October 11, 2006

Mr. Donald K. Cobb
Assistant Vice President
Nuclear Generation
Detroit Edison Company
6400 North Dixie Highway
Newport, MI 48166

SUBJECT: ERRATA TO FERMI NUCLEAR POWER STATION, UNIT 2
NRC INTEGRATED INSPECTION REPORT 05000341/2006003

Dear Mr. Cobb:

On August 2, 2006, the U.S. Nuclear Regulatory Commission (NRC) issued integrated Inspection Report 05000341/2006003 (ML062160540) for your Fermi Nuclear Power Station, Unit 2. The Summary of Findings had paragraphs exchanged and an erroneous assignment to the Emergency Preparedness cornerstone in the original report. The original Inspection Report contained an incorrect number of samples in Section 20S2.2, Radiological Work Planning.

The enclosed Summary of Findings contains the corrected page 3 (marked revised). Please insert the enclosed page 3 to replace the current page 3 in Inspection Report 05000341/2006003. The enclosed page 31 contains the correct number of samples for Section 20S2.2. Please insert the enclosed page 31 to replace the current page 31 in Inspection Report 05000341/2006003. Please remove and dispose of the original pages 3 and 31.

We apologize for any inconvenience to you and your staff.

Sincerely,

//RA/

Christine A. Lipa, Chief
Branch 4
Division of Reactor Projects

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

Enclosures: 1. Revised Summary of Findings to Inspection Report No. 05000341/2006003
2. Revised Page 31, to Inspection Report No. 05000341/2006003

See Attached Distribution

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The finding is of very low safety significance because the unauthorized transient combustible materials would not have ignited from existing sources of heat or electrical energy. The cause of the finding is related to the cross-cutting element of Problem Identification and Resolution. (Section 1R05.2)

- Green. The inspectors identified an NCV of Technical Specification 3.1.5.a.2, Amendment 38, for the standby liquid control (SLC) system being inoperable for longer than the allowed time without the plant being placed in hot shutdown. The licensee failed to properly evaluate the operability of SLC during sparging activities when the issue was raised in 1999. As a result, the licensee initiated a 21-hour sparge on the SLC tank on August 24, 1999, and failed to take actions in accordance with the Technical Specifications. After the deficient evaluation was identified on June 1, 2006, the licensee revised the applicable procedures to declare the SLC system inoperable during sparging the SLC tank. The licensee entered this issue into their corrective action program.

  This finding is more than minor because it affected the equipment performance attribute of the reactor safety cornerstone objective of ensuring the availability, reliability, and capability of mitigating equipment to respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance because the total time of sparging activities was short. (Section 1R15.2)

- Green. The inspectors identified an NCV of license condition 2.C(9), for the failure to appropriately store chemicals in accordance with the fire hazards analysis. The licensee failed to evaluate the fire fighting response guidelines in NFPA-49 for various chemicals brought into the protective area and, therefore, failed to appropriately store them as required by the licensee's fire hazards analysis. As a result, five normally stored chemicals in the building have recommended fire fighting strategies that are inconsistent with the licensee's approved fire protection pre-plan. The licensee entered this issue into their correction action program.

  This finding is more than minor because it represented a programmatic deficiency in the licensee's chemical control program which affected the ability of the fire brigade to respond to and mitigate the effects of a fire. Upon management review, the finding is of very low safety significance because the quantities of the relevant chemicals were low and the storage location was sufficiently remote from mitigating equipment. (Section 1R05.3)

Cornerstone: Occupational Radiation Safety

- Green. A self-revealed NCV was identified for the licensee's failure to comply with Technical Specification 5.4.1.a, written procedures shall be established, implemented, and maintained covering applicable procedures recommended in Regulatory Guide 1.33. The licensee did not adequately control the modification of the ventilation equipment used to vent airborne radioactive particulate to the refuel floor during reactor vessel floodup. Consequently, while raising reactor vessel water level, the improper venting led to personnel contaminations, uptakes of radioactive material, and the

These activities represented three inspection samples.

b. Findings

No findings of significance were identified.

.3 Verification of Dose Estimates and Exposure Tracking Systems

a. Inspection Scope

The licensee's process for adjusting exposure estimates or re-planning work, when unexpected changes in scope, emergent work or higher than anticipated radiation levels were encountered, was evaluated. This included determining that adjustments to estimated exposure (intended dose) were based on sound radiation protection and ALARA principles and not adjusted to account for failures to control the work. The frequency of these adjustments was reviewed to evaluate the adequacy of the original ALARA planning process.

These activities represented one inspection sample.

b. Findings

No findings of significance were identified.

.4 Job Site Inspections and ALARA Control

a. Inspection Scope

The inspectors observed the following five jobs that were being performed in radiation areas, airborne radioactivity areas, or high radiation areas for observation of work activities that presented the greatest radiological risk to workers.

3. Drywell Cooler Number Four Removal;
4. Cutout and Replace Check Valve E1100F031A;
5. Refuel Floor Activities;
6. Main Steam Reheater Replacement; and
7. In-Service Inspections.

The licensee's use of engineering controls to achieve dose reductions was evaluated to verify procedures and controls were consistent with the licensee's ALARA reviews, sufficient shielding of radiation sources was provided for, and the dose expended to install/remove the shielding did not exceed the dose reduction benefits afforded by the shielding.

These activities represented one inspection sample.

b. Findings

No findings of significance were identified.