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MAR 16 1988

MEMORANDUM FOR: E. G. Greenman, Director, Division of Reactor Projects

FROM: R. C. Knop, Chief, Reactor Projects Branch 3

SUBJECT: DISPOSITION OF OSTI FINDINGS AT FERMI 2

During the period from July 27 to August 7, 1987, NRR conducted an Operational Safety Team Inspection (OSTI) at Fermi 2. This inspection was requested by Region III to provide an independent assessment of plant operations. Region III felt that such an assessment would provide additional insight into why the licensee has encountered so many personnel and management difficulties.

Region III agreed with the general conclusions of the OSTI report. The OSTI presentation of conclusions to Region III management was a major input prompting the October 9, 1987, letter to the licensee. This letter is provided as attachment I. Also, monthly management meetings were mandated with the licensee to access their progress, due in part to the OSTI inspection.

The OSTI Team findings were documented in IER 87030. My staff has reviewed the report and categorized the findings into 20 concerns. These concerns were:

1. Operations did not always perform to the high standards associated with the nuclear industry.

2. Operational attitudes were production oriented causing insufficient attention to be paid to certain administrative aspects of plant operation.

3. Poor communication was exhibited by and between management and shift personnel.

4. Support personnel for plant operations were not utilized to the maximum extend possible.

5. Operators exhibited difficulty in using Technical Specifications as a working document.

6. Operators lacked commercial BWR operating experience.

7. The DER process was of limited depth.

8. QA could be utilized in a more performance based aggressive manner.

9. Improvements could be made in ISEG effectiveness.



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10. OSRO conducted "walkarounds" for their committee reviews.

11. Safety evaluations were weak.

12. The material condition of the plant needs improvement.

13. Procedures and the procedure revision process did not effectively support the proper performance of quality related activities.

14. The performance to paycheck concept had not been totally implemented.

15. The engineering support to plant problems was weak.

16. The surveillance program needs proper management attention to assure appropriate implementation.

17. Furmanite is being used in an unqualified application.

18. The MSIV control circuit design could create an unreviewed safety question.

19. Senior staff members did not routinely tour the facility contrary to the Group V. P.'s directives.

20. The Operations Superintendent could improve his effectiveness through formal site specific training.

The following approach is recommended to review licensee actions to these concerns:

1. Approximately 30 days after completion of the upcoming LLRT outage Region III DRS should perform a management overview/committee activities inspection. The inspection will address concerns 7, 8, 9, 10, 11, and 19.

2. Approximately 60 days after completion of the upcoming LLRT outage an OSTI type inspection should be performed by NRR (RSIB). The inspection will be of less scope than the OSTI concentrating on shift activities, the operator evolution evaluation program and operational communications. This inspection will address concerns 1, 2, 3, 4, 5, 14, 6 and 15.

3. Approximately 90 days after the completion of the upcoming LLRT outage Region III DRS will perform a surveillance program inspection. Also an inspection shall be performed in March to assess the quality of the newly written I & C surveillance procedures. These inspections will address concerns 16.

4. Region III DRS inspection documented in IER 87036 addressed concern 18. No unresolved safety question was identified. However, the licensee has a design change projected for the 1st refueling outage to help eliminate unplanned MSIV opening.

5. Resident inspection documented in IER 87031 paragraph 4 addressed concern 17. The matter is considered resolved.

6. Concern 20 and the portion of concern 13 dealing with inadequate procedure revisions will be pursued by the resident staff and documented in a future resident routine inspection.

7. In addition to the planned inspection activities Region III management shall assess licensee progress in a number of the areas of concern. Monthly management meetings with the licensee will provide overview or directly address concerns 1, 12, 14, 16 and the portion of 13 dealing with too many procedures.

As stated in the cover letter to the inspection report Region III was to evaluate the report for potential violations. This action has been completed with the potential violations being:

1. Numerous failure to follow procedures during performance of quality related activities.

2. Numerous administrative controls being out of date, having conflicting requirements and being ignored.

3. A procedure revision associated with the thermal recombiners was inadequate.

4. Inadequate safety evaluations were performed.

5. Surveillance procedure 24.139.03 did not adequately implement Technical Specification 4.3.2.1.

6. The committee review of OSRO was being inadequately implemented through walkarounds.

7. Furmanite was being used in an unqualified applicable.

8. I & C personnel did not initiate procedure revisions when required.

The following approach has been taken with these potential violations:

1. Violations 87027-01, 87027-02, 87027-03 and 87036-01 were indicative of the problems the OSTI team observed. With operator performance the corrective actions associated with these violations and the establishment of the operator evolution evaluation program in response to the regional administrators letter of October 9, 1987, address potential violation # 1.

2. Currently violation 87021-01 in IER 87021 was issued for inadequate safety evaluations. This violation addresses potential violation # 4.

3. Violations in IER 87044 cite other examples of inadequate surveillance procedures. Therefore, these violations encompass the deficiency of surveillance procedure 24.139.03 and the violation corrective actions address potential violation # 5.

4. Violation 87031-02 of IER 87031 addressed the inappropriate use of furmanite and potential violation # 7.

5. Potential violation # 2 will be reviewed by the resident staff in detail and will be explicitly documented in a future routine resident inspector report.

6. Potential violation # 6 shall be evaluated by Region III DRS inspectors at the next inspection of licensee committee activities.

7. Potential violations # 3 and # 8 involve areas subject to routine resident inspection. Licensee performance in these areas will continue to be monitored. Enforcement action shall be taken if future inspection findings dictate.

This memo has been written to provide a status as to those regional actions taken in response to your inspection. Also, I would like to express my appreciation for the OSTI and the insights gained from your inspection effort.

Sincerely,

RC Knop

R. C. Knop, Chief
Reactor Projects Branch 3

Attachment: As stated

cc: A. Bert Davis
C. J. Paperiello
H. J. Miller
R. W. Cooper
W. Rogers
C. J. Haughney

RCK YES

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Knop/pb