Fermi 2
4Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: SL-IV Oct 23, 2009
Identified By: Licensee
Item Type: VIO Violation
Failure to Provide Complete Information to the NRC which Impacted Licensing Decisions.
On August 13, 2009, during performance of a self-assessment, the licensee identified that two American National Standards Institute (ANSI) Standard requirements for physical examinations of licensed operators were no longer being administered by Fermi medical personnel. Specifically, olfactory and tactile testing were deleted by a procedure change that was implemented in May 1999. Because the issue affected the NRC=s ability to perform its regulatory function, it was evaluated using the traditional enforcement process. Although licensed operators were subsequently tested and found to have passed the olfactory and tactile tests, this failure had regulatory significance because the incomplete and inaccurate information was provided under a signed statement to the NRC and impacted numerous licensing decisions. This was preliminarily determined to be an apparent violation of 10 CFR 50.9, “Completeness and Accuracy of Information.” No cross cutting aspect was identified for the finding due to the age of the performance deficiency (e.g., 1999).
Inspection Report# : 2009010 *(pdf)*
Inspection Report# : 2009011 *(pdf)*

Significance: G Jun 30, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Adequately Dedicate a Commercial Grade Item for Safety-Related Use
A Green self-revealing finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B, Criterion VII, “Control of Purchased Material, Equipment, and Services,” was identified for the failure to adequately dedicate a commercial grade item for use in a safety-related application. The vendor supplied a mismatched stem and locknut in a valve rebuild kit which was procured as a commercial grade item and dedicated by the licensee for use in a safety-related application. The valve later failed when the locknut fell off the stem which caused the system to be inoperable.

The finding was determined to be more than minor because the finding was associated with the design control attribute and affected the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance from a Phase 1 SDP because it only affected the loss of function of one division of non-interruptible air supply system (NIAS) for less than the Technical Specification allowed outage time. There were no cross-cutting aspects associated with this finding since the deficiency was not reflective of current licensee performance.
Inspection Report# : 2009003 *(pdf)*

Significance: G Jun 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Adequately Control Potential Debris Source Term in Primary Containment
The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B,

Criterion III (Design Control), for the failure to control debris source term inside the drywell. The licensee installed ty wraps inside the drywell as part of a design modification without performing a debris transport and loading analysis of the emergency core cooling system (ECCS) suction strainers in the torus. Once identified, the licensee performed the analysis and replaced the ty-wraps with ones of an acceptable material.

The finding was determined to be more than minor because the failure to control the debris source term inside the primary containment could lead to loss of the ECCS during an accident condition. Specifically the debris could be transported from the drywell to the torus and cause the ECCS strainers to become blocked causing degradation in the ECCS flow during the accident and, therefore, affected the Mitigating Systems Cornerstone. The finding was determined to be of very low safety significance because the engineering analysis determined the ECCS flow rates would remain above the values assumed in the safety analysis and the debris loading did not exceed the structural limits of the strainers. There were no cross-cutting aspects associated with this finding since the deficiency was not reflective of current licensee performance.

Inspection Report# : 2009003 *(pdf)*

Significance: G Jun 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Completely Disassemble and Remove Scaffold from the Steam Tunnel
The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B, Criterion V (Procedures), for the failure to follow procedures. The licensee partially dismantled a scaffold and left the remaining scaffold poles in place which was contrary to the licensee's scaffold procedure. Once identified, the licensee removed the scaffold materials and entered the issue into their corrective action program for resolution.

The finding was determined to be more than minor because if left uncorrected, it would become a more significant safety concern. Specifically, the scaffold components represented potential high energy line break induced missiles which could have damaged components that were required to remain operable to mitigate the event and, therefore, affected the Mitigating Systems Cornerstone. This finding was determined to be of very low safety significance because the phase 3 SDP estimated the change in core damage frequency due to the finding was 3.8E-7/yr. This finding had a cross-cutting aspect in the area of human performance, work practices, because the licensee did not utilize human error prevention techniques (H.4(a)), such as self-checking and proper documentation of activities.

Inspection Report# : 2009003 *(pdf)*

Significance: G Mar 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedural Controls Over Construction of Storage Racks and Storage Areas
A finding of very low safety significance and an associated NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to include criteria in procedures for evaluation of storage areas and storage racks built in the power block. Licensee procedure MOP11, "Combustible Material," placed controls on the storages areas and storage racks to ensure that combustible loading remained acceptable but failed to incorporate adequate guidance for designating the storage area and constructing the racks to ensure nearby safety-related equipment would not be adversely affected during a plant transient or seismic event. After the issue was raised, modifications to the scaffold storage locations were completed, as needed.

The finding was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of design control (plant modifications) and it adversely impacted the cornerstone objectives. As a result of not evaluating the storage areas, safety-related components, systems or structures could have been affected. This finding was determined to be of very low safety significance because it did not result in loss of operability or functionality. The inspectors determined that the finding had an associated cross-cutting aspect of Problem Identification and Resolution, Corrective Action Program, Corrective Action (P.1 (d).

Inspection Report# : 2009002 *(pdf)*

Significance: G Mar 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Core Spray Pump Motor Oil Leak Not Promptly Identified and Corrected
A finding of very low safety significance (Green) and an associated NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was self-revealed for the failure to promptly identify and correct an oil leak that subsequently rendered a safety-related pump inoperable. Maintenance staff discovered an oil leak near a safety related pump and informed Operations staff of the leak but the licensee failed to identify the source of the leak for 5 days and, therefore, failed to take prompt corrective actions. Once identified, the licensee repaired the damaged instrument tube and restored the pump to service.

The finding was determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of Equipment Performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the oil leak ultimately rendered the pump inoperable. The finding was determined to be of very low safety significance because a Phase 2 SDP determined the risk to be very low. This finding had an associated cross-cutting aspect of Problem Identification and Resolution, Corrective Action Program, Issue Identification (P.1 (a)).
Inspection Report# : 2009002 *(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Oct 09, 2009
Identified By: NRC
Item Type: FIN Finding
PI&R Summary.
On the basis of the sample selected for review, the team concluded that implementation of the corrective action program (CAP) at Fermi was generally good. The licensee had a low threshold for identifying problems and entering

them in the CAP, however there was less than licensee-expected use of the system by site employees in some departments. Items entered into the CAP were screened and prioritized in a timely manner using established criteria and were properly evaluated commensurate with their safety significance. In general, causes for issues were adequately determined and corrective actions were generally implemented in a timely manner, commensurate with the safety significance. Some issues required reanalysis due to recurrence of the issues, in part, because of less than desired thoroughness of the original analysis and less than desired effectiveness of original corrective actions. The team noted that the licensee reviewed operating experience for applicability to station activities. Audits and self-assessments were determined to be performed at an appropriate level to identify deficiencies. On the basis of interviews conducted during the inspection, workers at the site expressed freedom to raise safety concerns through their supervisors, through the employee concerns program, or by use of the CAP. Some interviewees stated that the CAP was less than effective for resolving issues of low significance.
Inspection Report# : 2009007 *(pdf)*

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