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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/12/2000	1999016	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**The inspectors identified two examples of failures to document conditions in the control room unit log.** The inspectors identified two examples of failures to document conditions in the control room unit log: the completion of an Improved Technical Specification surveillance for local leak rate testing, and actions taken for tripping a reactor recirculation pump differential pressure transmitter (Section O1.2). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**The inspectors noted that some preventive maintenance activities were not finished before the freeze protect** The inspectors determined that the licensee had implemented the freeze protection procedure. However, the inspectors noted that some preventive maintenance activities were not finished before the freeze protection season. Further, work requests and condition assessment resolution documents written for deficiencies identified during the previous freeze protection inspection were not prioritized to be completed before this freeze protection season and the freeze protection issues remained unresolved. Although checks had been completed, the licensee missed that the instructions for freeze protection checks at the meteorological tower did not exist (Section O2.1). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** OPS **Sec:**	Licensee	POS	**Pri:** 1A **Sec:** **Ter:**	**The licensee effectively completed Year 2000 (Y2K) transition checklists before the year change.** The licensee effectively completed Year 2000 (Y2K) transition checklists before the year change. No Y2K related equipment issues occurred during the year transition (Section O1.3). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** OPS **Sec:**	Licensee	POS	**Pri:** 1A **Sec:** **Ter:**	**Operator responses to unexpected equipment problems that impacted plant operation were prompt and appı** Operator responses to unexpected equipment problems that impacted plant operation were prompt and appropriate (Section O1.4). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** OPS **Sec:**	Licensee	POS	**Pri:** 2B **Sec:** **Ter:**	**The licensee resolved the combustion turbine generator fuel oil contamination by draining and filtering, and** The licensee resolved the combustion turbine generator fuel oil contamination by draining and filtering, and proposed actions to preclude recurrence (Section M1.3). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** OPS **Sec:**	Licensee	STR	**Pri:** 1A **Sec:** **Ter:**	**The operators controlled the power reduction deliberately and per procedures for planned maintenance actiı** The operators controlled the power reduction deliberately and per procedures for planned maintenance activities (Sections O1.1). **Dockets Discussed:** 05000341 Fermi 2

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12/21/1999	99999	**Pri:** OPS **Sec:** MAINT	NRC	LIC	**Pri:** **Sec:** **Ter:**	**Management Changes** Ted Bergner, currently director, Organizational Development, will assume the position of superintendent of Operations. Don Cobb, currently superintendent of Operations, will become superintendent of Maintenance. Steve Booker, currently superintendent of Maintenance, will assume the superintendent of Work Control. **Dockets Discussed:** 05000016 Fermi 1 05000341 Fermi 2
12/03/1999	1999015	**Pri:** OPS **Sec:**	Licensee	MV	**Pri:** 1B **Sec:** **Ter:**	**A licensed operator inserted a control rod two notches instead of withdrawing it two notches during a control** A licensed operator inserted a control rod two notches instead of withdrawing it two notches during a control rod check procedure. The reactivity change was negligible and no change in reactor power, temperature, or pressure were noted. The cause was inattention to detail (Section O1.1). **Dockets Discussed:** 05000341 Fermi 2
12/03/1999	1999015	**Pri:** OPS **Sec:**	Licensee	POS	**Pri:** 1A **Sec:** **Ter:**	**Plant power changes to replace worn brushes on the motor-generator sets for the reactor recirculation pump** Plant power changes to replace worn brushes on the motor-generator sets for the reactor recirculation pumps were performed in a controlled manner (Section M1.2). **Dockets Discussed:** 05000341 Fermi 2
12/03/1999	1999020	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The inspectors concluded that an appropriate level of plant awareness existed in the control room.** The inspectors concluded that an appropriate level of plant awareness existed in the control room. The inspectors reviewed operator errors discussed in recent inspection reports. These errors were generally attributed to lack of attention to detail, poor self checking, or poor peer checking and not to inadequate training. (Sections O1.2, O4.1) **Dockets Discussed:** 05000341 Fermi 2
12/03/1999	1999020	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The facility licensee's evaluators conducted the licensed operator requalification examination in accordance** The facility licensee's evaluators conducted the licensed operator requalification examination in accordance with the station's procedures and applicable regulatory requirements. The evaluators administered an improved and more challenging written examination during this requalification cycle. This examination provided good feedback to the training program regarding operator knowledge. (Sections O4.2, O4.3) **Dockets Discussed:** 05000341 Fermi 2
12/03/1999	1999020	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The facility licensee implemented the training feedback process, remediation training program, and the prog** The facility licensee implemented the training feedback process, remediation training program, and the program for maintenance of operator licenses in accordance with the station's procedures and applicable regulatory requirements. (Sections O5.1, O5.2, O5.3) **Dockets Discussed:** 05000341 Fermi 2

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10/20/1999	1999014	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	Self	NEG	**Pri:** 3A **Sec:** **Ter:**	**inadvertent trip of emergency diesel generator 14 during testing.** Inattention to detail, lack of self-checking and lack of an effective peer review, resulted in an inadvertent trip of emergency diesel generator 14 during testing. An operator used the wrong switch to adjust voltage. The error resulted in the emergency diesel generator voltage regulator circuitry being damaged. The error caused extensive engineering and maintenance resources to be diverted from planned activities to troubleshoot, and repair the affected components (Section O1.2).
10/20/1999	1999014	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**a good questioning attitude** An operator exhibited a good questioning attitude that resulted in the identification of two leaking emergency equipment service water discharge check valves (Section M2.1).
10/20/1999	1999014	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**work was deferred as necessary to prevent plant impacts during a reactor core isolation cooling system outa** Operators performed thorough reviews of scheduled work and deferred work as necessary to prevent plant impacts during a reactor core isolation cooling system outage (Section M1.2).
10/20/1999	99999	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	NOED	**Pri:** 1A **Sec:** **Ter:**	**an NOED for drywell purge containment penetration valve** The licensee discovered that a drywell purge system containment penetration had failed a Technical Specification required local leak rate test. Subsequently, a Notice of Enforcement Discretion was issued by the NRC regarding the applicable Technical Specification action requirements. The licensee requested an exigent Technical Specification change and implemented the required compensatory actions necessary to continue operation with the inoperable penetration (Section O4.1).
09/11/1999	1999014	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**Operator Response to Unexpected Decrease in Reactor Recirculation Pump Speed** Control room operators took appropriate actions in accordance with procedures in promptly responding to an unexpected decrease in reactor recirculation pump speed. Operators stabilized the plant at 63 percent reactor power. Generally, the plant responded as expected (Section O1.1).
09/08/1999	1999011	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**in response to several emergent equipment problems the licensee promptly and appropriately took corrective** n response to several emergent equipment problems the licensee promptly and appropriately took corrective actions. For example, the licensee was pro-active in maintaining sufficient fuel oil level for the station blackout combustion turbine generator, an STA identified an inoperable data acquisition system and took appropriate steps to verify TS compliance and to restore the system promptly, and operations personnel responded appropriately to a sudden rise in hydrogen concentration that occurred after an off-gas system trip. (Section O1.1).

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09/08/1999	1999011	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Effective communication of plant status and equipment issues** Effective communication of plant status and equipment issues was exchanged during shift turnover and management meetings. Plant management asked challenging questions during these meetings, in particular, identifying and addressing potential error likely situations that may occur from a sudden change in the brush replacement schedule. (Sections O6.1 and M1.2)
09/08/1999	1999011	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	**Recent human performance errors were properly documented** Recent human performance errors were properly documented in the corrective action program. The licensees corrective actions included a site-wide work stand down to support training which focused on improving work practices which were conducive to decreasing human performance errors. (Section O4.1).
09/08/1999	1999011-01	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	NCV	**Pri:** 1A **Sec:** **Ter:**	**Operator Incorrectly Opened SLC Valve Which Diluted the Tank Boron Concentrtion** Inattention to detail, and less than thorough pre-job reviews contributed to the occurrence of several human performance errors. One non-cited violation was identified for an operator who inadvertently diluted the Standby Liquid Control tank sodium pentaborate concentration. (Section O4.1).
07/30/1999	1999013-01	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	NCV	**Pri:** 1A **Sec:** **Ter:**	**FAILURE TO FOLLOW A SURVEILLANCE PROCEDURE PERTAINING TO LOG TAKING.** during the midnight shift of September 20, 1998, an operator at the Fermi 2 facility deliberately falsified equipment surveillance log entries. The NRC took enforcement action against the individual.
07/23/1999	1999010	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**Lack of operator knowledge regarding the job scope and status of the work activity contributed to the inade** The licensee identified that the safety tagging record for maintenance on the general service water (GSW) sluice gate did not provide adequate protection and resulted in a near miss while restoring the system. Lack of operator knowledge regarding the job scope and status of the work activity contributed to the inadequate safety tagging record protection (Section O1.1).
07/23/1999	1999010	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee responded effectively to a small fire on the Division 2 Control Center Heating Ventilation Air Co** The inspectors concluded that the licensee responded effectively to a small fire on the Division 2 Control Center Heating Ventilation Air Conditioning Makeup Radiation Monitor Sample Pump Motor. Operators used the correct procedures for extinguishing the fire, classifying the event and making the proper notifications (Section O1.2).

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07/23/1999	1999010-01	**Pri:** OPS **Sec:**	NRC	VIO IV	**Pri:** 1A **Sec:** **Ter:**	**EDG 11 MAINTENANCE ACTIVITY WITH SLC B INOPERABLE** The NRC determined that on May 4, 1999, the licensee failed to verify, within 2 hours, the operability of Standby Liquid Control System B after Emergency Diesel Generator 11 was removed from service. Consequently, the licensee did not perform this verification and did not place the unit in Hot Shutdown within 12 hours after both Emergency Diesel Generator 11 and Standby Liquid Control System B remained inoperable for approximately 32 hours. One cited violation of Technical Specification 3.8.1.1.c was identified (Section O8.1).
Dockets Discussed: 05000341 Fermi 2						
06/18/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Operators responded effectively to several fouled heat exchangers cooled by the GSW system.** Operators responded effectively to several fouled heat exchangers cooled by the GSW system. Corrective maintenance activities were well planned and executed. There was good coordination among personnel from the engineering, operations, maintenance, and radiation protection organizations (Section O1.3)
Dockets Discussed: 05000341 Fermi 2						
06/18/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**Operators took prompt and appropriate action to scram the plant when the reactor entered the scram region** Operators took prompt and appropriate action to scram the plant when the reactor entered the scram region of the power to flow map following the unexpected trip of a reactor recirculation pump. Plant equipment responded as expected. Activities to restart the plant were well coordinated. The licensee's investigation of the cause for the recirculation pump trip was timely and thorough (Section O1.1)
Dockets Discussed: 05000341 Fermi 2						
06/18/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**Operators conducted the plant restart in a controlled and deliberate manner following the May 18, 1999, plan** Operators conducted the plant restart in a controlled and deliberate manner following the May 18, 1999, plant trip. Shift turnovers and pre-evolution briefs for the power escalation were thorough and were conducted in accordance with operations department policies (Section O1.2).
Dockets Discussed: 05000341 Fermi 2						
05/15/1999	1999007	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**During the power reduction, the inspectors noted that management expectations were not met by operators i** During the power reduction, the inspectors noted that management expectations were not met by operators in training in regard to: 1) attending pre-evolution briefs, 2) communicating when the control rod control power switch would be manipulated, and 3) obtaining permission to enter the area in front of the P603 Panel (Section O1.1).
Dockets Discussed: 05000341 Fermi 2						
05/15/1999	1999007	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The inspectors observed that a non-licensed operator properly conducted his rounds and was knowledgeable** The inspectors observed that a non-licensed operator properly conducted his rounds and was knowledgeable of plant and equipment parameters (Section O4.1).
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05/15/1999	1999007	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**The operators reduced power in a controlled and deliberate manner per the operating procedure in support** The operators reduced power in a controlled and deliberate manner per the operating procedure in support of planned maintenance activities. Generally, the inspectors noted effective communication and self-checking (Section O1.1) **Dockets Discussed:** 05000341 Fermi 2
05/15/1999	1999007	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**The licensee appropriately initiated a condition assessment resolution document to document an unexpected** The licensee appropriately initiated a condition assessment resolution document to document an unexpected scram of a control rod due to a bad fuse clip for a scram solenoid pilot valve. Operator response to the unexpected condition was prompt and appropriate. The licensee properly assessed this event for reportability (Section O1.1) **Dockets Discussed:** 05000341 Fermi 2
05/15/1999	1999007-02	**Pri:** OPS **Sec:**	Licensee	NCV	**Pri:** 1C **Sec:** **Ter:**	**The licensee indentified that the original intent of Generic Letters 82-02, 82-12, and 83-14; on the control of ov** The licensee identified that the original intent of Generic Letters 82-02, Nuclear Power Plant Staff Working Hours, 82-12, Definition of Key Maintenance Personnel, and 83-14, Nuclear Power Plant Staff Working Hours, for management approval of overtime deviations, justification for overtime deviation, and groups deviating from overtime limits was not met. Further, the licensee determined that the monthly overtime reviews and methods by supervisors in executing the program were less than adequate, and that personnel understanding of the program expectations were unclear. One non-cited violation was identified (Section O3.1). **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**Ineffective communication between the control room operators and radiation protection personnel following** Ineffective communication between the control room operators and radiation protection personnel following the inadvertent transfer of radioactive resins to the waste clarifier tank resulted in the failure to survey the waste clarifier tank room. Consequently, a maintenance worker and a health physics technician received a small unexpected dose when the room was subsequently entered for maintenance activities. (Section O1.3) **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**Although the out-of-service annunciators were properly tracked in the main control room, the licensee was n** Although the out-of-service annunciators were properly tracked in the main control room, the licensee was not effective in maintaining the configuration of the annunciators in the training simulator consistent with the main control room. (Section O2.2) **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The inspectors concluded that out-of-service main control room annunciator alarm windows were properly e** The inspectors concluded that out-of-service main control room annunciator alarm windows were properly evaluated, marked and tracked per procedure. Control Room personnel were aware of out-of-service alarms, and as necessary, compensatory measures were in place for the loss of alarm function. (Section O2.2) **Dockets Discussed:** 05000341 Fermi 2

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04/01/1999	1999003	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Operator response to the increase in the off-gas radiation levels was prompt and appropriate. (Section E1.1)** Operator response to the increase in the off-gas radiation levels was prompt and appropriate. (Section E1.1)
Dockets Discussed: 05000341 Fermi 2						
04/01/1999	1999003-01	**Pri:** OPS **Sec:**	Self	NCV	**Pri:** 1A **Sec:** **Ter:**	**A)Failure to Implement Procedure 24.307.16. B)Failure to Implement Procedure 23.701.14** Two separate instances occurred where operator performance of routine activities was not appropriate. First, an operator did not follow an emergency diesel generator test procedure sequence which caused the emergency diesel generator output breaker to trip open due to a reverse power condition. Second, inattention-to-detail, unfamiliarity with the job assignment, the lack of a peer review, and failure to self check by an operator resulted in the improper operation of the centrifuge feed tank agitator and caused an inadvertent transfer of radioactive resins. Two examples of a non-cited violation were identified. (Section O1.3)
Dockets Discussed: 05000341 Fermi 2						
02/17/1999	1999001	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**Although no equipment operability issues occurred, two operators did not communicate to the control room** Although no equipment operability issues occurred, two operators did not communicate to the control room that they manipulated a core spray pump minimum flow valve. Consequently, the valve was mispositioned and not noticed by control room operators for approximately 7 hours, even though operators walked down the control room panels every half hour. This demonstrated a low attention to detail during routine equipment status checks by control room operators. Plant personnel were distracted from their normal duties to investigate the cause and consequences of the mispositioned valve (Section O1.3).
Dockets Discussed: 05000341 Fermi 2						
02/17/1999	1999001	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1A **Sec:** **Ter:**	**Although no environmental consequences occurred during general service water (GSW) bromination, inatten** Although no environmental consequences occurred during general service water (GSW) bromination, inattention to detail, inaccurate assumptions of plant parameters and lack of communication among the operating crew caused mispositioning of a GSW de-ice valve, that went unnoticed for approximately 9.5 hours. An operator failed to update an operator aid placard, used to track valve position, because he was not trained on the existence of the operator aid placard (Section O1.4).
Dockets Discussed: 05000341 Fermi 2						
02/17/1999	1999001	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The inspectors concluded that the freeze protection program was not comprehensive. The program did not i** The inspectors concluded that the freeze protection program was not comprehensive. The program did not include monthly checks at the meteorological tower, condensate storage tank, condensate return tank, and demineralized water storage tank. In addition, cold weather conditions contributed to the automatic transfer function for the reactor core isolation cooling and high pressure coolant injection systems to be rendered inoperable for a short period of time (Section O2.2).
Dockets Discussed: 05000341 Fermi 2						
02/17/1999	1999001	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The inspectors verified that procedural guidance on operator response to a loss of annunciators existed and** The inspectors verified that procedural guidance on operator response to a loss of annunciators existed and was adequate. However, because it was not a stand alone procedure, some operators were not aware of its existence and had difficulty locating it. (Section O3.1).
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02/17/1999	1999001	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Inspectors observed a reactor building rounds operator performing his duties and determined that the round:** Inspectors observed a reactor building rounds operator performing his duties and determined that the rounds were effectively completed and the operator was knowledgeable of his responsibilities (Section O4.1).
02/17/1999	1999001	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**The power reduction to perform turbine valve testing, control rod pattern adjustment, and to repair a heater** The power reduction to perform turbine valve testing, control rod pattern adjustment, and to repair a heater feed pump leak was completed in a controlled and deliberate manner. The pre-job brief was thorough and communication during the evolutions was good (Section M1.3).
02/17/1999	1999001	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 3A **Sec:** 2A **Ter:**	**The inspectors concluded that the operators exhibited a good questioning attitude in identifying loose flange** The inspectors concluded that the operators exhibited a good questioning attitude in identifying loose flange bolts on the Division 1 Non-Interruptible Air Supply compressor aftercooler moisture separator (Section M1.4).
02/17/1999	1999001	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 5A **Sec:** 5B **Ter:**	**Operations management initiated a condition assessment resolution document to assess, collectively, the rec** Operations management initiated a condition assessment resolution document to assess, collectively, the recent operator errors that occurred during routine activities in order that potential common causes can be identified and addressed (Section O1.5).
02/17/1999	1999001-01	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000341 Fermi 2	Licensee	NCV	**Pri:** **Sec:** **Ter:**	**Failure to follow procedure while starting CTG 11-1.** The licensee identified that an operator rendered the Station Blackout Combustion Turbine Generator inoperable for 2 days because he did not follow the operating procedure while starting the generators. Lack in the use of self-checking techniques by the operator and peer reviewer, contributed to the error. The associated corrective actions were appropriate. The failure to follow procedure was a Non-Cited Violation (Section O1.2).
01/12/2000	1999016	**Pri:** MAINT **Sec:** **Dockets Discussed:** 05000341 Fermi 2	Licensee	NEG	**Pri:** 2A **Sec:** **Ter:**	**Delays occurred during theDiv. 1 non-interruptible air supply maintenance.** Overall performance of the Division 1 non-interruptible air supply maintenance was performed per procedures. However, delays occurred from tag outs, scope changes to work packages, changes to post maintenance testing of a motor control center change out, and minor parts pre-staging problems (Section M1.1).

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01/12/2000	1999016	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**The offsite department responsible for sampling the combustion turbine generator fuel oil ineffectively comm** The Detroit Edison offsite department responsible for sampling the combustion turbine generator fuel oil ineffectively communicated the water and sediment sample results to Fermi 2 which resulted in filling impure fuel oil into the tank and rendering the station blackout combustion turbine generator inoperable (Section M1.3). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**The wrong size opening spring was found to be installed in the reactor core isolation cooling turbine governo** The wrong size opening spring was found to be installed in the reactor core isolation cooling turbine governor control valve. This eventually resulted in valve failure to open fully. The cause was believed to be due to inattention to detail during maintenance (Section M1.4). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**The decision to perform post maintenance testing on on the 480 Volt 72 E electrical bus was not properly cor** The licensee took appropriate actions in refurbishing the three voltage regulator motors of the 480 volt 72E electrical bus. The decision to perform the post maintenance testing following the replacement of all three motors was not properly communicated to electrical maintenance personnel performing the actual field work (Section M1.5). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**Maintenance workers bumped the Division 1 low pressure coolant injection isolation valve switch causing in** While erecting scaffolding around a breaker switch for Division 1 low pressure coolant injection inboard isolation valve E1150F015A, maintenance workers bumped the switch causing inoperability of the residual heat removal low pressure coolant injection mode of operation (Section M1.6). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** MAINT **Sec:**	Licensee	POS	**Pri:** 2A **Sec:** **Ter:**	**The licensee developed and successfully performed a local leakage rate test in the reverse flow direction on** The licensee developed and successfully performed a local leakage rate test in the reverse flow direction on primary containment penetration X-26. This allowed the licensee to stop potentially detrimental testing on the inboard isolation valve (Section M1.2). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016-01	**Pri:** MAINT **Sec:**	Licensee	NCV	**Pri:** 2B **Sec:** **Ter:**	**Failure of instruction to ensure that motor phases were reconnected properly after breaker replacement.** An inadequate maintenance procedure resulted in improper wiring of a containment spray system valve and damage to the motor operator during maintenance and testing. The inadequate procedure was compounded by the fact that a crew change occurred while reconnecting the wires to the motor phases. One non-cited violation was identified (Section M1.7). **Dockets Discussed:** 05000341 Fermi 2

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12/03/1999	1999015	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**On November 12, 1999, the licensee experienced a reportable failure of the Emergency Response Informatior** On November 12, 1999, the licensee experienced a reportable failure of the Emergency Response Information System due to age-related component failures. The licensee made the necessary NRC notifications. The licensee initiated action to replace the system in 1993 but has not made much progress, due in part to lack of available resources. The licensee currently plans to replace the system in April 2000 (Section M1.4). **Dockets Discussed:** 05000341 Fermi 2
12/03/1999	1999015	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	**Distractions to the control room from the field during one pre-job brief to change worn brushes on the recircu** Distractions to the control room from the field during one pre-job brief to change worn brushes on the recirculation pump motor-generator sets made it difficult to effectively communicate essential elements of the task. Human performance training conducted to reduce these distractions and eliminate work environment error precursors was not entirely effective. Further, the expectation to use a drop light for changing the brushes was not effectively communicated or understood (Sections O6.1 and M1.2). **Dockets Discussed:** 05000341 Fermi 2
12/03/1999	1999015	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**Maintenance workers did not effectively implement human performance training during work to replace a re** Maintenance workers did not effectively implement human performance training during work to replace a residual heat removal pump motor. During the evolution, maintenance personnel struck and bent a drain pipe on the thermal recombiner system with a fork lift. The operators appropriately declared the thermal recombiner system inoperable until testing confirmed the system was not damaged (Sections O6.1 and M1.1). **Dockets Discussed:** 05000341 Fermi 2
12/03/1999	1999015-01	**Pri:** MAINT **Sec:**	Licensee	NCV	**Pri:** 3A **Sec:** **Ter:**	**Failure to perform adequate lineup verification of MDCT fan brake system.** The method used by personnel to verify the nitrogen supply valve alignment for the Mechanical Draft Cooling Tower "C" fan brake system was inadequate. As a result, a high pressure nitrogen cylinder was isolated for 14 days, causing a reservoir of the ultimate heat sink to exceed the allowed outage time in violation of Technical Specification 3.7.2. This Severity Level IV violation is being tracked as a non-cited violation, and is in the licensee's corrective action program as CARD 99-18349 (Section M1.3). **Dockets Discussed:** 05000341 Fermi 2
10/20/1999	1999014	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**Several age-related equipment problems that impacted plant operation and safety-related equipment were i** Several age-related equipment problems that impacted plant operation and safety-related equipment were identified, which included aging electrolytic capacitors and worn emergency equipment service water discharge check valves. Previous preventive maintenance programs had not been effective in preventing these failures (Sections O1.1, M2.1, and E1.2). **Dockets Discussed:** 05000341 Fermi 2
10/20/1999	1999014	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 2B **Sec:** **Ter:**	**The licensee identified that tag out protection requirements were not met during performance of maintenanc** The licensee identified that tag out protection requirements were not met during performance of maintenance activities on a feedwater heater valve. The work procedure was inadequate, in that it was not consistent with tag out protection requirements (Section M1.3). **Dockets Discussed:** 05000341 Fermi 2

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10/20/1999	1999014	Pri: MAINT Sec:	NRC	POS	Pri: 1C Sec: Ter:	**two surveillance tests that could have reduced the availability of Technical Specifications related systems** The work scheduling organization scheduled two surveillance tests that could have reduced the availability of Technical Specification related systems during a reactor core isolation cooling system maintenance outage. (Section M1.2). **Dockets Discussed:** 05000341 Fermi 2
09/08/1999	1999011	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: Ter:	**an inconsistency between the vendor manual and work request for the quantity of lubricant used in the resid** The inspectors identified an inconsistency between the vendor manual and work request for the quantity of lubricant used in the residual heat removal cooler fan bearing. Consequently, the component was under-lubricated. The error occurred because the work request was not updated to reflect the proper quantity after a different fan motor was installed in 1996. One minor violation was identified. (Section M3.1) **Dockets Discussed:** 05000341 Fermi 2
09/08/1999	1999011	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: Ter:	**inconsistencies in using protective equipment** Although industrial safety practices were followed, the inspectors noted inconsistencies in using protective equipment during the motor generator set exciter brush replacement. Maintenance personnel did not meet plant management expectations when the activity was started without changing an evaluator guide caution statement regarding the use of proper protective equipment. (Section M1.2) **Dockets Discussed:** 05000341 Fermi 2
09/08/1999	1999011	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	**maintenance activity for the residual heat removal room cooler was coordinated well.** The maintenance activity for the residual heat removal room cooler was coordinated well. Individuals used adequate radiation work practices. Quality Assurance personnel provided effective oversight. (Section M1.3) **Dockets Discussed:** 05000341 Fermi 2
09/08/1999	1999011	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	**The reactor recirculation MG set brush replacement work activity was performed effectively.** The reactor recirculation MG set brush replacement work activity was performed effectively. Workers followed appropriate work procedures and management provided sufficient oversight. (Section M1.2). **Dockets Discussed:** 05000341 Fermi 2
07/23/1999	1999010	Pri: MAINT Sec:	NRC	NEG	Pri: 2A Sec: Ter:	**Miscommunication among the maintenance crew and inadequate implementation of the safety tagging recor** Miscommunication among the maintenance crew and inadequate implementation of the safety tagging record program, by the protection leader, created a condition where the maintenance crew was not adequately protected during a GSW maintenance activity (Section O1.1). **Dockets Discussed:** 05000341 Fermi 2

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07/23/1999	1999010	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**Observed maintenance and surveillance activities were performed in accordance with approved procedures** Observed maintenance and surveillance activities were performed in accordance with approved procedures by knowledgeable individuals (Section M1.1). **Dockets Discussed:** 05000341 Fermi 2
06/18/1999	1999009	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**The pre-job brief and the coordination of troubleshooting activities for repairing a failed square root converte** The pre-job brief and the coordination of troubleshooting activities for repairing a failed square root converter for the feedwater master controller were effective. The work package was properly prepared in accordance with the work control procedure (Section M1.1) **Dockets Discussed:** 05000341 Fermi 2
06/18/1999	1999009	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**Instrumentation and Controls personnel demonstrated a good questioning attitude and effectively resolved a** Instrumentation and Controls personnel demonstrated a good questioning attitude and effectively resolved a calibration problem with a jet pump flow instrumentation string. (Section M1.2) **Dockets Discussed:** 05000341 Fermi 2
05/15/1999	1999007	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**One minor violation was identified when maintenance personnel did not follow a work request and over-grea** One minor violation was identified when maintenance personnel did not follow a work request and over-greased the control center heating ventilation and air conditioning return fan inboard bearing. Since maintenance personnel did not obtain engineering guidance to over-grease, engineering personnel incorrectly focused on over-greasing as a cause to the high temperatures. This caused unnecessary operation of the control center heating ventilation and air conditioning system and an additional operator burden re-tagging the system (Section M1.3). **Dockets Discussed:** 05000341 Fermi 2
05/15/1999	1999007	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2A **Sec:** **Ter:**	**A mechanic's response to hold together a fitting that had been separated during a maintenance activity on th** A mechanic's response to hold together a fitting that had been separated during a maintenance activity on the air piping for a scram solenoid pilot valve, until tightened, was prompt and averted a manual scram. The licensee's investigation into the improper installation of the fitting was thorough. The inspectors concluded that the licensee's approach for investigating possible improperly assembled air fittings on the remaining hydraulic control units was appropriate (Section M1.3). **Dockets Discussed:** 05000341 Fermi 2
05/15/1999	1999007	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**The inspectors observed effective coordination between operations and maintenance personnel.** The inspectors observed effective coordination between operations and maintenance personnel, and appropriate management oversight during the conduct of planned maintenance on the main condenser and the scram solenoid pilot valves (Section M1.2). **Dockets Discussed:** 05000341 Fermi 2

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04/01/1999	1999003	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	**The licensee lacked rigor while determining the initial work scope for a scheduled down power. Although th** The licensee lacked rigor while determining the initial work scope for a scheduled down power. Although the licensee followed their process for the addition of work, the change to the scheduled activities, the day before the power decrease, created a short lead time for radiation protection personnel to assess dose goals and perform the necessary surveys. (Section M1.2) **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**The inspectors concluded that improperly performed maintenance restoration activities resulted in the groun** The inspectors concluded that improperly performed maintenance restoration activities resulted in the grounding straps on three safety-related motor operated valves not being reconnected. The inspectors also determined that the disconnected grounding straps did not impact the ability of the valves to operate. (Section M1.3) **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**The inspectors concluded that the observed maintenance and surveillance testing activities were conducted i** The inspectors concluded that the observed maintenance and surveillance testing activities were conducted in a thorough, professional manner. The inspectors observed supervisors and system engineers supporting and monitoring the activities in progress. The inspectors also noted that appropriate radiation control measures were implemented and all of the maintenance activities were performed with the work package present and in use. (Section M1.1) **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003-02	**Pri:** MAINT **Sec:**	NRC	NCV	**Pri:** 5A **Sec:** 5C **Ter:**	**Failure to Implement Timely and Effective Corrective Action to Preclude the Repetition of Inadvertent Reposit** The licensee failed to implement effective corrective action to preclude the repetition of inadvertent repositioning of safety-related equipment due to accidental bumping. A non-cited violation was identified. (Section M7.1) **Dockets Discussed:** 05000341 Fermi 2
02/17/1999	1999001	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 2B **Sec:** **Ter:**	**The licensee identified that an incorrect classification of an emergency diesel generator (EDG) lube oil heater** The licensee identified that an incorrect classification of an emergency diesel generator (EDG) lube oil heater model, type, and series in 1993, caused an unavailability of spare parts for EDG 11 repairs in 1999, which caused a delay in restoring EDG 11 to operable status (Section M1.2). **Dockets Discussed:** 05000341 Fermi 2
02/17/1999	1999001	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 2B **Sec:** **Ter:**	**The inspectors concluded that the Non-Interruptible Air Supply compressor aftercooler was not properly insta** The inspectors concluded that the Non-Interruptible Air Supply compressor aftercooler was not properly installed on September 28, 1998, causing three out of eight flange bolts to loosen. Additionally, the licensee identified that the work request for cleaning the aftercooler did not include flange bolt torque values (Section M1.4). **Dockets Discussed:** 05000341 Fermi 2

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02/17/1999	1999001	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	**The inspectors identified three malfunctioning space heaters in the Residual Heat Removal complex. The re** The inspectors identified three malfunctioning space heaters in the Residual Heat Removal complex. The remaining heaters were sufficient to maintain the rooms within the Residual Heat Removal complex above freezing. The licensee lacked a periodic preventive maintenance program for these heaters (Section O2.2). **Dockets Discussed:** 05000341 Fermi 2
02/17/1999	1999001	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**Observed maintenance and surveillance activities were performed effectively by knowledgeable individuals u** Observed maintenance and surveillance activities were performed effectively by knowledgeable individuals using approved procedures (Section M1.1). **Dockets Discussed:** 05000341 Fermi 2
01/12/2000	1999016	**Pri:** ENG **Sec:**	Licensee	NEG	**Pri:** 4B **Sec:** **Ter:**	**A 1994 corrective action to isolate the air supply for the high pressure core spray test return line control valve** A 1994 corrective action to isolate the air supply for the high pressure core spray test return line control valve due to "hot shorts" during a postulated fire was not completed. Nevertheless, Generic Letter 86-010 did not require considering this valve for a "hot short" scenario (Section E1.1). **Dockets Discussed:** 05000341 Fermi 2
12/03/1999	1999015	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**The licensee lacked rigor and thoroughness in their evaluation of a vendor calculation that was used as the b** The licensee lacked rigor and thoroughness in their evaluation of a vendor calculation that was used as the basis for retracting a 4-hour notification regarding the inoperability of the high pressure coolant injection system. The site engineering organization did not formally review the vendor's analysis, and a test for the configuration in question had never been performed. The licensee initiated a condition assessment resolution document to re-evaluate the issue (Section E1.1). **Dockets Discussed:** 05000016 Fermi 1 05000341 Fermi 2
12/03/1999	1999015	**Pri:** ENG **Sec:**	Licensee	POS	**Pri:** 4B **Sec:** **Ter:**	**A voltage regulator for 480 Volt Bus 72E failed due to a seized motor bearing on the voltage regulator.** A voltage regulator for 480 Volt Bus 72E failed due to a seized motor bearing on the voltage regulator. The licensee sufficiently determined the operability limits to justify continued operation with the inoperable regulator. The licensee implemented appropriate compensatory actions, including periodic monitoring of bus voltage (Section E1.2). **Dockets Discussed:** 05000341 Fermi 2
10/20/1999	1999014	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**The operability determinations, engineering support and the engineering functional analysis** The operability determinations, engineering support and the engineering functional analysis to address the emergency equipment service water leaking valves were effective and thorough (Section M2.1). **Dockets Discussed:** 05000341 Fermi 2

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10/20/1999	1999014	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 5A **Sec:** **Ter:**	**The Independent Safety Engineering Group thoroughly reviewed and documented** The Independent Safety Engineering Group thoroughly reviewed and documented the circumstances surrounding the unexpected reactor recirculation flow decrease. The Independent Safety Engineering Group identified procedural guidance weaknesses regarding operator actions in response to reactor recirculation flow decreases. (Section E1.1). **Dockets Discussed:** 05000341 Fermi 2
10/20/1999	1999014	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 5C **Sec:** **Ter:**	**The licensee was appropriately addressing accelerated random failures** The licensee was appropriately addressing accelerated random failures of aging capacitors that caused equipment problems for nonsafety and safety systems. The corrective actions were comprehensive and included a preventive maintenance program to replace capacitors in circuits at an increased frequency (Section E1.2). **Dockets Discussed:** 05000341 Fermi 2
09/08/1999	1999011	**Pri:** ENG **Sec:**	Licensee	NEG	**Pri:** 4A **Sec:** **Ter:**	**a technical service request procedure did not provide clear guidance** The licensee identified that a technical service request procedure did not provide clear guidance on classifying the proper modification process after experiencing difficulty installing an air dryer on Emergency Diesel Generator 14. Consequently, engineering personnel misinterpreted the procedure requirement for the proper modification process and did not develop an engineering design package for installing the dryer. (Section E1.1) **Dockets Discussed:** 05000341 Fermi 2
07/23/1999	1999010	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**An engineer did not meet management's expectations for correcting deficiencies.** An engineer, who investigated the inspectors' concern of an unsecured emergency diesel generator oil drain line, did not meet management's expectations for correcting deficiencies when the engineer clamped the line without concurrence from the operations department and without a work request (Section O2.1). **Dockets Discussed:** 05000341 Fermi 2
07/23/1999	1999010	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**A modification to treat the GSW discharge header (the source of zebra mussel infestation) was not implemen** A modification to treat the GSW discharge header (the source of zebra mussel infestation) was not implemented as scheduled due to administrative delays including delays in developing effective procedures. Scheduling Biocide treatments late in Refueling Outage 6 resulted in treatments being performed with low GSW water temperatures, causing a delay in Biocide effectiveness. The delay in eradicating the zebra mussels contributed to the fouling of the GSW heat exchangers and, as a result, presented a challenge to the plant operators (Section E1.1). **Dockets Discussed:** 05000341 Fermi 2
07/23/1999	1999010	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**System engineers were generally knowledgeable of their respective systems.** The inspectors concluded, following system walkdowns and interviews with system engineers, that system engineers were generally knowledgeable of their respective systems. System health reports were established to evaluate system performance and Get Well plans were developed and implemented to improve system performance as needed (Section E4.1). **Dockets Discussed:** 05000341 Fermi 2

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07/23/1999	1999010-02	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4C **Sec:** **Ter:**	**INADEQUATE ABNORMAL OPERATING PROCEDURE FOR DEDICATED SHUTDOWN** This item involved a discrepancy that did not permanently correct a deficiency in the station, AOP 20.000.18, "Control of the Plant from the Dedicated Shutdown Panel," that could have caused the inadvertent draining of the CST to the hotwell. The CST water was required for use by the standby feedwater system to bring the reactor to a Cold Shutdown condition during a postulated fire as defined in 10 CFR 50, Appendix R. AOP 20.000.18, "Control of the Plant from the Dedicated Shutdown Panel," provided inadequate immediate operator actions in that performance of the instructions could have caused the inadvertent draining of the CST to the hotwell during a postulated Appendix R fire. This Severity Level IV violation is being treated as non-cited, consistent with Appendix C of the NRC enforcement policy (NCV 50-341/99010-02(DRP)). This violation is in the licensee's corrective action program as CARD 98-14910.
Dockets Discussed: 05000341 Fermi 2						
06/18/1999	1999009	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineering personnel provided effective support following the plant scram due to the unexpected trip of a r** Engineering personnel provided effective support following the plant scram due to the unexpected trip of a reactor recirculation pump and in resolving the plugged general service water coolers. Engineering personnel effectively provided support in operability determinations and during scheduled maintenance outages (Section E3.1).
Dockets Discussed: 05000341 Fermi 2						
05/15/1999	1999007	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**The inspectors concluded that the Independent Safety Engineering Group's review of the overtime program w** The inspectors concluded that the Independent Safety Engineering Group's review of the overtime program was thorough as reflected in the quality of the identified findings. The Independent Safety Engineering Group identified programmatic and procedural weaknesses and recommended appropriate corrective actions (Section O3.1).
Dockets Discussed: 05000341 Fermi 2						
05/15/1999	1999007	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**The inspectors observed engineering personnel providing effective support to maintenance personnel during** The inspectors observed engineering personnel providing effective support to maintenance personnel during the scram solenoid pilot valve replacement and main condenser tube repair evolutions and during routine maintenance and testing activities (Section E4.1).
Dockets Discussed: 05000341 Fermi 2						
05/15/1999	1999007	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 5A **Sec:** **Ter:**	**The licensee effectively identified the error that caused the control rod blades to be mispositioned in the 3-D** The licensee effectively identified the error that caused the control rod blades to be mispositioned in the 3-D Monicore and placed this deficiency in the corrective action program. The licensee's investigation of this issue was thorough (Section E1.1).
Dockets Discussed: 05000341 Fermi 2						
05/10/1999	9904280129	**Pri:** ENG **Sec:**	NRC	LIC	**Pri:** 4C **Sec:** **Ter:**	**Improving quality of licensing submittals.** Improving quality of licensing submittals. The staff reviewed the quality of recent submittals and indicated that licensee efforts to improve the quality had been, for the most part, successful. Most of the recent submittals did not require any requests for additional information or supplements in order for the staff to complete its review.
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04/08/1999	RR-A25	**Pri:** ENG **Sec:**	NRC	LIC	**Pri:** 4C **Sec:** **Ter:**	**Weakness in Licensee Submittal for Inservice Inspection Program Relief Request RR-A25** During the NRC's review of the Inservice Inspection Program Relief Request RR-A25 related to the inspection of reactor vessel circumferential welds, the staff noted that the licensee did not address the standby feedwater system in its discussion of the potential for a low-temperature overpressurization event. The staff considers the failure to address this plant unique system a weakness in the original submittal. **Dockets Discussed:** 05000016 Fermi 1 05000341 Fermi 2
04/01/1999	1999003	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineering personnel provided good support during the plant down power and during surveillance testing.** Engineering personnel provided good support during the plant down power and during surveillance testing. (Section M1.2). **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineering personnel coordinated well with the fuel vendor to determine that no fuel failure had occurred fo** Engineering personnel coordinated well with the fuel vendor to determine that no fuel failure had occurred following the increase in the off-gas radiation levels. (Section E1.1) **Dockets Discussed:** 05000341 Fermi 2
02/17/1999	1999001	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**System engineering support was not immediately available to assist in resolving a stuck high pressure turbin** System engineering support was not immediately available to assist in resolving a stuck high pressure turbine stop valve. This resulted in a deviation from the planned sequence of activities. The inspectors concluded that increased engineering support during this testing would have prevented unnecessary burden on the operators and would have avoided delays. (Section M1.3). **Dockets Discussed:** 05000341 Fermi 2
02/17/1999	1999001	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**Although it was a prudent decision to require the replacement of Core Spray Logic Relay K-9A be an infrequ** Although it was a prudent decision to require the replacement of Core Spray Logic Relay K-9A be an infrequently performed test or evolution, the initial temporary modification package for replacing the relay was not comprehensive (Section E4.1). **Dockets Discussed:** 05000341 Fermi 2
02/17/1999	1999001	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 5A **Sec:** **Ter:**	**Although he exhibited a good questioning attitude, a system engineer did not pursue with operations manag** Although he exhibited a good questioning attitude, a system engineer did not pursue with operations management his unanswered question for the elevated general service water (GSW) intake temperature and missed the opportunity to identify that the GSW De-Ice Valve was mispositioned (Section O1.4). **Dockets Discussed:** 05000341 Fermi 2

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02/17/1999	1999001	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**The inspectors concluded that the engineering functional analysis for oil contaminated wires to the emergen** The inspectors concluded that the engineering functional analysis for oil contaminated wires to the emergency diesel generator 11 Lube Oil Heater was well documented and prepared with appropriate conclusions (Section M1.2).
02/17/1999	1999001	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Reactor engineers provided good support of the power reduction.** Reactor engineers provided good support of the power reduction.
02/17/1999	1999001	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**The inspectors concluded that the engineering evaluation was thorough and properly justified that Division 1** The inspectors concluded that the engineering evaluation was thorough and properly justified that Division 1 Non-Interruptible Air Supply remained operable with three out of eight flange bolts loose for the aftercooler moisture separator (Section M1.4).
01/12/2000	1999016	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The inspectors concluded that a condition assessment resolution document corrective action, written to deve** The inspectors concluded that a condition assessment resolution document corrective action, written to develop a consistent method for tagging catch basin hoses, was not fully implemented since the inspectors identified inconsistencies in using radioactive material tags (Section R1.1).
12/03/1999	1999015-02	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	Licensee	NCV	**Pri:** 1C **Sec:** **Ter:**	**Engineered entered locked high radiation area without stay time tracking being performed** The licensee identified a Technical Specification violation when an engineer entered a locked high radiation area without stay time tracking. Procedural controls for tagging keys for locked high radiation areas did not exist. Inattention to detail and lack of a thorough review of the survey sheets by the radiological protection supervisor and the engineer involved contributed to the event. The licensee's root cause investigation was thorough and corrective actions appeared comprehensive. This Severity Level IV violation is being tracked as a non-cited violation and is in the licensee's corrective action system as CARD 99-15113 (Section R1.1).
11/19/1999	1999018	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Plant housekeeping was effective in maintaining areas free of unnecessary equipment and debris.** Plant housekeeping was effective in maintaining areas free of unnecessary equipment and debris. Radiological posting and labeling in the plant was appropriate. (Section R1.1)

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11/19/1999	1999018	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The RP staff properly implemented the 10 CFR Part 61 waste characterization program.** The RP staff properly implemented the 10 CFR Part 61 waste characterization program. The staff sampled waste streams and evaluated the results of the analyses in accordance with plant procedures and NRC regulations. (Section R1.2)
11/19/1999	1999018	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The RP staff properly packaged radioactive materials and wastes for shipment.** The RP staff properly packaged radioactive materials and wastes for shipment. Radioactive material shipments were completed in accordance with the current plant procedures and satisfied the requirements of 10 CFR Part 71 and 49 CFR Parts 172 and 173. (Section R1.3)
11/19/1999	1999018	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The radioactive waste processing and storage areas were secured, clean and well-organized, and waste cor** The radioactive waste processing and storage areas were secured, clean and well-organized, and waste containers were properly sealed and labeled. The staff effectively used the corrective action program for problem identification and resolution of On Site Storage Facility (OSSF) operational issues. (Section R1.4)
11/19/1999	1999018	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee effectively implemented administrative external dose controls to ensure that personnel doses w** The licensee effectively implemented administrative external dose controls to ensure that personnel doses were maintained ALARA (as-low-as-is-reasonably-achievable). Personnel doses were maintained in accordance with the established administrative controls and were below the limits prescribed by 10 CFR Part 20. (Section R1.5)
11/19/1999	1999018	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The RP staff calibrated and tested the direct reading dosimeters (DRDs) properly and the DRD program was ir** The RP staff calibrated and tested the direct reading dosimeters (DRDs) properly and the DRD program was implemented satisfactorily. (Section R2.1)
11/19/1999	1999018	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Licensee staff responded appropriately to a radiological incident and effectively used the corrective action p** Licensee staff responded appropriately to a radiological incident and effectively used the corrective action program. (Section R4.1)

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10/20/1999	1999014	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	**radiation areas were properly posted, high radiation areas were locked, monitoring equipment calibrated, ar** The inspectors concluded that radiation areas were properly posted, high radiation areas were locked, monitoring equipment calibrated, and personnel work practices were appropriate (Section R1.1). **Dockets Discussed:** 05000341 Fermi 2
09/27/1999	1999017	Pri: PLTSUP Sec:	NRC	WK	Pri: 1C Sec: Ter:	**The lack of written guidance or procedures for conducting searches of complex vehicles involving multiple s** The lack of written guidance or procedures for conducting searches of complex vehicles involving multiple search officers contributed to the inadequate searches. **Dockets Discussed:** 05000341 Fermi 2
09/27/1999	1999017	Pri: PLTSUP Sec:	NRC	WK	Pri: 1C Sec: Ter:	**A weakness also existed contributing to this event involving a failure to coordinate and communicate during** A weakness also existed contributing to this event involving a failure to coordinate and communicate during complex vehicle searches by more than one security officer. **Dockets Discussed:** 05000341 Fermi 2
09/27/1999	1999017-01	Pri: PLTSUP Sec:	Licensee	EEI	Pri: 1C Sec: Ter:	**Failure to Conduct Adequate Vehicle Search.** One apparent violation was identified regarding the failure by security force members to search a portion of the cargo area of a nondesignated vehicle that entered the protected area on two consecutive days. On the second day, the inadequate search precluded the discovery of a loaded handgun which entered the protected area. **Dockets Discussed:** 05000341 Fermi 2
09/08/1999	1999011	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3B Sec: Ter:	**the individual entered a contaminated area with short pants.** A maintenance individual lacked adequate protection from contamination when the individual entered a contaminated area with short pants. A lack of a clear understanding for proper protection caused this poor radiological work practice. (Section R1.1) **Dockets Discussed:** 05000341 Fermi 2
09/08/1999	1999011-02	Pri: PLTSUP Sec:	NRC	NCV	Pri: 3B Sec: Ter:	**Failure of two electricians to Wear TLDs on the Upper Torso as Required.** Several individuals, who were involved in overseeing the motor generator set brush replacement activity, missed that electricians had violated a radiation protection procedure when the electricians removed their dosimeters to work around the rotating equipment. The licensee identified that this was a site-wide practice during similar maintenance activities. The inspectors identified one non-cited violation. (Section M1.2) **Dockets Discussed:** 05000341 Fermi 2

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07/23/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Health physics and security personnel provided effective support during a small fire.** Health physics and security personnel provided effective support during a small fire on the Division 2 Control Center Heating Ventilation Air Conditioning Makeup Radiation Monitor Sample Pump Motor (Section O1.2). **Dockets Discussed:** 05000341 Fermi 2
07/23/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee appropriately classified that the loss of the emergency notification system and telecommunicatic** The licensee appropriately classified that the loss of the emergency notification system and telecommunications with Monroe County as an Unusual Event. The inspectors concluded that the licensee responded to the event in a prompt and conservative manner. Alternate communications were established effectively (Section P2.1). **Dockets Discussed:** 05000341 Fermi 2
07/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The RP staff properly implemented radiological controls and assessed radiological conditions** The RP staff properly implemented radiological controls and assessed radiological conditions within the plant to adequately limit dose to plant personnel. (Section R1.3) **Dockets Discussed:** 05000341 Fermi 2
07/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The PASS was maintained in an operable condition.** The PASS was maintained in an operable condition. Recent hardware changes improved system reliability and provided a highly functional system. Qualified staff experienced no difficulty in collecting and analyzing samples. (Section R2.1) **Dockets Discussed:** 05000341 Fermi 2
07/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The in-line instrumentation system was maintained in an operable condition** The in-line instrumentation system was maintained in an operable condition and was used effectively to monitor operational chemistry parameters. (Section R2.2) **Dockets Discussed:** 05000341 Fermi 2
07/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Operability of the meteorological tower instrumentation was effectively maintained** Operability of the meteorological tower instrumentation was effectively maintained and monitored by the staff, and calibrations and surveillances for the meteorological tower were properly performed. (Section R2.3) **Dockets Discussed:** 05000341 Fermi 2

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07/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**Implementation of the REMP was effective and no discernable radiological impact on the environment from p** Implementation of the REMP was effective and no discernable radiological impact on the environment from plant operations was identified. (Section R1.1) **Dockets Discussed:** 05000341 Fermi 2
07/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**Plant water quality and fuel integrity remained excellent.** Plant water quality and fuel integrity remained excellent. Chemistry staff effectively monitored various chemistry parameters throughout the facility and promptly responded to trending changes. (Section R1.2) **Dockets Discussed:** 05000341 Fermi 2
07/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**Chemistry personnel were knowledgeable** Chemistry personnel were knowledgeable of their various responsibilities, demonstrated good laboratory practice, and displayed ownership of chemistry department activities. The analytical performance of the chemistry technicians was excellent as evidenced by blind QC data for both chemistry and radiochemistry analyses. (Section R4.1) **Dockets Discussed:** 05000341 Fermi 2
07/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**Performance in the intercomparison programs for chemistry and radiochemistry was excellent.** Performance in the intercomparison programs for chemistry and radiochemistry was excellent. The instrumentation generally remained within statistical control parameters. Chemistry staff effectively reviewed biases related to instrument constancy and took appropriate action. (Section R7.1) **Dockets Discussed:** 05000341 Fermi 2
06/18/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**The licensee was effective in maintaining radiation protection survey equipment calibrated and implementin** The licensee was effective in maintaining radiation protection survey equipment calibrated and implementing effective radiation protection practices (Section R1.1) **Dockets Discussed:** 05000341 Fermi 2
05/15/1999	1999007	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Radiation protection personnel provided effective oversight coverage of the main condenser tube repair activ** Radiation protection personnel provided effective oversight coverage of the main condenser tube repair activity (Section M1.2). **Dockets Discussed:** 05000341 Fermi 2

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05/15/1999	1999007	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**The inspectors concluded that radiation protection controls were implemented effectively.** The inspectors concluded that radiation protection controls were implemented effectively (Section R1.1). **Dockets Discussed:** 05000341 Fermi 2
05/07/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The 1998 evaluation of adequacy of interface with State and local governments lacked supportive documenta** The 1998 evaluation of adequacy of interface with State and local governments lacked supportive documentation. (Section P7) **Dockets Discussed:** 05000341 Fermi 2
05/07/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Licensee personnel performed proper classifications and timely notifications during two actual activations of** Licensee personnel performed proper classifications and timely notifications during two actual activations of the emergency plan. (Section P1) **Dockets Discussed:** 05000341 Fermi 2
05/07/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Emergency response facilities, equipment, and supplies were well-maintained and in an adequate state of op** Emergency response facilities, equipment, and supplies were well-maintained and in an adequate state of operational readiness. Demonstration of selected emergency response equipment verified that the equipment was operable and ready for use. (Section P2) **Dockets Discussed:** 05000341 Fermi 2
05/07/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The Condition Assessment Resolution Document system was an effective method to track and close RERP issu** The Condition Assessment Resolution Document system was an effective method to track and close RERP issues. Procedures were clear and easy to use. (Section P3) **Dockets Discussed:** 05000341 Fermi 2
05/07/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Continued strong management support for the RERP program was indicated during discussions with site and I** Continued strong management support for the RERP program was indicated during discussions with site and RERP staff. The program showed evidence of improving trends. (Section P6) **Dockets Discussed:** 05000341 Fermi 2

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05/07/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee's 1997 and 1998 Nuclear Quality Assurance audits of the RERP program were adequate and satis** The licensee's 1997 and 1998 Nuclear Quality Assurance audits of the RERP program were adequate and satisfied the requirements of 10 Code of Federal Regulations 50.54(t). **Dockets Discussed:** 05000341 Fermi 2
05/07/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**The RERP training program appeared effective.** The RERP training program appeared effective. All personnel reviewed were qualified for their emergency response positions. Interviewed emergency response organization personnel successfully demonstrated good knowledge of their emergency roles and procedures. (Section P5) **Dockets Discussed:** 05000341 Fermi 2
04/09/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**Responders performance during two observed drills was poor. Officers acting in the Response Force Leader** Responders performance during two observed drills was poor. Officers acting in the Response Force Leader positions during the two observed drills failed several of their crucial tasks. Similar poor drill results had been previously identified and no action was taken to apply lessons learned to other shifts or track problems identified. One inspection followup item was identified to review the effectiveness of the licensee's "Contingency Drill Program Action Plan" to improve supervisory command and control and to develop a formal program to incorporate drill critique lessons learned into the ongoing training program. (Section S4.1) **Dockets Discussed:** 05000341 Fermi 2
04/09/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Training records reviewed were complete and accurate. The licensee improved the professional quality of th** Training records reviewed were complete and accurate. The licensee improved the professional quality of the onsite firearms training facility. (Section S5) **Dockets Discussed:** 05000341 Fermi 2
04/09/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The security organization was aggressively involved in the Y2K contingency planning. (Section S8).** The security organization was aggressively involved in the Y2K contingency planning. (Section S8). **Dockets Discussed:** 05000341 Fermi 2
04/09/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 5A **Ter:** 5C	**Self-assessments conducted by the security organization were a strength, except in the area of contingency** Self-assessments conducted by the security organization were a strength, except in the area of contingency drills. The self-assessment program was varied and well documented. Findings were effectively documented, tracked, and corrective actions implemented in a timely manner. (Section S7) **Dockets Discussed:** 05000341 Fermi 2

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04/09/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	**Management controls for reviewing security issues and events were adequate. A sample review of Condition** Management controls for reviewing security issues and events were adequate. A sample review of Condition Assessment Resolution Documents (CARDs) relating to security showed that the licensee was effective in identifying problems, elevating the problem to the proper level of management for resolution, performing root cause analysis and implementing corrective actions. (Section S3.1) **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Immediate personnel response to an inadvertent transfer of radioactive resins and subsequent elevated radia** Immediate personnel response to an inadvertent transfer of radioactive resins and subsequent elevated radiation level in the radwaste basement was prompt and appropriate. (Section O1.3) **Dockets Discussed:** 05000341 Fermi 2
04/01/1999	1999003	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**Radiation protection personnel provided effective oversight during the scram solenoid pilot valve replacemer** Radiation protection personnel provided effective oversight during the scram solenoid pilot valve replacement activities. (Section M1.2) **Dockets Discussed:** 05000341 Fermi 2
03/19/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The gaseous effluents program was implemented in accordance with the offsite dose calculation manual (OD** The gaseous effluents program was implemented in accordance with the offsite dose calculation manual (ODCM) and site procedures. Dose assessment calculations were accurate, and offsite doses were maintained well below regulatory limits and license commitments. (Section R1.1) **Dockets Discussed:** 05000341 Fermi 2
03/19/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Overall, the maintenance and testing program for the standby gas treatment system and control room ventilat** Overall, the maintenance and testing program for the standby gas treatment system and control room ventilation filtration systems was effectively implemented. The licensee performed system testing in accordance with Technical Specification requirements, and test results indicated acceptable system performance. (Section R2.1) **Dockets Discussed:** 05000341 Fermi 2
03/19/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee maintained effluent and process radiation monitors in accordance with license requirements. M** The licensee maintained effluent and process radiation monitors in accordance with license requirements. Monitor calibrations allowed the licensee to effectively assess release of radioactive effluents in accordance with regulatory limits. (Section R2.2) **Dockets Discussed:** 05000341 Fermi 2

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03/19/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Self-assessments were comprehensive, performance-based, and identified areas for improvement in the efflu** Self-assessments were comprehensive, performance-based, and identified areas for improvement in the effluent monitoring and transportation programs. The quality assurance audit identified some minor problems, and the staff took appropriate and prompt action to assess each finding, and to correct the identified problems. (Section R7.1) **Dockets Discussed:** 05000341 Fermi 2
03/19/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2A **Sec:** **Ter:**	**The licensee maintained the liquid radioactive waste handling systems in excellent condition and the solid w** The licensee maintained the liquid radioactive waste handling systems in excellent condition and the solid waste processing areas in acceptable condition. Some minor housekeeping issues were appropriately corrected by the licensee immediately during the inspection while others were identified for correction as part of longer term projects. (Section R1.2) **Dockets Discussed:** 05000341 Fermi 2
03/11/1999	1999005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Minimal amounts of combustible material were noted in the plant and the material condition of most fire pro** Minimal amounts of combustible material were noted in the plant and the material condition of most fire protection equipment appeared to be good. The fire brigade turnout gear was well controlled (Section F2). **Dockets Discussed:** 05000341 Fermi 2
03/11/1999	1999005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The inspector concluded that the fire protection procedures reviewed provided adequate fire protection cont** The inspector concluded that the fire protection procedures reviewed provided adequate fire protection controls and were adequately implemented by station personnel (Section F3.1). **Dockets Discussed:** 05000341 Fermi 2
03/11/1999	1999005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The inspector considered the performance of the fire drill to be good with the exception that brigade membe** The inspector considered the performance of the fire drill to be good with the exception that brigade members delayed entering the simulated fire area due to radio problems. Fire protection and engineering personnel exhibited in-depth knowledge of the plant design and fire protection issues (Section F4). **Dockets Discussed:** 05000341 Fermi 2
03/11/1999	1999005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The training for the onsite and offsite fire brigade members was acceptable. The requirements for drill parti** The training for the onsite and offsite fire brigade members was acceptable. The requirements for drill participation and medical examination were met with one minor exception. **Dockets Discussed:** 05000341 Fermi 2

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03/11/1999	1999005	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The inspector considered the fire protection audits to be acceptable (Section F7).** The inspector considered the fire protection audits to be acceptable (Section F7).
03/11/1999	1999005-01	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	IFI	**Pri:** 1C **Sec:** **Ter:**	**Review of Actual C- Factors Obtained from FPP 28.504.04** The response from engineering personnel concerning the lack of trending of suppression system coefficient of friction (C-factor) values used to compute hydraulic flow was prompt and demonstrated good engineering practices. One inspection followup item was identified to review the actual C-factor obtained from the next water suppression system surveillance (Section F3.2).
02/17/1999	1999001	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000341 Fermi 2	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The inspectors noted that areas in the plant were properly posted with rope barriers in place. Minor radiolog** The inspectors noted that areas in the plant were properly posted with rope barriers in place. Minor radiological events were identified and properly documented into the corrective action program. No significant radiological issues were identified (Section R1.1).

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Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.