UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

November 09, 2026

Peter Dietrich
Senior VP and Chief Nuclear Officer
DTE Electric Company
Fermi 2 – 260 TAC
6400 North Dixie Highway
Newport, MI 48166

SUBJECT: FERMI POWER PLANT, UNIT 2 – INTEGRATED INSPECTION REPORT 05000341/2026003

Dear Peter Dietrich:

On September 30, 2026, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at Fermi Power Plant, Unit 2. On October 28, 2026, the NRC inspectors discussed the results of this inspection with you and other members of your staff. The results of this inspection are documented in the enclosed report.

Five findings of very low safety significance (Green) are documented in this report. Four of these findings involved violations of NRC requirements. We are treating these violations as non-cited violations (NCVs) consistent with Section 2.3.2 of the Enforcement Policy.

If you contest the violations or the significance or severity of the violations documented in this inspection report, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555 0001; with copies to the Regional Administrator, Region III; 2056 Westings Avenue, Suite 400, Naperville, Il, 60563-2657; Director, Division of Reactor Projects, CNRI, Region III; and the NRC Resident Inspector at Fermi Power Plant, Unit 2.

If you disagree with a cross-cutting area assignment or an issue not associated with a regulatory requirement in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555 0001; with copies to the Regional Administrator, Region III; Region III; 2056 Westings Avenue, Suite 400, Naperville, Il, 60563-2657; Director, Division of Reactor Projects, CNRI, Region III; and the NRC Resident Inspector at Fermi Power Plant, Unit 2.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at http://www.nrc.gov/reading-rm/adams.html and at the NRC Public Document Room in accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

Signed by Elba Sanchez Santiago on 11/09/26

Elba M. Sanchez Santiago, Chief
Division of Reactor Safety
Regional Support Branch
Region III

Docket No. 05000341
License No. NPF–43

Enclosure:
As stated

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Letter to P. Dietrich from E. Sanchez Santiago dated November 09, 2026.

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U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report

Docket Number:	05000341
License Number:	NPF–43
Report Number:	05000341/2026003
Enterprise Identifier:	I-2026-003-0060
Licensee:	DTE Electric Company
Facility:	Fermi Power Plant, Unit 2
Location:	Newport, MI
Inspection Dates:	July 01, 2026 to September 30, 2026
Inspectors:	Thomas Taylor, Senior Resident Inspector James Beavers, Senior Resident Inspector Thomas Briley, Senior Reactor Inspector Russ Cassara, Senior Resident Inspector Zach Fleming, Resident Inspector Christopher Hunt, Senior Resident Inspector Raymond Ng, Senior Project Engineer
Approved By:	Elba M. Sanchez Santiago, Chief Division of Reactor Safety Regional Support Branch Region III

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting an integrated inspection at Fermi Power Plant, Unit 2, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to https://www.nrc.gov/reactors/operating/oversight.html for more information.

List of Findings and Violations

Failure to Maintain Fire and Carbon Dioxide Barrier			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Mitigating Systems	Green NCV 05000341/2026003-01 Open/Closed	Human Performance	71111.05
A Green finding and an associated non-cited violation (NCV) of License Condition 2.C(9) was identified by the inspectors for the licensee's failure to maintain the function of a credited three-hour fire and carbon dioxide (CO_2) barrier. Specifically, during a walkdown of fire area 11ABE (direct current (DC) motor control center (MCC) area), fire door R3-11, located between fire areas 11ABE and 12AB (division 2 switchgear room), was found not fully closed.			

Failure to Satisfactorily Inspect Test Leads Before Use			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Barrier Integrity	Green NCV 05000341/2026003-02 Open/Closed	Human Performance	71111.15
A Green finding and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed when test leads were not inspected per station instructions, resulting in a blown fuse when the leads fell from their connection point and contacted nearby wiring. The blown fuse caused a loss of control power to two primary containment isolation valves (PCIVs), which rendered them inoperable.			

Failure to Establish Acceptance Criteria to Determine Functionality of Division 1 Offsite Power Load Tap Changer			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Mitigating Systems	Green NCV 05000341/2026003-03 Open/Closed	Problem Identification and Resolution	71111.24
A Green finding and an associated non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed when it was discovered the load tap changer (LTC) for transformer 64, the division 1 technical specification required offsite power source, was nonfunctional, rendering the offsite power source inoperable. Specifically, operator rounds did not contain acceptance criteria to determine whether the load tap changer was functional.			

Failure to Review Replacement Current Transformer Enclosures per Engineering Process Results in Fire			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Initiating Events	Green FIN 05000341/2026003-04 Open/Closed	Human Performance	71152A
A finding of very low safety significance (Green) was self-revealed when a fire was discovered at the junction between the current transformer (CT) enclosure and isophase bus enclosure on the 'Y' phase of the main generator. Specifically, the licensee failed to incorporate internal operating experience and to perform engineering reviews on the new CT enclosures, in accordance with MES90, "Standard Design Process Interface," which resulted in circulating currents of sufficient magnitude to start a fire.			

Incorrect Switch Operation Results in Loss of Electrical Bus 72EB			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Mitigating Systems	Green NCV 05000341/2026003-05 Open/Closed	Human Performance	71153
A Green finding and an associated non-cited violation (NCV) of Technical Specification (TS) 5.4.1, "Procedures," was self-revealed when the licensee operated the incorrect switch while securing Emergency diesel generator (EDG) 12. As a result, power was lost to bus 72EB, including a loss of service water flow to the running EDG 12.			

Additional Tracking Items

None.

PLANT STATUS

Unit 2 began the inspection period in mode 1 at 83 percent power, limited by current induced heating in the current transformer enclosure of the main generator.

On July 3, a reactor scram occurred at 83 percent power following a lockout of bus 101 in the division 1 switchyard due to a ground fault caused by a conductor that was damaged during high winds. During the outage, the current transformer enclosure was modified to limit the circulating currents and reduce the operating temperatures inside the enclosure. The reactor achieved criticality on July 11, and the main generator was synchronized to the grid on July 12, ending the forced outage. Reactor power was increased to 100 percent on July 18.

Reactor power was lowered to 65 percent for a rod pattern adjustment on September 9 and subsequently restored to 100 percent on September 10.

Reactor power was lowered to 60 percent for a rod pattern adjustment on September 12. Reactor power was restored to 100 percent on September 13. The reactor remained at or near 100 percent power for the remainder of the inspection period.

INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, “Light-Water Reactor Inspection Program – Operations Phase.” The inspectors performed activities described in IMC 2515, Appendix D, “Plant Status,” observed risk significant activities, and completed onsite portions of IPs. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

REACTOR SAFETY

71111.04 – Equipment Alignment

Partial Walkdown (IP Section 03.01) (1 Sample)

The inspectors evaluated system configurations during partial walkdowns of the following systems/trains:

(1) Division 2 residual heat removal/residual heat removal service water (RHR/RHRSW) during safety system outage of division 1 RHR/RHRSW, completed the week ending September 19, 2026

71111.05 – Fire Protection

Fire Area Walkdown and Inspection (IP Section 03.01) (3 Samples

The inspectors evaluated the implementation of the fire protection program by conducting a walkdown and performing a review to verify program compliance, equipment functionality, material condition, and operational readiness of the following fire areas:

(1) Auxiliary building, direct current (DC) motor control center (MCC) room, zone 14 El. 643'6", completed the week ending July 18, 2026
(2) Turbine building, 1st floor, completed the week ending July 18, 2026
(3) Reactor building high pressure coolant injection pump and turbine room, zone 4, completed the week ending August 15, 2026

Fire Brigade Drill Performance (IP Section 03.02) (1 Sample)

(1) The inspectors evaluated the onsite fire brigade training and performance during an announced fire drill on August 21, 2026

71111.11A – Licensed Operator Requalification Program and Licensed Operator Performance

Licensed Operator Training/Examination Observations (IP Section 03.01) (1 Sample)

(1) The inspectors observed licensed operator training in the control room simulator covering loss of reactor water cleanup, drifting control rod, fuel cladding failure, and loss of reactor pressure vessel (RPV) level indication on September 30, 2026

71111.13 – Maintenance Risk Assessments and Emergent Work Control

Risk Assessment and Management (IP Section 03.01) (3 Samples)

The inspectors evaluated the accuracy and completeness of risk assessments for the following planned and emergent work activities to ensure configuration changes and appropriate work controls were addressed:

(1) Steam tunnel entry to backseat reactor core isolation cooling (RCIC) steam line outboard isolation valve, completed the week ending August 1, 2026
(2) Review of risk informed completion time (RICT) 26-002 associated with CARD 2026-58111, “Unable to Calibrate C11-N013D (RPS SDV High Water Level Channel B2 Float Switch),” completed the week ending August 21, 2026
(3) Risk during high pressure coolant injection (HPCI) pump maintenance, and unplanned Technical Specification entry during motor controller work for HPCI, completed the week ending August 15, 2026

71111.15 – Operability Determinations and Functionality Assessments

Operability Determination or Functionality Assessment (IP Section 03.01) (4 Samples)

The inspectors evaluated the licensee's justifications and actions associated with the following operability determinations and functionality assessments:

(1) Emergency diesel generator (EDG) 12 operability following loss of cooling water, completed the week ending July 18, 2026
(2) Slow control rod operability determination following procedure change, completed the week ending September 12, 2026
(3) Operability of mechanical draft cooling tower (MDCT) 'A' with degraded pinion cage cover bolting, completed on September 30, 2026
(4) Operability of RCIC and reactor water cleanup (RWCU) primary containment isolation valves following blown fuse and subsequent loss of control power to DC motor control center 2PB-1, completed on September 30, 2026

Temporary and Permanent Modifications (IP Section 03.02) (1 Sample)

The inspectors evaluated the following temporary or permanent modifications:

(1) The inspectors reviewed the temporary modification package for N2103F003, the four inch standby feedwater system flow control valve, and current functionality assessment following discovery of a broken yoke arm, completed the week ending September 26, 2026

71111.20 – Refueling and Other Outage Activities

Refueling/Other Outage Sample (IP Section 03.01) (1 Sample)

(1) The inspectors evaluated activities during a forced outage, outage caused by loss of division 1 offsite power which resulted in a reactor scram, from July 3, 2026 to July 12, 2026.

71111.24 – Testing and Maintenance of Equipment Important to Risk

The inspectors evaluated the following testing and maintenance activities to verify system operability and/or functionality:

Post-Maintenance and Surveillance Testing (IP Section 03.01) (10 Samples)

(1) Circulating water pump 5 after refurbishment during heat advisory warning, completed the week ending July 25, 2026
(2) EDG 14 slow start surveillance run, completed the week ending July 25, 2026
(3) Division 1 control center heating ventilation and cooling (CCHVAC) supply fan MCC after replacement of fuse box and disconnect switch, completed the week ending August 1, 2026
(4) EDG underground cable vaults 16947 A, B, and C water intrusion inspection completed the week ending August 1, 2026
(5) Division 1 RHR/low pressure coolant injection (LPCI) pump and valve operability testing, completed the week ending August 8, 2026

(6) EDG 12 service water, fuel oil transfer, and starting air testing, completed the week ending August 8, 2026
(7) General service water coating modification and subsequent temporary modification to restore header to service, completed the week ending August 22, 2026
(8) Division 2 scram discharge volume float switch calibration following procedure change, completed the week ending September 12, 2026
(9) Failure of transformer 64 load tap changer to function, completed the week ending September 26, 2026
(10) Division 2 RHR/RHRSW maintenance outage testing, completed on September 30, 2026

Inservice Testing (IST) (IP Section 03.01) (1 Sample)

(1) Division 1 emergency equipment service water and emergency equipment cooling water makeup pump and valve surveillance on September 1, 2026

Quality Control (IP Section 03.02) (1 Sample)

The inspectors reviewed the licensee's quality control measures for the following dedicated commercial grade materials.

(1)
- EDG fuel oil
- Hydraulic control unit threaded joint Teflon tape

Diverse and Flexible Coping Strategies (FLEX) Testing (IP Section 03.04) (1 Sample)

(1) 3-year performance testing of N train dominator and neptune equipment, completed the week ending August 8, 2026

SAFEGUARDS

71130.15 – Security Operations

Security Operations (IP Section 03.01) (1 Sample)

The inspectors evaluated security operations during observations of the following activity:
(1) Security officer fire watch patrol completed the week ending August 29, 2026

Security Equipment Condition (IP Section 03.02) (2 Samples)

The inspectors evaluated the ability of security equipment to perform its intended function through a walkdown of the following:

(1) Protection area fence on September 24, 2026.
(2) North and south security diesel generators, completed on September 30, 2026

OTHER ACTIVITIES – BASELINE

71152A – Annual Follow-up Problem Identification and Resolution

Annual Follow-up of Selected Issues (IP Section 03.03) (2 Samples 1 Partial)

The inspectors reviewed the licensee's implementation of its corrective action program related to the following issues:

(1) Isophase bus duct current transformer enclosure fire and subsequent modification, documented in CR-2026-56304
(2) Feedwater control system following south reactor feed pump rundown to minimum speed, documented in CR-2026-56906
(3) (Partial)
Bus 101 lockout resulting in reactor scram, documented in CR-2026-57152

71153 – Follow-Up of Events and Notices of Enforcement Discretion

Event Follow-up (IP Section 03.01) (1 Sample)

(1) The inspectors evaluated the loss of division 1 switchyard bus 101 and resultant reactor scram on July 3, 2026. The licensee's response was reviewed and inspection completed the week ending September 26, 2026.

INSPECTION RESULTS

Failure to Maintain Fire and Carbon Dioxide Barrier			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Mitigating Systems	Green NCV 05000341/2026003-01 Open/Closed	Human Performance	71111.05

A Green finding and an associated non-cited violation (NCV) of License Condition 2.C(9) was identified by the inspectors for the licensee's failure to maintain the function of a credited three-hour fire and carbon dioxide (CO_2) barrier. Specifically, during a walkdown of fire area 11ABE (direct current (DC) motor control center (MCC) area), fire door R3-11, located between fire areas 11ABE and 12AB (division 2 switchgear room), was found not fully closed.

Description:

On July 15, 2026, during a walkdown of fire area 11ABE, the inspectors discovered fire door R3-11 unlatched, which rendered the door non-functional. The door separates fire areas 11ABE, the DC MCC Room, and 12AB, the division 2 switchgear room. Both rooms are located in the auxiliary building and house equipment necessary for post-fire safe shutdown. Fire door R3-11 acts as a three-hour barrier to prevent propagation of fire, and as a CO_2 boundary between the two affected fire areas.

According to the licensee's fire hazard analysis, a postulated fire in the DC MCC Room requires the standby feedwater system (SBFW) for safe shutdown. The SBFW system has a cable routed through the division 2 switchgear room that has the vulnerability of a conductor-to-conductor short which would prevent SBFW injection. Conversely, a postulated fire in the division 2 switchgear room requires the reactor core isolation cooling (RCIC)

system for safe shutdown. However, the system has several motor control units located in the DC MCC Room. Therefore, because a fire in either the DC MCC Room or the division 2 switchgear room when the barrier is in place (door closed) would require equipment in the opposite room for safe shutdown, the plant's safe shutdown capabilities would have been challenged if a fire were to occur. Additionally, because the door acts as a three-hour barrier and a CO_2 boundary, the door being nonfunctional invalidated the barrier and the CO_2 automatic suppression capability in the DC MCC Room.

The inspectors notified the licensee, and the door was declared non-functional per Technical Requirement Limiting Condition of Operation (TRLCO) 3.12.8, which requires the establishment of a continuous fire watch of the affected fire areas within one hour. The licensee restored functionality of the door by inspecting it and ensuring that the door would self-close and latch closed, within the allowed TRLCO timeframe. Upon investigation, the inspectors noted an alarm was received on the plant computer for the door being open, but the condition was not recognized until the inspector brought the matter to the licensee's attention.

Corrective Actions: The door was inspected and completely opened and allowed to self-close several times, restoring functionality of the fire barrier.

Corrective Action References: CR-2026-57407, CR-2026-57875

Performance Assessment:

Performance Deficiency: The licensee failed to meet the approved fire protection program as required by License Condition 2.C(9) and described in the Updated Final Safety Analysis Report (UFSAR). Specifically, the licensee failed to close fire door R3-11, which is described in the UFSAR as a normally closed door. This failure constitutes a performance deficiency.

Screening and Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix F, "Fire Protection Significance Determination Process."

The finding was determined to affect the Mitigating Systems cornerstone and screened to Green, or very low safety significance, based on the appropriate questions in IMC 0609 Appendix F. Specifically, the category chosen was 'Fire Confinement' due to the performance deficiency affecting a fire door. Step 1.3 requires a determination of degradation and Step 02.03.05 of Attachment 2 was used to determine that the performance deficiency was high degradation due to the fire door being open. Continuing with the fire confinement category questions:

Step 1.4.4, Question A was answered no because the door would no longer prevent propagation of fire from one fire area to another.

Step 1.4.4, Question B was answered yes because it involved an open fire door that protected equipment important to safe shutdown.

Step 1.4.4, Question C was answered yes because both affected fire areas housed equipment important to safe shutdown.

Step 1.4.4, Question D was answered no because, although there was an automatic suppression system in the DC MCC Room, it was non-functional while the door was open.

Step 1.4.4, Question E was answered yes because the performance deficiency involved the failure of a door to latch, but not to close, and both affected fire areas housing a gaseous suppression system.

Step 1.4.4, Question F was answered no, and screened to Green, because the additional damage target was not sufficiently nearby that it could be affected by a fire spreading through the open fire door. Specifically, the SBFW cables routed through the division 2 switchgear room are located more than 20 feet from the fire door.

Cross-Cutting Area: Human Performance

Individuals did not recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes. Specifically, following use of the fire door, the licensee did not apply appropriate verification techniques to ensure the door was fully closed and latched. As a result, the fire door was left in an open and unlatched condition.

Enforcement:

Violation: Fermi Operating License Condition 2.C(9) states, in part, the licensee, "shall implement and maintain in effect all provisions of the approved fire protection program as described in its Final Safety Analysis Report." Final Safety Analysis Report Section 9A.5 position d.1(j) states, in part, that as detailed in section 9A.4, door openings are protected with equivalent rated doors, and that such doors are normally closed and alarmed with alarm and annunciation in the control room. Fire door R3-11 is described in section 9A.4 as a Class A fire door (3-hour rating) that separates fire areas 11ABE and 12AB.

Contrary to the above, on July 15, 2026, the licensee failed to implement and maintain in effect all provisions of the approved fire protection program as described in its Final Safety Analysis Report. Specifically, fire door R3-11 was not closed after last used. This invalidated the required three-hour fire barrier and CO_2 automatic suppression capability.

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

Failure to Satisfactorily Inspect Test Leads Before Use			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Barrier Integrity	Green NCV 05000341/2026003-02 Open/Closed	Human Performance	71111.15

A Green finding and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed when test leads were not inspected per station instructions, resulting in a blown fuse when the leads fell from their connection point and contacted nearby wiring. The blown fuse caused a loss of control power to two primary containment isolation valves (PCIVs), which rendered them inoperable.

Description:

On August 14, 2026, the licensee was performing work order (WO) 69500650, "Inspect/Test 260 VDC MCC 2PB-1 Pos. 8A, Feeds E4150F007." During setup of test equipment, personnel attached a booted alligator-clip test lead to a terminal point. The clip unexpectedly

detached and contacted adjacent energized terminals, creating an electrical bridge that caused a fuse to fail and resulted in the loss of control power to motor control center (MCC) 2PB-1.

The loss of control power rendered multiple loads inoperable, including the reactor water cleanup supply outboard isolation valve and the reactor core isolation cooling turbine exhaust line vacuum breaker inboard isolation valve. These valves serve as PCIVs and rely on control power to perform their containment isolation function. The licensee entered Technical Specification (TS) 3.6.1.3 Condition A, requiring isolation of the affected flow path within four hours by establishing at least one closed and de-energized valve. The licensee made the NRC aware of the issue at this time by contacting the resident inspector.

The licensee replaced the blown fuse and restored control power to MCC 2PB-1, returning both PCIVs to operable status within the required completion time.

Licensee instruction MDI-058, “Technical Skills,” requires workers to use properly inspected test leads to minimize inadvertent contact with energized circuits and directs personnel to inspect leads for insulation integrity and modifications prior to use. The licensee’s investigation, documented in CR-2026-58026, determined that the test lead’s retention capability was inadequate in that it had degraded such that it couldn’t support the weight of the test lead, and that the booted style clip allowed exposed conductive surfaces due to boot movement, contributing to the inadvertent contact.

Corrective Actions: The licensee replaced the failed fuse, restoring control power to MCC 2PB-1 and returning the affected PCIVs to operable status. In addition, the training program was updated to require a practical demonstration of proper inspection and routing of test leads prior to their use.

Corrective Action References: CR-2026-58026

Performance Assessment:

Performance Deficiency: The licensee failed to use properly inspected test leads for maintenance on safety related equipment as required by MDI-058. Specifically, the licensee did not verify the retention capability of the test leads prior to use resulting in an inadvertent contact that caused multiple PCIVs to become inoperable. This failure constitutes a performance deficiency.

Screening and Significance: The inspectors determined that the finding adversely affected the Barrier Integrity cornerstone. The inspectors assessed the significance of the finding using IMC 0609 Appendix A, “The At-Power Significance Determination Process.” The finding screened to Green, or very low safety significance, based on Exhibit 3, Question C.3 being answered Yes. Specifically, each flow path had another isolation valve that would still function.

Cross-Cutting Area: Human Performance

Personnel did not adequately consider the possibility of mistakes, latent equipment issues, or the inherent risk associated with maintenance on safety-related systems. Specifically, maintenance personnel did not scrutinize the condition of the test leads and routing to minimize inadvertent contact with energized circuits.

Enforcement:

Violation: 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” requires that activities affecting quality be prescribed by documented instructions, procedures, or drawings appropriate to the circumstances and accomplished in accordance with those instructions.

Licensee instruction MDI-058, “Technical Skills,” Section 4, “Test Leads,” states: Use appropriate test leads for the job to minimize inadvertent contact with energized circuits.

Contrary to the above, on August 14, 2026, the licensee failed to follow MDI-058, “Technical Skills,” Section 4, “Test Leads.” Specifically, the licensee did not use appropriate test leads for the job to minimize inadvertent contact with energized circuits, leading to an alligator-clip test lead detaching from its terminal point and contacting adjacent energized equipment. This resulted in the loss of control power to MCC 2PB-1 and caused two PCIVs to become inoperable.

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

Failure to Establish Acceptance Criteria to Determine Functionality of Division 1 Offsite Power Load Tap Changer			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Mitigating Systems	Green NCV 05000341/2026003-03 Open/Closed	Problem Identification and Resolution	71111.24

A Green finding and an associated non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was self-revealed when it was discovered the load tap changer (LTC) for transformer 64, the division 1 technical specification required offsite power source, was nonfunctional, rendering the offsite power source inoperable. Specifically, operator rounds did not contain acceptance criteria to determine whether the load tap changer was functional.

Description:

The NRC issued NCV 05000341/2025004-02 on February 10, 2026, (ADAMS Accession No. (ML26041A034). The NCV discussed a failure of the licensee to promptly identify a nonconformance with the design basis, affecting the operability of transformer 64, which is one of the two credited offsite electrical feeds to plant safety buses (division 1 in this case). The LTC is assumed to function during accidents to maintain voltage on its 4160V safety buses above the degraded voltage relay setpoint, to ensure safety related loads continue to operate without having to transfer to the emergency diesel generators. The NCV described a period of time where the LTC had failed to function in automatic without the impact to operability being recognized. The licensee implemented actions to monitor the operability of transformer 64. These measures included revising the operator rounds, which are conducted in accordance with procedure 27.000.05, “Operator Rounds,” and are used to monitor and trend equipment performance on a daily basis. The revised rounds required operators to verify the LTC was “tapping” (i.e., adjusting to maintain bus voltage in a certain band) by

checking the tap counter each day. The intent was to ensure the LTC was functioning as expected by verifying it was tapping and by checking that the counter had incremented at some point, and if not, to further investigate if there was an issue with the LTC. Based on offsite electrical grid conditions and changing plant loads, voltage is expected to vary any given day, requiring adjustment.

On July 15, 2026, the licensee instituted compensatory monitoring for transformer 64 due to a locked in trouble alarm caused by an overvoltage condition, as read at the local alarm panel. The NRC became aware of the issue approximately the same day. Associated safety related bus voltages appeared acceptable on the control room meters. The monitoring was to ensure no conditions, other than the suspected spurious overvoltage alarm, came in undetected pending troubleshooting. During troubleshooting on August 10, the thermal overloads (TOLs) for the LTC motor were found tripped, precluding operation of the LTC. The TOLs were reset and the LTC appeared to function normally. Investigation revealed that the LTC had not tapped since July 1, implying potential past operability/functionality concerns. Additionally, it was noted that while the operator rounds required logging the LTC's tap counter, there were no readily available acceptance criteria, nor trending performed to assess the LTC's functionality (the same number of counts had been logged repeatedly). Monitoring the LTC tap counter to ensure it was tapping was a corrective action in response to NCV 05000341/2025004-02. The licensee subsequently revised the operator rounds to check that the LTC was incrementing. During further monitoring, the TOLs were found tripped two more times, on August 19 and August 21. On August 22, the licensee placed the LTC in manual and adjusted voltage as needed, per procedure, until the LTC motor was replaced on September 2, 2026.

Corrective Actions: The licensee placed the LTC in manual and monitored safety related bus voltages per procedure until the LTC motor was replaced. An engineering evaluation was performed to assess past operability/functionality.

Corrective Action References: CR-2026-57932

Performance Assessment:

Performance Deficiency: The licensee's failure to establish acceptance criteria for verifying LTC functionality in accordance with 10 CFR Appendix B, Criterion V, "Instructions, Procedures and Drawings," was a performance deficiency. Specifically, operator rounds did not include acceptance criteria for verifying the LTC was performing its tapping function. As a result, the licensee failed to identify the transformer had become inoperable.

Screening and Significance: The inspectors determined that the finding adversely affected the Mitigating Systems cornerstone. The inspectors assessed the significance of the finding using IMC 0609 Appendix A, "The At-Power Significance Determination Process." Utilizing Exhibit 2, Section A, since question 3 was answered 'yes,' based on the cumulative time the PRA function was lost.

A senior reactor analyst performed a detailed risk evaluation using SPAR model version 8.81 with SAPHIRE version 8.2.12. The analyst applied a bounding assumption that the performance deficiency resulted in a degraded condition that would render transformer 64 unavailable to perform its required function as an offsite power source for safety buses 64B and 64C during any event that would require the use of emergency core cooling system (ECCS) equipment used to mitigate a loss of coolant accident (LOCA). The licensee

performed an engineering evaluation which determined the operability/functionality of the LTC over the timeframe associated with the performance deficiency. Based on a review of the evaluation, operator logs, and corrective action documents, the resident inspectors agreed that the degraded condition represented an exposure time of approximately 243 hours for the offsite power source. Using the events and condition assessment (ECA) workspace, the analyst set the basic event ACP-TFM-FC-64, “Failure of Transformer 64 During Operation (R1200S002),” to TRUE. The analyst also provided credit for the use of diverse and flexible (FLEX) coping strategies by setting the basic event FLX-XHE-XE-ELAP, “Operators Fail to Declare ELAP When Beneficial,” to a value to 1.0E-2 for both the nominal and condition case. The analyst assumed an exposure time of 500 hours, which bounds the 243-hour exposure time. No additional recovery credit or mitigation capabilities were included in the analysis. With the modeling adjustments described above, the analyst quantified the SPAR model for all internal events not involving a loss of offsite power (LOOP) and obtained a total increase in average annual core damage frequency (delta-CDF) of 7.93E-8/yr. Dominant sequences included a loss of AC Bus 301 with: (1) failure of the standby feedwater, reactor core isolation cooling (RCIC), high pressure coolant injection (HPCI), core spray, low pressure coolant injection (LPCI), suppression pool cooling, shutdown cooling, containment spray cooling, and containment venting functions; or (2) failure of the emergency diesel generators with failure of the HPCI and emergency depressurization functions.

Based on a total delta-CDF for all internal events being bound to less than 1.0E-7/yr, the analyst determined that risk associated with external events did not need to be analyzed to determine the safety significance of this finding. The analyst also determined that risk attributable to large early release frequency (LERF) was not a dominant metric in the significance determination for this finding. Based on a total delta-CDF of less than 7.93E-8/yr, the analyst concluded the finding was of very low safety significance (Green).

Cross-Cutting Area: Problem Identification and Resolution

The licensee did not take effective corrective actions to address issues in a timely manner commensurate with their safety significance. Specifically, the corrective actions to revise operating logs to detect inoperability/non-functionality of the division 1 offsite power source were insufficient, as inoperability/non-functionality were not detected.

Enforcement:

Violation: 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” requires, in part, that instructions, procedures, or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished. The licensee established 27.000.05, “Operator Rounds,” Revision 34 as the implementing procedure for recording and trending equipment operation. The procedure states, in Section 5.14, that inoperability of a system, subsystem, division, component, or device may be determined from the readings recorded, an activity affecting quality.

Contrary to the above, from July 1, 2026, until August 22, 2026, the licensee failed to include appropriate quantitative or qualitative acceptance criteria in procedure 27.000.05, “Operator Rounds,” for determining that important activities have been satisfactorily accomplished. Specifically, procedure 27.000.05, “Operator Rounds,” Revision 34, did not include acceptance criteria to determine the checks for operability of the division 1 offsite power

source were satisfactorily accomplished which resulted in an undetected inoperability of the division 1 offsite power source.

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

Failure to Review Replacement Current Transformer Enclosures per Engineering Process Results in Fire

Cornerstone	Significance	Cross-Cutting Area	Report Section
Initiating Events	Green FIN 05000341/2026003-04 Open/Closed	Human Performance	71152A

A finding of very low safety significance (Green) was self-revealed when a fire was discovered at the junction between the current transformer (CT) enclosure and isophase bus enclosure on the 'Y' phase of the main generator. Specifically, the licensee failed to incorporate internal operating experience and to perform engineering reviews on the new CT enclosures, in accordance with MES90, “Standard Design Process Interface,” which resulted in circulating currents of sufficient magnitude to start a fire.

Description:

On May 18, 2026, during power ascension following the refueling outage at approximately 84 percent power, a fire occurred at the foam seal between the ‘Y’ phase main generator isophase enclosure and the CT enclosure directly above in the turbine building. The reactor was manually scrammed and turbine tripped, and the fire was extinguished within approximately 10 minutes. The plant was stabilized in Mode 3 without complication. Suspecting that circulating currents in the CT enclosure, induced by the high-current carrying buses, might have contributed to the fire, the licensee cut slits on the enclosure and welded on covers, (instead of bolting) to help alleviate the condition. Further, temporary air conditioning units were brought in to cool the enclosures, and the grounding configuration was reevaluated pending more investigation and a permanent modification. The NRC was notified and became aware of the issue on May 18, 2026.

The plant was started up on May 22, 2026, with temperatures being monitored in the areas of concern. The plant reached approximately 83 percent power before temperatures on the CT enclosures reached a pre-determined temperature below the flash point of the foam seal. The plant remained at 83 percent monitoring the temperatures until July 3, 2026, when the plant scrammed due to a loss of division 1 offsite power during a storm. During the ensuing outage, a modification was completed and new CT enclosures were installed. Material was changed to a less resistive form of aluminum; bolting and brackets were removed where circulating currents were thought to be most concentrated; structural heat sinks were added; the insulating material was replaced with a higher flash point material, and a paint was applied to help radiate heat away from the CT enclosures. The outage ended on July 12, 2026, and the plant returned to 100 percent on July 18, 2026, with CT enclosure temperatures remaining below the limits.

Later investigation revealed a history of documented issues regarding circulating currents and heat damage associated with the CT enclosures going back to 1992. Over the years, signs of overheating and degradation of the foam and parts of the enclosure prompted periodic

infrared temperature monitoring. A rising trend from approximately 260 degrees F to 417 degrees F was noted over several years. Some efforts to alleviate the heating, such as adding a metal bracket inside as a heat sink, did not alleviate the concern. In 2019, when the 417 degrees F was measured, the associated corrective action document noted the enclosures would likely be replaced as part of the main generator replacement project in 2020. However, the generator replacement project was postponed until the 2026 refueling outage due to other technical issues.

The original plan for the generator replacement project was for the CT enclosures to be reused, despite an action item from a latent issue review regarding heating of the enclosures (CARD 18-30070-77). It stated: “suggest investigation and evaluation for elimination of latent issue vice mitigation of latent issue.” The recommended action to address the latent issue remained open and was not evaluated as the replacement project commenced. During the final stages of planning in approximately January of 2026, a decision was made to construct new CT enclosures as part of the project. During the installation of the replacement generator in the 2026 refueling outage, it was noted that the grounding configuration for the CT enclosures would have to change as work commenced on them. A field change request was added to the generator design change for the work needed on the CT enclosures and a condition report (CR) was written. The CR noted the correct configuration would need to be validated so “additional ground loops and circulating currents” would be avoided. Further, an IEEE standard was attached to the CR, stating “consideration shall be given to the problem of induced circulating currents in nearby metallic members.”

Procedure MES90, “Standard Design Process Interface,” Revision 4.3, governs engineering changes. Section 3.5.10 requires a design verification/engineering review during development of the design change package and following field change requests. Items to consider include a review of operating experience, checking that acceptance criteria incorporated in design documents is sufficient to verify design requirements have been satisfactorily accomplished, and that materials are compatible with each other and the environmental conditions to which they will be exposed. Contrary to MES90, the configuration details provided to the vendor for manufacture of the CT enclosures lacked details such as dimensions and the specific type of aluminum. Design details developed by the vendor were not reviewed by site engineering. Steps in the work order implementing the generator modification regarding the CT enclosures were not revised per work management procedures, bypassing required planning and review functions. Throughout, prior circulating current induced heating issues were not referenced during design and construction of the new CT enclosures. While considered a “like for like” replacement, validation of the as-built configuration and confirmation of the vendor’s design were not performed.

Corrective Actions: The licensee followed the design process, modified the design of the enclosure and commenced a root cause evaluation.

Corrective Action References: CR-2026-56304

Performance Assessment:

Performance Deficiency: The inspectors determined that the licensee’s failure to follow MES90, “Standard Design Process Interface,” Revision 4.3, for the modification to the CT enclosure was a performance deficiency. Specifically, given the prior site operating experience regarding current induced heating, the licensee did not verify appropriate materials, dimensions, and design of the new CT enclosures, and did not follow the work management process for revisions to work orders implementing the design changes.

Screening and Significance: The inspectors determined that the finding adversely affected the Initiating Events cornerstone. The inspectors assessed the significance of the finding using IMC 0609 Appendix A, “The At-Power Significance Determination Process (SDP).” Specifically, per Exhibit 1, Section B, the performance deficiency resulted in a reactor trip but there was no loss of mitigation equipment. Therefore, the finding screened as Green.

Cross-Cutting Area: Human Performance

A proposed action is determined to be safe in order to proceed, rather than unsafe in order to stop. Assumptions are not rationalized when completing tasks. Specifically, as work scope changed involving the CT enclosures within the engineering change for the main generator, assumptions regarding circulating currents/heating and construction of new enclosures were not validated.

Enforcement:

Inspectors did not identify a violation of regulatory requirements associated with this finding.

Incorrect Switch Operation Results in Loss of Electrical Bus 72EB			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Mitigating Systems	Green NCV 05000341/2026003-05 Open/Closed	Human Performance	71153

A Green finding and an associated non-cited violation (NCV) of Technical Specification (TS) 5.4.1, “Procedures,” was self-revealed when the licensee operated the incorrect switch while securing Emergency diesel generator (EDG) 12. As a result, power was lost to bus 72EB, including a loss of service water flow to the running EDG 12.

Description:

On July 4, 2026, the plant was in Mode 3 and the licensee was restoring division 1 safety-related buses to the offsite source following the event described in LER 05000341/2026-002-00. EDG 12 was paralleled to the offsite source, and operators were transferring control of EDG 12 to the local station in preparation for securing the machine and placing it in standby. EDG 11 and EDG 12 were considered inoperable, along with their associated safety related buses, for the transfer back to offsite power.

Procedure 23.307, “Emergency Diesel Generator System,” Revision 139, Section 7.6 was utilized to transfer to local control. Step 7.6.2.5 required the control room operator to place the switch for the EDG 12 output breaker, 12EB position EB3, in the open position following transfer to local control. Contrary to this step, and prior to achieving local control, the operator placed the switch for 12EB position EB5 to the open position, securing power to 480-volt (V) bus 72EB. Bus 72EB powers auxiliaries associated with EDG 12, the division 1 emergency essential service water (EESW) pump, and division 1 ultimate heat sink loads. The service water pump (DGSW) that was cooling EDG 12 was lost.

Service water system design at Fermi 2 consists of individual DGSW pumps servicing their associated systems. Therefore, neither the division 1 residual heat removal service water pumps, nor any other EDG was impacted. Additionally, the division 1 EESW pump had not been running, as per design the system only actuates when needed for emergencies. Quickly

after, in response to multiple control room alarms and indications, main control room operators noted the loss of bus 72EB and the EDG 12 DGSW pump. The local operators were directed to trip EDG 12. The EDG was tripped, offsite power continued to power the safety buses (except 72EB as described), and operators continued securing EDG 12 and placing it in standby. After confirming the loss of 72EB was caused by operator error, power was restored to the bus. A subsequent engineering evaluation demonstrated the EDG remained operable following the approximate 3.8 minutes the EDG ran with the service water pump secured. The NRC became aware of the issue on or about the same day as the event.

Corrective Actions: The licensee restored power to bus 72EB by closing the 12EB position EB5 breaker and performed an engineering evaluation to evaluate impacts to EDG 12 following the loss of DGSW.

Corrective Action References: CR-2026-57171

Performance Assessment:

Performance Deficiency: The failure to follow step 7.6.2.5 of procedure 23.307, "Emergency Diesel Generator System," Revision 139, was a performance deficiency. Specifically, an incorrect switch was operated and caused Bus 72EB to lose power.

Screening and Significance: The inspectors determined that the finding adversely affected the Mitigating Systems cornerstone. The inspectors assessed the significance of the finding using IMC 0609 Appendix A, "The At-Power Significance Determination Process (SDP)." Utilizing Exhibit 2, section A, question 1, the inspectors determined that while EDG 12 and its associated electrical buses were already inoperable, the incorrect switch operation rendered EDG 12 and bus 72EB PRA nonfunctional (along with loads off of the 72EB bus, such as the division 1 EESW pump). Continuing in Exhibit 2 section A, the remaining questions were answered 'no,' screening the issue to Green, or very low safety significance.

Cross-Cutting Area: Human Performance

The licensee failed to recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes. Specifically, appropriate error reduction tools were not implemented, such as a peer-check or flagging.

Enforcement:

Violation: TS section 5.4.1.a. requires, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978.

NRC Regulatory Guide 1.33, Revision 2, Appendix A, Section 4 addresses "Procedure for Startup, Operation, and Shutdown of Safety-Related BWR Systems," and Section "w.(2)(a)" addresses "Emergency Power Sources (e.g. diesel generator, batteries)."

The licensee established Procedure 23.307, "Emergency Diesel Generator System," to address operation of the EDGs. Procedure 23.307, Revision 139, Step 7.6.2.5 requires the switch for EDG 12 output breaker EB3 to be placed in the open position.

Contrary to the above, on July 4, 2026, the licensee failed to implement written procedures recommended in Regulatory Guide 1.33. Specifically, the licensee placed the EB5 switch,

instead of EB3 switch, in the open position as directed by Procedure 23.307 step 7.6.2.5, which caused bus 72EB to lose power.

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

- On October 28, 2026, the inspectors presented the integrated inspection results to P. Dietrich, Senior Vice President and Chief Nuclear Officer, and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71111.04	Drawings	6M721-2084	Residual Heat Removal (RHR) Division 1	75
	Procedures	23.205	Residual Heat Removal System	152
		23.208	RHR Complex Service Water Systems	138
71111.05	Calculations	DC-5702	Fire Loading Calculation	N
	Corrective Action Documents Resulting from Inspection	CR-2026-57386	NRC Identified, Transient Combustible Permit Expired on 07/08/2026	07/14/2026
		CR-2026-57407	NRC Identified: Double Doors Between Div 2 Switchgear and DC MCC Area Found Open, Do Not Self Close Fully (R3-11): Condition Report	07/15/2026
	Fire Plans	FP-AB-3-14F	Auxiliary Building, DC Motor Control Center (MCC) Room, Zone 14, El. 643'6"	6
		FP-RB-SB-4a	High Pressure Coolant Injection Pump and Turbine Room, Zone 4	5
		FP-TB	Turbine Building	11
		FP-TRANSFORMERS	Transformers	4
	Miscellaneous	26-0178	Transient Combustible Permit	06/03/2026
		MOP11-100	Fire Protection Implementation	10
	Procedures	20.000.22	Plant Fires	51.1
		LP-FP-940-29YX	Fire Drill - Fire in Main Unit 2B	0
		MOP10001	Fire Brigade Drill Record Form	5
		MOP11-100	Fire Protection Implementation	10
71111.11A	Procedures	20.000.07	Fuel Cladding Failure	27
		20.106.07	Control Rod Drift	24
		23.707	Reactor Water Clean Up	152
		29.100.01 SH 3	RPV Flooding	17
		EP-101	Classification of Emergencies	45
		MNT18	Conduct of Operations Training Manual	6
71111.13	Corrective Action Documents	CR-2026-58026	Lost Control of Jumper Working on Inspection/Test 260 VDC MCC 2PB-1 Pos. 8A Feeds E4150F007	08/13/2026

		CR-2026-58111	Unable to Calibrate C11-N013D (RPS SDV High Water Level Channel B2 Float Switch)	08/19/2026
	Drawings	6M721-5449	Diagram Control Rod Hydraulic System Reactor Building Part 2 of 2	22
	Miscellaneous		Shift Manager Daily Alignment Meeting	08/13/2026
		100308	Update MPR Calculation 021 014 AW1 to include Backseat Operational Condition for DC MOVs E4150F600 and E5150F008	08/23/2023
		23-0112	50.59 Screen	0
		ODE-20	Protected Equipment	31
		Risk Management Plan	RB-1 Steam Tunnel Entry to Operate E5150-F008 / E4150-F600	07/27/2026
	Procedures	44.010.047	RPS - Scram Discharge Volume High Water Level Trip System A, Channel A2/C Level Switch Calibration/Functional Test	39
		44.010.048	RPS - Scram Discharge Volume High Water Level Trip System B, Channel B2/D Level Switch Calibration/Functional Test	37
		MMR 12	Equipment Out of Service Risk Management	22
		MMR Appendix H	Online Core Damage Risk Management Guidelines	18
		MOP26	Risk Informed Completion Time	0
	Radiation Surveys	P-M-20250131-8	RB1ST Lower Level	01/31/2025
		P-M-20260713-14	RB1ST Lower Level	07/13/2026
71111.15	Corrective Action Documents	CR-2024-42470	Bad Megger Readings Control Circuit	09/25/2024
		CR-2026-55098	HCU 58-43 Accumulator Trouble Alarmed Within 2 Minutes during Performance 24.106.08	04/16/2026
		CR-2026-55111	Many HCU's Received Accumulator Troubles within 10 Minutes during Performance of 24.106.08	04/16/2026
		CR-2026-55112	Evaluate Change Management Associated with 24.106.08 Rev. 10	04/16/2026
		CR-2026-56942	Corrosion of MDCT Fan 'A' Gear Reducer	06/22/2026
		CR-2026-57289	N2103-F003 (FW/SBFW Pumps N2103C001 & N2103C002 to RPV ISO MOV) Found on Walkdown with Broken Yoke	07/09/2026

		CR-2026-57484	Entry into TRLCO 3.0.3 Required for Appendix R Alternate Shutdown Auxiliary Systems (N21F003 Control Circuit)	07/17/2026
		CR-2026-58026	Temporary Test Lead Slipped off its Point of Connection on INSPECT/TEST 260 VDC 2PB-1 Pos. 8A. Feeds E4150F007	08/14/2026
	Drawings	6M721-5083	Piping & Instrument Diagram Standby Feedwater System	U
	Engineering Changes	DCP-26-0022	Gag N2103F003 Closed Due to Broken Yoke Arm	0
	Miscellaneous	Event Review Sheet	Temporary Test Lead Slipped off its Point of Connection	08/14/2026
	Procedures	20.000.18	Control of the Plant from the Dedicated Shutdown Panel	59
		23.107.01	Standby Feedwater System	47
		24.106.08	CRD Hydraulic Unit Accumulator Integrity Test	10
		35.205.004	RHR Cooling Tower Fan - Gear Reducer Inspection and Maintenance	28
		54.000.03	Control Rod Scram Insert Time Test, Attachment 4, Slow Rod Tracking List	Various
		MDI-058	Technical Skills	4
	Self-Assessments	Performance Gap Analysis	Temporary Test Lead Alligator-Clip Detached During as-left Testing and Contacted Adjacent Energized Terminals	09/11/2026
	Work Orders	61045156	Inspect/Test 260 VDC MCC 2PC-1 POS 5B	09/25/2024
		69500650	Inspect/Test 260 VDC MCC 2PB-1 Pos. 8A, Feeds E4150F007	08/14/2026
71111.20	Procedures	22.000.02	Plant Startup to 25% Power	113
		22.000.03	Power Operation 25% to 100% to 25%	110
		22.000.05	Pressure/Temperature Monitoring During Heatup and Cooldown	55
71111.24	Corrective Action Documents	CR-2024-41787	Installed Material Does Not Meet Dedication Requirements	08/26/2024
		CR-2024-42121	Dedication Plan Does Not Align with Equivalency Evaluation	09/10/2024
		CR-2024-42200	Conservative Approach for CGI Dedication Material Masters	09/13/2024

		CR-2025-49330	System Service Transformer 64 Load Tap Changer Past Operability Investigation	08/06/2025
		CR-2026-54460	P4100F336 Should be Replaced if Needed for Protection/Isolation	04/01/2026
		CR-2026-54970	Request Torque Value for Flanges with Graphite Gaskets on GSW Temp Mod	04/14/2026
		CR-2026-55096	NQA RF23 – Gap in Implementing Required ASTM Standards During Transition to Abrasive Blasting for GSW Coating Project	04/16/2026
		CR-2026-55341	NQA RF23 – Bolting Material Discrepancy Identified During Walkdown of 26-0004 Alternate TB Room Cooler GSW Supply	04/22/2026
		CR-2026-57570	Y4100P042 Manhole 16947B Sump Pump Control Panel Pump Run Light and Pump Run Counter Not Functioning as Designed	07/22/2026
		CR-2026-57574	Oil/Water Alarm Not Working on Manhole 16947C: Condition Report	07/23/2026
		CR-2026-57685	Div. 1 CCHVAC Supply Fan Disconnect Hot to Touch	07/29/2026
		CR-2026-57932	Transformer 64 Load Tap Changer (LTC) Motor Thermal Overloads Found Tripped	08/10/2026
		CR-2026-58023	Ops Shift 3 CLO for Transformer 64 LTC Motor Thermal Overloads Found Tripped	08/13/2026
		CR-2026-58111	While Performing 44.010.048, C11N013D (CRD Hydraulic Control TRL Scram DISCH INST VOL RPS Channel B2 HI Water Level Scram Level SW) Was Found Out of Tolerance	08/19/2026
		CR-2026-58113	Transformer 64 Load Tap Changer (LTC) Motor Thermal Overloads Found Tripped (Repeat Issue)	08/19/2026
		CR-2026-58178	SST 64 LTC Motor TOL Tripped	08/21/2026
		CR-2026-58180	Ops Shift 2 CLO for TS Requirement when Transformer 64 LTC motor Thermal Overloads Tripped	08/22/2026
		CR-2026-58630	Tagging to Support Work Order 64912674 on E1100-F014B Was Not Performed as Scheduled	09/14/2026
	Corrective Action Documents	CR-2026-58302	NRC Identified: Numeric Error Discovered and Classification Error Discovered in TSR 101072	08/27/2026

	Resulting from Inspection			
	Drawings	5SD721-2521-12	Internal Connections 480V. MCC Non-Reversing Starter with Sequence Control & Current Monitoring	I
		6E721-2980-49	Underground Ducts (Division I & II) Plot Plan South & West of Reactor Building	0
		6E721-2980-54	Electrical Manholes 16946A & 16947A (Division I & II) Plan, Sections & Details Reactor Bldg. Airlock Transfer Pad	0
		6I721-2578-05	Relay and Metering Diagram 4160V Ess Bus 64B	U
		6I721-2578-07	Relaying and Metering Diagram 4160V Ess Bus 64C	P
		6I721-2611-31	Rx Bldg. Main Control Room A/C Supply Fan T4100B007 Div. 1	AA
		6M721-2010	Diagram General Service Water System	111
		6M721-2125	Yard – Plot No. 1 Northeast Corner	50
	Engineering Changes	ERE 34114	Replacement of Obsolete MCC Fuse Holder to Remedy Overheating Problems	0
		TSR-101072	Scram Discharge Volume (SDV) Float Switches C11N013A-D	0
	Engineering Evaluations	CR-2026-58111-MRFF01	Maintenance Rule Functional Failure Review	09/09/2026
		TE-R12-26-028	Past Operability of SST 64 Load Tap Changer After Thermal Overloads were Found to be Tripped	0
	Miscellaneous	25-0006	50.59 Screen – 10 CFR 59 Review of DEC 700044 GSW Cross-tie Leak Prevention Internal Liner	2, 3
		DECP 700044	GSW Cross-tie Leak Prevention Internal Liner	3
		MM 100022789-02	Commercial Grade Item Dedication Plan for HCU Teflon Tape	07/21/2026
		MM 100310283	Commercial Grade Item Dedication Plan for EDG Diesel Fuel Oil	11/11/2013
		NUC-001: R2	Nuclear Plant Operating Agreement for the Fermi 2 Nuclear Power Plant	14
		PO 4702094033	Tape, Sealing, Federal Process Part No. TT40, Teflon, 1/2" Wide	04/10/2026
		PO 4702105348	Fuel, Diesel, Ultra Low Sulfur, No. 2	05/20/2026

		TE-T22-10-058	Past Operability Review for Open Doors R2-3 (T2200Y017), R2-4 (T2200Y018), R1-4 (T2200Y012), and R1-5 (T2200Y013)	0
		TM 26-0004	Alternate TB Room Cooler GSW Supply	0
		TRVEND	[PROPRIETERY/CONFIDENTIAL] Failure Modes and Effects Analysis - Spray-in-place Pipe Epoxy Lining System	2
	Procedures	00356.053PR-003	[CONFIDENTIAL] Spin Coat Installation of Structural Spray-in-place PIPE Epoxy Lining System in GSW System	6
		23.320, Encl. B	Manual Operation of Load Tap Changers (LTC) (SS Transformers 64, 65, 66 and 68)	0
		24.000.02	Shiftly, Daily, and Weekly Required Surveillances	166
		24.204.01	Div. 1 LPCI and Suppression Pool Cooling/Spray Pump and Valve Operability Test	87
		24.307.17	Emergency Diesel Generator 14 – Start and Load Test	65
		24.307.35	DGSW, DFOT and Starting Air Operability Test-EDG12	61
		27.000.05	Operator Rounds	34
		35.306.018	Spectrum Technology Motor Control Center Load Compartment	22
		44.010.048	RPS – Scram Discharge Volume High Water Level Trip System B, Channel B2/D Level Switch Calibration/Functional Test	38
		46.000.042	Calibration of ITT-Barton Models 288A/289A/291A/580A-2/200 Differential Pressure Instruments	43
		47.000.88	Infrared Inspection	7A
		74.000.18	Chemistry Shiftly, 72-Hour, and Situation Surveillances	66
		ARP 9D22	Division I Bus Voltage Low	17
		ARP 9D8	SS 64 Transformer Trouble	16
		MES60	Electrical Cable Monitoring Program	12
		MMM11	Dedication of Commercial Grade Items	20
		MMM12	Receipt and Source Inspections	37
	Work Orders	62083293	SPV, NEIL Required, Perform Tear-Down Inspection. Rework as Required. Circ Water Pump 5	10/30/2025

		62440881	Perform 44.010.048 RPS SDV High Wtr Lvl Trip Sys B, Ch B2/D Flt Switch Cal/Funct	08/26/2026
		64912674	E1100F014B, RHR Div2 HX 'B' Service Water Inlet Will Not Close	09/14/2026
		73044643	License Renewal – Perform Periodic Inspections for Water Accumulation in EDG Division 2 Safety-related Electrical Cable Manhole 16947A(Y4100P044)/16947B (Y4100P042)/16947C (Y4100P040)	07/20/2026
		950016059	DEC-700044 Cleaning and Epoxy Coating of Piping from P4100F041N	04/21/2026
		950037915	Calibrate Division 2 RHR Discharge Flow Switch Per NE-6.6-EQMS.080	09/14/2026
		950038283	Perform 24.204.01 DIV. 1 LPCI & Suppression Pool Cooling Pump & Valve Operability Test	08/04/2026
		950109165	Perform 24.307.17 SEC-5.1 EDG 14 Start and Load Test - Slow Start	07/20/2026
		950110211	Perform 24.204.06 Division 2 LPCI and Suppression Pool Cooling Pump and Valve Operability Test	09/16/2026
		950114378	Perform 24.208.01 D1 EESW Pumps and Valve Operability (Section 5.1)	09/01/2026
		950115869	Perform 24.208.01 D1 EESW Pumps and Valve Operability (Section 5.2)	09/01/2026
		950118978	Perform 3-Year Performance Testing of N Train Dominator and Neptune Equipment	08/06/2026
		950130082	Replace C11N325 HCU 46-31 Pressure Switch	07/25/2026
		950131205	Div. 1 CCHVAC Supply Fan Disconnect Hot to Touch	07/30/2026
71130.15	Miscellaneous		Compensatory Firewatch Rounds / Relief Checklist	08/25/2026
		SEP-SE1-08002	Equipment Guide	8
	Procedures	23.304	Security Diesel Generators	12
71152A	Corrective Action Documents	03-22529	Main Generator Current Transformer Housing 'Y Phase' Induced Current Heating	11/01/2023
		07-21180	The System Vulnerability Assessment of the Reactor Feedwater System (N2100) identified an area for improvement:	10/28/2023

		08-25395	Quick Hit SPV RFP Woodward Governor Single Point Vulnerabilities identified	10/27/2023
		10-22632	Automatic Reactor Scram Due to Main Turbine Trip	10/13/2023
		10-31618	North Reactor Feedwater Pump Oscillations Result in Runback	10/15/2023
		11-21893	North Reactor Feedpump Speed Oscillations Result in Manual Tripping of Pump	09/18/2023
		14-24676	Possible Anomaly Found on MN GEN Neutral Bus Enclosure	09/17/2023
		18-30018	2018 LIR FW – Obsolete Governor Control for RFP System	09/13/2023
		19-24438	Potential Thermal Anomalies with Temperature Greater than 400 Degree F	09/12/2023
		CR-2026-54462	Grounding of Line Side CT Enclosure	04/01/2026
		CR-2026-54775	Generator Project - New Flex Links Require Modification	04/09/2026
		CR-2026-563-4	Fire in ISO Phase Bus	05/18/2026
		CR-2026-56304	Fire in ISO Phase Bus	05/18/2026
		CR-2026-56906	South Reactor Feed Pump rand down to 429 RPM	06/19/2026
		CR-2026-56918	Single Failure Vulnerability within RFP Woodward Governor Controls	06/21/2026
		CR-2026-57152	Bus 101 Lockout – Rx Scram	07/04/2026
		CR-2026-58055	Differences Between the Simulator and the Plant	08/16/2026
		CR-2026-58259	Request WO to Investigate SRFP Low Suction Pressure Trip Circuit	08/26/2026
		CR-2026-58940	Evaluate Current Transformer (CT) Enclosure Critical Production Asset Classification	09/25/2026
	Drawings	6SD721-2500-02	One Line Diagram 13.8KV	64
	Engineering Changes	ECR 32110-24	Installation of Alternate AC Power Source (AACPS)-for Station Blackout and Appendix R Events	0
		EDP-32110	Station Blackout Diesel Gen Project	0
	Miscellaneous		Post-Scram Data and Evaluation	07/08/2026
		18-30070-69	TMTE-18-0056 Latent Issue Review Deficiency LI-IDC-002-Overheating of Isophase	12/19/2018
		18-30070-77	2018-LIR-TMTE-18-0056 Latent Issue Review Deficiency LI-IC-002-Overheating	12/20/2018

		EDP 80000	[CONFIDENTIAL] Replace Main Turbine Generator (MTG)	6
		Field Change 80000-60	Main Turbine Generator CT Enclosure Modification	0
		Field Change 80000-61	Add Strike Shielding to Isophase Bus Ducts	6
		Field Change Request 80000-28	Revise Grounding for MTG CT Enclosures	6
		LER 2026-002-00	Automatic Reactor Scram Following Bus 101 Lockout Caused by Faulted Abandoned Switchyard Conductor	08/25/2026
	Procedures	MES02	Design Configuration Management	31A
		MES90	Engineering Support Conduct Manual, Chapter 90 - Standard Design Process Interface	4.3
		MES90	Standard Design Process Interface	4.3
		MWC10	Work Package Preparation	53
	Work Orders	37211712	EDP-32110 - ECR-24 - ELEC REMOVAL - SBO Diesel Generators	08/13/2026
		53991462	EDP-80000 Remove/Reinstall Neutral and ISO-Phase Duct, Bus and CTs	09/23/2026
71153	Corrective Action Documents	CR-2026-57171	Manual Trip of EDG 12 Due to Opening of 12EB Pos EB5 (Level 3 Mispositioning)	07/04/2026
		CR-2026-58363	Procedure Enhancement to 23.320 “Balance of Plant Auxiliary Electrical Distribution System” Enclosure B	08/31/2026
	Miscellaneous	EF2-PRA-005.07	Emergency Diesel Generators	4
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		23.307	Emergency Diesel Generator System	139
		23.320	Balance of Plant Auxiliary Electrical Distribution System	87
		23.321	Engineered Safety Features Auxiliary Electrical Distribution System	70
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