

William S. Orser  
Vice President  
Nuclear Operations

**Detroit  
Edison**

Fermi 2  
6400 North Dixie Highway  
Newport, Michigan 48166  
(313) 586-5201



Nuclear  
Generation

April 16, 1990  
NRC-90-0050

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

References: 1) Fermi 2  
NRC Docket No. 50-341  
NRC License No. NPF-43

2) NRC Inspection Report No. 50-341/89034

Subject: Response to a Notice of Violations 89-034-03/04/05

Attached is Detroit Edison's response to the notice of violation for: (1) the Off Gas System being placed into service without performing the Technical Specification surveillance to verify the Hydrogen Monitor operable; and that compensatory measures for four hour grab samples per Technical Specifications were not initiated; and (2) the violations associated with the B31-F020 valve not being stroke time tested when its' surveillance was due.

These violations were reported by Detroit Edison by Licensee Event Report (LER) 89-035, "Off Gas Hydrogen Monitoring Surveillance was not Completed as Required by Technical Specification" and LERs 89-037 and 89-037-01, "Testing Required by Technical Specifications for the Reactor Water Sample Line Isolation Valve had not been Completed due to Personnel Error". Detroit Edison has initiated corrective actions to resolve these problems. Included in the response is a discussion of: (1) corrective action taken and the results achieved; (2) corrective action to be taken to avoid further violations; and (3) the date when full compliance will be achieved.

Our response date was extended to April 16, 1990, due to a mail delay. This extension was discussed with and authorized by your staff on March 16, 1990.

If there are any questions relating to this response, please contact Joseph Pendergast, Compliance Engineer, at (313) 586-1682.

Sincerely,

Enclosure

cc: A. B. Davis  
R. W. DeFayette  
W. G. Rogers  
J. F. Stang

9004250197 900416  
PDR ADCK 05000341  
Q PDC

LEO/11

Statement of Violation 89-034-03

Technical Specification 3.3.7.12 and associated Table 3.3.7.12-1, Item 2.a requires the offgas system hydrogen monitor to be operable when the offgas system is in operation or to take Action 124 in the Table. Technical Specification Table 3.3.7.12-1, Action 124 allows four hour grab samples in lieu of having the hydrogen monitor operable.

Technical Specification 4.3.7.12 and associated Table 4.3.7.12-1, Item 2.a requires periodic channel calibration and functional tests be performed for the offgas system hydrogen monitor when the offgas system is in operation.

Contrary to the above, the offgas system was placed into service on December 10, 1989 without performing surveillance 44.080.501 to verify the hydrogen monitor operable nor were the compensatory four hour grab samples initiated. This condition existed until discovery on December 12, 1989.

Corrective Actions That Have Been Taken and Results Achieved:

Upon discovery, the Hydrogen Monitors were declared inoperable. Grab sampling was then initiated and hydrogen concentration within offgas was found to be well within specification. The Hydrogen Monitor surveillance was successfully completed on December 13, 1989, at 1600 hours.

Procedures 22.000.02, 23.712, 23.125 and 44.080.501 had precautions or prerequisites placed in them as appropriate to flag personnel for the need to perform the surveillance or verify its current status before placing the Off Gas System in service.

The Chemistry Department incorporated verification of the mode change surveillance requirements into the Shiftly Situational Surveillance Checklist. This requires that the lead chemistry technician review chemistry surveillances with the Nuclear Shift Supervisor or his delegate shiftly.

Required reading describing this event was given to Operations, Surveillance Tracking, Instrument and Controls, and Chemistry Personnel. This increased their awareness of the sequence of events.

Corrective Action That Will Be Taken to Avoid Further Violations:

The potential generic ramifications of this event were considered in the accountability action plan developed by Detroit Edison as described in Detroit Edison letter NRC-89-0300. Included in this action plan was verification that there were no other unidentified problems with the return to service of safety-related equipment from



the outage or startup following the outage. This plan has focused on professionalism, accountability, followup and simplification of work activities. It will serve to improve performance of personnel in all activities throughout the plant.

All personnel in Operations, Surveillance Tracking, Instrument and Controls, and Chemistry have viewed the Fermi 2 professionalism video presented by management which included a presentation of the facts concerning this event. This video emphasized the level of professionalism that is needed from nuclear personnel.

Nuclear Quality Assurance (NQA) has provided an oversight review function for the Accountability Action Plan. The NQA oversight team found that the specific reviews identified in this action plan has raised the confidence level such that no additional problems similar to those identified in December 1989 had occurred. Additionally, the actions to improve existing programs such as the LCO Program, Abnormal Lineup Sheet Program and the Surveillance Scheduling and Tracking Program should be effective in minimizing recurrence of these problems. The NQA assessment team will continue to follow through on the remaining action items.

Date When Full Compliance Will Be Achieved:

Detroit Edison is in full compliance.

Statement of Violation 89-034-04

Technical Specification 3.0.4 states in part "Entry into an OPERATIONAL CONDITION shall not be made unless the conditions for the Limiting Condition for Operation are met without reliance on provisions contained in the ACTION requirements."

Technical Specification 3.6.3 requires all primary containment isolation valves to be operable in OPERATIONAL CONDITIONS 1, 2 and 3. Table 3.6.3-1 Item A.2 of this specification identifies valve B31-F020 as a primary containment isolation valve.

Contrary to the above, plant operators entered into OPERATIONAL CONDITION 2 on December 6, 1989, with valve B31-F020 inoperable in that the quarterly ASME Section XI stroke time test had not been performed.

Corrective Actions That Have Been Taken and Results Achieved:

A critique of this event was developed and issued to Operations personnel as required reading. This critique included a description of the sequence of events, consequences of the event, conclusions, lessons learned, and recommendations.

The administrative procedure governing LCOs, NPP-OF1-11, was revised. Revisions included prohibiting the combining of LCOs and requiring identification of components that are out of service to enhance tracking of equipment status. This procedure revision was approved and has been implemented following training of the operating crews.

The Surveillance Performance Form has been revised to clearly indicate when a surveillance is partially completed. This will assure surveillance group personnel are aware of the work that needs to be done before the surveillance is completed.

Corrective Action That Will Be Taken to Avoid Further Violations:

Procedure NPP-CT1-01, "Surveillance-Performance Package Control", will be revised. This revision will ensure that credit for an entire surveillance cannot be taken unless the entire procedure has been completed satisfactorily.

The potential generic ramifications of this event were considered in the accountability action plan developed by Detroit Edison as described in Detroit Edison letter NRC-89-0300. Included in this action plan was verification that there were no other unidentified problems with the return to service of safety-related equipment from the outage or startup following the outage. This plan has focused on professionalism, accountability, followup and simplification of work activities. It will serve to improve performance of personnel in all activities throughout the plant.

All personnel in Operations have viewed the Fermi 2 professionalism video presented by management which included a presentation of the facts concerning this event. This video emphasized the level of professionalism that is needed from nuclear personnel.

Nuclear Quality Assurance (NQA) has provided an oversight review function for the Accountability Action Plan. The NQA oversight team found that the specific reviews identified in this action plan has raised the confidence level such that no additional problems similar to those identified in December 1989 had occurred. Additionally, the actions to improve existing programs such as the LCO Program, Abnormal Lineup Sheet Program and the Surveillance Scheduling and Tracking Program should be effective in minimizing recurrence of these problems. The NQA assessment team will continue to follow through on the remaining action items.

Date When Full Compliance Will Be Achieved:

The change to NPP-CT1-01 will be completed by the end of June 1990. Fermi 2 is presently in compliance with the requirements of Technical Specifications 3.0.4 and 3.6.3.



Statement of Violation 89-034-05

10 CFR 50, Appendix B, Criterion V, requires in part "Activities affecting quality shall be prescribed by...procedures...and shall be accomplished in accordance with these...procedures..."

Administrative Procedure NPP-OP1-12, "Tagging and Protective Barrier System," provides the implementing instructions for tagging valves and switches to prevent inadvertent operation of structures, systems and components as required by 10 CFR 50, Appendix B, Criterion XIV, "Inspection, Test, and Operation Status." Section 6 of NPP-OP1-12 requires documentation of independent verifications, reactor operator authorization to establish a selected tagging boundary, senior reactor operator acknowledgement of tagging boundary being implemented/removed, and notification to maintenance personnel of a modification to the tagging boundary.

Contrary to the above:

- a. The tagging measures associated with valve B31-F020 allowed the valve to be opened on December 18-19, 1989, without any reasonable tagging measure present to prohibit such an action even though the tagging records required the valve to be closed.
- b. Operators failed to comply with the administrative tagging procedure when establishing and modifying the tagging boundary under Abnormal Lineup Sheet 89-1478 in that an independent valve position verification was not present, a reactor operator authorization signature for a tagging boundary modification was not present, a senior reactor operator signature was not present for acknowledgement of a tagging boundary modification, and some notification stamps to maintenance personnel that the tagging boundary had been modified were not present.

Detroit Edison considers these violations to be attributable to procedural inadequacies and personnel errors.

Corrective Action That Have Been Taken and Results Achieved:

The Operations Department developed a critique of this event in order to capture the lessons learned. This critique was included in the Operations Required Reading program in order to disseminate the lessons learned. In this critique, several corrective actions were recommended; including revising NPP-OP1-11 and NPP-OP1-12 to prevent similar occurrences in the future.

Corrective Action That Will Be Taken to Avoid Further Violations:

Revisions were made to both NPP-OP1-11 and NPP-OP1-12 based upon the conclusions of the critique of this event. The revision to NPP-OP1-11 included prohibiting combining entries in the Limiting Condition for Operation (LCO) system and identification of the specific component or system affected as part of the LCO entry. Also, if an LCO entry is rewritten, the procedure requires a complete review of the rewrite be performed. This will verify that pertinent information is correctly transferred.

NPP-OP1-12 was revised to require components aligned outside their normal status be tagged and those being worked be listed in the Red Tag Record.

A video tape covering the revisions to NPP-OP1-11 and NPP-OP1-12 was presented to the operators in early April.

All the major elements of the corrective action program have been completed. The final steps of transferring the existing control room red-line annotation to the new tagging center mylars is being completed on a priority basis.

Operations personnel have viewed the Fermi 2 professionalism video presented by Management. This video emphasized the need for attention to detail and the level of professionalism necessary for nuclear personnel.

Nuclear Quality Assurance (NQA) has provided an oversight review function for the Accountability Action Plan. The NQA oversight team found that the specific reviews identified in this action plan has raised the confidence level such that no additional problems similar to those identified in December 1989 had occurred. Additionally, the actions to improve existing programs such as the LCO Program, Abnormal Lineup Sheet Program and the Surveillance Scheduling and Tracking Program should be effective in minimizing recurrence of these problems. The NQA assessment team will continue to follow through on the remaining action items.

Date When Full Compliance Will Be Achieved:

Fermi 2 is presently in full compliance with the requirements of NPP-OP1-12.