

Detroit
Edison

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February 10, 1995
NRC-95-0014

U. S. Nuclear Regulatory Commission
Attn: 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 50-341/94016,
dated January 11, 1995

Subject: Response to NRC Inspection Report 94016

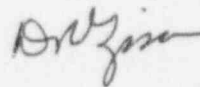
Enclosed is Detroit Edison's response to the Notice of Violation
contained in Reference 2.

The following commitments are being made in this letter:

1. Management feedback will be provided to first line supervision regarding their role in maintaining plant conditions during maintenance and modification activities.
2. Detroit Edison will evaluate housekeeping practices for primary containment, including techniques used at other plants.
3. Deviation Event Report 94-0655 will be covered in first quarter of Instrument and Controls technician continuing training to be completed March 31, 1995.
4. Surveillance Procedure 44.220.103 will be reviewed and revised prior to next scheduled use.

If there are any questions related to this response, please contact
Elizabeth A. Hare, Senior Compliance Engineer, at (313) 586-1427.

Sincerely,



Enclosure

cc: T. G. Colburn
J. B. Martin
M. P. Phillips
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I. Statement of Noncompliance 94-016-02

10 CFR Part 50, Appendix B, Criteria II, Quality Assurance Program, requires in part that activities affecting quality shall be accomplished under suitably controlled conditions. Controlled conditions included suitable environmental conditions for accomplishing the activity, such as adequate cleanliness.

Contrary to the above, on November 13, 1994 and December 4, 1994 based on inspectors observations of debris, the licensee failed to ensure that the torus and drywell, respectively, were sufficiently cleaned in preparation for plant operation.

Reason For The Violation

The primary reason for the material control problem in the drywell and torus was that first line supervision did not in all cases hold their personnel accountable for material control at the job site. It was evident personnel were not in all cases reporting to their supervisors material brought onto the job site that they were unable to account for when they finished the job.

The second reason for the material control problem was that personnel performed inadequate walkdowns for the drywell and torus. Management expectations were not met with regards to how the drywell and torus walkdowns were performed.

Corrective Actions Taken And Results Achieved

The clean-up and walkdown of the torus and drywell was reperformed following the initial NRC walkdown to ensure all debris was removed prior to plant startup. Annual site orientation training for plant personnel was conducted in January 1995. This included a discussion of the plant housekeeping problems encountered during the outage and the potential consequences.

Corrective Actions To Be Taken To Prevent Recurrence

Management feedback will be provided to appropriate first line supervisors regarding their role in maintaining and restoring acceptable plant conditions during maintenance and modification activities.

Prior to the next refueling outage, Detroit Edison will evaluate housekeeping practices for Primary Containment. This will include evaluation of techniques used at other plants to identify those which can improve Fermi 2 performance in this area.

The Date When Full Compliance Will Be Achieved

NRC inspection report 50-341/94016(DRP) states: "The inspectors concluded that overall, foreign material exclusion controls were adequate. However the following weaknesses were identified:...etc...". Corrective action was taken prior to plant start-up to correct the weakness identified by NRC inspection report 50-341/94016(DRP). The material condition of the plant has improved significantly since the outage, and full compliance has been achieved.

II. Statement of Noncompliance 94-016-03

Technical Specification 6.8.1.d requires that written procedures shall be established, implemented and maintained covering surveillance and test activities of safety related equipment. Step 6.4.9.1 of Surveillance Procedure 44.220.103, "Reactor Recirculation System Instrument Lines Excess Flow Check Valves Function Test," required personnel to open the low side drain valve associated with Transmitter B21-N032.

Contrary to the above, on November 3, 1994, personnel performing Step 6.4.9.1 of Surveillance Procedure 44.220.103 opened the low side drain valve for Transmitter B21-N085B and not the valve for Transmitter B21-N032.

Reason for the Violation

Three Instrument and Control (I&C) repairmen were assigned to the surveillance. Two repairmen were located at Jet Pump Rack H21-P010, near the south side Hydraulic Control Units. The lead repairman for the surveillance was in the Control Room in contact with the repairmen at the rack via headphones. The lead had the master copy of the surveillance and signed off the steps as they were completed. The event occurred when the I&C Repairmen (at the rack) read procedure step 6.4.9.1 to open B21-N032 LO Side Drain Valve but opened the LO side Drain Valve on B21-N085B. This caused excess flow check valve (EFCV) B21-F508 to close, resulting in the isolation of Reactor Pressure Vessel pressure and level instruments. When this occurred, the technician was directed to close the drain valve, resulting in the reopening of the affected EFCV a short time later.

The inappropriate action in this event is that the I&C repairman operated a valve before he obtained positive verification from his co-worker that he was on the correct valve. The primary cause for the inappropriate action is that the I&C repairmen misunderstood the second I&C repairman (verifier) and did not allow him time to perform the "Verification" part of procedure step 6.4.9.1. Just prior to operation of the valve, the I&C repairmen should have obtained concurrence (positive indication) from the other I&C repairman (verifier) that he had his hand on the correct valve. During the performance of the earlier procedure steps, the verifier had given his concurrence just prior to the valves being operated.

A contributing factor in the event was a mindset created by the sequence of the surveillance procedure steps. In the steps prior to 6.4.9.1, the procedure has the repairmen open the HI Side Drain Valve and then the LO Side Drain Valve of the same transmitter before proceeding to the next transmitter on the rack. Step 6.4.9.1 breaks this sequence by taking the repairmen from the HI Side Drain Valve on one transmitter to the LO Side Drain Valve on an adjacent transmitter. The valve that the repairmen operated in error was the LO Side Drain Valve on the same transmitter which he had just previously operated the HI Side Drain Valve.

Corrective Actions Taken and Results Achieved

A Plant Manager's Lessons Learned meeting was held with the individuals involved and their management. The purpose of this meeting was to learn the appropriate lessons from this event and to ensure the personnel who need this information receive it in the most appropriate format. A Human Performance Enhancement System (HPES) Report 94-001 was issued evaluating this specific event. Interim Corrective Action was to describe this event and the need for positive verification actions in the I&C shop briefings.

Corrective Actions to Be Taken To Prevent Recurrence

Deviation Event Report 94-0655, "B21-F508 Isolated During Testing", will be covered in the first quarter of I&C continuing training. This will include practical training on verification/communications. This will be completed by March 31, 1995. Surveillance 44.220.103 will be reviewed and revised to ensure a proper logical uniform sequence. This may require moving portions of this procedure to other surveillances. This will be completed prior to next use of the procedure.

Date When Full Compliance Will Be Achieved

Detroit Edison is currently in compliance with Technical Specification 6.8.1.d.