

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-341/84-63(DRP)

Docket No. 50-341

Licensee: The Detroit Edison Company  
2000 Second Avenue  
Detroit, MI 48224

Facility Name: Enrico Fermi Nuclear Power Plant, Unit 2

Inspection At: Enrico Fermi 2 Site, Monroe, MI

Inspection Conducted: November 26-30, December 3-7 and 17-21, 1984

Inspectors: P. M. Byron  
Senior Resident Inspector

C. H. Scheibelhut

V. J. Elsbergas

Approved By: R. C. Knop, Chief  
Reactor Projects Section 1C

*J. McCormick-Borgen for RCK* 1/25/85  
Date

Inspection Summary

Inspection on November 26-30, December 3-7 and 17-21, 1984 (Report No. 50-341/84-63[DRP])

Areas Inspected: Routine safety inspection by regional personnel of licensee action on previously identified items, 10 CFR 50.55(e) items and evaluation of licensee action with regard to allegations and a Region III request. This inspection involved a total of 216 inspector-hours onsite by two NRC regional inspectors, including 0 inspector-hours onsite during off-shifts.

Results: In the four areas inspected, no items of noncompliance or deviations were identified.

## Details

### 1. Persons Contacted

#### The Detroit Edison Company

J. M. DuBay, Director, Planning and Control

L. P. Bregni, Engineer, Licensing

D. E. McKenzie, Engineer, Licensing

The inspectors also interviewed other licensee and contractor personnel during the course of the inspection.

### 2. Licensee Actions on Previously Identified Items

- a. (Closed) Safety Evaluation Report (SER) Open Item (341/81-10-06 DRDP), "Tests of Voltage Drop in Distribution System (8.2.1)". The SER approved the results of the licensee's voltage analysis to ascertain that adequate voltages will be available for Class 1E equipment for steady-state as well as transient conditions. However, the SER (Section 8.2.1) requires that the analytical technique and assumptions used in voltage analysis be verified by actual measurement.

The required field measurements were made as a part of the PRET.R1102.001 preoperational test. The results of this test are documented in the licensee's internal memo EF2-72330, dated December 13, 1984. As concluded in the memo, the test results confirm that the mathematical model used does correctly represent the field conditions as required in the SER. The inspector concurs with this conclusion. This item is considered to be closed.

- b. (Closed) Safety Evaluation Report (SER) Open Item (341/81-17-03 DRDP), "Inclusion in the Plant Emergency Operating Procedures of Directions for Mitigating Anticipated Transients Without Scram (ATWS)". Supplement 1 to the Fermi 2 SER requires verification by the Office of Inspection and Enforcement of certain items before an operating license is issued including the above item.

The licensee prepared Plant Operating Manual Procedure 29.000.08, "Reactivity Control", to fulfill the requirement.

The inspector reviewed Rev. 1 dated September 12, 1984, of the procedure and found that it meets the requirements for having directions for mitigating anticipated transients without scram in the emergency procedures. This item is closed.

- c. (Closed) SER Open Item (341/81-17-06 DRDP), "Completion of Installation and Testing of the Control Room Evacuation Alarm and Computer Software". Supplement 1 to the Safety Evaluation Report for Fermi 2 (SSER No. 1, NUREG 0798) identified open items requiring verification by the Office of Inspection and Enforcement. This item called for a demonstration of the adequacy of the control room emergency evacuation alarm and the availability of the process computer software.

The inspector observed a demonstration of the control room emergency evacuation alarm. With all panel alarms sounding simultaneously, the emergency control room evacuation alarm was sounded. The distinctive alarm could be heard easily in all areas of the control room.

The process computer system has undergone preoperation testing Test C 9100.001, "Process Computer Interface Systems". The objective of this test was to demonstrate that the scan, log, and alarm software and associated hardware were operable. The test results were reviewed by the test review committee and found acceptable. The inspector reviewed a sample of the test results and witnessed a demonstration of the computer in the control room and concludes that the computer software is available. This item is considered to be closed.

- d. (Open) Item of Noncompliance (341/83-20-03 DRDP), "Discrepancies in the Storage and Handling of Safety-Related Materials - 10 Examples". The licensee was found to have violated his procedures in the storage and handling of safety-related materials. Examples A, D, E, F, G, and H were previously closed in Inspection Report 50-341/84-20 DRP.

Example C stated a Class 1 valve that was located in the warehouse had the words "QC HOLD" written on the accept tag.

The licensee revised Nuclear Quality Assurance Procedure (NQAP) 0801, "Identification, Tagging, and Control of Material at Receipt Inspection", by adding a new paragraph (6.3.1.2). This paragraph requires that the accept tag be removed from items returned to a QC receiving hold area for reinspection or QC disposition and appropriately tagged "Hold" or "Reject". The accept tag may be placed in an envelope and attached to the item to maintain traceability to the original inspection.

The revised procedure was reviewed and found to contain the above requirements. This is acceptable and Example C is considered closed.

Example I stated that the inspector observed material awaiting inspection in the HOLD area of the QC Material Receipt Inspection Area. Following the NRC inspection, the licensee made a review of all items in each of the following areas: Accepted, Hold, Reject, and Awaiting Inspection. The item found misplaced in the Hold area was the only discrepancy found and believed to be an isolated instance. Since only material tagged "Accepted" is allowed to be issued such isolated instances have not affected the quality of Fermi 2.

The inspector concurs in this conclusion and Example I is considered closed.

Example J was concerned with the control of items with a defined or recommended shelf life. This example was the subject of a later

item of noncompliance (341/84-32-04 DRP) since the licensee did not take prompt corrective action. This item of noncompliance was closed in Inspection Report 341/84-48. Its closure automatically closes Example J.

The item remains open until Example B can be closed.

- e. (Closed) Unresolved Item (341/83-30-05 DRDP), "Possible Overpressurization of RHR Heat Exchanger A During Hydrostatic Test". During hydrostatic testing of piping adjacent to RHR heat exchanger A, and with the heat exchanger shell relief valve gagged, it was found that the pressure in the piping would not increase above 1300 psig which was short of the required pressure. It was then discovered that water was leaking from the head flange joint of the heat exchanger. The test was terminated. Subsequent tests indicated that there was leakage through the isolation between the heat exchanger shell and the high pressure side. The design pressure of the heat exchanger shell is 450 psig. The subsequent tests also did not prove that the heat exchanger was not overpressurized.

The licensee wrote Nonconformance Report (NCR) 84-0083 to document the event and provide a disposition. The event was also reported to the NRC as a 10 CFR 50.55(e) Item 50-341/84-06-EE (licensee No. 114). The licensee concluded that the heat exchanger was overpressurized. Assuming a postulated worst case condition of 1330 psig, the heat exchanger manufacturer was asked to review the capability of the vessel to withstand the postulated pressure. The manufacturer identified two areas as possible weak points that should be examined for possible damage. Extensive nondestructive examination of these areas revealed no evidence of damage. Hydraulic testing of the tube side of the heat exchanger indicated that no tube damage (cracking or collapse) had occurred.

The licensee also made an engineering evaluation of the applicable ASME Code requirements. The evaluation was conducted under the guidelines of ASME Section XI Code Case N-145. This code case requires an assessment per Appendix F of Section III. The stress calculations required by the faulted condition assessment showed that the structural integrity of the vessel is assured for the one time event. The calculations actually showed that the structural integrity was also assured in applying emergency condition (a less severe condition) assessment rules. Under these rules, the condition could recur 25 times. Operational and functional assessments included leak testing, pressure drop testing, flow testing and vessel inspection for deformation. It passed all of these tests.

The inspector reviewed the NCR, the testing results, and the ASME code calculations. The review indicated that the test showed no structural damage to the vessel and code case N-145 was the proper case to use in evaluating the code requirements for the incident. Further inspection also showed that plant procedure POM 21.000.06, "Documentation of Allowable Operating Transients", requires reporting of events such as this and Engineering Procedure NE 4.4, "Cycle Monitoring" requires logging of all transients in a code allowable

operating transient cycle program. This event has been logged in the program. We conclude that the heat exchanger has passed all stated code criteria and is fit for continued operation. This item is closed.

- f. (Closed) Item of Noncompliance (341/84-19-03 DRP) "The Licensee Dispositioned Seven Construction Assessment Team (CAT) Findings by Using Other than Nonconformance Reports (NCRs)". During the course of CAT activities, deficiencies were found that required corrective action. In several instances, Field Modification Requests (FMRs) or Design Change Requests (DCRs) were used to correct the deficiencies instead of using NCRs. This was in violation of the licensee's procedures and Criterion XV of Appendix B to 10 CFR 50.

When the licensee's management became aware of the problem, a five member Nuclear Quality Assurance (NQA) group was assigned to assist the Edison Construction Assessment Support Team (CAST) review of the concerns originated by the CAT. As part of its responsibilities, the NQA group assured that all of the pertinent CAT concerns and findings were processed under the Fermi 2 QA program using an NCR. This included the items that formed the basis of the item of noncompliance. This action provided the corrective action necessary to resolve the identified problem. To avoid further nonconformance, the licensee reviewed the Quality Assurance Program and implementing procedures to assure that all Fermi 2 organizations were using consistent and correct methods to identify, report, and disposition nonconforming conditions. As a result of this review, a new procedure was written. It is Fermi 2 Nuclear Operations Interfacing Procedure 11.000.52, "Deviation and Corrective Action Reporting", dated November 9, 1984. This procedure supercedes Plant Operations Manual Procedure 12.000.52T, "Nonconformance Reports" and Administrative Plant Operating Manual Procedure 12.000.32, "Deviation and Corrective Action Reporting". Training was provided to applicable personnel on the requirements of the new procedure.

The inspector reviewed the NCRs generated to correct the item of noncompliance. These were 84-1074 covering CAT Item 24, 84-1147 covering CAT Item 22, and 84-1108 covering CAT Items 17, 18, and 23. It was found that CAT Items 13 and 14 did not require the issuance of NCRs. The review showed that the NCRs were properly completed. The new procedure, 11.000.52, was reviewed along with the memo (QA-84-2927, dated November 12, 1984) requiring indoctrination training by supervisors, maintenance, and technical personnel, operators, and NQA personnel. This review showed that the corrective action taken to avoid further nonconformance should be effective. This item is closed.

- g. (Closed) Unresolved Item (341/84-19-09 DRP), "Emergency Diesel Generator 14 Turbocharger Overheated Because the Cooling Water Isolation Valve was Shut". This event was caused by operator and supervisor error and confusion as to which procedure to follow.

The licensee wrote "Deviation/Event Report (DER) NP-84-053 to document the event and provide corrective action and action to prevent

recurrence. At the time that Inspection Report 50-341/84-19 was written, the licensee had not accepted closure of the DER and was continuing investigation of the event.

The licensee has closed the DER. The inspector's review showed that a proper root cause of the event has been indicated. Corrective action taken included opening the valve and the requirement that all future work be conducted and maintained in accordance with Administrative Procedure 21.000.01, "Shift Operations and Control Room". To prevent recurrence, the nuclear shift supervisors were instructed to use all administrative controls applicable to "turned over" systems to all operable systems regardless of status. This should effectively prevent recurrence. This item is closed.

- h. (Closed) SER Open Item (341/84-20-03 DRP), "The Evacuation Signal System was not Connected and could not be Evaluated". This item is the same as the first part of SER Open Item 341/81-17-06 discussed above. This item is considered to be closed.
- i. (Closed) Safety Evaluation Report (SER) Open Item (341/84-20-06 DRP), "Units are not Identified on Plant Radiation Monitoring System (PRMS) Records on Panel H11-P601". Certain recorders on the PRMS panel did not have the units (i.e., counts per second, mr per hour, etc.) displayed so the readout was unknown.

The licensee properly marked the scales on the recorders. Field Modification Request (FMR) No. 7208 was issued to perform the work.

The inspector reviewed the FMR and inspected all of the PMRS recorders. All have the proper units identified on the scales. This item is closed.

- j. (Closed) Safety Evaluation Report (SER) Open Item (341/84-20-09 DRP), "On Many Recorders There is No Indication of Units". Many process instrumentation recorders did not have the units marked on the scales.

The licensee has properly marked the scales on the recorders. FMR No. 6065 was issued to perform the work.

The inspector reviewed the FMR and inspected a large sampling of the process recorders. All inspected had the proper units identified on the scales. This item is closed.

- k. (Open) Unresolved Item (341/84-21-08 DRP). The review by the Construction Assessment Team (CAT) from Duke Power Company revealed that the "Open" and "Close" pushbutton switches (100C7 and 100C8) on the remote shutdown panel H21-P100 for control of the Residual Heat Removal (RHR) shutdown cooling suction isolation valve (E1150-MO-F009) had their wiring reversed such that pushing the "Open" button would close the valve and vice versa. The CAT questioned how the miswiring occurred, why it was not detected during testing, and if there were generic breakdowns in the testing program that could have resulted in similar problems with controls of other equipment in the plant.

In response to the NRC concerns, the licensee carried out an investigation to identify the circumstances that resulted in the miswiring of the pushbutton switches 100C7 and 100C8, and the failure to detect this condition. The review showed that proper operation of valve E1150-MO-F009 was verified in Preoperational Test Procedure PRET.E1100.001, Rev. 2 on September 22, 1983. Subsequently, modification was carried out on Panel H21-P100 per Field Modification Request (FMR) 3871 to correct human factors discrepancies per Item 4.7 of Appendix D of the SER. The modification involved providing black side borders for the pushbutton switches. This required removal of the switches to modify the cutout. Switches 100C7 and 100C8 were two of the switches that were removed. These switches are two-part, mechanically connected devices consisting of a backlighted pushbutton and a switch block. Although apparently it was expected that the work would require disconnection of wires at the switch block, this was not clearly stated in the work procedure of FMR 3871. Actually, no wires were disconnected since it was realized in the field that the pushbuttons could be mechanically separated from the switch blocks, allowing their removal from the panel. After the panel work was completed, the switch blocks were remounted on the wrong pushbuttons. This was not detected because although the QA Inspection Requirements in Item 5.0 of FMR 3871 included both a visual inspection and point-to-point continuity wire check, the latter was not performed because the panel was energized, and no wires were disconnected. A visual inspection was made, but apparently it does not require identifying the wires at the devices, and as such failed to reveal interchange of the switch blocks. Nuclear Quality Assurance (NQA) QCIR No. G-1.0-E834 was improperly signed off indicating that the required inspection per Item 5.0 of FMR 387 has been performed (including point-to-point continuity check).

The miswiring of switches 100C7 and 100C8 was documented in Nonconformance Report (NCR) 84-0904. As a part of the disposition of this NCR, all other pushbutton switches on panel H21-P100, reworked per FMR 3871, were reviewed for proper configuration. The review revealed that the switch blocks were also interchanged on pushbuttons 100C9 and 100C10 associated with valve E1150-MO-F008. All of the deviations found were corrected under Work Order PN-21 No. 978497 on June 22, 1984.

Corrective actions taken by the licensee to prevent reoccurrence of similar faults include: (1) Revision of Startup Instructions S.I. 4.7.1.02 and S.I. 7.4.3.04 to require retest following pushbutton disassembly, (2) Revision of the Startup Completion Organization Procedure SC06.1 to require review of Contractor's work package prior to issuance to field, (3) Revision of Procedure POM 12.000.15 concerning testing after preventive/corrective maintenance, and (4) Retraining of Maintenance and Modification Nuclear Quality Assurance inspectors in performing continuity verification wherever specified, and in correct documentation of inspection reports.

To ensure that there were no generic breakdowns in the testing program that could have resulted in similar problems with controls

of other equipment in the plant, the licensee had committed to the NRC, at a meeting on October 31, 1984, at the Fermi 2 site, to include verification of correct configuration of approximately 200 valves as a part of the Integrated Leak Rate Test (ILRT) program. As documented in an internal memo SU-84-1961, dated December 14, 1984, the required data were collected. Problems, however, were found with two Target Rock valves that require additional verification of valve controls. A Data Collection Procedure has been prepared for this purpose and is attached to memo SU-84-1961. The verification program includes approximately 300 safety-related valves. This item remains open pending satisfactory completion of the verification program by the licensee and subsequent review by the NRC.

No items of noncompliance or deviations were identified.

3. Licensee Action on 10 CFR 50.55(e) Items

- a. (Open) 50.55(e) Item 50-341/83-10-EE (licensee No. 95), "Post-LOCA Containment Gas Monitoring Systems". Comsip, Inc. has notified its customers and the NRC of a deficiency in the catalyst beds models K-III and K-IV shipped prior to April 1983. Model K-IV is used in the Fermi 2 containment hydrogen-oxygen analyzers. The deficiency involves poisoning of the catalyst beds by fission-fragment iodine which may be present in the containment atmosphere after LOCA with core melt-down.

The initial review of the reported discrepancy by the licensee concluded that near-term accident data could be obtained with the existing hydrogen/oxygen analyzers and subsequently the Post Accident Sampling System (PASS) would be used to obtain gaseous samples. Eventually, however, the EQ group determined that the existing analyzers could not be qualified to meet the requirements of NUREG-0588. As a consequence, the existing Comsip oxygen/hydrogen analyzers are to be replaced by different units (see memo EF2-72135).

As stated in the final report to the NRC on Item 95 (letter EF2-64305, dated June 24, 1983), the licensee considers the PASS system as the main system for post-LOCA containment gas monitoring and because of this considers Item 95 not to be reportable per 10 CFR 50.55(e) requirements. A continuous monitoring of hydrogen concentration is however a requirement of NUREG-0737 (II.F.1, Attachment 6). As stated by the licensee the schedule for installation of new monitors meeting the EQ requirements is being discussed with NRR. This item remains open pending the conclusions of these discussions regarding the use of the existing monitors.

- b. (Closed) 50.55(e) Item 50-341/83-19-EE (licensee No. 105), "Thermal Separation Criteria Violations". The licensee identified violations of the thermal separation criteria of the Edison Specification 3071-33. As discussed in Inspection Report 50-341/84-58, the required corrections in the drywell were completed per Deviation Disposition Requests (DDRs) Nos. E-13079, E-13080, and E-13083. The violations



found in the steam tunnel were resolved per Nonconformance Report (NCR) No. 84-1516. The concerns that remained unresolved included thermal separation in other areas of the plant (in addition to the drywell and main steam tunnel), temperature ratings of certain cables, and a need for a surveillance program.

In response to the inspector's concerns, the licensee has now provided additional information. As stated in an internal memo EF2-103,514, Rev. A, dated November 29, 1984, the inspection for thermal separation outside the drywell and steam tunnel was carried out per Quality Control Instruction E1.0 and also per Walkdown Procedure 12.00.49T. The found violations were documented in DDRs Nos. E-13294, E-13494, and E-13495, and in NCRs Nos. 84-0183, 84-0685, and 84-0578. NCR 84-0578 was disposed of by rerouting the conduits. The separation violations in the other two NCRs and the three DDRs did not require any rework as based on the analysis of the ambient temperatures.

The second concern involved the use of Okonite cables in the drywell with an ambient temperature of 158°F (the value used in the design of thermal shielding for instrumentation cables), since these cables, as stated in the licensee's memo EF2-64225, dated December 7, 1983, are not recommended by the manufacturer for operation in an ambient temperature above 140°F. This matter was further discussed with the licensee's cognizant personnel. The discussion revealed that the stated temperature limit of 140°F was based on unsupported extrapolated data for a certain type of Okonite cables. Actually, all of the cables in the plant have a temperature rating of 190°F. Furthermore, as discussed in memo EF2-58589, dated July 20, 1984, an investigation by the Qualification Engineering (QE) Group concluded that even at ambient temperature of 235°F an operating life of 5.14 years can be justified for the Okonite cables. Also, as stated in memo EF2-103,514, Rev. A, the licensee has decided in response to the NRR requirements (see letter EF2-72237, dated September 7, 1984) to participate in the EPRI/University of Connecticut study on cable aging, and will establish a surveillance program for cables inside the drywell based on the findings of this study.

To conclude, as presently designed, the ambient temperature of cables in certain areas of the plant is expected to be somewhat higher than originally assumed. The highest ambient temperature expected during normal operation is 158°F for the instrumentation cables in the drywell, as compared to the average drywell ambient temperature of approximately 135°F. However, as based on information discussed above, this is expected to have only a negligible effect on cable operating characteristics or life, especially with the containment inerted. Also, the surveillance program that is to be established based on the results of the EPRI/University of Connecticut study should detect changes, if any, in the cable operating characteristics. This item is considered to be closed.

- c. (Closed) 50.55(e) Item 50-341/84-06-EE (licensee No. 114), "North RHR Heat Exchanger Overpressurized During Test". This event and its

conclusion is discussed under Unresolved Item 341/83-30-05 in Section 2.e of this report. Since the Unresolved Item has been closed, this item is also closed.

- d. (Closed) 50.55(e) Item 50-341/84-10-EE (licensee No. 118), "Nitrogen Inerting System Isolation Valves, Design Deficiency". During a review of the Design Change Package that installed the primary containment nitrogen inerting system, the licensee found that the design for the control of isolation valves did not meet the single failure criterion. The nitrogen inerting system is not safety-related. However, the portion within primary containment and the isolation valves were designed and installed using QA Level 1 standards. The control system was designed as fail-safe; that is, the valves should automatically close on loss of power. However, the solenoid controls for the inside containment isolation valves were not environmentally qualified and could, therefore, stick in the open position even if deenergized. Also, the control circuits were not designed as Class 1E and as a result, would not automatically call for closure in response to an isolation signal.

The licensee wrote NCR 84-1608 to document the deficiency and provide proper corrective action. To eliminate the deficiency, the design was modified to provide environmentally qualified QA Level 1 solenoid control valves and Class 1E divisional isolation controls and wiring.

The inspector reviewed the NCR and accompanying documentation, the revised design, the pertinent Field Modification Request (FMRs), Design Change Notices (DCNs), and associated Quality Assurance records, and concludes that the modified design and implementation meets the isolation criteria stated in Fermi 2 Final Safety Analysis Report (FSAR) in Chapter 6, Section 6.2; 10 CFR 20, Appendix A, General Design Criteria 21, 54, 55, 56, and 57; and Regulatory Guide 1.11. This item is closed.

- e. (Closed) 50.55(e) Item 50-341/84-32-EE (licensee No. 140), "Deficiency in Low Voltage Switchgear-Static Trip Device". During testing to verify calibration settings, two static trip devices on Brown Boveri (formerly ITE) low voltage circuit breakers failed to operate on their short-time function. Further review of recent nonconformance reports identified one additional trip unit which provided a continuous output from the short-time function whenever load current was carried by the breaker.

One of the units which would not provide a trip output from the short-time function was returned to Brown Boveri for investigation. The investigation revealed a broken solder run on the short-time/ground printed circuit board that could not be repaired. The defective board was replaced and the unit operated properly. The second unit that would not operate on the short-time function was examined by the licensee's Relay Division. The original failure could not be identified as the unit functioned correctly during the investigation. The unit with a continuous output from the short-time function was found to have a defective output transistor

(Q601). This transistor was replaced and the unit operated properly.

Since the investigation of the three failed units revealed no generic or common defects, the licensee concluded that this item is not reportable under 10 CFR 50.55(e). The inspector concurs with this conclusion. This item is closed.

- f. (Closed) 50.55(e) Item 50-341/84-33-EE (licensee No. 141), "Deviations from Specified Clearance Between Cable Trays and Vertical Support Members". During an area walkdown in the Residual Heat Removal (RHR) Building, it was identified that the cable tray location of four safety-related hangers did not meet the requirements of Specification 3071-128 and the general notes for cable tray installation contained on drawings 6E721-2808-01, and -03. These documents require that the vertical members of Class 1E cable tray hangers be located two inches ( $\pm 1/4$  inch) clear of the outside face of the cable tray. Subsequently, in addition to the four hangers originally identified, some deviations were identified on 37 hangers in various buildings. The deviations were documented on Nonconformance Report (NCR) 84-1585.

As stated by the licensee in a letter to the NRC, EF2-70227, dated December 18, 1984, the as-built tray/hanger clearance for each of the items identified in NCR 84-1585 has been analyzed and found acceptable. Also, at the licensee's request, Sargent & Lundy Engineers evaluated the tray/hanger clearance for a sample of 42 hangers in the Auxiliary Building and Residual Heat Removal Complex. This sample had been selected to emphasize hangers expected to be most sensitive to variations in the location of the cable tray on the hanger. All of these hangers were found to be acceptable. Also, a review of the cable tray general notes drawings (6E721-2808-1 and 6E721-2808-3) has been performed to identify any other requirements not implemented. No deficiencies have been identified as confirmed by the licensee's cognizant personnel.

Since the reviews have shown that the noted deficiencies would not have adversely affected the safety of the plant, the licensee considers this item not to be reportable under 10 CFR 50.55(e). The inspector concurs with this conclusion. This item is closed.

No items of noncompliance or deviations were identified.

#### 4. Licensee Actions on Allegations

(Open) Allegation (RIII-84-A-0116). Inspection Report 50-341/84-20 details 19 allegations received by a newspaper over a three-month period and turned over to the NRC. A number of these allegations had been previously identified by the licensee or the NRC. At the time the Inspection Report was written, a final disposition of the identified items had not been made and it was not possible to close those allegations. Some of these have now received final disposition and can be closed.

- a. Allegation 9, "Seismic clearance of rattlespace. It was 1981 before Detroit Edison issued a design criteria for seismic clearance, much too late for most of the plant. Sample survey was conducted on fixes".

In the spring of 1982, the licensee directed a contractor, Sargent & Lundy (S&L), to conduct a complete walkdown of Category 1 buildings of work completed prior to issuance of the criteria to verify that adequate spacing exists between components. The walkdown identified over 300 violations of the criteria. The engineering review of the violations of criteria identified 110 places where interaction could occur. These were all subsequently redesigned and reworked to prevent interaction using approved procedures. In a second phase, starting in June 1983, the licensee directed S&L to walkdown all work done since the criteria were in effect. This walkdown resulted in a few more examples that were subsequently corrected. After this phase was completed, the licensee's field engineering group has been making subsequent walkdowns of current work.

The inspector reviewed a sampling of the S&L reports, the work packages required for the fixes, and more current field engineering reports. While it is true that seismic clearance criteria were not in place until 1981, the review showed that the licensee took the necessary steps to assure that seismic clearance would be adequate in the completed plant. This item is closed.

- b. Allegation 16, "Checkout and Initial Operation (CAIO) testing. Completed CAIO test data is being reviewed by the Startup Assurance Group at Fermi and this group has found numerous errors with this data, yet correction has not been taken for all identified problems. In fact, just finding these errors is serious in that management has approved this data prior to this review taking place".

As stated in the referenced Inspection Report, there were numerous errors with the CAIO data which were principally incomplete filling out of the data forms. Management does not approve CAIO data with the exception of valve position. The inspection verified that all deficiencies were identified and tracked. The item was kept open until all significant deficiencies were reviewed.

The inspector reviewed all of the deficiencies that remain to be closed. The inspector determined that all significant deficiencies requiring review and resolution prior to the issuance of an operating license have been closed. The SRI will confirm disposition and adequacy of the remaining minor deficiencies during a subsequent inspection. This item is closed.

Allegations 6, 7 and 18 remain open because all of the previously identified deficiencies have not been closed.

No items of noncompliance or deviations were identified.

5. Followup on Regional Requests

Review of SERs Issued by NRR on IE Bulletin 80-06

As requested by the Region, the inspector reviewed the Fermi 2 SER and FSAR as required to determine if there is any difference between the original and final commitments regarding Bulletin 80-06. The review shows that the licensee's response to Bulletin 80-06 provided in Amendment 35, dated May 1981, to Item 222.52 of Appendix E of the FSAR remains unchanged. The NRR evaluation based on this response is provided in Section 7.3 of the SER. The design was found to be acceptable. Also, as committed in Item 222.52, the licensee is carrying out verification that the equipment is installed according to the schematics on which the compliance to Bulletin 80-06 was based. It is expected that any conditions found during the testing that do not agree with the statements in Item 222.52 would be corrected, or changes reported to the NRC via an amendment to Item 222.52.

No items of noncompliance or deviations were identified.

6. Exit Interview

The inspectors met with the resident inspectors and licensee representatives (denoted in Paragraph 1) at the conclusion of the inspection on December 21, 1984. The resident inspectors summarized the scope and findings of the inspection. The licensee acknowledged the inspectors' findings.