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NRC-95-0111

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

- References:
- 1) Fermi 2
NRC Docket No. 50-341
NRC License No. NPF-43
 - 2) NRC Inspection Report 50-341/95013,
dated December 6, 1995

Subject: Reply to a Notice of Violations (95013-02 & 95013-03)

Enclosed is Detroit Edison's response to the Notice of Violations (NOVs) contained in Reference 2. The NOVs concern failure to follow procedure, which resulted in modifications and maintenance of components on the refueling floor without proper documentation following the Fermi 2 second refueling outage.

As documented in Reference 2, an independent investigation of the refueling floor activities "irregularities" issues was conducted. In addition, during litigation against the company, certain information was learned by Corporate Counsel and not all of the issues were fully communicated to senior Fermi 2 management. As you are aware, these matters go beyond the violations cited above. Detroit Edison now recognizes that lawsuits and NRC Office of Investigation (OI) investigations present opportunities to learn of potentially legitimate concerns for which action has not been taken, and therefore, such information needs to be shared with appropriate management personnel. In the future, transcripts of civil case depositions will be reviewed by Fermi personnel not directly involved in the litigation to identify any new uninvestigated and unaddressed issues. Also, interviews will be held with legal personnel during OI

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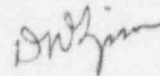
investigations to determine if any new issues exist. These actions will help ensure that issues are appropriately communicated and addressed. These lessons learned have been shared with licensing, legal and senior management personnel.

The following commitments are being made in this letter:

1. The practice of conducting pre-outage refueling floor team meetings will be continued through the fifth refueling outage, and will be evaluated for continuation for future outages.
2. Information on civil cases and OI investigations will be reviewed to identify any new uninvestigated and unaddressed issues.

If there are any questions related to this response, please contact Ken Riches, Compliance Engineer at (313) 586-5529.

Sincerely,



Enclosure

cc: T. G. Colburn
M. J. Jordan
H. J. Miller
A. Vogel

Response to Notice of Violation 50-341/95013-02

Statement of Notice of Violation

Technical Specification 6.8.a. requires that written procedures shall be established, implemented, and maintained covering activities for applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, Section 9.e (1) requires, in part, the procedures for the control of modifications should include...method for obtaining permission and clearance for operation personnel to work...

Fermi 2 Interfacing Procedure, FIP-CM1-12, Revision 4 (dated April 18, 1991), "Engineering Design Packages," Section 5.1 requires, in part, that "all QA Level 1 and 1M Engineering Design Packages (EDPs), generated to modify systems, structures, or components contained within...(5.1.1 Reactor Building), shall be designated as Type 1 EDPs, and shall be generated in accordance with all applicable requirements of the procedure."

Contrary to the above, during June 1991, a supervisor, the Refuel Floor Coordinator modified a Reactor Building component, specifically the New Fuel Uprighting Stand, by removing the mounting anchor bolts without generating a Type 1 EDP.

Reason for the Violation

In June 1991, a General Maintenance Journeyman (GMJ) removed anchor bolts that were installed on the refueling floor for the New Fuel Uprighting Stand mounts and the New Fuel Storage Container Stop. The GMJ believed that these bolts were a personnel safety hazard and removed them without performing the appropriate evaluations and obtaining written authorization as required by the procedures governing engineering design packages and work control.

Several administrative barriers that were in place to prevent unauthorized plant modifications were either negated or neglected during the evolution of this event. These barriers included training, procedure usage, and management involvement.

Corrective Actions Taken and the Results Achieved

In July 1993, an independent investigation was conducted, and documented on a deviation event report (DER) after allegations that "irregularities" existed with modifications to the new fuel transfer crane and removal of mounting bolts on the refuel floor for the uprighting stand. As a result of this independent investigation, an engineering design change package was completed showing the

as-built configuration of the refueling floor (i.e., documented no safety concern with removing the anchor bolts). In addition, the individual involved in this event received counseling on procedure adherence by the plant manager and on-the-job training. There were no similar repeat occurrences by the individual of the type addressed by this violation after he received the additional training.

Other actions taken include: (1) increased quality assurance (QA) personnel presence on the refueling floor to perform the refueling floor activities audit during the fourth refueling outage (RF04); (2) in April 1994, a lessons learned package was developed and communicated to personnel involved in refueling floor activities; and (3) prior to RF04 refueling activities, a team building session was conducted to stress procedure adherence and compliance, to discuss lessons learned from previous refueling outages and from other plants, to review the duties and responsibilities of the various refueling floor positions, and to ensure that all personnel understand the importance of proper work control and procedure adherence. The lessons learned explicitly addressed not making alterations to the plant (such as removing unused bolts mounted in the floor) and ensuring that such activities are evaluated for the potential to be plant modifications. The QA RF04 refueling floor activities audit determined that there was good training on previous deficiencies and industry events, that there was good coordination and questioning attitude between various work groups on the refueling floor, and that there was good management involvement with day-to-day activities.

Furthermore, during investigation of this event, when Fermi management recognized that procedures had been violated and that management expectations were not met, the individual and his supervisor received discipline in December 1995 in accordance with Detroit Edison's positive discipline program.

The corrective actions as described above have been effective as evidenced by no repeat violations of this nature by refueling floor personnel since the corrective actions were taken.

Corrective Actions Taken to Prevent Recurrence

Based on the effectiveness of the corrective actions taken to date, no additional corrective actions are considered necessary. The practice of conducting pre-outage refueling floor team meetings will be continued through the fifth refueling outage, and will be evaluated for continuation for future outages.

Date When Full Compliance Will Be Achieved

Detroit Edison is presently in full compliance.

Response to Notice of Violation 50-341/95013-03

Statement of Notice of Violation

Technical Specification 6.8.a. requires that written procedures shall be established, implemented, and maintained covering activities for applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, Section 9.c requires that procedures for the repair or replacement of equipment should be prepared prior to beginning work.

Nuclear Production - Fermi 2 Administrative Procedure, NPP-MA1-01, Revision 7 (dated December 11, 1991), "Work Control," Section 5.1 requires, in part, that "maintenance activities on Important Work, which is defined as any maintenance or modification activity performed on plant systems, structures or components that is Tech Spec related, QA Level 1 or 1M or requires a permit such as a Protective Tagging, Welding, etc., shall be completed through planned Work Requests. Furthermore, Work Requests are required for repairs and rework of plant systems, structures and equipment as described..."

Contrary to the above, on August 30, 1992, a licensee's supervisor, the Refuel Floor Coordinator repaired the New Fuel Transfer Crane without a Work Request.

Reason for the Violation

On August 30, 1992, after a transfer of a new fuel bundle from the inspection stand to the new fuel preparation machine, the detent pin came out while moving to the west in preparation for the next new fuel transfer, resulting in erratic crane movements. The detent is a feature that prevents operation of the crane in any position of the beam other than at 90 degrees. The Refueling Floor Coordinator (RFC) recognized this as a condition where the detent solenoid had energized. The RFC had also recognized that a similar failure had previously occurred. The RFC disconnected (determinated) power cables to the swing beam detent solenoid to put the crane in a safe condition from a potential industrial accident perspective by preventing erratic crane operation. There were no loads attached to the crane at the time of the maintenance activities. New fuel movement recommenced after determination of the detent solenoid power cable. None of Fermi's procedures, processes, or policies allowed the RFC to disable the swing beam detent solenoid. The RFC did not record the determination of the detent solenoid's power cables on an interim alteration checklist (IACL), in the refuel floor logs, or on a work request. The RFC believed that the corrective maintenance activity was within his skill-of-the-craft.

Several administrative barriers that were in place to prevent unauthorized plant alterations were either negated or neglected during the evolution of this event. These barriers included training, procedure usage, management involvement, and identification of errors.

Corrective Actions Taken and the Results Achieved

Appropriate corrective actions to repair and return the crane to conformance of its original requirements were subsequently taken after the remaining fuel bundle transfers were completed.

In July 1993, an independent investigation was conducted, and documented on a deviation event report (DER), after allegations that "irregularities" existed with modifications to the new fuel transfer crane and removal of mounting bolts on the refuel floor for the uprighting stand. As a result of this independent investigation, the individual involved in this event received counseling on procedure adherence by the plant manager and on-the-job training. There were no similar repeat occurrences by the RFC of the type addressed by this violation after the RFC received the additional training.

Other actions taken include: (1) increased quality assurance (QA) personnel presence on the refueling floor to perform the refueling floor activities audit during the fourth refueling outage (RF04); (2) in April 1994, a lessons learned package was developed and communicated to personnel involved in refueling floor activities; and (3) prior to RF04 refueling activities, a team building session was conducted to stress procedure adherence and compliance, to discuss lessons learned from previous refueling outages and from other plants, to review the duties and responsibilities of the various refueling floor positions, and to ensure that all personnel understand the importance of proper work control and procedure adherence. The lessons learned explicitly addressed that if the equipment does not function as designed/required, take steps to get the equipment repaired or modified in accordance with work control and modification procedures. The QA RF04 refueling floor activities audit determined that there was good training on previous deficiencies and industry events, that there was good coordination and questioning attitude between various work groups on the refueling floor, and that there was good management involvement with day-to-day activities.

Furthermore, during investigation of this event, when Fermi management recognized that procedures had been violated and that management expectations were not met, the individual and his supervisor received discipline in December 1995 in accordance with Detroit Edison's positive discipline program.

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Overall, the corrective actions as described above have been effective as evidenced by no repeat violations of this nature by refueling floor personnel.

Additionally, responsibility for refuel floor work coordination is being transferred to the Maintenance Department for unrelated reasons. This transfer will place the refueling floor coordinator under the accredited maintenance supervisor training program.

Corrective Actions Taken to Prevent Recurrence

Based on the effectiveness of the corrective actions taken to date, no additional corrective actions are considered necessary. The practice of conducting pre-outage refueling floor team meetings will be continued through the fifth refueling outage, and will be evaluated for continuation for future outages.

Date When Full Compliance Will Be Achieved

Detroit Edison is presently in full compliance.