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APR 15 1988

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

FROM: Richard C. Knop, Chief, Projects Branch 3

SUBJECT: FERMI 2 STATUS REPORT FOR THE PERIOD FEBRUARY 20, 1988 - MARCH 18, 1988

Attached is the Fermi 2 monthly status report from the NRC resident office at Fermi 2. Two NRC resident inspectors, one operator licensing examiner, and the project inspector monitored licensee activities at the plant during this period.

Status reports of this type are intended to provide NRC management and the public with an overview of plant activities and NRC inspection activities. I plan to continue issuing monthly status reports until the licensee completes the startup test program and will reassess the need for subsequent reports at that time.

*Richard C Knop*

Richard C. Knop, Chief  
Projects Branch 3

Attachment: As stated

See Attached Distribution

YES  
RIII  
*RPD*  
Pelke/pb  
5/31/88

YES  
RIII  
*AWC*  
Cooper  
3/31/88

RIII *yes*  
*RcK*  
Knop  
3/31/88

RIII  
*EG*  
Greenman  
4/1/88

RIII  
*CJP*  
Pappariello  
4/4/88

RIII  
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Davis  
4/13/88

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APR 15 1988

cc w/enclosure:

Patricia Anthony, Licensing

P. A. Marquardt, Corporate

Legal Department

DCD/DCB (RIDS)

Licensing Fee Management Branch

Resident Inspector, RIII

Ronald Callen, Michigan

Public Service Commission

Harry H. Voight, Esq.

Michigan Department of

Public Health

Monroe County Office of

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F. Ali, Emergency Planning,

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Canada

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Programs

1. Plant Status

As of 0800 on March 18, 1988, the plant was in cold shutdown in the middle of a planned 6 week local leak rate testing (LLRT) outage.

2. Facility Operations Summary

The licensee operated in Mode 1 (Power Operations) until February 26th at which time the unit was required to shutdown due to all the Emergency Diesel Generators (EDGs) being declared inoperable as discussed below. Upon shutdown the licensee began a scheduled 6 week LLRT outage. While the unit was operating, sulfate levels continued to restrict startup testing. The licensee is operating within EPRI chemistry guidelines for testing.

3. Item(s) of Special Interest

Control Room Evolution Evaluation Program - The licensee continued to perform assessments of control room activities twice a week during the reporting period.

Technical Specification Difficulties - As part of the Technical Specification improvement program (a licensee program), Detroit Edison identified on February 26, 1988, that some of the undervoltage circuitry associated with EDG automatic start had not been tested as required by Technical Specifications. This resulted in the EDGs being declared inoperable and the unit shutting down. Subsequently, the undervoltage circuits were tested and found to be satisfactory.

Outage Observations - The licensee has identified damage to the lower portion of the inside of the Moisture Separator Reheaters (MSRs). The lower tubesheet has been deformed/cracked and the steel wool bundles damaged. Once cracked a large number of stub tubes which had been cold rolled into the tubesheet became separated from the tubesheet. Some of the stub tubes have been found in the suction strainers of the reactor feedwater pumps. The licensee is formulating an action plan to inspect the applicable portions of the feedwater system. The licensee has identified bearing damage in the lower half of the south condensate pump. Excessive seal leakage had been identified prior to the plant shutdown. Efforts are underway to determine the root cause of the damage. Some of the motor operated valves in the HPCI and RCIC systems have experienced hydraulic lockup during MOVATS testing. The licensee is exploring what is causing this situation. As a result of LLRT testing, the MSIVs have failed their LLRT. All MSIVs are being reworked to reduce their seat leakage. Had this been the time for an integrated leak rate test (Type A), this leakage would have been sufficient to cause the MSIVs to fail the Type A test. However, since 10CFR50, Appendix J, Type A testing frequency begins at the declaration of commercial operation and not the preoperational Type A acceptance test, the Type A test is not due yet. MSIV leakage of this type is not atypical.

LERs - Over the period of this report, seven events occurred that will result in the submittal of LERs. Of the seven, four were attributed to personnel error, two to equipment failure, and one to inadequate procedures. Personnel errors in the area of operations have increased. Region III will meet with the licensee on April 13, 1988 to discuss this concern.

Licensee Identified Violations - The licensee determined that the routine channel checks which are required to be performed during each shift, had not been performed on the afternoon shift of March 13th. This is the first time that the channel checks have been missed. Subsequent channel checks were acceptable.

The licensee is trying to determine if a containment pressure rack valve was closed while the unit was in operation. If the valve was closed this would be a violation of the Technical Specifications in that a channel of containment high pressure would have been valved out of service.

4. Change to Monthly Status Reporting

This report will continue to be issued monthly with the next report due on April 28, 1988.

5. NRC Staff Activities During the Period

The resident staff consisted of the senior resident inspector (Walt Rogers) and the resident inspector (Mike Parker) for two weeks. The resident inspector has been promoted to the SRI position at Duane Arnold. The resident staff was supplemented by the project inspector one week and a licensing examiner one week. Major inspection findings included:

A breakdown of the licensee's safety related parts authorization program was identified. Prior to 1985, replacement parts were entered into the Spare Parts Reference System without an engineering review as to whether the replacement part was suitable. The licensee QC organization is currently reviewing all work requests prior to submittal to the Nuclear Station Supervisor (NSS) for completion signoff and system restoration to assure the replacement parts have the proper review.

On January 14, 1988, one of the two noninterruptable air system (NIAS) control compressors failed during testing. The air compressor is necessary to support the operability of a division of standby gas treatment, a division of control center HVAC and a division of main steam isolation valve leakage control. However, since there were no explicit Technical Specifications on the NIAS, no LCO action statement was entered for the affected Technical Specification systems. This issue is under consideration for escalated enforcement action.

During the assessment period, a core spray leakage detector was declared inoperable and the applicable action statement was

invoked. This action statement required a channel check of the local leakage indicator at least once every 12 hours. Operators had performed the local indicator check in excess of 12 hours on numerous occasions. Although the results of the channel checks were acceptable, this indicates a breakdown of the licensee's understanding of the Technical Specifications.

During the week of February 7, 1988, a DRSS two man inspection of radiological controls was conducted. No major problems were identified.

On February 7, 1988, a three week maintenance inspection commenced by three DRS inspectors. The inspectors identified that the licensee was not properly following maintenance procedures even though licensee QA personnel were monitoring the activity. After being informed of this situation by the inspector, the licensee suspended all maintenance activities until all personnel received direction from senior management on the use of procedures. While numerous discrepancies were identified during the inspection, the licensee has initiated a number of corrective actions and a general overall improving trend was noted in plant maintenance.

From March 10 through March 18 a security inspection was conducted by two DRSS inspectors. Several concerns were identified regarding drawing of a handgun by a Security guard and contractor access control. Some of these concerns are under consideration for escalated enforcement action.