William S. Orser
Executive Vice President
Nuclear Generation

Detroit Edison

Fermi 2
6400 North Dixie Highway
Newport, Michigan 48166
(313) 586-5201

Nuclear Operations

January 15, 1993
NRC-92-0135

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

References: 1) Fermi 2
NRC Docket No. 50-341
NRC License No. NPF-43

2) NRC Region III to Detroit Edison,
Allegation RIII-92-A-0112
dated October 20, 1992

3) Detroit Edison Letter NRC-92-0129
Response to Allegation RIII-92-A-0112
dated November 23, 1992

4) Detroit Edison Letter NRC-92-0134
Supplemental Response to Allegation
RIII-92-A-0112, dated December 18, 1992

5) NRC Inspection Report No. 50-341/92017
dated December 11, 1992

Subject: Reply to Notice of Violation 92017-01

Enclosed is Detroit Edison's response to the Notice of Violation contained in Reference 5. This violation was for ineffective corrective actions to prevent recurrence. Overtime violations were identified in April-May 1991 during the second refuel outage and in September-October 1992, during the third refuel outage by Detroit Edison. This enclosure also responds to a commitment made by Detroit Edison in Reference 4 to explain the extent of the failure to control overtime, the reason, and corrective actions.

As discussed in References 3 and 4, which were written to respond to Allegation RIII-92-A-0112, contained in Reference 2, Detroit Edison had initiated a Quality Assurance (QA) surveillance on overtime. This pre-planned surveillance reviewed hours worked by Fermi 2 site personnel and assessed the effectiveness of the site administrative control of overtime during the third refuel outage. QA had previously cited control of overtime as a problem during the second refuel outage. During the second refuel outage QA identified one hundred and ninety personnel who worked overtime in excess of procedural guidelines without prior management approval as required by the

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administrative procedure. The recent third refuel outage surveillance determined that the problem still existed. Sixty-one individuals violated procedural overtime limits. Although the scope of the procedure includes essentially all personnel onsite, of the sixty-one procedural violations, seven of these were determined to have actually involved individuals and activities governed by the requirements in Section 6 of the Technical Specifications. A Deviation Event Report was written and corrective action was initiated to resolve the problem as described in the enclosed response to the Notice of Violation.

An extension to this reply for a Notice of Violation was granted per discussion with the Senior Resident Inspector. Therefore, Detroit Edison is responding on January 15, instead of January 11, 1993. If there are any questions regarding this response, please contact Mr. Joseph Pendergast, Compliance Engineer, at (313) 586-1682.

Sincerely,

Enclosure

cc: T. G. Colburn
A. B. Davis
W. J. Kropp
M. P. Phillips
Region III

Reply to Notice of Violation 50-341/92017-01

Statement of Violation 50-341/92017-01:

"10 CFR 50, Appendix B, Criterion XVI, "Corrective Action" requires that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above, failure to comply with the Technical Specification overtime requirements previously identified by the licensee in April-May 1991 were not corrected in that these same failures occurred in September 1992."

The Reason For The Violation:

Procedure FIP-AD4-03, "Overtime and Fitness for Duty Guidelines", was originally written, in January 1989, to include only those personnel identified in the Technical Specifications. In March 1991, prior to the second refuel outage, the procedure was revised to include all site personnel for all work performed and thus substantially exceeded the requirements of the Technical Specifications. A routine site notification was made concerning this procedure change. However, special training was not provided.

Quality Assurance (QA) performed an overtime surveillance June 1991, following the second refuel outage. QA found that many site personnel were not aware of the revision to FIP-AD4-03 and that the procedure now applied to them. Those who were aware of the new procedural requirements incorrectly counted only the time spent working on safety related equipment. Corrective actions were taken to clarify guidance given in the procedure and to provide training on the procedure.

In December 1991, the plant was shutdown approximately two weeks to replace a main unit transformer. Another QA overtime surveillance was performed to assess the effectiveness of corrective actions. Potential overtime violations were identified, but an investigation was conducted and it was determined there were no violations of procedure FIP-AD4-03 because the procedure did not clearly define the allowed shift turnover time. Procedure FIP-AD4-03 did limit shift turnover to one hour, but it did not state how often a group could perform a turnover. As a result, the number and length of shift turnovers varied. The procedure was revised to allow only one hour for shift turnover per shift. Prior to the start of the third refuel outage, FIP-AD4-03 was again revised to allow only one-half hour for shift turnover per shift.

In the third refuel outage another QA overtime surveillance was performed which reviewed hours reported on time cards from September 6 until October 4, 1992 to assess the effectiveness of corrective

actions. There were sixty-one personnel identified who exceeded overtime restrictions given in procedure FIP-AD4-03. Seven of these personnel were determined to have performed safety related work and fell under the Technical Specification requirements. The investigation found that, in general, site personnel were aware that the procedure applied to them, but not all of the specific guidelines in the procedure were understood. In addition to the sixty-one personnel, the investigation of the Deviation Event Report found that maintenance craft supervision, who had received prior verbal authorization, scheduled craft personnel for one-half hour over procedural overtime limits for a seven day period without obtaining prior written authorization as required by the procedure.

Reference 4 stated that sixty-five individuals violated overtime procedural guidelines, however, further review determined that four of these personnel were in actuality in compliance with procedural controls.

There were several reasons (i.e., causes) for the deviation from the established overtime guidelines:

- Inappropriately tracking the number of hours for seven consecutive days by calendar week, (i.e., Monday to Sunday) instead of a rolling seven days.

- Individuals and supervisors were not tracking time worked accurately enough to realize when limits were reached.

- Exceeding the established half hour for shift turnover. This applied to exceeding procedural requirements and not Technical Specifications.

- Personnel made mistakes when processing staffing deviation forms.

- In some cases paperwork was lost or personnel loaned to other organizations were not properly tracking their overtime hours.

The root cause of the third refuel outage problems is distinctly different from the root cause of the problems identified during the second refuel outage. During the second refuel outage personnel were not aware of the procedure requirements. In the third refuel outage personnel were aware of the procedure revision and the fact that the procedure applied to them, but they did not always understand the specific guidance in the procedure.

The reason (i.e., cause) for the ineffective corrective action following the second refuel was that procedural guidance was vague and that the training provided on this procedure was inadequate.

The Corrective Steps That Have Been Taken And The Results Achieved:

QA surveillances were performed during the second refuel outage, main unit transformer outage and the third refuel outage to monitor the

effectiveness of corrective actions. The corrective actions taken did result in some reduction of the overtime problem, however, the problem was not eliminated.

Subsequent to the third refuel outage, discipline was administered to the appropriate personnel and their supervisors in accordance with Detroit Edison's Positive Discipline policy. Site personnel who did not follow the procedural guidelines are now aware of the requirement to follow these guidelines.

The Corrective Steps That Will Be Taken To Avoid Further Violations:

FIP-AD4-03 will be revised to contain additional guidance to track overtime, to define shift turnover and to define work periods. Emphasis will be placed on the process for submitting and approving staffing deviation forms. Overtime restrictions will be limited to those situations defined in Technical Specification Section 6.2.2.f. The procedure is scheduled to be revised by the end of February 1993.

Training will be given to reinforce adherence to Technical Specification guidelines and will be completed by the end of March 1993.

QA will perform a surveillance following the above training to assess the effectiveness of that training. This will be completed by June 1993.

QA will perform a surveillance during the fourth refueling outage to re-assess overtime control.

Management is evaluating the use of a computer tracking program which may help mitigate future overtime violations and reduce the administrative burden.

The Date When Full Compliance Will Be Achieved:

Detroit Edison will be in full compliance when training is completed by the end of March 1993.