UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

May 27, 1998

Mr. D. R. Gipson
Senior Vice President
Nuclear Generation
The Detroit Edison Company
6400 North Dixie Highway
Newport, MI 48166

SUBJECT: PLANT PERFORMANCE REVIEW (PPR) - FERMI

Dear Mr. Gipson:

The NRC staff recently completed the semiannual Plant Performance Review (PPR) of the Fermi Nuclear Power Plant. The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. The PPR for the Fermi plant involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period of October 1997 through March 1998. PPRs provide NRC management with a current summary of licensee performance and serve as inputs to the NRC Systematic Assessment of Licensee Performance (SALP) and senior management meeting (SMM) reviews.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated view of licensee performance trends. The PIM includes only items from inspection reports or other docketed correspondence between the NRC and Detroit Edison. The PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the PDR as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our planned inspection effort resulting from the Fermi PPR process. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 2 details our inspection plan for the next 6 months. The rationale or basis for each inspection outside the core inspection program is provided so that you are aware of the reason for emphasis in these program areas. Resident inspections are not listed due to their ongoing and continuous nature.



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cc: encl

Addl: AEOD/SPD 1 1

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at 630/829-9629.

Sincerely,

Bruce L. Burgess, Chief
Reactor Projects Branch 6

Docket No.: 50-341
License No.: NPF-43

Enclosures: 1. Plant Issues Matrix
2. Inspection Plan

cc w/encls: M. Peterson, Director
Nuclear Licensing
P. A. Marquardt, Corporate
Legal Department
Richard Whale, Michigan Public
Service Commission
Michigan Department of
Environmental Quality
Monroe County, Emergency
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# PLANT ISSUES MATRIX

5/27/98

## Fermi

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "Date" ; Beginning Date = "10/1/97" ; Ending Date = "3/31/98"

| # | DATE | TYPE | SOURCE | ID BY | SALP | SMM CODES | DESCRIPTION |
|---|---|---|---|---|---|---|---|
| 1 | 3/16/1998 | Positive | IR 98003 | NRC | Operations | 1B | Operators responded to an inadvertent load shed of Safety Bus 72E in a coordinated and methodical manner. Shift supervision provided clear direction to operators and support personnel responding to the event. Support personnel, including a crew of operators from training, were effectively utilized. Notification of the event to the NRC, Technical Specification actions, and documentation of events were appropriate and complete. (Section O1.2) |
| 2 | 3/16/1998 | Positive | IR 98003 | NRC | Operations | 1B 2A | Operator response to a reactor scram caused by a main turbine trip was conducted in a controlled and coordinated manner. Shift supervisory personnel provided clear, conservative direction. Support organizations' efforts were coordinated. In general, plant equipment response was good. (Section O1.1) |
| 3 | 3/16/1998 | DEV | IR 98003 | NRC | Operations | 1C | Two examples of a deviation from a commitment to comply with Regulatory Guide 1.78, "Control Room Habitability," were identified. The licensee's practices regarding availability of backup respirators in the control room and training on toxic chemical recognition and prompt donning of respirators for operators, did not comply with the Regulatory Guide. Additionally, two issues affecting the ability to respond adequately to a chlorine release were identified. (Section O8.1) |
| 4 | 3/16/1998 | Negative | IR 98003 | NRC | Maintenance | 1C 2B | An inadvertent load shed on Safety Bus 72E was caused by an unclear surveillance test procedure step. Inadequate reviews of the procedure revision and a lack of questioning attitude by maintenance workers contributed to the event. A violation was identified for an inadequate procedure. The licensee's investigation was prompt and thorough. (Section M3.2) |
| 5 | 3/16/1998 | Negative | IR 98003 | NRC | Maintenance | 2A | Residual Heat Removal Pump B developed multiple indications of unusual wear. The inspectors expressed concern about the pump's long term operability when the licensee evaluated the motor as acceptable. Subsequently, the decision was made to replace the motor. (Section M2.1) |

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|---|---|---|---|---|---|---|---|---|
| 6 | 3/16/1998 | Positive | IR 98003 | NRC | Maintenance | 2B | | Plant management discussed three instances of potential preconditioning, identified by the NRC and licensee personnel, with plant staff to further sensitize personnel to potential preconditioning issues during maintenance and testing. The licensee intended to evaluate the response to specific issues after creation of a station policy on the subject based on industry and regulatory practices in this area. A systematic review of maintenance and testing practices against this policy was also planned. (Section M1.2) |
| 7 | 3/16/1998 | Negative | IR 98003<br>IR 98003 | NRC | Maintenance | 2B | 2A | The inspectors concluded that the licensee's failure to provide adequate instructions to ensure proper configuration control of switchyard electrical components resulted in the installation of a protective relaying circuit card with an improper configuration. Switchyard configuration control was assigned to an offsite organization, which did not use the station's configuration control program. The licensee's corrective actions were comprehensive, including an extensive verification of switchyard component configuration. (Section M3.1) |
| 8 | 3/16/1998 | Positive | IR 98003 | NRC | Maintenance | 2B | 2A | The licensee effectively addressed emergent equipment problems identified during the forced outage and the subsequent plant startup. A good questioning attitude was demonstrated during the replacement of the control room chlorine detector, but inadequate preparation for the work resulted in the inability to complete the job after entering a limiting condition for operation. A motor-operated potentiometer was not properly adjusted prior to installation, resulting in a challenge to the emergency diesel generator and delays in returning it to service. (Section M1.1) |
| 9 | 3/16/1998 | Negative | IR 98003 | NRC | Maintenance | 2B | 3B | The inspectors identified that maintenance personnel incorrectly concluded that as-found relay timing data for an alarm circuit associated with the scram discharge instrument volume could be copied from a previously performed test. The relay was replaced as part of regularly scheduled preventive maintenance. The old relay was successfully tested after the inspectors questioned the lack of as-found testing. The omission was caused by a confusing work package step. (Section M3.3) |

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|---|---|---|---|---|---|---|---|---|
| 10 | 3/16/1998 | Positive | IR 98003 | NRC | Engineering | 4B | 2A | The inspectors concluded that the licensee acted in a conservative manner and declared both systems of low pressure coolant injection inoperable when it was discovered that manual operator action was required for proper low pressure coolant injection actuation. The conditions resulted in some complications in the conduct of surveillance testing. (Section E2.1) |
| 11 | 3/16/1998 | Negative | IR 98003 | NRC | Engineering | 4B | 2A | The inspectors concluded that slow turbine valve stroke times, which caused higher than design turbine speeds during a load rejection, were the result of corrosion products found in the EHC system from in leakage in the turbine hydraulic oil coolers. This condition went unnoticed for a longer period of time because of the reduced frequency of valve testing . The inspectors were concerned with the corrective actions to apply a graphite lubrication in a high temperature and moist environment, since that lubricant would lose its effectiveness over time in that environment. (Section E2.2) |
| 12 | 3/16/1998 | NCV | IR 98003 | NRC | Engineering | 4B | 5B | The licensee appropriately conducted a thorough review of all inputs to and calculations used to support the core thermal power computation. No other errors were identified. A non-cited violation was identified for having exceeded the licensed core thermal power at one or more times in the past by a small fraction of a percent. (Section E8.1) |
| 13 | 3/5/1998 | Licensing | TELEPHONE CONFERENCE MEMO | NRC | Engineering | 4C | | Problems Encountered in Fermi Licensing Submittals<br><br>The original submittal for the Cycle 6 minimum critical power ratio (MCPR) amendment (NRC-96-0075) failed to provide adequate information to support the MCPR Safety Limit adjustment for single loop operation. Previous single loop adders for this same fuel were 0.01. In the Cycle 6 submittal this value was changed to 0.02. The staff requested and received additional information to explain this change. |

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|---|---|---|---|---|---|---|---|
| 14 | 3/5/1998 | Licensing | TELEPHONE CONFERENCE MEMO | NRC | Engineering | 4C | Problems Encountered in Fermi Licensing Submittals<br><br>The original submittal for valve relief requests VR-63 & VR-64 (NRC-97-0001) did not conform with the guidance of NUREG-1482, AGuidelines for Inservice Testing at Nuclear Power Plants,@ April 1995. No alternative testing was proposed short of the current exercise although the NUREG specifically stated that simply verifying that the valves function is not an acceptable alternative. A revised submittal was prepared after the NRC raised this issue. |
| 15 | 3/5/1998 | Licensing | TELEPHONE CONFERENCE MEMO | NRC | Engineering | 4C | Problems Encountered in Fermi Licensing Submittals<br><br>After Project Manager presented the problems that existed in some recent submittals, the licensee explained steps that it has taken to ensure high quality submittals. The licensee entered the problems into its corrective action program for evaluation and action. A small team was formed for the evaluation. The six submittals from the licensee dated January 28, 1998, received extra reviews by editors and technical personnel. The licensee has also developed a template intended to guide authors through the development of a submittal that supplies all of the necessary information in the correct format. It appears that the actions described should correct the problems that were encountered. The NRC will continue to assess the quality of submittals in the future. |
| 16 | 3/5/1998 | Licensing | TELEPHONE CONFERENCE MEMO | NRC | Engineering | 4C | Problems Encountered in Fermi Licensing Submittals<br><br>The recirculation motor-generator set stops amendment (NRC-97-0037) contained a substantive word omission in the no significant hazards consideration discussion. The response to question2 originally read, in part The proposed...change does result in any changes to the design...or operation of the plant... |
| 17 | 3/5/1998 | Licensing | TELEPHONE CONFERENCE MEMO | NRC | Engineering | 4C | Problems Encountered in Fermi Licensing Submittals<br><br>The power range neutron monitoring amendment was missing an affected technical specification page (NRC-97-0105). The missing page was 3/4 3-44a which contains control rod block setpoints. The contents of the section on that page for rod blocks associated with reactor coolant system recirculation flow were to be removed or relocated. |

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|---|---|---|---|---|---|---|---|
| 18 | 3/4/1998 | VIO/SL-IV | IR 97011, EA 97-479 | NRC | Engineering | 4A | The licensee failed to identify an apparent unreviewed safety question in that a possibility of equipment malfunctions due to inadequate emergency equipment cooling water flow was not previously analyzed in the Updated Final Safety Analysis Report (UFSAR), despite the need for operator actions to rectify the situation. |
| 19 | 2/26/1998 | VIO/SL-IV | IR 98004 | NRC | Operations | 1C | The complex evolution involving fuel inspection was performed without an appropriate level of administrative controls. The work request used to control the evolution was inappropriate to the circumstances for which a violation was issued. The inspectors concluded that the limitations of using a work request contributed to unclear roles and responsibilities for operators and other supervisory personnel. Licensee corrective actions for this problem were appropriate and comprehensive. (Section O3.1) |
| 20 | 2/26/1998 | DEV | IR 98004 | NRC | Operations | 1C | Operators did not question the practice of storing fuel in the fuel preparation machine (FPM) overnight, even though this practice was not specified in the governing work request or discussed during shift briefings. When the inspector questioned the practice, the nuclear shift supervisor acted conservatively to place the bundle in question back in the normal storage rack until the issue could be further evaluated. The licensee intended to store fuel overnight in the FPM, but did not document the intent, did not brief it during the shift briefing with plant operators, and did not evaluate the acceptability of storage of spent fuel in the FPM prior to its use. A deviation from a regulatory commitment was identified. (Section O1.2) |
| 21 | 2/26/1998 | Negative | IR 98004 | NRC | Operations | 1C | The inspector concluded that operators were unfamiliar with the prerequisites required to be performed prior to granting permission to move fuel and conduct fuel inspection activities. This appeared to be due primarily to a lack of administrative control and documentation. In addition, control room operators were not as involved in the movement and inspection of fuel as they would be during refueling activities. (Section O1.1) |
| 22 | 2/26/1998 | Positive | IR 98004 | NRC | Plant Support | 3A | The inspector observed that radiation protection personnel were closely involved in all phases of the preparation and execution of the fuel inspections. Workers were observed to follow good radiation worker practices. The inspectors observed good foreign material controls and tool accountability during the work. (Section R1.1) |

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|---|---|---|---|---|---|---|---|
| 23 | 2/26/1998 | Negative | IR 98004 | NRC | Engineering | 3B | The inspector concluded that the licensee had an informal training and qualification process with respect to refueling and associated work tasks. No specific deficiencies related to training activities were identified and workers were observed to be knowledgeable of the work activities. However, knowledge weaknesses were noted in emergency response to a fuel handling mishap. (Section E5.1) |
| 24 | 2/26/1998 | VIO/SL-IV | IR 98004 | NRC | Engineering | 3B 1C 4B | The inspector concluded that the licensee did not analyze for or implement adequate criticality controls for fuel bundle disassembly and handling of multiple fuel rods simultaneously, which was considered a violation. The condition was briefly considered and dispositioned informally without using any documented analysis, since none was available onsite. Subsequent analyses demonstrated that no potentially critical configuration existed. However, the first of these analyses was not available for more than a month after the fuel inspection. (Section E3.1) |
| 25 | 2/26/1998 | Negative | IR 98004 | NRC | Engineering | 4C | The inspector identified a lack of formal design control measures and documentation for the FPM's upper travel limit and radiation monitor interlock. No regulatory requirements were violated. (Section E3.2) |
| 26 | 2/13/1998 | Negative | IR 98002 | NRC | Maintenance | 2B | The approach to establishing the risk ranking for SSCs was adequate, although the downgrading of systems were not always sufficiently justified. (Section M1.2.b.2) |
| 27 | 2/13/1998 | VIO/SL-IV | IR 98002 | NRC | Maintenance | 2B | The scoping determinations were appropriate for most structures, systems, and components (SSCs) and functions. However, a weakness in the scoping process resulted in a violation in that four SSCs/functions were inappropriately excluded from the scope of the MR program. (Section M1.1) |
| 28 | 2/13/1998 | Positive | IR 98002 | NRC | Maintenance | 2B | Although the periodic assessment was adequate to meet the requirements of the MR, some areas were not assessed in great detail in the report. (Section M1.3) |
| 29 | 2/13/1998 | Positive | IR 98002 | Licensee | Maintenance | 2B | The processes for assessing plant risk resulting from equipment being out-of-service for on-line maintenance and shutdown risk management were determined to be good. The use of the Initiating Events Guidance Document was considered a good additional initiative to assess the risk associated with on-line maintenance. (Section M1.5) |

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|---|---|---|---|---|---|---|---|
| 30 | 2/13/1998 | VIO/SL-IV | IR 98002 | NRC | Maintenance | 2B | The performance criteria for reliability and unavailability were good. However, one isolated violation was identified concerning monitoring an SSC reliability at the system versus the divisional level. (Section M1.6) |
| 31 | 2/13/1998 | VIO/SL-IV | IR 98002 | NRC | Maintenance | 2B | Several functional failures were not identified by the program process, which showed a weakness in evaluating problems for MR applicability. Specifically, failures were not always assessed based on a system licensing basis and design functionality; and potentially allowing compensatory measures to satisfy the system function. Inappropriate functional failure determinations were also identified as a concern by the recent self-assessments. One violation was identified for failure to adequately monitor an (a)(1) SSC against goals. (Sections M1.6.b.1.3) |
| 32 | 2/13/1998 | Positive | IR 98002 | NRC | Maintenance | 2B | The structural monitoring program was effective. Inspections adequately assessed the conditions of structures and corrective actions were initiated to correct deficiencies. (Section M1.6.b.4) |
| 33 | 2/13/1998 | Positive | IR 98002 | NRC | Engineering | 4B | The system engineers were experienced and knowledgeable about their systems and their responsibilities with respect to the MR. Several tools available to the system engineers were beneficial to provide support in the monitoring of system performance with respect to the MR. (Section E4.1) |
| 34 | 2/13/1998 | Misc | IR 98002 | NRC | Maintenance | 5A 2B | The recent assessments of the MR program were acceptable. The use of outside personnel provided independent insights into the MR program and added to the overall quality of the audit. (Section M7.1) |
| 35 | 2/1/1998 | LER | LER 98001 | Licensee | Maintenance | 2A 1B | Automatic Reactor Scram due to Main Turbine Trip |
| 36 | 1/5/1998 | Negative | IR 97016 | NRC | Operations | 1A | The inspectors concluded that power uprate testing was conducted in a coordinated manner. However, the determination of plant response at higher power levels was limited in scope. The inspectors concluded that by not performing a detailed plant walkdown, unanticipated changes in plant conditions may have been missed (Section O2.2). |
| 37 | 1/5/1998 | Positive | IR 97016 | NRC | Operations | 1A 1C 3A | The inspectors concluded that, in general, the operators performed well during this inspection period. High visibility operations were well coordinated and conducted. (Section O1.1) |

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| 38 | 1/5/1998 | Negative | IR 97016 | NRC | Operations | 1A 2A | Operators continued to accept a lower standard of available documentation, equipment labeling, and training related to switchyard equipment than for regular plant equipment. (Section O1.2.b) |
| 39 | 1/5/1998 | Positive | IR 97016 | NRC | Operations | 1B | On December 29, 1997, operators identified a feedwater controller anomaly and obtained assistance from support organizations. The licensee acted promptly to reduce power below 25 percent in order to remove the affected controller from service and avoid challenging the plant (Section O1.1.b). |
| 40 | 1/5/1998 | Negative | IR 97016 | NRC | Operations | 1C | Two procedural weaknesses were identified; one that delayed identification of the loss of the process computer by the operators and the other that could potentially result in missed commitments due to changes to operator round sheets. (Section O1.1) (PIM Item dated 1/5/98, IR 97016). |
| 41 | 1/5/1998 | Positive | IR 97016 | NRC | Operations | 1C 1A | The licensee promptly identified two safety tagging errors and took appropriate immediate actions. The inspectors concluded that each event had minimal safety significance. However, the inspectors were concerned that multiple barriers designed to make safety tagging error-free were rendered ineffective by operator practices. The licensee's corrective actions included a human performance review day for all site personnel that included a detailed review of the safety tagging errors (Section O1.2). |
| 42 | 1/5/1998 | Negative | IR 97016 | NRC | Maintenance | 2A | In general, the freeze protection program was adequately implemented; however, system design and equipment deficiencies in the turbine building ventilation and reactor building ventilation system continued to challenge operators (Section M2.1). |
| 43 | 1/5/1998 | Negative | IR 97016 | NRC | Maintenance | 2B | The inspectors concluded that the accepted practice of disregarding gauge use restriction labels could potentially result in the introduction of foreign material into plant systems. Also, the use of the data from an imprecise gauge reading resulted in measurements that were close to the alert range of the Division 2 Emergency Equipment Cooling Water pump. The alert range testing would result in increased unnecessary testing and equipment wear. The inspectors concluded that lack of a questioning attitude and training contributed to the event (Section M1.3). |

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|---|---|---|---|---|---|---|---|---|
| 44 | 1/5/1998 | Positive | IR 97016 | NRC | Maintenance | 2B | 5B | Maintenance workers and component engineers work effectively with system engineers and operations personnel to troubleshoot and repair the feedwater controller in an expeditious manner. (M1.1.b) |
| 45 | 1/5/1998 | Negative | IR 97016 | NRC | Maintenance | 3A | | Two personnel errors were promptly investigated and corrective actions implemented. The licensee's planned corrective action included a comprehensive assessment and review of the two events during a human performance review day, which will include all station personnel. Neither error was safety significant, but these events indicated a continuing trend in personnel errors during maintenance activities previously documented in Inspection Report No. 50-341/97013 (Section M1.2). |
| 46 | 1/5/1998 | Weakness | IR 97016 | NRC | Plant Support | 3A | | The inspectors concluded that the licensee performed appropriate surveys following changes in plant conditions, such as starting up the hydrogen water chemistry system. However, general area survey maps were not superseded when conditions on a portion of the map changed. It was not always clear that additional survey maps needed to be reviewed (Section R3.1). |
| 47 | 1/5/1998 | URI | IR 97016 URI 97016-02 URI 97016-03 | NRC | Engineering | 4B | | The inspectors concluded that the licensee did not process the 10 CFR 21 notice concerning Asea Brown Boveria K-Line breakers in a timely manner. This delayed an operability evaluation of breakers which were associated with multiple safety components. The inspectors were concerned that an adequate evaluation of the use of cross tie breakers was not performed prior to using maintenance crosstie breakers to supply power to Residual Heat Removal service water crosstie valves. Two unresolved items were identified pending review by the licensee (Section E2.2). |
| 48 | 12/5/1997 | Negative | IR 97017 | NRC | Operations | 1A | | Communications were at times informal and did not always meet management expectations for three way communication. Also, some lapse in formal controls to restrict personnel access to vital control areas in the control room was observed. (Section O1.1) |
| 49 | 12/5/1997 | Positive | IR 97017 | NRC | Operations | 1A | | Control Room operators demonstrated an appropriate level of attentiveness to the operating panels and were knowledgeable of plant conditions. (Section O1.1) |
| 50 | 12/5/1997 | Positive | IR 97017 | NRC | Operations | 1A | 1C | The licensee's continued implementation of the Operational Excellence Plan have shown improvements in the conduct of operations as noted in recent resident inspection reports. (Section O5.1) |

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| 51 | 12/5/1997 | Positive | IR 97017 | NRC | Operations | 3B | | The licensee's controls to revise the licensed operator requalification training program were satisfactory. (Section O5.4) |
| 52 | 12/5/1997 | Positive | IR 97017 | NRC | Operations | 3B | | In general, all portions of the annual requalification examination met the minimum criteria in accordance with the guidance given in NUREG 1021, "Operator Licensing Examination Standards for Power Reactors," Interim Revision 8. (Sections O5.2, O5.3) |
| 53 | 12/5/1997 | Positive | IR 97017 | NRC | Operations | 3B | | The licensee's incorporation of current industry events into the operator training program was good. (Section O5.2.2) |
| 54 | 12/5/1997 | Weakness | IR 97017 | NRC | Operations | 3B | | The simulator scenarios lacked sufficient complexity. Some scenarios had no component or instrument failures following the major malfunction, and the scenarios did not readily incorporate equipment out-of-service or have existing technical specification limiting conditions for operation as part of the initial conditions. (Section O5.2.1) |
| 55 | 12/5/1997 | Weakness | IR 97017 | NRC | Operations | 3B | | The excessive repetition of examination material from week to week and during remediation re-evaluation generated questions pertaining to examination integrity. (Sections O5.3.2, O5.5) |
| 56 | 12/5/1997 | Weakness | IR 97017 | NRC | Operations | 3B | | In general, the requalification examination material bank contained the minimum qualitative attributes to provide an adequate evaluation of operator skills; however, the quantity of examination material in the bank was marginal. (Section O5.2.1) |
| 57 | 12/5/1997 | Negative | IR 97017 | NRC | Operations | 3B | 1A | Some knowledge and operating weaknesses were observed during the requalification examination (written and operating). The operating weaknesses included erroneous emergency classification and weak command and control. (Sections O1.2, O5.3.1) |
| 58 | 12/5/1997 | Weakness | IR 97017 | NRC | Operations | 5C | | The differences between assessments and formal evaluations posed potential problems for meeting the requirements of an annual evaluation of licensed operators. The licensee's procedure allowed the use of the same failed simulator scenario for the remedial re-evaluation following an unsatisfactory assessment. (Section O5.5) |
| 59 | 11/7/1997 | ********** | IR 97001 | ********** | ********** | ** | | *** SALP 16 ENDS *** |

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|---|---|---|---|---|---|---|---|---|
| 60 | 11/7/1997 | Positive | IR 97014 | NRC | Operations | 1A | | The inspectors concluded that operators continued to exhibit improved performance in monitoring plant conditions. Personnel on rounds continued to be effective in identifying and reporting problems. Supervisory presence in the field for operations increased, partly as a result of having reduced the administrative burden in the control room. (Section O1.1) |
| 61 | 11/7/1997 | Positive | IR 97014 | NRC | Operations | 1A | | Both startup and shutdown evolutions were performed smoothly and without error. Licensed operator trainees in the control room were properly supervised and contributed positively to crew performance. Briefings were frequent and effective. (Section O1.2) |
| 62 | 11/7/1997 | Positive | IR97014 | NRC | Operations | 1A | | The reactor vessel pressure test at the conclusion of the mid-cycle outage was performed expeditiously in a coordinated and controlled manner. Preparations, particularly the use of the simulator, were effective in minimizing the time spent with shutdown cooling secured during a relatively high decay heat condition. However, the inspectors concluded that distractions from the test were not effectively minimized in the control room. (Section O1.3) |
| 63 | 11/7/1997 | ViO/SL-IV | IR 97014<br>IR97014 | NRC | Operations | 1A | 3A | The licensee identified that operators violated a TS required situational surveillance check of electrical power source operability, when it was completed nine minutes late. This TS violation is of additional concern because it is similar to a recent failure to verify electrical power availability documented in Inspection Report 50-341/97007. Prompt corrective actions significantly raised the visibility of TS actions among operators. (Section O1.4) |
| 64 | 11/7/1997 | Negative | IR 97014 | NRC | Operations | 1C | | Inspectors identified concerns with a lack of documentation of entries into allowed Technical Specification (TS) exceptions with limited time duration. (Section O1.1). |
| 65 | 11/7/1997 | Positive | IR 97014 | NRC | Operations | 1C | 2A | The licensee was able to reduce the number of Limiting Condition for Operations (LCOs) entries by maintaining good equipment performance and by operations staff actively pursuing resolution of all LCO issues and holding organizations accountable for timely resolution. (Section O2.1) |

# PLANT ISSUES MATRIX
## Fermi

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "Date" ; Beginning Date = "10/1/97" ; Ending Date = "3/31/98"

| # | DATE | TYPE | SOURCE | ID BY | SALP | SMM CODES | | DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| 66 | 11/7/1997 | Negative | IR 97014 | NRC | Maintenance | 2A | | The inspectors identified that the standby liquid control system configuration challenged operators while performing surveillance testing, and that the high pressure coolant injection surveillance test procedure did not include guidance to pump down the suppression pool. (Section M1.1) |
| 67 | 11/7/1997 | Negative | IR 97014 | NRC | Maintenance | 2B | | Coordination of switchyard maintenance with offsite personnel, though improved over the last several months, continued to need additional improvement. (Section M1.1) |
| 68 | 11/7/1997 | Positive | IR 97014 | NRC | Maintenance | 2B | | The mid-cycle outage was planned in greater detail than past outages, resulting in better reviews, more complete preparations, and few schedule-related problems. Problems observed during the previous refueling outage were observed to have been effectively corrected. Teamwork and coordination were evident in identification of equipment problems and performance of refueling floor activities. Outage management personnel effectively communicated the results of risk analyses to the entire site. These improvements resulted in completing an aggressive outage schedule slightly ahead of schedule with a minimum of problems. (Section M1.2) |
| 69 | 11/7/1997 | Negative | IR 97014 | NRC | Maintenance | 2B | 2A | During a turbine building HVAC system outage, turbine building temperature rose to within 10 degrees of the trip setpoint for Main Steam Isolation Valve (Group 1) closure. The outage was terminated due to high temperatures in the turbine building. Inspectors identified that high temperatures affected resistance temperature detectors ( Section M1.1.b) |
| 70 | 11/7/1997 | Negative | IR 97014 | NRC | Operations | 3A | 3B | Operators inadvertantly deenrigized the west station air compressor necessitating entry into abnormal procedures for a loss of air due to failure to update a load list. A similiar problem occurred with the inadvertant deenergizing loads that occurred during motor control center fused disconnect switch lubrication efforts in March -April 1997. ( Section O1.1.b) |

# PLANT ISSUES MATRIX

## Fermi

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "Date" ; Beginning Date = "10/1/97" ; Ending Date = "3/31/98"

| # | DATE | TYPE | SOURCE | ID BY | SALP | SMM CODES | DESCRIPTION |
|---|---|---|---|---|---|---|---|
| 71 | 11/7/1997 | NCV | IR 97014 | NRC | Engineering | 4A | Inverted Boraflex panels in SFP storage racks were not documented in UFSAR. The licensee determined that the combined effects of the two conditions discussed in Section E8.4 were not accounted for because the results of the eight storage cells with inverted panels were not documented in the UFSAR. Failure to maintain the UFSAR updated with the current configuration of the SFP storage racks was a violation of 10 CFR 50.71. However, this non-repetitive, licensee-identified and corrected violation is being treated as a non-cited violation (Section E8.5). |
| 72 | 11/7/1997 | Positive | IR 97014 | NRC | Engineering | 4B | The licensee effectively utilized several teams designated to conduct equipment walkdowns, particularly in normally inaccessible areas of the plant. These walkdowns were scheduled at appropriate times during both startup and shutdown sequences when dose was acceptably low but the systems of concern were hot and pressurized. During startup, this effort included a vacuum leak team which was effective in ensuring the plant returned to operation with a low air inleakage rate. Although these walkdowns were performed jointly by operators, system engineers, and RP personnel, this is an example of increased engineering support (Section M1.2.b.5) |
| 73 | 11/7/1997 | Misc | IR 97014 | NRC | Engineering | 4B | The inspectors were concerned that the licensee did not formally evaluate and document the operational impact of the potential failure of selected solenoid operated valves remaining in service. Consequently, the licensee implemented additional measures to periodically verify operability of the affected valves. The licensee's corrective action of increasing surveillance of selected systems was acceptable. (Section E1.1) |
| 74 | 10/10/1997 | Positive | IR 97015 | NRC | Plant Support | 1C | ALARA planning for the 97-02 Mid-Cycle Outage was based on historical data and actual job doses coincided well with the dose estimates. In addition, the outage ALARA planning demonstrated contingency planning and use of dose reduction techniques to minimize radworker occupational dose (Section R1.1). |
| 75 | 10/10/1997 | Positive | IR 97015 | NRC | Plant Support | 3A | The licensee's records incident to decommisioning were well-maintained and were in compliance with 10 CFR 50.75(g) and other NRC guidance (Section R3.1). |

# PLANT ISSUES MATRIX

## Fermi

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "Date" ; Beginning Date = "10/1/97" ; Ending Date = "3/31/98"

| # | DATE | TYPE | SOURCE | ID BY | SALP | SMM CODES | DESCRIPTION |
|---|---|---|---|---|---|---|---|
| 76 | 10/10/1997 | Positive | IR 97015 | NRC | Plant Support | 3A | The chemistry staff successfully implemented a process to expedite floodup and improve water quality/clarity, and plant personnel effectively monitored fuel integrity issues throughout the fuel cycle. The Depleted Zinc Oxide injection continued to minimize cobalt deposition on plant piping (Section R2.1). |
| 77 | 10/10/1997 | Positive | IR 97015 | NRC | Plant Support | 3A | The fuel sipping and reactor head activities were efficiently performed. The jobs were well-planned and implemented with appropriate ALARA considerations. These evolutions incorporated extensive research and evaluations, attention to lessons learned, and effective preventative maintenance (Section R1.3). |
| 78 | 10/10/1997 | Positive | IR 97015 | NRC | Plant Support | 3A | Radiological posting and labeling, housekeeping, and solid radwaste control measures were effectively implemented. Contamination control practices in the plant were thorough and included radiation surveys to detect alpha contamination; no alpha contamination was detected (Section R1.2). |
| 79 | 10/10/1997 | NCV | IR 97015 | NRC | Plant Support | 3A | The radiation protection support and radworker practices were generally good. However, the inspectors observed one instance of inappropriate contamination control and one Non-Cited Violation was identified regarding the issuance of alarming dosimetry with an incorrect dose alarm setpoint (Section R4.1). |
| 80 | 10/10/1997 | Positive | IR 97015 | NRC | Plant Support | 3A 2A 1C | The reactor water cleanup (RWCU) pre-job briefings informed radworkers of the radiological conditions, dosimetry requirements and ALARA measures. Both the RWCU repair work and radiation protection job oversight were effective. The RWCU materiel condition continued to challenge the staff and the difficulties with pump disassembly will be reviewed further by Region III (Section R1.4). |

# PLANT ISSUES MATRIX

## Fermi

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "Date" ; Beginning Date = "10/1/97" ; Ending Date = "3/31/98"

| # | DATE | TYPE | SOURCE | ID BY | SALP | SMM CODES | DESCRIPTION |
|---|---|---|---|---|---|---|---|
| 81 | 10/10/1997 | LER | LER 97014 | Licensee | Engineering | 4A | Turbine Building and Auxiliary Building Mezzanine Not Fully Meeting License Condition 2.C.9. During independent design verification of an Engineering Design Package, unsealed electrical penetrations were discovered in the auxiliary building wall fire rated separation barrier and in the adjacent and parallel turbine building fire barrier.. This prompted a review of the fire hazards analysis and the 10CFR50, Appendix R assumptions used for this area. This review was completed on October 10, 1997 and revealed that of the 20 penetrations in these walls, 16 were not sealed at the auxiliary building wall and 4 were not sealed at the turbine building wall. There were no openings which were unsealed at both the turbine building wall and the auxiliary building wall. The 16 unsealed penetrations in the auxiliary building wall are located over a horizontal distance in excess of 25 feet and interface with areas which contain both redundant shutdown divisions. The lack of penetration seals in the fire barriers could allow a fire in the turbine building to exit the turbine building through any of the 4 unsealed penetrations and enter the auxiliary building at any of the sixteen unsealed penetrations. These 16 unsealed penetrations could then introduce a fire hazard within 20 feet of cable trays containing both Division I and Division II shutdown divisions. This condition is not in compliance with 10CFR50, Appendix R and is also reportable within 24 hours under License Condition 2.C(9). |

## GENERAL DESCRIPTION OF PIM TABLE LABELS

| | |
|---|---|
| # | A counter number used for NRC internal editing. |
| DATE | The date of the event or significant issue. For those items that have a clear date of occurrence use the actual date. If the actual date is not known, use the date the issue was identified. For issues that do not have an actual date or a date of identification, use the LER or inspection report date. |
| TYPE | The categorization of the issue - see the TYPE ITEM CODE table. |
| SOURCE | The document that contains the issue information: IR for NRC Inspection Report or LER for Licensee Event Report. |
| ID BY | Identification of who discovered the issue - see table. |
| SALP | SALP Functional Area Codes - Engineering, Maintenance, Operations, Plant Support and All/Multiple (i.e., more than one SALP area affected). |
| SMM CODES | Senior Manager Meeting Codes - see table. |
| DESCRIPTION | Details of the issue from the LER text or from the IR Executive Summaries. |

## TYPE ITEM CODE

| | |
|---|---|
| DEV | Deviation from NRC Requirements |
| ED | Escalated Discretion - No Civil Penalty |
| EEI* | Escalated Enforcement Issue - Waiting Final NRC Action |
| LER | License Event Report to the NRC |
| Licensing | Licensing Issue from NRR |
| Misc | Miscellaneous (Emergency Preparedness Finding, etc.) |
| NCV | Non-Cited Violation |
| Negative | Individual Poor Licensee Performance |
| Positive | Individual Good Licensee Performance |
| Strength | Overall Strong Licensee Performance |
| URI** | Unresolved Inspection Item |
| VIO/SL-I | Notice of Violation - Severity Level I |
| VIO/SL-II | Notice of Violation - Severity Level II |
| VIO/SL-III | Notice of Violation - Severity Level III |
| VIO/SL-IV | Notice of Violation - Severity Level IV |
| Weakness | Overall Weak Licensee Performance |

## ID BY

| | |
|---|---|
| Licensee | The licensed utility |
| NRC | The Nuclear Regulatory Commission |
| Self-Revealed | Identification by an event (e.g., equipment breakdown) |
| Other | Identification unknown |

## NOTES

* EEIs are apparent violations of NRC requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.

** URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

## SENIOR MANAGEMENT MEETING CODES

| | |
|---|---|
| 1 | Operational Performance:<br>A - Normal<br>B - During Transients<br>C - Programs and Processes |
| 2 | Material Condition:<br>A - Equipment Condition<br>B - Programs and Processes |
| 3 | Human Performance:<br>A - Work Performance<br>B - Knowledge, Skills, and Abilities<br>C - Work Environment |
| 4 | Engineering/Design:<br>A - Design<br>B - Engineering Support<br>C - Programs and Processes |
| 5 | Problem Identification and Resolution:<br>A - Identification<br>B - Analysis<br>C - Resolution |

ENCLOSURE 2

**FERMI**
**INSPECTION/ACTIVITY PLAN**

IP - Inspection Procedure
TI - Temporary Instruction
Core Inspection - Minimum NRC Inspection Program (mandatory all plants)

| INSPECTION/ ACTIVITY | TITLE/ PROGRAM AREA | NUMBER OF NRC INSPECTORS/ INDIVIDUALS | PLANNED DATES | TYPE OF INSPECTION/ACTIVITY-COMMENTS |
|---|---|---|---|---|
| IP 73753 | Inservice Inspection (ISI) | 1 | 8/15-9/25/98 | Core |
| IP 81700 | Security Inspection | 1 | 8/24-8/31/98 | Regional Initiative |
| IP 62706 | Maintenance Rule Followup | 2 | 10/05-9/19 | Regional Initiative |
| IP 82301/ 82302 | Emergency Preparedness | 4 | 6/8-6/16/98 | Core |
| IP 86750 | Radiation Protection | 1 | 6/8-15/98 | Core |
| IP 83750 | Radiation Protection | 1 | 8/31-9/07/98 | Core |