301 926-7036

SERCH

SERVICE FOR EVALUATING REGULATORY CHANGES

FOIA/PA REQUEST
Case No: 97-264
Date Rec'd: 7-18-97
Action Off: Brown
Related Case: _____

July 7, 1997

Mr. D. H. Grimsley, Director
Division of Freedom of Information & Publication Services
Office of Administration
U. S. Nuclear Regulatory Commission
Washington, DC 20555

Dear Mr. Grimsley:

Pursuant to the Freedom of Information Act, and the implementing regulations in Title 10 of the Code of Federal Regulations, I am requesting that the Plant Issues Matrix for Fermi 2 be placed in the Public Document Room.

Very truly yours,

Nancy G. Chapman
SERCH Manager

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PLANT ISSUES MATRIX

28-Jul-97

Fermi

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
5/6/1997	**********	**********	*** GENERATOR LOADED ONTO GRID **** First time since shutdown for refueling outage on 9/27/96.	**********	******
5/2/1997	Licensee	Plant Support	The audits of RERP activities satisfied the requirements of 10 CFR 50.54(t) and were excellent in scope and detail.	Self-Critical	IR 97006
5/2/1997	**********	Plant Support	The overall effectiveness of the licensee's emergency preparedness facilities, equipment, training, and organization was very good.	**********	IR 97006
5/2/1997	**********	Plant Support	Licensee personnel appropriately declared two Unusual Events during actual activations of the RERP Plan. Emergency classifications had been made correctly and offsite notifications had been made in a timely manner.	Teamwork/Skill Level	IR 97006
5/2/1997	NRC	Plant Support	The emergency response facilities were well maintained and in very good material condition.	Involved Management	IR 97006
5/2/1997	NRC	Plant Support	Management support for the RERP program was identified as a strength by the RERP Supervisor. The RERP staff was proactive in maintaining and improving the program and responsive to identified issues.	Involved Management	IR 97006
5/2/1997	NRC	Plant Support	The RERP program was effective in maintaining the operational readiness of your emergency response facilities, equipment, and personnel. Emergency response facilities, equipment, and supplies were in a very good state of operational readiness. Interviews with emergency response organization personnel demonstrated very good knowledge of emergency implementing procedures and responsibilities. Management support was strong.	Involved Management	IR 97006
5/2/1997	NRC	Plant Support	The inspector completed Temporary Instruction 2515/134 "Onshift Dose Assessment Capabilities" and verified that the licensee's capabilities met requirements.	**********	IR 97006
5/2/1997	**********	**********	*** Reactor Startup after forced outage (1/17/97) ****	**********	*******
5/2/1997	NRC	Plant Support	Interviews with key emergency response organization personnel demonstrated very good knowledge of the emergency implementing procedures and their responsibilities.	Teamwork/Skill Level	IR 97006

Portions withheld, EX. 5, 7A + 7C

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
4/15/1997	**********	**********	**** SMM SCREENING MEETING ****	**********	********
4/10/1997	Licensee	Engineering	Discovered that ITE model 5600 480 VAC - 250 VDC breakers may not fully latch. Latter expanded to ALL 1129 breakers (339 Safety Related). Licensee did not perform preventive maintenance for about 18 months. Inspectors found corrective actions (4/17/87) to be inadequate. Possible escalated enforcement.	Engineering/Design Deficiency	ENS 32127
4/2/1997	Licensee	Engineering	Discovered that power and control cables to emergency equipment cooling water (EECW) Division I & II primary containment inboard return isolation valves would be affected by high energy line break (HELB) during DBA LOCA. *** RETRACTED ON 4/17/97 ***	Engineering/Design Deficiency	ENS 32073
3/19/1997	NRC	Plant Support	Inspectors assessed selected portions of the February Emergency Preparedness Drill, which included partial state and local participation. Overall performance was acceptable.	Other/NA	IR 97002
3/19/1997	**********	Plant Support	Excellent radiological protection support was observed during calibration work in a contaminated sump. Workers identified a good way to perform work from outside the contaminated area, minimizing exposure.	Teamwork/Skill Level	IR 97002
3/19/1997	NRC	Maintenance	(FME): The inspectors identified weaknesses in foreign material exclusion during the conduct of maintenance the high pressure coolant injection valve.	Inadequate Procedure/Instruction	IR 97002/URI/LER 97002
3/19/1997	NRC	Plant Support	Inspectors identified improper control of a visitor inside the protected area by a guard performing escort duties.	Personnel Performance Deficiency	IR 97002
3/19/1997	Licensee	Plant Support	The licensee identified poor administrative control of designated vehicles.	Other/NA	IR 97002

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3/19/1997	NRC	Maintenance	The inspectors identified weaknesses in the control of troubleshooting performed before initiating a work request. Troubleshooting was performed by operators that did not have had the appropriate skills to do the checks. Also, an annunciator card was removed from an operable Emergency Diesel Generator (EDG) to troubleshoot a problem in another EDG. Since the root cause of the original failure had not been determined, operability of both EDG was put into jeopardy. (M1.2) 3/19/97	Teamwork/Skill Level	IR 97002
3/19/1997	NRC	Plant Support	Inspectors identified a security door card reader that was fully functional and being used, but which was labelled as inactive and for emergency use. This was considered a weak practice.	Other/NA	IR 97002
3/18/1997	NRC	Operations	The inspector noted continued improvement in operator control room formality, operator shift briefings, and communication of issues to site management.	Involved Management	IR 97002
3/18/1997	NRC	Operations	Review of unresolved item 50-341/96016-03 identified failure of operators to document a problem with calibration of the oxygen monitor. This is an apparent violation.	Personnel Performance Deficiency	IR 97002
3/18/1997	**********	Maintenance	Two equipment functional failures occurred in EDG 14. Licensee operability determinations and repair efforts showed good coordination and communication between Operations, Maintenance, and System Engineering.	Teamwork/Skill Level	IR 97002
3/18/1997	Licensee	Engineering	The licensee identified an error in the computer calculation of reactor power. This was reported because at times during three previous operating cycles, the maximum licensed power limit was exceeded by 0.6 MWth.	Engineering/Design Deficiency	IR 97002
3/18/1997	NRC	Engineering	The inspectors identified that the licensee operated with less than the required number of primary containment oxygen monitors during nine periods in the past. The monitors were rendered inoperable unknowingly because the calibration method induced a non-conservative error. The inaccuracy was identified in mid-1996 by System Engineering and Operations was notified; however, the operability implications were not recognized and investigated. This is an apparent violation.	Inadequate Oversight	IR 97002

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/18/1997	Licensee	Engineering	The licensee identified several design issues that potentially placed the Emergency Equipment Cooling Water System outside its design basis. Modification and analytical work was in progress to resolve the issues at the end of the inspection.	Engineering/Design Deficiency	IR 97002
3/14/1997	**********	**********	***** PPR MEETING (9/96 - 3/97) *****	**********	*******
3/7/1997	Licensee	Engineering	Discovery that emergency equipment cooling system (EECW) makeup tank will not be proberly aligned for use from the remote shutdown panel (Appendix R issue). Licensee install modification of an interlock between the makeup tank isolation valve and the EECW/reactor building closed cooling water cross-tie valves. The interlock prevents the makeup tank isolation valve from opening with the cross-tie valves open. The manipulation of the cross-tie valves can not be performed from the remote panel and a bypass of the interlock is not provided.	Engineering/Design Deficiency	ENS 31909
3/3/1997	Licensee	Engineering	Discovery that a single failure of a divisional power source may result in a loss of primary containment function for the emergency equippment cooling water (EECW) subsystems. Loss of a single motor control center will result in the loss of power to 4 containment isolation MOVs and 2 cross-tie MOVs between EECW and reactor building closed cooling water. This results in a possible release path from containment to environment during a postulated high energy line break accident.	Engineering/Design Deficiency	ENS 31878
3/1/1997	**********	**********	END OF PPR PERIOD (9/96 - 3/97)	**********	*****
2/26/1997	**********	Maintenance	Two equipment functional failures occurred in EDG 14. Licensee operability determinations and repair efforts showed good coordination and communication between Operations, Maintenance, and System Engineering.	Teamwork/Skill Level	IR 97002

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/25/1997	Self-Revealed	Maintenance	Three Un-related isolated failures caused 2 engine trips and stopping surveillance testing on the Emergency Diesel Generator (EDG) 14. (1) On 2/26/97 during fast start surveillance testing, overspeed alarms were received during two test attempts. An alarm and overspeed trip was received during the third attempt. The system engineer and maintenance personnel found the overspeed microswitch, which was bolted to the engine, was loose. This allowed the switch to intermittently touch the fuel rack lever, falsely indicating an overspeed condition. The switch was replaced and secured properly. The same switch had been replaced during RFO5 a few months previously. This was considered a Maintenance Rule functional failure, and was being investigated as a maintenance preventable failure. The system engineer inspected the remaining EDGs for possible common mode failures, and found the other switches properly secured. (2) On 2/27/97 following repairs, EDG 14 was again fast started for post-maintenance testing. Forty-five minutes into its run, operators smelled an acrid odor, received permission to open the local control panel, and found thin smoke coming from the Low Speed Auxiliaries Relay. Before they could get permission to unload and shutdown the diesel, it tripped on reverse power. (3) On 2/28/97 following replacement of the failed relay, the engine was successfully tested on February 28, but the KW meter on the local panel stuck while unloading. At 1800KW, the meter stuck and then freed itself and indicated 800KW. The EDG was shutdown. The system engineer determined that the safety function was not affected by the meter sticking, but Operations decided to repair the meter before returning the EDG to operable status.	Equipment Malfunction	
2/16/1997	Licensee	Maintenance	HPCI discharge valve failed to open during surveillance. Failure was due to pinon gear dis-engaging with shaft. Other MOVs may also be affected. Licensee on 3/3/97 made a committement to inspected and modify as needed 72 safety related MOVs before startup.	Equipment Malfunction	ENS 31796
2/6/1997	Licensee	Engineering	Thermal power limit exceeded for operating cycles 1-3 due to error in density compensating computer algorithm used to convert differential pressures into mass flow rates.	Engineering/Design Deficiency	ENS 31743

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2/3/1997	Licensee	Operations	A non-licensed operator improperly operated a knife switch without properly identifying it, tripping both generator output breakers when the generator was shutdown. Lack of supervision, system knowledge, and procedural guidance did not stop the operator from taking an inappropriate action.	Personnel Performance Deficiency	IR 97002/NOV
2/1/1997	NRC	Plant Support	Background investigation information was received in some cases before written consent was obtained to do the investigation.	Personnel Performance Deficiency	IR 96015
2/1/1997	**********	**********	Main Generator Rotor shipped off-site for balancing. Rotor bowing caused by gernerator motorizing event. Forced outage of 6 or mor weeks	**********	
2/1/1997	Licensee	Plant Support	Several measurement standards for the Excellence Plan have not been developed.	Inadequate Oversight	IR 96015
2/1/1997	NRC	Plant Support	Compensation was not provided for some cable trays containing safety related cables located outside of a vital area.	Personnel Performance Deficiency	IR 96015
2/1/1997	NRC	Plant Support	Required element of security force physical examination was not completed in some cases.	Inadequate Oversight	IR 96015
2/1/1997	NRC	Plant Support	(STRENGTH): Security department participation in the Deviation Event Report program has improved significantly within the last six months of 1996.	Self-Critical	IR 96015
2/1/1997	NRC	Plant Support	(STRENGTH): Quality Assurance has continued to be effective in identifying decline of effectiveness in some aspects of the security organization.	Self-Critical	IR 96015
2/1/1997	NRC	Plant Support	Procedures were not prepared for control and use of weapons, and for processing Mutual Assistance Forces if needed.	Personnel Performance Deficiency	IR 96015
2/1/1997	NRC	Plant Support	Number of security force errors has not decreased for the last half of 1996.	Personnel Performance Deficiency	IR 96015

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1/31/1997	NRC	Operations	(STRENGTH): Operator performance during numerous plant startups and shutdowns was focused and controlled. Communications and control room formality showed improvement.	Teamwork/Skill Level	IR 96016
1/31/1997	NRC	Operations	(STRENGTH): NQA assessments of operations improved	Teamwork/Skill Level	IR 96016
1/24/1997	Licensee	Operations	Manual instrument line containment isolation valve found closed. ENS 31646 latter retracted.	Personnel Performance Deficiency	ENS 31646
1/17/1997	Self-Revealed	Multiple	Rolled turbine and attempted to synchronize. First generator output breaker indicated it didn't shut, but apparently 1 phase did. Opened field breaker to deenergize generator and trip the turbine, but turbine did not coast down. Opened another breaker in switchyard and had the system deenergize one 345KV line to deenergize generator, then saw turbine coast down. Maintenance of switch yard componenets weak. Operations performance during event weak.	Equipment Malfunction	IR 96016
1/17/1997	**********	**********	***** FORCED OUTAGE - MOTORIZED MAIN GENERATOR *****	**********	*******
1/15/1997	Self-Revealed	Operations	A minor reactor water level transient was mitigated by operators. On January 15, while the turbine was shutdown for balancing with the reactor at low power dumping steam to the main condenser, a small access plate was removed from the north end of Number 2 Low Pressure Turbine to install a balance weight. This allowed air to leak into the main condenser. The increased air leakage into the condenser was enough to cause a slight lowering of vacuum in the north half of the condenser that displaced water from the north part of the hotwell to the south part. South hotwell level was raised to the point where the hotwell level controller caused water to be rejected to the Condensate Storage Tank. The condenser reject flow reduced feedwater flow to the reactor, causing a two inch water level decrease. Operators responded properly and minimized the impact of the transient.	Teamwork/Skill Level	IR 96016
1/13/1997	**********	**********	***** STARTUP FROM OUTAGE FOR TURBINE VIBRATION (1/10/97) *****	**********	*******

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/10/1997	**********	**********	***** SHUTDOWN DUE TO OFFGAS VALVE PROBLEM (INADEQUATE MAINTENANCE) & TURBINE VIBRATION *****	**********	*******
1/1/1997	**********	**********	***** STARTUP FROM REACTOR TRIP (12/28/96) *****	**********	********
1/1/1997	Self-Revealed	Maintenance	Developed a turbine rub that resulted in a high vibration turbine trip before it could be settled. With turbine off line, developed an offgas problem with drain tank operation for the SJAE suction path; lost suction a few times briefly, so shut down. Caused by sludge in instrument lines and improperly adjusted AOVs not shutting completely.	Equipment Malfunction	IR 96016
12/28/1996	Self-Revealed	Multiple	During attempted to place reference leg backfill system in service, got a pressure spike in the instrument line which caused a very brief level 8-level 2 indication spike that caused a scram. Three days investigating because some ESF actuations did not occur (due to 56 msec duration).	Engineering/Design Deficiency	IR 96016/NOV/ENS 31518
12/28/1996	**********	**********	***** REACTOR TRIP (see REF LEG BACKFILL) *****	**********	********
12/26/1996	NRC	Maintenance	Inspectors identified that an inadequate review of TS surveillance and mode change restraint requirements for Primary Containment Monitoring System resulted in a late startup scheduling change to avoid exceeding surveillance interval. Near Miss prevented by NRC intervention.	Inadequate Oversight	IR 96016
12/26/1996	**********	**********	***** STARTUP FROM FORCED SHUTDOWN (12/24/96) *****	**********	*******
12/24/1996	Self-Revealed	Maintenance	Technical Specification required shutdown due to a failure of a Drywell Vacuum Breaker to close during surveillance testing. The failure was due to an inadequate procedure that did not ensure the magnet assembly was secured.	Inadequate Procedure/Instruction	IR 96016/NOV/ENS 31507
12/24/1996	**********	**********	***** FORCED SHUTDOWN (VACUUM BKR FAILED) *****	**********	********
12/23/1996	**********	**********	***** STARTUP FROM FORCED OUTAGE (12/22/96) *****	Self-Critical	********
12/22/1996	**********	**********	***** FORCED OUTAGE (SRV "D" FAILED) *****	**********	*******
12/21/1996	**********	**********	***** STARTUP FROM FORCED OUTAGE (12/8/96) *****	**********	*******

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12/21/1996	Self-Revealed	Maintenance	SRV "D" stuck open. Closed itself just before operators inserted a manual scram. Investigation found bent solenoid valve stem.	Equipment Malfunction	
12/19/1996	Self-Revealed	Maintenance	The licensee replaced a new Intermediate Range Monitor detector that was damaged by mishandling while attempting to free the detector drive. An investigation revealed that the drive malfunctioned due to undetected material from a previous bearing failure in the gearbox.	Other/NA	IR 96016
12/16/1996	NRC	Engineering	The 10 CFR 50.59 program was generally adequate. However, a safety evaluation for the impact of using the Emergency Equipment Cooling Water (EECW) System to supplement drywell cooling during extended hot weather did not consider all applicable scenarios.	Inadequate Oversight	IR 96013
12/16/1996	NRC	Engineering	The inspectors identified informal and untimely corrective actions for a problem with the EDG 12 muffler. The issue was improperly assigned a low significance and closed. Corrective actions were rescheduled without reassessing the operability determination.	Inadequate Oversight	IR 96013/NOV
12/16/1996	Licensee	Maintenance	Wrong Reactor Water Cleanup (RWCU) system valves were worked during the outage. During startup, control indication showed a 15 gpm leak out of the RWCU. The correct valves were repaired following plant shutdown.	Personnel Performance Deficiency	IR 96013
12/16/1996	Self-Revealed	Maintenance	Two surveillances were started without meeting the plant conditions to complete the tests. Reviews by schedulers and operators were inadequate.	Inadequate Oversight	IR 96013
12/16/1996	NRC	Operations	Performance of operations activities during plant startup, shutdown, and refueling activities were well-controlled. Communications and coordination were good. In contrast, a number of routine evolutions were not properly controlled and errors were made which resulted in one scram and overflowing the spent fuel pool. A non-cited violation was issued for the performance related to the scram.	Teamwork/Skill Level	IR 96013

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12/16/1996	Licensee	Maintenance	The licensee identified two cases of lifted leads that were not relanded following maintenance. Both cases were found by workers but not reported or corrected until post maintenance checks. In one case, the investigation did not identify the cause. The inspectors determined the surveillance procedure was inadequate to verify proper system restoration.	Inadequate Procedure/Instruction	IR 96013/NOV
12/16/1996	Self-Revealed	Maintenance	The control center emergency makeup air filter overheated due to improper/inadequate maintenance. The investigation was unable to determine how the heater came to be set 100F too high. Response to the event was proper, but the filter had to be replaced. Valves needed to deluge the filter were found incorrectly labelled.	Personnel Performance Deficiency	IR 96013/NCV
12/16/1996	NRC	Engineering	The inspectors identified that a technical specification (TS) change was required as a result of the core reload analysis. Existing rod block monitor (RBM) operability requirements were not adequate to prevent exceeding fuel mechanical overpower limits during a rod withdrawal error event, but the 50.59 evaluation did not determine a TS change was necessary.	Inadequate Oversight	IR 96013/NOV
12/12/1996	Self-Revealed	Engineering	Battery charger would not work when 2 of 3 circuit boards were replaced with updated boards. The design change package evaluated the change to have no effect.	Personnel Performance Deficiency	IR 96012
12/12/1996	Licensee	Engineering	The stem (arm) to disk (bucket) connection for the turbine control valves were considerably out of tolerance due to improperly heat treated collars holding the disk to the stem.	Engineering/Design Deficiency	IR 96012
12/12/1996	NRC	Maintenance	Rust was found underneath snubber N30-3259-G68 on the 52 inch main steam manifold pipe. Although the snubber tested satisfactorily, and the rust was only on the outer sleeve, the thrust ring showed extensive wear caused by vibration.	Inadequate Oversight	IR 96012
12/12/1996	NRC	Engineering	Numerous problems were encountered during testing and startup of the station blackout combustion turbine generator (CTG) 11-1 . The turbine generator vibration exceeded the licensee's specifications. A ground was discovered in the generator field during testing that appeared to contribute to excessive vibration in the unit.	Engineering/Design Deficiency	IR 96012

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12/12/1996	NRC	Engineering	Oversight of the CTG-11 contractor was weak in the areas of design reviews, installation, inspection, and testing. This led to dependance on an alternate power source for station blackout and Appendix R shutdown power for twice as long as originally planned.	Inadequate Oversight	IR 96012
12/12/1996	Licensee	Engineering	The damaged rotors on the three low pressure turbines were replaced with ones having a integral cast shaft and rather than a shaft with shrink fit disks as were the original rotors in order to reduce the turbine vibration problems.	Conservative Decision	IR 96012
12/12/1996	NRC	Engineering	Cracked welds were found on the spring hanger supports beneath two of four pipes between the control valves and the turbine.	Engineering/Design Deficiency	IR 96012
12/8/1996	**********	**********	***** FORCED SHUTDOWN (see PIM dated 12/7/96 - "SRV -A did not indicate) *****	Equipment Malfunction	*******
12/7/1996	Self-Revealed	Engineering	SRV ".\" did not indicate again. TS required S/D. Found sonic flow was creating low pressure region near pressure switch that provided position indication, causing improper indication. Modification installed to move instrument line.	Engineering/Design Deficiency	IR 96013/LER 96022
12/7/1996	**********	**********	***** STARTUP FROM FORCED OUTAGE (12/2/96) *****	**********	*******
12/4/1996	Self-Revealed	Operations	During performance of a surveillance, Operators inserted a manual scram and did not follow Abnormal Operating Procedure 20.000.21, "Reactor Scram," by not verify that a Scram Discharge Volume Level High alarm was received, then the Scram Discharge Volume High Water Level Scram, and then reset the scram. By performing this out of sequence, a second scram resulted.ESF ACTUATION	Personnel Performance Deficiency	IR 96013/NOV

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12/3/1996	Self-Revealed	**********	LOSS OF SHUTDOWN COOLING DUE TO UNEXPLAINED CLOSURE OF THE SUCTION PATH ISOLATION VALVE: The "C" RHR pump tripped while in the shutdown cooling mode. The pump tripped when the suction path valve (E11F009) closed for no apparent reason. This is the only suction line for shutdown cooling, so even though other RHR pumps were available, shutdown cooling was lost for 25 minutes. Vessel temperature increased 2 degrees before the valve could be reopened and shutdown cooling restored. CAUSE WAS DETERMINED BY LICENSEE TO BE A SPURIOUS INVALID REACTOR PRESSURE SIGNAL.	Other/NA	IR 96013/LER 96020/ENS 31398
12/2/1996	**********	**********	***** SHUTDOWN (see SRV "A" entry dated 11/29/96) *****	**********	********
11/29/1996	**********	**********	***** STARUP FROM 5th REFUELING OUTAGE *****	**********	*********
11/29/1996	Self-Revealed	Engineering	SRV "A" did not indicate open when valve was open. Indication required for accident monitoring.	Engineering/Design Deficiency	
11/22/1996	Licensee	Operations	Licensee controls to revise the licensed operator requalification training program were satisfactory	Involved Management	IR 96014
11/22/1996	NRC	Operations	The Licensed Operator Requalification training program was not effective in all areas. A pattern of poor operator performance existed that was attributable to inadequate and incorrect procedures, operator usage of procedures, and operators failing to control work activities.	Inadequate Procedure/Instruction	IR 96014
11/22/199o	Licensee	Operations	The requalification dynamic simulator scenarios contained all the quantitative and qualitative attributes necessary to provide an effective evaluation of operator skills. The job performance measures (JPMs) satisfied the quality checklist and were considered good. The facility did not administer a written examination. Minor weaknesses existed in the operators' usage of procedures and in three-way communications during the dynamic simulator scenarios.	Teamwork/Skill Level	IR 96014

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11/22/1996	NRC	Operations	(STRENGTH): The feedback process was correctly implemented. Operator and crew weaknesses as well as operator training requests were used to select training requirements for the upcoming training cycle. There was a satisfactory tracking program to incorporate changes to the examination bank material when procedure changes or modifications were implemented. The program was current and up to date.	Self-Critical	IR 96014
11/22/1996	NRC	Operations	One concern involving the operation of the Rod Worth Minimizer on the simulator was identified.	Engineering/Design Deficiency	IR 96014
11/22/1996	NRC	Operations	(STRENGTH): The facility evaluators adequately identified operator performance errors during the operating examinations.	Self-Critical	IR 96014
11/22/1996	Self-Revealed	Operations	One entire crew failed their requalification examination because they failed to properly execute plant emergency operating procedures. Control room communications were a contributing cause to the failures.	Teamwork/Skill Level	IR 96014
11/20/1996	**********	**********	SMM Screening Meeting - FERMI Full Discussion	**********	**********
11/15/1996	Licensee	Engineering	Inadequate water supply to the standby feedwater system for Appendix R requirements.	Engineering/Design Deficiency	LER 96019
11/14/1996	Self-Revealed	Maintenance	RCIC Valve Failed Logic Test due to Wiring Error. While conducting post maintenance test, I&C identified that the RCIC steam inlet valve had two wires which were not connected.	Personnel Performance Deficiency	IR 96013/NOV
11/14/1996	Licensee	Maintenance	Reactor Recirculation Pump trip coil not connected. One of four trip coils were found to be disconnected. Maintenance and post maintenance testing had been performed before the fault was found.	Personnel Performance Deficiency	IR 96013/NOV
11/13/1996	Self-Revealed	Maintenance	Loads tripped during diesel testing: During the LOOP & LOCA test of the EDG, the "A" core spray pump and the "A" RHR pumps sequenced onto the emergency bus but tripped on over current. The cause was due to a faulty card in the under voltage circuit. The system was worked on during the outage but pass several tests before the failure.	Equipment Malfunction	**********
11/7/1996	**********	**********	PPR end (3/96-9/96) - PPR Meeting	**********	**********

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11/5/1996	Self-Revealed	Maintenance	Failure to communicate conditions on the refuel floor resulted in a missed technical specification surveillance: The maintenance technicians on the refueling floor mis-communicated that the tensioning of the head bolts were complete. The control room operators then made a mode change from Mode 5 to Mode 4. Later, personnel on the refueling floor found a stud not tensioned and did not report this condition to the control room. The stud was re-tensioned. When the control room personnel found that the head had not been tensioned as first reported, they found that a Mode 5 required surveillance was not performed.	Inadequate Oversight	IR 96017 [redacted] EX.5
10/31/1996	NRC	Operations	The Onsite Review Safety Organization (ORSO) inappropriately approved a Technical Specification Clarification (TSC) in an attempt to operate the plant in a condition that was prohibited by TS rather than requesting a Notice of Enforcement Discretion (NOED) or an amendment to the TS. [redacted] exempt on 5 EX.5	Inadequate Oversight	IR 9601 [redacted] exempt on 5 EX.5
10/31/1996	NRC	Operations	Inspectors identified that control room operators failed to take specific corrective actions required in an Alarm Response Procedure in responding to a Fuel Pool Cooling Trouble alarm during the last inspection period. This inaction resulted in overflowing the spent fuel pool.	Personnel Performance Deficiency	IR 96016/NOV
10/31/1996	Self-Revealed	Operations	The Fuel Pool was Over-Filled and resulted in 300 gallon spill into the ventillation system: A 3 inch valve on the line used to add water to the fuel pool was mispositioned. The individual was to open a 1 inch valve with a "garden hose" attached was used to decon equipment that was removed from the fuel pool.	Personnel Performance Deficiency	IR 96013/NOV
10/30/1996	NRC	Engineering	Corrective actions on the EDG loose baffle was not timely commensurate with the safety significance of the system. NOV ISSUED - OPERABILITY EVALUATION requirements were not tracked and resulted in maintenance activities being rescheduled beyound SE considerations.	Inadequate Oversight	IR 96013/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/30/1996	NRC	Engineering	Safety evaluation missed the requirement to amend the technical specification for the rod block monitor based on the new core reload analysis. The NRC intervened.	Inadequate Oversight	IR 96013/NOV
10/30/1996	**********	Engineering	The control rod position indication system upgrade project and the low pressure turbine replacement and steam path upgrade project were carefully planned and executed with few problems. Coordination for both projects was good. (STRENGTH)	Teamwork/Skill Level	IR 96013
10/28/1996	Self-Revealed	Engineering	5 of 6 SRVs failed to lift within allowed set point: Subsequently, 14 of 15 valves failed test. Licensee's analysis showed that plant could have exceeded a safety limit during transient.	Equipment Malfunction	IR 96013/LER 96017
10/25/1996	**********	Plant Support	Radiation Protection provided close support of outage work.	Teamwork/Skill Level	IR 96010
10/25/1996	NRC	Engineering	Inspectors identified two sets of safety system indications in the control room, which were not updated to indicate the new operating bands when system changes were made by Engineering, indicating weak support of operations.	Other/NA	IR 96010
10/23/1996	Licensee	Engineering	Licensee inspections of Emergency Diesel Generators coolers found that anode plugs had deteriorated and large flakes were coming off the anode and blocking a limited number of tubes in all but one cooler. Anode replacement intervals had been extended significantly, contributing to this problem.	Other/NA	IR 96010
10/25/1996	Licensee	Maintenance	RCIC pump inspection revealed numerous instances of foreign material and a possible assembly error. These had not affected pump operability in the past.	Other/NA	IR 96010
10/25/1996	Self-Revealed	**********	Four Engineered Safety Feature (ESF) occurred due to performing tasks simultaneously, misunderstanding work instructions, and not ensuring system configuration. These errors occurred during refueling outage evolutions, post maintenance testing, and sureveillance activities.	**********	IR 96010
10/25/1996	NRC	Plant Support	Radiation Protection provided close support of outage work.	Teamwork/Skill Level	IR 96010

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/25/1996	Self-Revealed	Engineering	During a routine safety bus undervoltage surveillance, operators were unable to start a residual heat removal service water pump. This pump was not previously identified as being rendered inoperable during performance of these surveillances, and thus TS action statements were not entered. A violation was cited for this event (NOV). (E3.2)	Inadequate Procedure/Instruction	IR 96010/NOV
10/25/1996	Self-Revealed	Operations	Plant configuration control problems resulted in two minor contamination spills and various tagout problems.	Personnel Performance Deficiency	IR 96010/NCV
10/22/1996	NRC	Engineering	Special Test was not stopped as required: A test for natural circulation in the core was performed to allow work on the RHR shutdown cooling suction valves. The licensee had set up several temperature detectors in the core to monitor the temperature of the coolant to verify that natural circulation was occurring. The procedure gave specific instructions to terminate the test if temperature monitoring was lost. The test engineer pushed the wrong button and lost indication. The engineer made several attempts to regain indication and left the area twice to seek assistance. The control room was not informed of this condition until the inspectors identified it to them. The control room stopped the test and restored shutdown cooling.	Personnel Performance Deficiency	IR 96010/NOV
10/17/1996	Licensee	Engineering	Fuel Rack Design Deficency: The licensee identified in 1983 that seven fuel storage rack panels were manufactured upside down. The analysis determined that the racks were acceptable. In 1991, the licensee responded to an industry concern with Boraflex gapping and determined that they were not susceptible. They failed to evaluate the previous design issue of racks being manufactured upside down. In 1996, they discovered this error and removed all spent fuel from the affected racks.	Personnel Performance Deficiency	IR 96010
10/16/1996	Self-Revealed	Maintenance	ESF: While preparing for a safety battery test discharge, the fuses for a test battery were not installed when it was connected to the bus. As a result, the bus was unintentionally deenergized when attempting to restore from the test, resulting in ESF actuations. The cause was similar to a battery charger testing problem a year earlier.	Inadequate Procedure/Instruction	IR 96010/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/14/1996	Self-Revealed	Maintenance	Vacuum breaker "J" stuck open, necessitating shutdown per TS. Found magnet assembly improperly installed during the refueling outage.	Equipment Malfunction	IR 96016/NOV
10/11/1996	Licensee	Plant Support	Lessons learned compiled from RFO4 ALARA post job reviews were effectively implemented for RFO5 and resulted in a net dose savings during the outage.	Teamwork/Skill Level	IR 96011
10/11/1996	Licensee	Plant Support	Excellent control of potentially contaminated materials existed. All potentially contaminated items were either within the designated areas or were bagged and labeled appropriately.	Teamwork/Skill Level	IR 96011
10/11/1996	Licensee	Plant Support	RP coverage for specific jobs and routine rounds was evident. RP techs at the control points adequately briefed workers and exercised appropriate control of various tasks.	Teamwork/Skill Level	IR 96011
10/11/1996	NRC	Plant Support	10/11/96,NRC,Plant Support,NRC identification of chewed gum in the reactor building indicated a continuing problem. The licensee had identified evidence of eating and drinking on August 19 in the Radwaste Building and on August 26 around the turbine office,	Personnel Performance Deficiency	IR 96011
10/11/1996	Licensee	Plant Support	The ALARA Committee planning for dose reduction and ALARA activities for RFO5 was of sufficient scope and depth to contribute to dose savings achieved. The ALARA committee was effective in communicating high expectations to both the radiation protection staff and Task Managers.	Involved Management	IR 96011
10/11/1996	NRC	Plant Support	Planning for the control rod position indicating probe modification task significantly underestimated the work scope and the dose expenditure for the scaffolding and cable installation phases.	Personnel Performance Deficiency	IR 96011
10/8/1996	NRC	Engineering	Inspectors identified that an inadequate safety evaluation was performed prior to taking the General Service Water System out of service for maintenance. As a result, Engineering failed to evaluate the need to provide an alternate source of makeup to the Ultimate Heat Sink to compensate for evaporative losses while in shutdown cooling.	Inadequate Oversight	IR 96010/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/8/1996	Self-Revealed	Maintenance	Personnel error resulted in tripping the Emergency Diesel Generator 12 during post maintenance testing.	Personnel Performance Deficiency	IR 96010/NCV
10/7/1996	Self-Revealed	Engineering	Error in Thermal Power Indication: An error in the computer resulted in a 3 Mwt error in the non-conservative direction. Limits were not exceeded since the licensee was administratively limited to about 86 percent power due to excessive turbine vibration.	Inadequate Oversight	LER 96013
10/4/1996	Self-Revealed	Operations	On October 4, Operations deenergized bus 72ED in preparation for maintenance. This action removed power to motor operated valves (MOVs) E1150-F602A and F602B. These MOVs are one of two cross-tie lines for the Residual Heat Removal (RHR) reservoirs. The reservoirs were inoperable, cross-tie capability defeated for about 28 hours.	Inadequate Oversight	IR 9601[redacted] Ex. 5
10/4/1996	Licensee	Engineering	Non-conservative scaling error in the process computer inputs for reactor recirculation pump power, caused the plant to exceed its licensed power levels at times during three previous operating cycles, by a small amount.(URI 96010-10)	Other/NA	IR 96010/LER 96013/URI
10/3/1996	Self-Revealed	Maintenance	Two surveillances were started without meeting the plant conditions to complete the tests. On October 3, Surveillance 42.302.04, "Division 2 Bus 65E/13EC UV Logic Fnctional Test," conflicted with Non-interruptible Air System being cross-tied for eactor Building Closed Cooling Water (RBCCW) system outage. Deviation Event Report (DER) 96-1291 was written to document the event and track corrective action. On October 28, Surveillance 44.030.052, "ECCS - RHR Division 2 Logic Functional Test"required securing Division 1 SDC at a time when it was required by TS, and an alternate method of removing decay heat was not available.	Inadequate Oversight	IR 96013
10/3/1996	Self-Revealed	Maintenance	ESF: The wrong end of an electrical lead was lifted during troubleshooting, resulting in an ESF actuation isolation of seal water flow to a shutdown reactor recircu¹ation pump. Supervisor misunderstood work instructions. Licensee does not believe that this qualified as an ESF actuation.	Personnel Performance Deficiency	IR 96010/NCV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/2/1996	Self-Revealed	Operations	While attempting to use the Core Spray Keep Fill System to fill the reactor vessel, the throttle valve overloads tripped. The inspectors questioned the use of a safety system as a matter of convenience to fill the reactor, when non-safety systems were available.	Personnel Performance Deficiency	IR 96010
9/28/1996	Self-Revealed	Operations	ESF ACTUATION: Torus-Drywell vacuum breaker opened. Operations did not account for energy added to the torus from RHR while purging the drywell.	Inadequate Oversight	IR 96010/LER 96-11
9/28/1996	Self-Revealed	Operations	ESF ACTUATION: During fill and venting of EECW system, auto start of pump occurred. Operations was filling two portions of the system simultaneously when low pressure conditions occurred.	Inadequate Oversight	IR 96010/NOV/LER 96-15
9/27/1996	**********	**********	PLANT SHUTDOWN FOR REFUEL OUTAGE	**********	**********
9/27/1996	**********	Operations	Plant shutdown for the refueling outage was controlled and deliberate.	Teamwork/Skill Level	IR 96010
9/25/1996	**********	**********	Station held a day-long stand down. Meetings were conducted to emphasis reactor safety, adherence to procedures, and work control.	**********	IR 96010
9/23/1996	Licensee	Maintenance	Licensee personnel found and stopped unauthorised maintenance activities on the refueling bridge by system engineer and contract personnel.	Personnel Performance Deficiency	IR 96010/NCV
9/18/1996	Self-Revealed	Maintenance	Technician connected portable test instrumentation across wrong terminals on 24/48 V battery. Damaged only test instrumentation.	Personnel Performance Deficiency	IR 96010/NCV
9/13/1996	NRC	Operations	There were significant weaknesses regarding the failure of licensee corrective actions to prevent recurrence of problems. For example, in the operations area, deficiencies were identified in procedure preparation and upgrade during 1994 and part of 1995 in deviation report. The repetitive nature of the problem was noted in a recently issued adverse trend report. Also in the operations area, the lack of effectiveness of corrective action initiatives were evidenced by recurrent improper component manipulations, and by repetitive failures to enter Technical Specification action statements.	Inadequate Oversight	IR 96201

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
9/13/1996	NRC	Engineering	One calculation had to be created to verify that existing instrumentation would detect a pressure transient in the HPCI system steam exhaust line and isolate the system as required. Other calculations, such as one for fuse selection, and one for motor operated valve (MOV) pickup voltage, required corrections in order to verify system operability.	Engineering/Design Deficiency	IR 96201
9/13/1996	NRC	Engineering	HPCI system and the NIAS were capable of performing their intended safety functions; however, numerous inconsistencies in the UFSAR and design basis documents were identified.	Engineering/Design Deficiency	IR 96201
9/13/1996	NRC	Maintenance	In the biannual audits of the corrective action program, NQA did not follow the requirements of the QA manual for generating DERs and for escalating repetitive issues to management attention.	Inadequate Oversight	IR 96201
9/13/1996	NRC	Maintenance	Nuclear quality assurance (NQA) audits and surveillances did not reflect the adverse trends apparent from the DERs in the areas of work control and operations.	Inadequate Oversight	IR 96201
9/13/1996	NRC	Maintenance	There was some resistance by craft personnel to participate in the DER initiation.	Personnel Performance Deficiency	IR 96201
9/13/1996	Licensee	Plant Support	Failure to follow radiological administrative procedures: Licensee identified several instances of eating and drinking in the radiologically restricted area. Prompt corrective measures were taken.	Personnel Performance Deficiency	IR 96007/NCV
9/13/1996	NRC	Maintenance	Weaknesses in initial characterization of problems, assignment of probable cause, and root cause analysis contributed to the inadequate corrective actions. For example, a substantial number of the work control related DERs had the same probable cause "inattention to detail." The corresponding corrective actions were generally limited to counseling and retraining of employees. The lack of specific requirements to bring recurring issues to the attention of upper levels of management also contributed to the chronic nature of the problems.	Inadequate Oversight	IR 96201

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
9/13/1996	Self-Revealed	Maintenance	Equipment material condition: A series of existing equipment deficiencies in a reactor building equipment drain sump went unidentified until a new equipment leak began increasing the input to the sump.	Other/NA	IR 96007
9/13/1996	NRC	Engineering	Surveillance test acceptance criteria disagreed with supporting calculations. Maximum leakage rates allowed by surveillance could exceed NIAS system capacity. Also minimum pickup voltage for an MOV exceeded the voltage available at the valve.	Engineering/Design Deficiency	IR 96201
9/13/1996	NRC	Operations	Weaknesses in the corrective action and quality assurance programs contributed to weak performance in the area of operations.	Inadequate Oversight	IR 96201
9/13/1996	NRC	Operations	Corrective actions repeatedly failed to prevent recurrent personnel performance problems.	Inadequate Oversight	IR 96201
9/13/1996	NRC	Operations	The site-wide problem identification and corrective action process using Deviation Event Reports (DERs) was comprehensive and continued to gain acceptance by site personnel. The tracking and trending of the DERs within the corrective action program identified adverse trends in the areas of operations, maintenance and engineering.	Self-Critical	IR 96201
9/13/1996	NRC	Operations	Root cause analyses were not probing enough to determine the appropriate causal factors, and there was no escalation process to bring management attention to longstanding issues.	Inadequate Procedure/Instruction	IR 96201
9/13/1996	NRC	Operations	Guidance needed to properly classify DERs according to the significance of the problem or event was not provided. The procedure also lacked specific requirements to escalate long standing repetitive issues to the attention of upper management.	Inadequate Procedure/Instruction	IR 96201
9/13/1996	NRC	Operations	Licensee self-assements of OPERATIONS continued to be weak: Assessments routinely do not find problems in operations area. Frequency and rigor has not changed even though OPERATIONS was rated Category 3 for last two SALPS. Confirmed by Special Inspections Branch (FOSI) inspection.	Other/NA	IR 96201

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DATE	ID B.	SALP	DESCRIPTION	CAUSE	REF
9/13/1996	Self-Revealed	Maintenance	Inadequate surveillance procedure resulted in the residual heat removal service water pump beining inoperable without operations knowledge.	Inadequate Procedure/Instruction	IR 96010/NOV
9/10/1996	NRC	Maintenance	Work activity was performed outside the 10CFR50.59 safety evaluation: Inspectors identified that safety system service water modification was performed in manner contrary to the applicable 10 CFR 50.59 safety evaluation.	Inadequate Oversight	IR 96007/NOV
9/9/1996	Self-Revealed	Operations	Reactor Core Isolation Cooling system rendered inoperable and required an entry into Technical Specification LCO actions: Operators failed to adequately evaluate the consequences of removing the Reactor Core Isolation Cooling Barometric Condenser Condensate Pump from service, which subsequently rendered the Reactor Core Isolation Cooling system inoperable and required an entry into Technical Specification LCO actions.	Inadequate Oversight	IR 96007/NOV
9/6/1996	Licensee	Operations	Ventilation damper not restored after maintenance due to inadequate restoration procedure: Licensee identified inadequate restoration from emergency diesel generator switchgear room maintenance resulted in a damper being left in the wrong configuration. This was an additional example of a continuing concern with inadequate configuration control on restoration from maintenance activities. INEFFECTIVE COMMUNICATIONS BETWEEN DEPARTMENTS	Inadequate Procedure/Instruction	IR 96007/NOV
9/6/1996	**********	Maintenance	Implementation of FIRST reduced backlog (STRENGTH): Fermi Integrated Resource Support Team (FIRST) implemented for simple/minor maintenance, initially worked over one-third of new work requests. May allow Maintenance to focus more on significant work.	Self-Critical	IR 96007
9/1/1996	**********	**********	**** END OF PPR (3/96 - 9/96) ****	**********	
8/21/1996	NRC	Maintenance	Two examples of failure to follow procedures (8/3/96 & 8/21/96): On August 21, 1996, four scaffolds erected in the Auxiliary Building were not inspected by a senior reactor operator or reactor operator. On August 3, 1996, a general supervisor failed to initial and date a change in step sequence, a minor revision to Work Instruction.	Personnel Performance Deficiency	IR 96007/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/15/1996	Self-Revealed	Maintenance	Response to diesel trip (STRENGTH): Maintenance, Engineering, and Operations response to an emergency diesel generator trip was prompt and well coordinated. The potential for common mode failure was effectively addressed.	Teamwork/Skill Level	IR 96007
8/2/1996	**********	Engineering	Timely and through root cause determination (STRENGTH): The root cause investigation of the fire in the Reactor Water Cleanup Filter Demineralizer control panel was timely and thorough, and supported a prompt repair and return to service without adversely impacting reactor water chemistry.	Teamwork/Skill Level	IR 96006
8/2/1996	Licensee	Maintenance	Coordination problems during service water outage: A series of general service water pump problems resulted in having one pump unavailable or in reduced status, during most of the inspection period. Lack of coordination within maintenance and among supporting groups contributed to the extended period this important system was at a reduced capability.	Inadequate Oversight	IR 96006
8/2/1996	Self-Revealed	Operations	Status of plant equipment was not maintained: Control room operators and a chemistry technician were unaware of the abnormal Post Accident Sampling System lineup when they attempted to draw a sample for the emergency exercise. When flow could not be established, operators discovered that the flow path had been tagged shut for almost 2 months. OPERATOR KNOWLEDGE DEFICIENCY	Inadequate Oversight	IR 96006
8/2/1996	**********	Operations	Use of procedures and good coordination during simulator training (STRENGTH): Inspectors observed proper use of procedures and emergency declarations, and good coordination and teamwork in the simulator during a training session and the Fermi Emergency Preparedness Exercise.	Teamwork/Skill Level	IR 96006
8/2/1996	Self-Revealed	Operations	Near-miss on entry into required technical specification action requirement: A near miss occurred on Technical Specification action statement entry during an Emergency Diesel Generator 12 surveillance. Lack of attention to detail and the absence of a pre-job brief contributed to the event. OPERATOR KNOWLEDGE DEFICENCY	Inadequate Oversight	IR 96006

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/2/1996	NRC	Engineering	Overall followup of SWSOPI was adequate: NRC followup inspection of the licensee-perfo:med Service Water System Operational Performance Inspection found some areas which were not covered by the licensee team. However, the NRC identified no additional concerns and concluded tha: the licensee self assessment was adequate.	Other/NA	IR 96006
8/2/1996	Licensee	Plant Support	Work performed under wrong radiological work permit: Instrumentation and Controls workers performed surveillance activities on the scram discharge volume instruments under the wrong Radiation Work Permit, and a radiation protection supervisor missed an opportunity to catch the error.	Personnel Performance Deficiency	IR 96006/NCV
8/2/1996	Licensee	Plant Support	Violation of radiological controls: Two instances were identified where personnel new to the site violated site radiological controls. While the consequences of the events were minor, the adequacy of radiation worker training was of concern.	Personnel Performance Deficiency	IR 96006/NCV
8/2/1996	**********	Plant Support	Emergency preparedness exercise very good (STRENGTH): Overall performance during the 1996 emergency preparedness exercise was very good and as indicated by the following observations. Emergency classifications and notifications to offsite authorities were made in a timely manner. Technical Support Center staff rapidly evaluated plant conditions and made appropriate emergency classifications. Command and control and offsite communications were very good in the Emergency Operations Facility.	Teamwork/Skill Level	IR 96006
8/2/1996	NRC	Maintenance	Preparation and execution of work during maintenance outages declined: Problems were identified in timely assignment of outage managers, parts availability, and coordination between organizations. As and example, restoration from High Pressure Coolant Injection (HPCI) motor operated valve testing resulted in a delay in returning HPCI back to service. Two bolts were not installed on the valve actuator cover housing. This required the valve actuator to be disassembled to check for damage and to restore the actuator to a normal operation.	Inadequate Oversight	IR 96006

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/1/1996	**********	Plant Support	[redacted] EX. 7A	Other/NA	**********
8/1/1996	NRC	Maintenance	Failure to follow procedure: A Temporary Plant Space Request was not initiated for equipment which were not seismically restrained in the Division II Battery Room, located in the Auxiliary Building.	Personnel Performance Deficiency	IR 96006/NOV
7/29/1996	NRC	Engineering	Inadequate corrective actions: A drain line for the Division I safety related service water common return line to the mechanical draft cooling towers was found by the inspectors to be partially plugged for the second time in four months. Corrective actions for Violation 341/96004-03 failed to identify this repeat occurrence.	Inadequate Oversight	IR 96006/NOV
7/19/1996	Self-Revealed	Maintenance	HPCI suction valves switched from Condensate Storage Tank to Torus - ESF Actuation: Technicians inadvertently caused actuation while performing unrelated surveillance in cabinet.	Personnel Performance Deficiency	IR 96006/ ENS 30767/ LER 96010
7/11/1996	NRC	Operations	Inadequate operating procedure: Inspectors identified an example of an inadequate system operating procedure for Residual Heat Removal Service Water in that all system valves were not included in the system lineup.	Inadequate Procedure/Instruction	IR 96006/NOV
6/28/1996	NRC	Engineering	Weak plant engineering support contributed to management decision-making without all the necessary information: This resulted in control room operators and operations management not being aware of the effect of filter clogging in the reactor water level instrument reference leg backfill system. NRC identification of this situation resulted in prompt corrective action.	Inadequate Oversight	IR 96005
6/28/1996	**********	Engineering	Site engineers and licensing staff demonstrated a good questioning attitude in identifying an existing divisional separation Appendix R issue (STRENGTH): This issue identified a postulated fire that could affect both divisions of safety-related air systems.	Teamwork/Skill Level	IR 96005

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
6/28/1996	NRC	Engineering	Inadequate engineering support of testing: Lack of system engineering experience and an inadequate procedure complicated testing of the CCHVAC Emergency Makeup Filter following filter sampling. This resulted in the plant being within 12 minutes of a Technical Specification required shutdown.	Inadequate Oversight	IR 96005
6/28/1996	Licensee	Engineering	Missed surveillance due to document control: The document changes and temporary modification necessary to permit performance of an 18 month inspection of the diesel fire pump with the plant at power were uncoordinated. This resulted in exceeding the periodicity of the surveillance. The end product of the temporary modification was good following correction of initial inadequacies.	Inadequate Oversight	IR 96005
6/28/1996	**********	Engineering	System startup testing for the Hydrogen Water Chemistry System was performed in a coordinated, deliberate manner (STRENGTH).	Other/NA	IR 96005
6/28/1996	**********	Plant Support	Radiation protection (RP) and chemistry support for HWC system testing, and RP support of maintenance on a contaminated pump were observed to be very effective (STRENGTH).	Teamwork/Skill Level	IR 96005
6/28/1996	NRC	Operations	Inadequate procedure reviews failed to identify that the abnormal operating procedure for restoration of Control Center Heating, Ventilation and Air Conditioning (CCHVAC) on a loss of air could not be performed. Once deficiencies were identified, operations was slow to communicate the problems to management. This procedure was being relied upon to mitigate the effects of a licensee identified Appendix R issue.	Inadequate Procedure/Instruction	IR 96005
6/14/1996	NRC	Maintenance	Improvements in material condition: Plant material condition, which was previously an operator distraction, improved during the force outage in March. Control Rod position Indication Probe issue was one of the major problems that were eliminated.	Teamwork/Skill Level	IR 96006

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
6/12/1996	NRC	Operations	RCIC pump was inadvertently operated without a discharge flow path. This was due to operators not promptly recognizing the failure of the system minimum flow valve to open. Operators allowed the RCIC pump to run against dead-head for about 9 minutes. The minimum flow valve did not open because of a failed opening coil. OPERATOR KNOWLEDGE DEFICENCY	Personnel Performance Deficiency	IR 96004/NCV
6/10/1996	Licensee	Operations	West Circulating Water Reservoir Decanting (CWRD) Pump Run Without Discharge Flow Path: A non-licensed operator identified that the West CWRD Pump was running with the discharge valve closed. The West CWRD Pump was started by another non-licensed operator in accordance with procedures but did not open the pump discharge valve. The pump was left running at shut-off head for approximately two hours. Though the potential for pump damage existed, no pump damage was noted. OPERATOR KNOWLEDGE DEFICENCY	Personnel Performance Deficiency	IR 96004/IR 96005
6/7/1996	NRC	Maintenance	Diesel Fire Pump (DFP) Work Performed Without Meeting Required Plant Conditions: On June 7, maintenance personnel signed on to Job FP87960412 to perform an 18-Month surveillance inspection of the Fermi 2 DFP. The job paperwork had a note that stated "This test should be performed while the plant is shutdown - per UFSAR (Updated Final Safety Analysis Report)." The copy of the surveillance procedure used to start work, 34.501.002, "Fire Pump (Diesel) Inspection," Revision 27, listed required plant conditions as "Plant cold (Mode 4 or 5)." The inspectors reviewed the requirements of the UFSAR and found that Section 9A.6.2.2.2.c required that the inspection be performed during a plant shutdown.The inspectors further determined that Licensing Change Request (LCR) 95-0-99-UFS had been approved to permit erformance on line, and that Revision 28 to the surveillance procedure was issued on June 3 to support on line performance. Operating shift personnel had reviewed the revised procedure and concluded the work was permitted while operating, but did not notice the copy actually signed on was the previous revision (Revision 27), that required the plant to be shutdown.	Inadequate Oversight	IR 96005/NCV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
5/28/1996	NRC	Maintenance	Problems with scheduling and work control during maintenance outage on CCHVAC: Preparations for this system outage did not adequately prepare for contingencies. Despite a recent history of damper boot seal failures and scheduled work on a number of the damper actuators, no spare seals were available. System engineers involved in the test had no experience with the emergency makeup filter test. Difficulties with that test due to an inadequate procedure nearly resulted in a plant scram to comply with required TS actions because the procedure was inadequate. The major equipment problems experienced in this outage were probably caused by a combination of the maintenance personnel performing the work and the age of the inflatable seal, which were not replaced periodically and were likely original equipment.	Inadequate Oversight	IR 96004/NCV
5/25/1996	Licensee	Maintenance	ESF Actuation due to personnel error and maintenance: A Technician inadvertently cracked the indicating lamp socket during maintenance. Later an auxiliary operator discovered the power ready light for Division 2 Torus Water Management System (TWMS) local panel was broken. While attempting to investigate the broken socket, an auxiliary operator caused a short circuit that resulted in an ESF actuation of the TWMS isolation valves.	Personnel Performance Deficiency	IR 96004/ LER 96009/ ENS 30545
5/16/1996	NRC	Operations	Inspector identified deficiencies with abnormal operating procedure: Several ventilation dampers were found in configurations that did not agree with AOP 20.413.01 Rev 12 for CCHVAC.	Inadequate Procedure/Instruction	IR 96004/NCV
5/15/1996	**********	Operations	Operators demonstrated good command and control during performance of a plant shutdown and startup (STRENGTH): During startup on 4/22, operator performance in conducting activities was good, even though the operators were challenged by equipment problems.	Teamwork/Skill Level	IR 96004

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
5/15/1996	NRC	Maintenance	Four examples of inadequate Foreign Material Exclusion: licensee discovered a piece of wire lodged near the disc and seat of Safety Relief Valve Vacuum Breaker (3/28) during Division 2 EECW Heat Exchanger cleaning, the licensee identified a wad of fibrous material stuck to the tube sheet on the emergency equipment service water side of the heat exchanger (4/1) during disassembly of the North Feedwater Heater Drain Valve, the licensee identified that foreign material (a 2-1/2" long threaded stud and a 1/2" pin) were found inside the valve body (4/2) during NRC walkdown of the RHR complex, a plastic bottle and a piece of wood were found floating in the Division 2 Ultimate Heat Sink Reservoir. In addition, numerous grating clamps were found missing or broken. Some of the missing clamps most likely had fallen into the reservoir. Inside the pump rooms, two floor penetrations were not covered, allowing the possibility for debris to fall into the reservoir (5/2)	Other/NA	IR 96004
5/15/1996	NRC	Operations	Four examples of inadequate operator performance involving inadequate procedure compliance: This is a continuing concern. During performance of Emergency Diesel Generator (EDG) 14surveillance testing, an operator opened a disconnect and electricians installed a jumper on the wrong motorcontrol center cabinet position (3/30) while cross-tying divisions of the non-interruptible instrument air system (NIAS), operators failed to open the NIAS Division 1 and Division 2 Cross Tie Isolation Valve (4/3) during the Division 1 EECW surveillance test, the EECW pump did not start and received a tripped indication. Licensee investigation revealed that the breaker charging spring toggle switch was in "off," which prevented the charging spring from being recharged following the previous operation (4/11) while performing a licensed operator walkdown of the Control Rod Drive (CRD) Hydraulic Control Units (HCUs) following maintenance activities, the Charging Water Isolation Valve (C11-F113) for HCU 38-51 was found closed when required to be open.	Personnel Performance Deficiency	IR 96004/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
5/13/1996	**********	Engineering	Site engineers and licensing staff demonstrated a good questioning attitude in identifying an existing divisional separation Appendix R issue (STRENGTH): A condition was identified where inadequate separation of Division 1 and 2 NIAS control circuits existed. As a result, the potential existed for both divisions of NIAS to be affected by a fire near the Division 2 compressor. The licensee took prompt corrective actions.	Conservative Decision	IR 96004/LER 96008/ENS 30461
5/2/1996	NRC	Engineering	Failure to identify cause: On February 23, 1995, a flow reduction occurred in the Division II Residual Heat Removal Service Water, Emergency Equipment Service Water, and Emergency Diesel Generator #3 Service Water systems, which was a significant condition adverse to quality, and as of May 2, 1996, the licensee failed to identify the cause for the condition.	Inadequate Oversight	IR 96004/NOV
4/19/1996	NRC	Operations	Problems during Startup: Several personnel errors occurred during the startup from the force outage due to the service watermakeup tank design problem. these included Residual heat removal sevice water system waterhammer (4/15), and mispositioned hydrualic control unit charging water isolation valve (4/16)	**********	**********
4/19/1996	NRC	Engineering	Problems during Startup: Several personnel errors occurred during the startup from the force outage due to the service watermakeup tank design problem. these included Residual heat removal sevice water system waterhammer (4/15), seismic monitoring system surveillance testing requirements not being verified (4/17), reactor water cleanup system sample sink gauge glass rupture that resulte din contamination (4/18), and the general approach to performing the makeup tank modification (developed as the outage proressed without adequate pre-planning).	**********	**********
4/19/1996	NRC	Maintenance	Problems during Startup: Several personnel errors occurred during the startup from the force outage due to the service watermakeup tank design problem. these included near miss on perfroming post maintenance testing (friction testing) on control rod drives (4/16), seismic monitoring system surveillance testing requirements not being verified (4/17), and the general approach to performing the makeup tank modification (developed as the outage proressed without adequate pre-planning).	**********	**********

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
4/18/1996	Self-Revealed	Engineering	Repeated Failure of Primary Coolant Sample Flow Gage Glass: During a plant pressure increase as part of plant startup on April 18, the flow gage glass associated with Reactor Recirculation Loop B ruptured and caused a spill while the sample point was in service. The same flow glass had cracked and leaked on August 1, 1995, as documented in Inspection Report 95009. That failure occurred while placing the sample point in service, and had been attributed to age or material defect.	Engineering/Design Deficiency	IR 96004
4/10/1996	Self-Revealed	Operations	Water Hammer Occurred in the Emergency Equipment Cooling Water System (EECW): On April 10, following modifications to Division 1 of the EECW system and heat exchanger cleaning, the system was started for testing. A water hammer event was witnessed by operators and engineers present. Engineering walked down the portion of the system and found no problems. The licensee determined that no fill and vent of the system was performed, contributing to the occurrence of this water hammer event. No previous occurrence of water hammer in this system was identified by the licensee.	Inadequate Procedure/Instruction	IR 96004
4/4/1996	**********	Plant Support	Low collective dose and good rad worker practices.	Involved Management	IR 96002 IR96006
4/4/1996	NRC	Plant Support	Decreased Drywell dose rates. Radiation detection instrumentation maintained in exceelent condition and calibrated. Personnel proficient in use of detection instrumentation. Management oversight of radioactive material was effective as demonstrated by lack of errors in shipments.	Involved Management	IR 96002, IR 96006
4/3/1996	**********	**********	SALP 15 ENDS	**********	**********
4/2/1996	Licensee	Maintenance	Bolts Loosened during Maintenance on Wrong Control Rod Drive Mechanism (CRDM): contract workers were under the reactor vessel preparing CRDM 30-51 for removal when they identified that they had loosened 6 of the 8 bolts on the wrong CRDM (34-51).	Personnel Performance Deficiency	IR 96004/NCV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
4/2/1996	Licensee	Engineering	The licensee also identified a crack on the No. 2 High Pressure Control Valve spring-can housing. The crack was due to vibration between the turbine stop and control valves. Previous reports (IR 96002 and 95012) identified other cracks due to turbine stop & control valve vibration. The crack did not impact the operability of the spring-can support. The occurrence of this and the previous failures continue to be of concern.	Engineering/Design Deficiency	IR 96003
4/2/1996	NRC	Operations	Blocked Drain Lines to Mechanical Draft Cooling towers (MDCT): drain lines for the combined Residual Heat Removal service water return to the MDCT were found to be blocked by corrosion and debris buildup. This has a impact on the MDCTs to function during extreme winter conditins and may have been frozen when the diesel generator service water pumps were inoperable due to frozen intakes (see entry on 2/6/96)	**********	IR 96003
3/28/1996	**********	**********	SMM SCREENING MEETING	**********	**********
3/27/1996	Licensee	Engineering	Licensee identified that the emergency equipment cooling water system makeup tanks would not meet their design criteria during either an accident or seismic event. Licensee entered TS 3.0.3 and shutdown to cold shutdown.	Engineering/Design Deficiency	50.72 (30179)
3/27/1996	Licensee	Operations	Torus sample was missed: The torus was vented before the required sample was taken.	Inadequate Oversight	IR 96003
3/27/1996	**********	Operations	Operators performed a plant shutdown following identification of EECW design deficiencies without problems (STRENGTH). The operators performed the shutdown methodically and per plant procedures. All activities were well-coordinated and expected plant response to equipment manipulation was properly anticipated. The nuclear shift supervisor and nuclear assistant shift supervisor provided excellent oversight of the evolution.	Teamwork/Skill Level	IR 96003
3/18/1996	Licensee	Maintenance	Testing of the 12 Emergency Diesel Generator resulted in a plant condition outside of design basis.	**********	LER 96003
3/18/1996	Licensee	Engineering	Testing of the 12 Emergency Diesel Generator resulted in a plant condition outside of design basis.	**********	LER 96003

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/10/1996	NRC	Plant Support	!NRC [redacted] identified: Inappropriate Certification of Quality !Control (QC) Inspector: On June 29, 1994, Detroit Edison certified, as a !Level III QC Inspector, an individual with an associate degree who had !less than seven years of related experience in the areas of polymer, !metal, and electrical testing. The licensee's initial investigation of an !internal concern was inadequate.	Inadequate Oversight	IR 96002/NOV
3/10/1996	NRC	Maintenance	!Material condition of balance of plant continues to distract operators: !Several systems are distractions to the operators. rod position !indications (rod drift alarms) turbine building ventilation (fans - !repeated failures) main steam line vibration (supports and subsystems !lines cracking and fatigue).	Equipment Malfunction	IR 96002
3/10/1996	Licensee	Engineering	!UFSAR Disagreement (STRENGTH): Table 9.2-3 and section 9.2.2.2 of !the UFSAR, listed the maximum flow rate through the shell side of the !EESW/EECW heat exchanger as 1450 gpm. As documented in !Inspection Report 341/95009, routine surveillance runs used a flow rate !of 1670 gpm. The licensee was in the process of determining corrective !actions.	Other/NA	IR 96002/IR 95009
3/9/1996	Licensee	Engineering	!UFSAR Disagreement (STRENGTH): Section 8.3.1.5.1 of the UFSAR, !stated that safety equipment cabling was color coded orange for Division !1 and blue for Division 2, while !BOP cabling was black, or magenta in a few cases. However, during !construction extra divisional color coded cabling was used to complete !BOP electrical distribution.	Other/NA	IR 96002

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/9/1996	Licensee	Engineering	UFSAR Disagreement (STRENGTH): Section 11.5 of the UFSAR, stated that the "heart of the permanent Fermi 2 solid radwaste system is the radwaste volume reduction and solidification system," and that a vendor system is to be used when the asphalt system (above) is not working or at plant management discretion. Section 11.5 documented the various elements of that system including the asphalt system, evaporator, etc. However, the permanent system was not the primary system and has not been used for several years. The vendor system, which was also described in this section, had been used exclusively. The UFSAR also stated that two freon dry-cleaning units are used for cleaning contaminated laundry. However, the license used an offsite vendor facility for this purpose.	Other/NA	IR 96002
3/8/1996	NRC	Maintenance	Two events occurred due to equipment being unexpectedly affected by maintenance activities: On March 4, work on a local switch enclosure for the EDG 11 starting air compressor caused a short. The short resulted in a blown control power fuse and an EDG 11 starting air receiver tank low pressure alarm. Following the alarm, the air start header was cross-tied to EDG 12 air header. The blown fuse was identified and replaced. The starting air receivers were promptly restored to normal. On March 8, inspectors identified that the drain valve for the EDG 11 Engine Driven Air Coolant Pump was open. The valve should have been shut to prevent draining of the jacket water expansion tank. As previously documented in Inspection Report (IR) 96002, a similar valve on EDG 14 was found out of position open on February 26, 1996. The licensee determined that the valve was most likely inadvertently bumped opened due to unrelated maintenance near the valve.	Personnel Performance Deficiency	IR 96002
3/7/1996	Licensee	Operations	Emergency Diesel Generator 11 was inoperable due to degraded fuel oil. An extension of technical specifications was granted (NOED) to allow continued operations while fuel oil was replaced.	Other/NA	IR 96003/LER 96004/10CFR 50.72
3/7/1996	Self-Revealed	Engineering	Rod Position Indication Continue to be Problem: Excessive control rod drive drift alarms and loss of notch position indication. Caused by control rod position indication probe cable/connector problems.	Equipment Malfunction	IR 96002 IR 95012 IR 95009 IR 95004

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/7/1996	Licensee	Operations	Inadvertent actuation of Drywell-to-Torus vacuum breaker due to operator error.	Personnel Performance Deficiency	LER 96002
3/1/1996	**********	**********	END OF PPR (9/95 - 3/96)	**********	**********
2/23/1996	Self-Revealed	Operations	EDG 14 returned to stand-by without the starting air being lined up.	Personnel Performance Deficiency	IR 96002
2/16/1996	Self-Revealed	Engineering	Continued problems with reactor building VAC. Frequent trips and temperature control problems.	Engineering/Design Deficiency	IR 96002
2/14/1996	NRC	Operations	Inadequate Procedures: Operating procedures affecting the Residual Heat Removal system were found to contain incorrect setpoints. Changes due to system modifications were not incorporated into operating procedures.	Inadequate Procedure/Instruction	IR 96002/NOV
2/12/1996	NRC	Maintenance	Inadequate Work Control: Work Request was inadequate in that it failed to ensure that the Combustion Turbine Generator Unit 11-1 was returned to service with its battery in an acceptable state of charge.	Personnel Performance Deficiency	IR 96002/NOV
2/12/1996	Licensee	Engineering	Surveillance Testing was Outside of Design Basis (STRENGTH): Licensee determine that during past performance of Bus 64C undervoltage protection surveillances, that the plant was outside the design basis. While in "test," the automatic transfer of swing bus 72CF would not occur. This affected Low Pressure Core Injection valves. Engineering performed a prompt and thorough review of this condition.	Engineering/Design Deficiency	IR 96002/LER 96003
2/7/1996	Self-Revealed	Operations	Personnel Error Cause Vacuum Breaker Actuation: An operator failed to implement System Operating Procedure 23.409, Section 5.0, Ready Mode, Note (2), in that the division I thermal recombiner suction was lined up to the drywell and torus simultaneously in a non-emergency situation. This resulted in the actuation of the Containment Vacuum Breaker.	Personnel Performance Deficiency	IR 96002/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/6/1996	Self-Revealed	Operations	Both Division I & II Emergency Diesel Generator Service Water systems potentially inoperable due to icing of pumps "B" & "C" discharges. Licensee did not recognize the potential for common mode failure.	Engineering/Design Deficiency	IR 96002\50.72\LER 96001
2/6/1996	NRC	Operations	Both Division I & II Emergency Diesel Generator Service Water systems potentially inoperable due to icing of pumps "B" & "C" discharges. Licensee did not recognize the potential for common mode failure.	Engineering/Design Deficiency	IR 96002\50.72\LER 96001
1/31/1996	Self-Revealed	Maintenance	Repeat Work: Repeat gasket failure on waste collection filter resulted in spills of 2000 and 6000 gals.	Personnel Performance Deficiency	IR 96002/IR 95014
1/23/1996	Licensee	Maintenance	Inadequate surveillance procedure resulted in the Ultimate Heat Sink being isolated for a brief period. Inadequate system knowledge contributed.	Inadequate Procedure/Instruction	IR 96002
1/10/1996	NRC	Plant Support	Post accident sampling system was poorly maintained.	Inadequate Oversight	IR 95014
1/10/1996	NRC	Plant Support	Chemistry department's corrective actions to QA findings were narrowly focussed and did not resolve identified problems.	Inadequate Oversight	IR 95014
1/9/1996	Self-Revealed	Maintenance	Maintenance personnel worked on Div I & II mechanical draft cooling towers at same time without authorization.	Personnel Performance Deficiency	IR 96002
1/1/1996	Self-Revealed	Maintenance	Repeated cooling tower deice system failures. Failures resulted in operator distractions.	Engineering/Design Deficiency	IR 96002
12/29/1995	Self-Revealed	Operations	Wrong lube oil was added to RCIC pump during preventive maintenance.	Personnel Performance Deficiency	IR 95014
12/29/1995	NRC	Maintenance	Wrong lube oil was added to RCIC pump during preventive maintenance.	Personnel Performance Deficiency	IR 95014

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/21/1995	Self-Revealed	Operations	Initiation of CO2 in Battery Charger room. Operators bagged CO2 detectors. (Turbine and Aux BLDGs were evacuated and the residents were not informed).	Personnel Performance Deficiency	IR 95014\50.72
12/21/1995	Self-Revealed	Maintenance	Initiation of CO2 in Battery Charger room. Operators bagged CO2 detectors. (Turbine and Aux BLDGs were evacuated and the residents were not informed).	Personnel Performance Deficiency	IR 95014\50.72
12/13/1995	Licensee	Engineering	STRENGTH: Engineering discovered a nonconservative ommission in the heat balance calulations for core thermal power. Control rod drive flow was not included. Error created about 1 MWt. Licensee's review of power histroy indicated that limits were not exceeded during current cycle. However, licensed limit could have been exceed on one or more occassions during previous 3 cycles.	Teamwork/Skill Level	LER 95008
12/13/1995	NRC	Plant Support	Radiation postings were inadequate to indicate actual conditions in the heater rooms (signs and ropes not rehung).	Inadequate Procedure/Instruction	IR 95014
12/12/1995	Licensee	Operations	STRENGTH: Good control of work activities involving reactor water cleanup sstem repairs.	Teamwork/Skill Level	IR 96002\IR 95012
12/12/1995	Licensee	Maintenance	STRENGTH: Good control of work activities involving reactor water cleanup sstem repairs.	Teamwork/Skill Level	IR 96002\IR 95012
12/12/1995	NRC	Operations	QA and ISEG oversight of operations was weak. Examples included the improper testing that rendered the battery inoperable and the failure to recognize the emergency diesel generator inoperability.	Inadequate Oversight	IR 95012
12/11/1995	Self-Revealed	Operations	South East Generator Hydrogen cooler leak. General service water was isolated and Generator returned in degraded condition. Work coordination was good and repairs were prompt.	Equipment Malfunction	IR 95014

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/11/1995	Self-Revealed	Maintenance	South East Generator Hydrogen cooler leak. General service water was isolated and Generator returned in degraded condition. Work coordination was good and repairs were prompt.	Equipment Malfunction	IR 95014
12/10/1995	NRC	Maintenance	Main steam line hanger found broken and not supporting pipe run.	Equipment Malfunction	IR 95014
12/5/1995	Self-Revealed	Operations	Unexpected auto start of Div I control air compressor due to incorrect tagout lineup being performed. (repeat problem)	Personnel Performance Deficiency	IR 95014
12/1/1995	Licensee	Engineering	Several temporary modification implementation errors during installation of alternate air system.	Personnel Performance Deficiency	IR 95014
12/1/1995	Licensee	Engineering	Inadequate coordination between departments resulted in problems and delays during Circulating Water Pmp No. 5 modification. (This is an example of lack of coordination between departments impacting implementation of modifications, this is a long standing Engineering support problem.)	Inadequate Oversight	IR 96002
12/1/1995	NRC	Engineering	Several temporary modification implementation errors during installation of alternate air system.	Personnel Performance Deficiency	IR 95014
12/1/1995	NRC	Maintenance	Inadequate coordination between departments resulted in problems and delays during Circulating Water Pmp No. 5 modification. (This is an example of lack of coordination between departments impacting implementation of modifications, this is a long standing Engineering support problem.)	Inadequate Oversight	IR 96002
12/1/1995	NRC	Engineering	Degraded material condition of station blackout turbine generator (CTG-11-1). Licensee to refurbish unit in 4/96.	Inadequate Oversight	IR 95012\IR 95011
11/26/1995	Self-Revealed	Maintenance	Repeat gasket failure on waste collection filter resulted in spills of 2000 and 6000 gals.	Inadequate Oversight	IR 96002\IR 95014

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/16/1995	NRC	Maintenance	Safety related station battery had excessive corrosion. One cell required removal and cleaning of a terminal post. Battery seismic storage racks were also degrading.	Inadequate Oversight	IR 95012\NOV
11/16/1995	NRC	Engineering	Safety related station battery had excessive corrosion. One cell required removal and cleaning of a terminal post. Battery seismic storage racks were also degrading.	Inadequate Oversight	IR 95012\NOV
10/23/1995	Self-Revealed	Maintenance	During preventive maintenance to the Division 2 control room HVAC system, an electrician improperly connected the test leads resulting in damage to the ground fault circuit.	Personnel Performance Deficiency	IR 95012
10/20/1995	Self-Revealed	Operations	Small reactor fuel leak identified and prompt actions were taken including reducing power. Testing confirmed a leak on the core periphery. Three control rods were inserted to suppress power and limit release rate from the leak.	Equipment Malfunction	IR 95012
10/20/1995	Self-Revealed	Engineering	Small reactor fuel leak identified and prompt actions were taken including reducing power. Testing confirmed a leak on the core periphery. Three control rods were inserted to suppress power and limit release rate from the leak.	Equipment Malfunction	IR 95012
10/19/1995	NRC	Operations	Argon was used to fill hydraulic contol unit accumulators for 10 weeks instead of Nitrogen required by procedure.	Personnel Performance Deficiency	IR 95012\NOV
10/11/1995	NRC	Plant Support	The need for increased security followup and oversight of security contingency training because of training delays caused by the extended outage for turbine repair. This is a long term issue that has not been resolved.	Inadequate Oversight	IR 95011
10/4/1995	Self-Revealed	Engineering	Supply line to number 8 turbine bearing developed a crack at a weld for a support lug. The cause of the crack related to turbine vibration. A series of repairs were made to reduce vibration of the pipe.	Equipment Malfunction	IR 95012
10/3/1995	NRC	Maintenance	Battery & Charger unintentionally made inoperable due to installation of test load.	Personnel Performance Deficiency	IR 95012\SL III

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/3/1995	NRC	Operations	Battery & Charger unintentionally made inoperable due to installation of test load.	Personnel Performance Deficiency	IR 95012\SL III
9/25/1995	Self-Revealed	Plant Support	Two occurrences of inadequate compensatory actions. On 9/24/95, a vital area door failed to alarm when thumblocked open. Compensatory action was taken but later removed and the associated security card reader was disabled. Upon review by security supervision, it was determined that disabling the card reader was not a proper compensatory measure. Appropriate compensatory measures were restored. On 9/29/95, a similar event occurred.	Personnel Performance Deficiency	IR 95012\73.71
9/22/1995	Self-Revealed	Maintenance	Operators failed to recognize that Core Spray was inoperable during a surveillance resulting in not entering the TS LCO. TS Requirements were not violated.	Personnel Performance Deficiency	IR 95012
9/22/1995	Self-Revealed	Operations	Operators failed to recognize that Core Spray was inoperable during a surveillance resulting in not entering the TS LCO. TS Requirements were not violated.	Personnel Performance Deficiency	IR 95012
9/20/1995	NRC	Engineering	EDG 11 was made inoperable by a worker accidentally bumping a switch. Operations did not recognize inop condition due to inadequate procedures and ineffective communications between departments.	Personnel Performance Deficiency	IR 95012
9/20/1995	Self-Revealed	Operations	EDG 11 was made inoperable by a worker accidentally bumping a switch. Operations did not recognize inop condition due to inadequate procedures and ineffective communications between departments.	Personnel Performance Deficiency	IR 95012
9/19/1995	NRC	Plant Support	High failure rate of emergency lights.	Inadequate Oversight	IR 95009\NOV
9/19/1995	NRC	Maintenance	High failure rate of emergency lights.	Inadequate Oversight	IR 95009\NOV
9/7/1995	NRC	Operations	Degrading material condition of General Service Water System. Several cracks and through-wall holes found in General Service Water piping.	Equipment Malfunction	IR 95012\IR 95011\IR 95009
9/7/1995	NRC	Engineering	Degrading material condition of General Service Water System. Several cracks and through-wall holes found in General Service Water piping.	Equipment Malfunction	IR 95012\IR 95011\IR 95009

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
6/1/1995	Self-Revealed	Engineering	From 6/95 to present, excessive control rod drive drift alarms and loss of notch position indication. Caused by control rod position indication probe cable/connector problems.	Engineering/Design Deficiency	IR 96002\IR 95012\IR 95009 5R 95004
6/1/1995	Self-Revealed	Maintenance	From 6/95 to present, excessive control rod drive drift alarms and loss of notch position indication. Caused by control rod position indication probe cable/connector problems.	Engineering/Design Deficiency	IR 96002\IR 95012\IR 95009 IR 95004