and Findings

The licensee began a modification to the combined safety system cooling water return lines to the mechanical draft cooling towers on September 10. As documented in Inspection Report 96004, inspectors identified the one-inch drain lines from these return lines clogged, defeating the design function to prevent freezing of the lines. Violation 90004-05 was issued for failing to maintain the design function of the drain lines. On July 29, inspectors again found plugging in one of the drain lines on the Division 1 system. Violation 96006-03 was issued for inadequate corrective actions to prevent recurrence.

On September 10 and 11, the inspectors observed installation of EDP 28556 to relocate the drain lines to the side of the pipe so sediment would not plug the drains. Both drain lines on Division 1 were removed at the same time, and both new drain line penetrations were bored at the same time.

The inspectors reviewed the basis for the decision to perform the modification without declaring the affected division inoperable. Safety Evaluation 96-0086, Revision 0 evaluated the effect of water spraying from the pipe when the boundary did not meet its licensing basis (not intact). Specific compensatory actions were discussed in the safety evaluation to avoid spraying other equipment and to plug open holes if any of the associated pumps automatically started. The "Partial Implementation" section stated: "This EDP shall be implemented as necessary by the plant for each line individually. Both drain lines in a single division shall not be replaced in parallel, nor shall drain lines in separate divisions be replaced in parallel." Contrary to this statement, the licensee replaced the Division 1 drain lines in parallel. Upon discovering that this requirement was not met, the inspectors brought it to the attention of the licensee.

The inspectors reviewed the four work packages for performing the four drain line replacements and EDP 28556 installation instructions. None of these documents included instructions that drain line work was to be done individually, as specified in the safety evaluation.

Following identification of the problem on September 11, engineering immediately reevaluated the safety aspects of the modification to determine the impact of performing work on both drain lines in a single division in parallel and determined the added risk was negligible. DER 96-1115 was written to document the event and track corrective actions.

The licensee promptly stopped all work in progress for which a safety evaluation had been prepared pending a comparison of safety evaluation requirements against implementing documents. No additional problems were identified. The event was promptly investigated by the licensee. Corrective actions were being developed at the close of this inspection period.

c. Conclusions

The inspectors considered this event to be a violation of the 10 CFR 50.59 process for changes to the licensed facility. The results of the evaluation of the safety implications of the change to the plant, in this case the modification to RHRSW, was not carried through in the implementing documents to maintain the validity of the evaluation. Failure to implement the modification to RHRSW drain lines in the manner specified in Safety Evaluation 96-0086 was a violation of 10 CFR 50.59 (50-341/96-07-08).

E2 Engineering Support of Facilities and Equipment

E2.1 Inadequate Reporting of RCIC Leak

On September 4, inspectors identified a pin hole leak on the RCIC turbine gland exhaust. Further investigation revealed that the leak was identified by the system engineer in December, 1995, but operations and radiation protection were unaware of the leak. The hose was scheduled to be replaced during a system outage in June 1996, but just prior to the outage, the work was removed from the schedule because the wrong part was ordered. The leak was potentially contaminated, but was not being collected, nor was a contaminated area marked around the leak. Following inspector inquiries, a catch was installed and a contaminated area sign was posted. The failure of system engineers to follow through on communication of the leak to radiation protection and operations was considered a weaknesses.

E2.2 Licensee Review of Updated Final Safety Analysis Report

Starting in June, 1996, the licensee began a review of the Fermi 2 Updated Final Safety Analysis Report (UFSAR). The first phase was comprised of the review of about 440 sections of the UFSAR by the responsible system expert to determine if the text was substantially an accurate description of the current plant. After completing the initial review, the need for additional reviews was to be assessed.

The inspectors reviewed more than 70 DERs generated to track items identified during this review. These mostly requested clarifications to the existing text to match existing plant configuration, although in several cases the DERs requested a reduction in the level of detail. The inspectors identified no issues of immediate safety consequence among the DERs.

E2.3 Discrepancies Identified in the UFSAR

A recent discovery of a licensee operating their facility in a manner contrary to the Updated Final Safety Analysis Report (UFSAR) description highlighted the need for a special focused review that compares plant practices, procedures, and parameters to the UFSAR descriptions. While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the UFSAR that related to the areas inspected. The inspectors verified that the UFSAR wording was consistent with the observed plant practices, procedures, and parameters.

E7 Quality Assurance in Engineering Activities

E7.1 Data Recorder Failure Mechanism Identified During Pre-Installation Testing

a. Inspection Scope (37551)

The inspectors reviewed corrective actions following licensee identification of problems with a number of data recorders used in the plant. Engineers and operators involved in the investigation were interviewed and available investigation documents were reviewed.

b. Observations and Findings

While installing new data recorders in the control room simulator in preparation for plant installation per EDP 27297, the simulator group identified that the recorders locked up and indicated "Data Corrupt" following cycling of electrical power. While attempting to recover from this condition, the specific programming was lost and the recorders reverted to factory-default settings. DER 96-0914 was written and operations was informed.

EDP 27297 was to install 12 Westronics Model 2100 recorders with circuit cards susceptible to this type of failure (revisions "A" and "C"). The licensee determined that four recorders of the same type were installed in the control room with circuit cards susceptible to this problem, but their operability was determined to be unimpaired because they were powered by a reliable battery. The programming was verified to be intact for the plant recorders.

The vendor was contacted by engineering, and was aware of this behavior. However, the vendor did not consider this behavior to be a failure mode, and thus had not issued a 10 CFR Part 21 report. A hardware fix was identified by the vendor, that was incorporated in a later circuit card revision than the ones in the recorders received by Fermi. The licensee performed the modification recommended by the vendor on installed recorders, and were then unable to repeat the problem.

The licensee was reviewing this issue for 10 CFR Part 21 reporting criteria.

c. Conclusions

The inspectors concluded that the licensee identification and prompt reporting of this possible failure mode was proper. The operability determination and corrective actions were prompt and appropriate.

E8 Miscellaneous Engineering Issues (92902)

E8.1 (Closed) Inspection Followup Item 50-341/95003-01: Drywell sump level recorder indication differs from actual drywell level (Licensee Event Report 94009). The existing recorder scale is 0-40 inches. Since the

bottom of the sump is 12 inches below the level detector. The inspector reviewed EDP 27223, that indicated the recorder scale has been changed to 12-54 inches. This change provides level indication that reflects actual drywell sump level. This item is closed.

- E8.2 (Closed) Inspection Followup Item 50-341/95011-02: Calculations to ensure that piping support margins for torus hardened vent piping are adequate. The inspectors reviewed Design Calculation (DC) 3121, Volume 1A, Revision A. The calculation shows that portions of the vent attached to the torus has been evaluated for seismic static and dynamic loads, also for higher temperatures associated with venting. The flow in the hardened vent line is initiated through the six inch bypass instead of the 20 or 24 inch pipe run. The main pipe is opened later if needed. Since the downstream valves are opened first, the flow is through an essentially open ended pipe. Calculated condensation resulting from an assumed nominal 135 degree fahrenheit temperature and 100 percent humidity in the torus during plant operations was approximately two ounces, not enough to have a deleterious effect on the pipe during flow initiation. This item is closed.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 Eating and Drinking in Radiologically Restricted Area (RRA)

a. Inspection Scope (71750)

As previously documented in Inspection Report 96006, the licensee identified several examples where plant personnel did not follow site radiation protection guidance, including eating and drinking in the radiologically restricted area (RRA). During this inspection period the licensee identified additional evidence that personnel were eating and drinking in the RRA.

On August 19, security personnel found a soda can and candy wrappers in a desk drawer on the second floor mezzanine of the radwaste building. Deviation Event Report 96-0998 was initiated to document the problem. In addition, on August 26, radiation protection supervision identified chewed gum and sunflower seeds in and around the Turbine Building third floor turbine office. Deviation Event Report 96-1042 was initiated to document the problem.

Licensee corrective actions to prevent further problems with the control of activities in the RRA included:

- additional training to maintenance, security and contractor workers on RRA requirements;
- site-wide communication of recent problems to increase site

- awareness of RRA requirements;
● increased supervisory tours to increase awareness;

c. Conclusions

The inspectors concluded that licensee corrective actions in response to the above events were aggressive. This licensee-identified and corrected violation of radiologically administrative procedures is being treated as a non-cited violation, consistent with Section VII.8.2 of the NRC Enforcement Policy (50-341/96007-10).

S1 Security and Safeguards Activities

S1.1 Fitness For Duty Issue

On August 15, the licensee notified the NRC Operations Center in accordance with 10 CFR 26.73 that a supervisor tested positive for alcohol. The test was administered due to the odor of alcohol on the individual's breath upon reporting for work. The individual's access to the plant's protected area was suspended, and it was confirmed that no safety related duties had been performed. This event will be reviewed as an inspection followup item (50-341/96-07-09)

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on September 16, 1996. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

X3 Management Meeting Summary

On September 12, W. Axelson, Acting Deputy Regional Administrator, Region III called the Senior Vice President, Nuclear to discuss the occurrence of events discussed in sections 04.1, M4.1, and E1.1 above.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

S. Booker, Supervisor, Electrical Maintenance
C. Cassise, General Supervisor, Maintenance
W. Colonnello, Director, Safety Engineering
R. Delong, Superintendent, Rad/Chem
T. Dong, NSSS, Technical Engineering
R. Eberhardt, Director, Nuclear Training
P. Fessler, Plant Manager, Operations
D. Gipson, Senior Vice President, Generation
M. Hoffmann, Compliance Leader, NQA
J. Hughes, Supervisor, Inspection & Supervisor Group
R. Johnson, Audits Supervisor, NQA
E. Kokosky, Superintendent, RP and Chemistry
J. Korte, Director, Nuclear Security
R. McKeon, Assistant Vice President/Manager, Operations
J. Nolloth, Superintendent, Maintenance
N. Pederson, Supervisor, Compliance
J. Plona, Technical Director
W. Romberg, Assistant Vice President and Manager, Technical
J. Thorson, Supervisor, Reactor Engineering
E. Vinsko, Supervisor, Maintenance

INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering
IP 40500: Self-Assessment
IP 62703: Maintenance Observation
IP 71707: Plant Operations
IP 71750: Plant Support Activities
IP 92902: Followup - Engineering

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-341/96-07-01	IFI	Review of acceptance criteria for placement of scaffolding near safety related equipment
50-341/96-07-02	VIO	Inadequate procedure for restoration of EDG switchgear room dampers
50-341/96-07-03	URI	Entry into emergency operating procedure due to faulty indication
50-341/96-07-04	IFI	Failure of EDG 12 circuit card in the automatic voltage regulator
50-341/96-07-05	VIO	Scaffolding in the Auxiliary Building not inspected by operators
50-341/96-07-06	VIO	Failure of work group supervisor to date and initial step sequence change in WR 000Z964041
50-341/96-07-07	VIO	RCIC online maintenance resulted in unintentionally rendering the system inoperable
50-341/96-07-08	VIO	Failure to implement modification to RHRSW drain lines in the manner specified in Safety Evaluation 96-0086
50-341/96-07-09	IFI	Fitness for Duty Issue - Failed For-Cause Test
50-341/96-07-10	NCV	Violation of radiological administrative procedure

Closed

50-341/95003-01	IFI	Drywell sump level recorder indication differs from actual drywell level
50-341/95011-02	IFI	Calculation to ensure that piping support margins for torus hardened vent piping are adequate

LIST OF ACRONYMS USED

CFR	Code of Federal Regulations
CTG	Combustion Turbine Generator
DECo	Detroit Edison Company
DER	Deviation Event Report
EDG	Emergency Diesel Generator
EDP	Engineering Design Package
ECCS	Emergency Core Cooling System
IFI	Inspection Followup Item
IR	Inspection Report
LCO	Limiting Condition for Operation
LER	Licensee Event Report
LPIV	Low Pressure Intercept Valves
NRC	Nuclear Regulatory Commission
NSS	Nuclear Shift Supervisor
PCMS	Primary Containment Monitoring System
RCIC	Reactor Coolant Injection System
RHR	Residual Heat Removal
RHRSW	Residual Heat Removal Service Water
RO	Reactor Operator
RP	Radiation Protection
RRA	Radiologically Restricted Area
SBGT	Standby Gas Treatment System
SOP	System Operating Procedure
SRO	Senior Reactor Operator
TS	Technical Specification
UHS	Ultimate Heat Sink
VIO	Violation