January 11, 2005

EA-04-213

Mr. Christopher M. Crane
President and CEO
AmerGen Energy Company, LLC
200 Exelon Way, KSA 3-E
Kennett Square, PA 19348

SUBJECT: OYSTER CREEK NRC EMERGENCY PREPAREDNESS PROGRAM INSPECTION REPORT 05000219/2004009; PRELIMINARY WHITE FINDING

Dear Mr. Crane:

On November 29, 2004, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection of your Oyster Creek Generating Station, which began during the week of August 23, 2004, with in-office review continuing until November 29, 2004. The enclosed inspection report documents the inspection findings, which were discussed with Mr. B. Swenson, Site Vice President, and other members on your staff during the exit meetings on August 26 and November 29, 2004.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspector reviewed procedures and records, observed activities, and interviewed personnel.

The report discusses a finding that appears to have low to moderate safety significance. As described in Section 1EP4 of this report, this finding involved untimely actions to change an Emergency Action Level (EAL), namely Fission Product Barrier Matrix threshold value used for making a General Emergency (GE) and/or Site Area Emergency (SAE) declaration. This finding was assessed using the emergency preparedness significance determination process dated March 6, 2003, and was preliminarily determined to be "White," i.e., a finding with some increased importance to safety which may require additional NRC inspection. The finding has low to moderate safety significance because a Risk Significant Planning Standard (RSPS) function was degraded. Specifically, it was degraded because an incorrect EAL scheme could, under certain circumstances, delay actions directed by State and local response plans.

AmerGen did not properly ensure that the EALs used for making a GE and/or SAE declaration were correct following a change made to the Minimum Steam Cooling Reactor Water Level (MSCRWL) threshold value in the Emergency Operating Procedures (EOP). The MSCRWL value of minus 30" from top of active fuel is a part of the EAL scheme and it was incorrect for a period of nine days until it was identified and corrected by the licensee. The correct value was minus 20" from top of active fuel. The limit ensures adequate core cooling during certain leak scenarios; and, if the limit is projected to be exceeded in accident conditions, a radiation release might be imminent warranting onsite and offsite actions. During this time for a narrow

range of scenarios, the situation of the EOPs and EALs having two different limits, albeit a small difference, may have delayed the proper emergency classification. Oyster Creek personnel would have had to rely upon operator recognition of the inconsistency between the EALs and the EOPs instead of being presented appropriate classification guidance consistent with the EOPs. Although only a very small portion of the EAL scheme was affected by this inconsistency, this situation is contrary to the NRC's requirements that accurate EALs be in place. There were several program implementation and human performance deficiencies that were contributing factors to this finding. More specifically, a configuration change process was not properly used to ensure that the responsible AmerGen department was aware of a plant configuration change that would require a simultaneous change to an affected EAL related to the emergency declaration.

Upon notification, your staff implemented immediate corrective actions, including reducing reactor power in order to support the rod pattern change to satisfy the previous MSCRWL limit and correcting the EAL threshold value. Therefore, the finding does not present an immediate safety concern. We understand that long-term corrective and preventive measures are being developed.

The finding is an apparent violation of NRC requirements (10 CFR 50.54(q), 50.47(b)(4), and TS 6.8, along with associated implementing procedures) and is being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for the NRC Enforcement Actions" (Enforcement Policy) NUREG-1600. The current policy is included on the NRC's website at http://www.nrc.gov/reading-rm/adams.html.

We believe we have sufficient information to make a final risk significance determination on this issue. However, before we make a final decision on this matter, we are providing you an opportunity to: (1) present to the NRC your perspectives on the facts and assumptions, used by the NRC to arrive at the finding and its significance, at a Regulatory Conference, or (2) submit your position on the finding to the NRC in writing. If you request a Regulatory Conference, it should be held within 30 days of the receipt of this letter and we encourage you to submit supporting documentation at least one week prior to the conference in an effort to make the conference more efficient and effective. If a Regulatory Conference is held, it will be open for public observation and a press release will be issued announcing it. If you decide to submit only a written response, such submittal should be sent to the NRC within 30 days of the receipt of this letter.

Please contact Mr. Richard Conte at (610) 337-5183 within 10 business days of the date of this letter to notify the NRC of your intentions. If we have not heard from you within 10 business days, we will continue with our significance determination and enforcement decision and you will be advised by separate correspondence of the results of our deliberations on this matter.

Since the NRC has not yet made a final determination in this matter, no Notice of Violation is being issued for these inspection findings at this time. In addition, please be advised that the characterization of the apparent violation described in the enclosed report may change as a result of further NRC review.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response if any will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).
(Note: Public access to ADAMS has been temporarily suspended so that security reviews of publicly available documents may be performed and potentially sensitive information removed. Please check the NRC website for updates on the resumption of ADAMS access.)

Should you have any questions concerning this inspection, I will be pleased to discuss them with you.

Sincerely,

/RA/

Wayne D. Lanning, Director
Division of Reactor Safety

Docket No. 50-219
License No. DPR-16

Enclosure: Inspection Report 05000219/2004009

cc w/encl:
Chief Operating Officer, AmerGen
Site Vice President, Oyster Creek Nuclear Generating Station, AmerGen
Plant Manager, Oyster Creek Generating Station, AmerGen
Regulatory Assurance Manager Oyster Creek, AmerGen
Senior Vice President - Nuclear Services, AmerGen
Vice President - Mid-Atlantic Operations, AmerGen
Vice President - Operations Support, AmerGen
Vice President - Licensing and Regulatory Affairs, AmerGen
Director Licensing, AmerGen
Manager Licensing - Oyster Creek, AmerGen
Vice President, General Counsel and Secretary, AmerGen
T. O'Neill, Associate General Counsel, Exelon Generation Company
J. Fewell, Assistant General Counsel, Exelon Nuclear
Correspondence Control Desk, AmerGen
J. Matthews, Esquire, Morgan, Lewis & Bockius LLP
Mayor of Lacey Township
J. Lipoti, Ph.D., Assistant Director of Radiation Programs, State of New Jersey
K. Tosch - Chief, Bureau of Nuclear Engineering, NJ Dept. of Environmental Protection
R. Shadis, New England Coalition Staff
N. Cohen, Coordinator - Unplug Salem Campaign
W. Costanzo, Technical Advisor - Jersey Shore Nuclear Watch
E. Zobian, Coordinator - Jersey Shore Anti Nuclear Alliance
J. Picciano, Acting Regional Director, FEMA Region II

Distribution w/encl: **(VIA E-MAIL)**
S. Collins, RA
J. Wiggins, DRA
P. Eselgroth, DRP
R. Barkley, DRP
R. Summers, DRP, Senior Resident Inspector
J Herrera, DRP, Resident Inspector
J. DeVries, DRP, Resident OA
J. Jolicoeur, RI OEDO
R. Laufer, NRR
P. Tam, PM, NRR
T. Colburn, NRR
Region I Docket Room (with concurrences)
W. Kane, NRR
B. Sheron, NRR
D. Dambly, OGC
S. Figueroa, OE
D. Holody, EO, RI
R. Urban, ORA, RI
D. Corlew, ORA, RI
F. Congel, OE (OEMAIL)
K. Farrar, RI, RC
R. Kahler, NSIR/EPD
S. LaVie, NSIR/EPD
W. Lanning, DRS
R. Conte, DRS
N. McNamara, DRS

DOCUMENT NAME: E:\Filenet\ML050120053.wpd
SISP Review Complete: RJC (Reviewer's Initials)
After declaring this document "An Official Agency Record" it **will** be released to the Public.
To receive a copy of this document, indicate in the box: "**C**" = Copy without attachment/enclosure "**E**" = Copy with attachment/enclosure "**N**" = No copy

OFFICE	RI/DRS		RI/DRS		RI/DRP		RI/DRS/SRA		RI/OE	
NAME	NMcNamara (NTM)		RConte (RJC)		PEselgroth (PWE)		WSchmidt (WLS)		RUrban (RJU)	
DATE	12/04/04		01/04/05		12/17/04		01/05/05		12/17/04	

OFFICE	NSIR/EPD		RI/DRS							
NAME	LaVie (via email)		WLanning (WDL)							
DATE	12/26/05		01/11/05		01/ /05		01/ /05		01/ /05	

OFFICIAL RECORD COPY

U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No.	50-219
License No.	DPR-16
Report No.	05000219/2004009
Licensee:	AmerGen Energy Company, LLC (AmerGen)
Facility:	Oyster Creek Generating Station
Location:	Forked River, New Jersey
Dates:	August 23 - 26, 2004 (onsite) August 27 - November 29, 2004 (in-office)
Inspector:	Nancy T. McNamara, Emergency Preparedness Inspector
Approved by:	Richard J. Conte, Chief Operational Safety Branch Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

IR 05000219/2004-009; 08/23-08/26/2004 and 08/27-11/29/2004; Oyster Creek Generating Station; IP 71114, Emergency Preparedness and IP 71151, Performance Indicators.

This announced inspection was conducted by a regional emergency preparedness inspector. One potentially greater than Green finding and apparent violation was identified. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

A. NRC-Identified Findings

Cornerstone: Emergency Preparedness (EP)

- White (Preliminary). An apparent violation associated with emergency planning standard 10 CFR 50.47(b)(4) and Technical Specification 6.8, along with its associated implementing procedures related to configuration control, was identified which has low to moderate safety significance because the Emergency Action Level, Fission Product Barrier Matrix contained an incorrect threshold value used for making a General Emergency and/or Site Area Emergency declaration.

  The finding is more than minor because it is associated with the EP cornerstone attribute of standard emergency classification and action level scheme and offsite EP. It affects the cornerstone objective of ensuring the capability to implement measures to protect the health and safety of the public during an emergency. The finding is potentially greater than very low safety significance because an untimely General Emergency could delay actions directed by State and local response plans. (1EP4)

B. Licensee-Identified Findings

Four violations of very low safety significance which were identified by the licensee were reviewed by the inspector. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. These violations are listed in Section 40A7 of this report.

REPORT DETAILS

3. REACTOR SAFETY

Cornerstone: Emergency Preparedness

1EP2 Alert and Notification System (ANS)

a. Inspection Scope (71114.02 - 1 Sample)

An onsite review of the licensee's ANS was conducted to ensure prompt notification of the public for taking protective actions. The inspection included a review of the 2003/2004 siren test and maintenance records and the following procedures: (1) EP-MA-121-1002, ANS Description Testing Maintenance and Performance Trending Program; (2) EP-MA-121-1004, Exelon East ANS Corrective Maintenance; and (3) EP-MA-121-1006, Exelon East ANS Siren Monitoring Troubleshooting and Testing. The inspector interviewed the siren program manager and reviewed the 2003/2004 associated Corrective Action Process (CAP) reports to determine if the failures were being immediately assessed and if inoperable sirens were being expediently repaired. The inspection was conducted in accordance with NRC Inspection Procedure 71114, Attachment 02, and the applicable planning standard, 10 CFR 50.47(b)(5) and its related 10 CFR 50, Appendix E requirements were used as reference criteria.

b. Findings

No findings of significance were identified.

1EP3 Emergency Response Organization (ERO) Augmentation

a. Inspection Scope (71114.03 - 1 Sample)

An onsite review of Oyster Creek's ERO augmentation staffing requirements and the process for notifying the ERO was conducted to ensure the readiness of key staff for responding to an event and timely facility activation. The inspector reviewed the 2003/2004 communication pager test records and associated CAP reports. Also, the Emergency Plan (E-Plan) qualification records for key ERO positions were reviewed to ensure qualifications were current. Finally, the inspector attended a meeting conducted by the plant manager for ERO staff in response to a negative trend in failures to respond to unannounced pager tests. The inspection was conducted in accordance with NRC Inspection Procedure 71114, Attachment 03, and the applicable planning standard, 10 CFR 50.47(b)(2) and its related 10 CFR 50, Appendix E requirements were used as reference criteria.

The inspector reviewed CAP No. 02004-2296 that was generated during the inspection regarding inadequate responses to ERO pager tests and unannounced drive-in drills.

b. Findings

The Oyster Creek E-Plan staffing requirements did not appear to meet the NUREG-0654, Table B-1, minimum staffing criteria. The licensee's E-Plan commits to five on-shift Radiation Protection (RP) Technicians/Personnel and two on-shift repair and corrective action personnel with no dedicated number of the required nine (9) 60-minute responders delineated in Table B-1, "Emergency Response Organization." This constituted a potential inadequate plan in meeting planning standard 10 CFR 50.47(b)(2) concerning the adequacy of augmentation staff to respond to emergencies.

NUREG-0654 FEMA-REP-1, Revision 1, "Criteria for Preparation and Evaluation of Radiological Emergency Response Plans and Nuclear Power Plants," Table B-1, describes the minimum staffing guidance for nuclear power plant emergencies. The table specifically delineates 11 RP Technician/Personnel positions (on-shift and 60-minute augmentation) for performing onsite surveys, in-plant surveys, and in-plant protective actions. The inspector determined that the licensee's E-Plan requirements met the required on-shift complement (5); however, the E-Plan did not have a committed number of responders (6) to fulfill the 60-minute requirement. In addition, the E-Plan does not commit to the three required 60-minute responders in the area of mechanical maintenance, Rad Waste Operator and Electrical Maintenance. For the expected 60-minute responders, the E-Plan states "personnel numbers depend on the type and extent of the emergency."

The inspector determined that the 60-minute responder positions, described above, are not part of the ERO pager system and the licensee stated the call-out process for those positions has never been exercised during an off-hours drive-in drill for meeting the intent of a timely response. There was no EP implementing procedure that described the process for notifying those responders or for determining the adequate number of personnel needed to respond. Finally, at the time of the inspection, AmerGen was not able to locate an emergency response duty roster for these positions to ensure the availability of response personnel to fill emergency positions.

The licensee's E-Plan staffing requirements were inconsistent with those prescribed in NUREG-0654, a licensing standard used by the NRC staff in order to evaluate a plan for meeting planning standard 10 CFR 50.47(b)(2). This planning standard states, in part, "that adequate staffing to provide initial facility accident response in key functional areas is maintained at all times, and timely augmentation of response capabilities is available." It is uncertain when or if the plan change reflecting the above augmentation problem was approved by the NRC. This issue is unresolved pending further review of the licensing basis for this section of the E-Plan, subsequent changes approved by the NRC or the licensee, and a review of the original NRC-approved Oyster Creek E-Plan and procedures establishing a protocol for notifying the subject responders during an emergency event. The issue was entered into the corrective action system (CAP No. 02004-2296). **(URI 05000219/200409-01)**

1EP4 Emergency Action Level (EAL) and Emergency Plan Changes

a. Inspection Scope (71114.04 - 1 Sample)

A regional in-office review was conducted of licensee-submitted revisions to the E-Plan, implementing procedures and EALs that were received by the NRC during the period of April through December 2004. A thorough review was conducted of plan aspects related to the Risk Significant Planning Standards (RSPS), such as classifications, notifications and protective action recommendations. The non-RSPS portions were also reviewed. However, in July 2004, AmerGen issued a new standard E-Plan for the Oyster Creek site. The 10 CFR 50.54(q) reviews associated with the specific changes/deletions made from the original E-Plan to the current E-Plan will continue to be reviewed and assessed in-office to ensure that AmerGen did not decrease the effectiveness of the original E-Plan during the transition. The inspection was conducted in accordance with NRC Inspection Procedure 71114, Attachment 04, and the applicable requirements in 10 CFR 50.54(q) were used as reference criteria.

On July 30, 2004, the licensee identified that an EAL, Fission Product Barrier Matrix, contained an incorrect threshold value used for making a General Emergency (GE) and/or Site Area Emergency (SAE) declaration. The inspector reviewed the licensee's prompt analysis investigation report, root cause evaluation, several associated CAP reports, 10 CFR 50.54(q) change analysis and conducted interviews to determine the adequacy of the licensee's assessment and corrective actions related to this issue.

b. Findings

Introduction. An apparent violation (AV) associated with emergency planning standard 10 CFR 50.47(b)(4) was identified. The inspector determined that a performance deficiency existed in that an inadequate EAL for GE or SAE levels was in-place in July 2004 that could have delayed an emergency declaration, and potentially resulted in a delay by State and local response agencies in taking minimum initial offsite response measures. This performance deficiency was apparently caused by the improper use of the configuration control process. Specifically, an EAL contained an incorrect threshold value used for making a GE and/or SAE declaration and this EAL corresponds to the Minimum Steam Cooling Reactor Water Level (MSCRWL) threshold value in the Emergency Operating Procedures (EOPs) and is related to Fuel Clad Barrier Loss. As a result of this inconsistency, Oyster Creek personnel would have had to rely upon operator recognition of the inconsistency between the EALs and the EOPs instead of being presented appropriate classification guidance consistent with the EOPs. By not having an accurate EAL scheme for use in making a GE and/or SAE declaration, the licensee failed to satisfy planning standard 10 CFR 50.47(b)(4).

Description. In February 2004, AmerGen's Operations Department issued a CAP report discussing the potential change of the MSCRWL from minus 30" top of active fuel (TAF) to minus 20" TAF based upon analysis errors discovered by General Electric. This water level is utilized to preclude fuel damage when Reactor Pressure Vessel (RPV) water level is below the TAF. The minus 20" TAF threshold value is specifically used for meeting Oyster Creek's EAL threshold value for making a GE and/or SAE declaration as described in EP-OC-1010 EAL Matrix, "Fission Product Barrier Status, Fuel Clad Barrier,

RPV Water level." The CAP report further stated that, should the analysis be validated, changes would be needed to the EOPs, the E-Plan EALs, and the associated EAL basis document. The final review of this issue was completed in June 2004, which stated that minus 20" TAF was the correct value upon implementation of an end of cycle rod pattern configuration change. The licensee issued a CAP report to change the associated EOPs and again stated that an EAL change would be necessary.

On July 15, 2004, a CAP report was issued to the EP Department to make the associated changes to the EAL and the action was assigned a due date of August 30, 2004. On July 23, 2004, the EOP change and the related end of cycle rod pattern change were completed, however, the corresponding EAL change was not made prior to the configuration change.

On July 28, 2004, a training instructor questioned if the EAL change had been made. The change had not occurred and no CAP report was submitted indicating that the urgency for the EAL change was not recognized. On July 30, 2004, a Nuclear Oversight (NOS) auditor found the EAL was in error and no compensatory actions were in place as a result of the revised basis document. To correct the situation, the licensee performed a rod pattern adjustment to restore bundle power peaking to the previously analyzed levels for minus 30" TAF MSCRWL. On July 31, 2004, the licensee appropriately revised the EAL to the appropriate threshold (minus 20" TAF), which restored consistency between the EOPs and the EP EAL such that the operators could properly declare a SAE and/or GE for a postulated loss of fuel barrier integrity. At that time, reactor power was reduced in order to support the rod pattern change to satisfy the MSCRWL limit of minus 30" TAF.

The inspector determined that, during the period of July 23-31, 2004, AmerGen's EAL scheme no longer ensured that the GE and/or SAE classifications would be based upon the minimum reactor water level for steam cooling limit in effect at the time (minus 20" TAF). Instead, an accurate classification would have relied upon operator recognition of the inconsistency between the EALs and EOPs and judgment to use the property water level limit. AmerGen did not properly implement the configuration change process for ensuring the EAL change was made concurrent with the EOP change prior to implementation.

The inspector noted there were multiple examples over a five-month period of program/procedure and human performance deficiencies as noted below that resulted in several missed opportunities to ensure the EAL was revised in a timely manner.

1. The process used to change this critical plant parameter and evaluation of its impact on other station plans and programs was not properly used. A procedure change process was used, versus a configuration control type process, that would have provided a larger spectrum of program evaluations.

2. The corrective action review process failed to assign resolution actions to the Emergency Planning organization, which is responsible for maintaining the E-Plan and EALs current, in spite of the fact that for about five months it was common knowledge that the EALs would have to be changed if the MSCRWL value changed.

3. The CAP Coordinator for the Training Department is a participant in the CAP review process. The Training Department has responsibility for the Emergency Planning Department. Yet the Training Department CAP Coordinator who reviewed the CAP failed to recognize that the EP Manager wasn't assigned as part of the CAP.

4. The station PORC reviewed and approved the EOP procedure change. However, the station PORC failed to recognize the need for similar EAL procedure changes in spite of the fact that the PORC members were all senior ERO members who have frequently been required to classify emergency conditions, have received training on EAL use and bases, and understood the significance of event classification.

5. The individuals or committees involved in the EOP change failed to review the 10 CFR 50.54(q) process for making E-Plan changes or failed to contact the EP staff to ensure that the EAL change needed to coincide with the EOP change and, more importantly, prior to changing the core bundle power peaking.

6. There was a lack of understanding of the urgency to have the EAL accurate for responding to an emergency event by assigning a 30-day time frame for making the EAL change.

In addition to the above, the NRC Resident Inspector identified AmerGen's extent-of-condition review failed to identify that the appropriate changes to certain functional guidelines/notes that required the operators to ascertain if core damage had occurred still contained the MSCRWL value as minus 30" TAF, as an indication of core damage.

The incorrect EAL threshold value could have directly impacted the following under emergency conditions:

1. The PAR would have been impacted because under a loss of two barriers and the potential loss of a third barrier, the PAR would be to evacuate 0-2 miles; however, under the revised MSCRWL, the fuel clad barrier would be considered lost once the RPV level drops below minus 20" TAF resulting in a PAR to evacuate 0-5 miles.

2. The dose assessment model, which also used the MSCRWL minus 30" TAF value as an input condition, would have had to be "manually" overridden to avoid dose assessment errors assuming dose assessment was aware of the MSCRWL discrepancy.

3. A late declaration would have a direct impact on the timeliness for providing a PAR to the State and local response agencies for taking minimum initial offsite response measures.

Following the identification of this issue, AmerGen took immediate corrective actions that included: (1) the reactor power was reduced in order to support the rod pattern change to satify the previous MSCRWL limit of minus 30" TAF; (2) a 10 CFR 50.54(q) review was conducted to ensure the change would not decrease the effectiveness of the

plan; and (3) the EAL change was reviewed by PORC and approval was obtained from the State of New Jersey, Bureau of Nuclear Engineering prior to implementation.

Analysis. The performance deficiency is that the E-Plan EAL threshold value used for making an emergency declaration was inadequate which is contrary to 10 CFR 50.54(q) and 50.47(b)(4) in that it did not accurately reflect an EOP change for MSCRWL, which is used as a threshold for declaring a GE and/or SAE. This performance deficiency apparently resulted from not properly using the configuration control process which is contrary to TS 6.8 and associated facility procedures. AmerGen's EAL scheme no longer ensured that the GE/SAE classifications would be based upon the associated EOP parameter. Instead, an accurate classification would have relied upon operator recognition of the inconsistency between the EALs and EOPs.

The performance deficiency is more than minor because it affects the EP cornerstone objective and the attribute of procedure quality (having standard emergency classification and action level scheme). The attribute of offsite EP is also affected in that, an incorrect EAL scheme may delay actions directed by State and local response plans, which rely on timely and accurate information for taking minimum initial offsite response measures.

This finding was processed using Inspection Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," Sheet 1, "Failure to Comply" in responding "yes" to the SDP screening operation: "Is this finding associated with a failure to meet or implement a regulation requirement?" The finding was determined to have low to moderate safety significance because the non-compliance resulted in the RSPS function being degraded, but not lost. The function was degraded in that the timeliness of the declaration was affected more so than the capability of making a declaration.

Enforcement. 10 CFR 50.54(q) requires that the facility licensee shall follow and maintain in effect emergency plans which meet the standards in 10 CFR 50.47(b). 10 CFR 50.47(b)(4) requires that emergency response plans include "A standard emergency classification and action level scheme, the bases of which include facility system and effluent parameters, is in use by the nuclear facility licensee, and State and local response plans call for reliance on information provided by facility licensees for determinations of minimum initial offsite response measures."

Contrary to the above, for the period of July 23-31, 2004, an EAL, Fission Product Barrier Matrix contained an incorrect threshold value used for making a GE and/or SAE declaration. As a result, an inadequate EAL scheme could potentially delay taking minimum initial offsite response measures for the general public as directed by State and local response plans because these response plans rely on correct information provided by the facility licensee.

In addition, Technical Specification 6.8 requires written procedures shall be implemented covering the applicable procedures in Appendix "A" of Regulatory Guide 1.33 as referenced in the Oyster Creek Operational Quality Assurance Program. Chapter 6 of the Exelon Quality Assurance Topical Report, NO-AA-10, Revision 72, dated March 8, 2004, describes that the Company has in place programmatic controls,

which ensure that procedures are technically correct before use and that procedures are reviewed and revised as needed, when pertinent source material is changed, when the plant design is changed, or when deficiencies are identified and corrected. In implementing these measures, Procedure, CC-AA-104, "Document Change Requests," requires use of procedure, CC-AA-102, "Design Input and Configuration Change Impact Screening," for necessary procedure changes. Procedure, CC-AA-102, directs the responsible engineer to "identify procedure changes per direction in CC-AA-102 Attachment 9," which requires responsible departments to identify the procedures within their scope of responsibility that are affected by the configuration change and to create action requests to track the procedure changes. Also, Step 4.1.30 of procedure CC-AA-102, directs the responsible engineer to determine the effect of the configuration change on the general station emergency response plans or scenarios.

Contrary to the above, in February 2004, the licensee did not follow the configuration control process for implementing the necessary changes to station procedures when the pertinent source material changed (MSCRWL value), resulting in the failure to make the necessary changes to the EALs, as well as to EOP flow chart procedure, 2000-EMG-3200.12, "Secondary Containment and Reactivity Release Control," Table 14, and to the Emergency Plan Implementing Procedure, EP-OC-123-1006, "Radiological Assessment Computer Program Technical Basis. These configuration control deficiencies and inadequate EAL are considered to be an apparent violation of 10 CFR 50.47(b)(4) and Technical Specification 6.8. **(AV 05000219/2004009-02)**

The licensee is pursuing long term corrective actions to prevent recurrence. The licensee has entered this issue into their corrective action process under CAP No. 02004-1986 and 02004-2098.

1EP5 Correction of Emergency Preparedness Weaknesses and Deficiencies

a. Inspection Scope (71114.05 - 1 Sample)

The inspector reviewed corrective actions pertaining to findings from 2003/2004 EP drill/exercise reports and the associated CAPs to determine the significance of the issues and to determine if repeat problems were occurring. Interviews were conducted with the EP Director to understand repetitive issues found in exercise reports and to ensure the EP staff was aggressively pursuing actions that will keep these issues from recurring in future drill/exercises. A list of CAPs are contained in an attachment to this report. Also, the 2003/2004 quality assurance audit reports were reviewed to assess AmerGen's ability to identify issues, assess repetitive issues and the effectiveness of corrective actions through their independent audit process. This inspection was conducted according to NRC Inspection Procedure 71114, Attachment 05, and the applicable planning standard, 10 CFR 50.47(b)(14) and its related 10 CFR 50, Appendix E requirements were used as reference criteria.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES [OA]

4OA1 Performance Indicator (PI) Verification

a. Inspection Scope (71151 - 3 Samples)

The inspector reviewed the licensee's procedure for developing the data for the EP PIs which are: (1) Drill and Exercise Performance (DEP); (2) ERO Drill Participation; and (3) ANS Reliability. The inspector reviewed documentation from drills in 2003 and 2004, and ANS testing results to verify the accuracy of the reported data. EP PI Data generated for the period of September 2003 - June 2004, was reviewed during this inspection. The review of these performance indicators was conducted in accordance with NRC Inspection Procedure 71151. The acceptance criteria used for the review were 10 CFR 50.9 and NEI 99-02, Revision 2, Regulatory Assessment Performance Indicator Guidelines.

a. Findings

In June 2003, AmerGen increased the frequency of their ANS testing from quarterly growl tests to monthly and biweekly silent tests to weekly for aligning the testing frequency for all the Exelon East plants (Peach Bottom/Limerick/Three Mile Island/Oyster Creek). A review of the PI data indicated the Oyster Creek ANS was operating within the 97-98% green response band and no negative operability trends were noted prompting the change. However, this change in testing methodology was not submitted to the Federal Emergency Management Agency (FEMA) for approval prior to implementation. Also, Exelon did not inform the NRC of the testing change as stated in Frequently Asked Question (FAQ) No. 358, dated February 19, 2004, regarding changing ANS testing methodologies. The FAQ response states, "if prior to this FAQ response, a plant changed their testing methodology, it is not necessary to recalculate their past PI data from the time of the change." However, those plants still need to update the affected PI data report by noting the change in the comment section. This issue is being treated as an Unresolved Item **(URI 05000219/2004009-03)** pending FEMA's review of the testing methodology change and an update to the NRC with the licensee's PI data submittal. (CR No. 00248572 and CAP No. 02004-2399)

40A6 Meetings, including Exit

On August 26, 2004, the inspector presented the results of the inspection to this licensee staff in a preliminary exit. At that time, there was one unresolved item involving the preliminary White finding. On November 29, 2004, the NRC re-exited with Mr. B. Swenson, Vice President and other members of your staff, via a conference call indicating the preliminary resolution of the item. The licensee had no objections to the NRC's observations. The inspector confirmed that proprietary information was not provided or examined during the inspection.

40A7 Licensee-Identified Violations

The following findings of very low significance were identified by Exelon and are violations of NRC requirements which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as Non-Cited Violations.

- 10 CFR 50.54(q), follow and maintain in effect an E-Plan. The Emergency Offsite Facility did not contain a radiation monitoring system as described in the station's Updated Final Safety Analysis Report (UFSAR) and the E-Plan. This issue was discovered during a NOS audit. (CAP No. 02004-2004)

- 10 CFR 50.54(q)(7); Appendix E.IV.F.1, radiological orientation training shall be made available to local services personnel. Media kits were not provided to the media in 2003. This issue was discovered during a NOS audit. (CR No. 00213917)

- 10 CFR 50.54(q), follow and maintain in effect an E-Plan. Public education brochures for emergency response actions to operators of recreational areas in the 10 Mile EPZ were not made available. This issue was discovered during a NOS audit. (CAP No. 02004-1056)

- 10 CFR 50.54(t), results of the annual program review must be made available to State and local governments. During a NOS audit, it was found that the 2002 and 2003 audits were not made available to the State and local governments within the yearly requirement. (CAP 2003-1168 and CAP 2004-1042)

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

J. Karkoska, Exelon, MAROG EP Manager
K. Poletti, EP Manager
J. Cohen, Lead NOS Auditor

New Jersey State Department of Environmental Protections

R. Russell, Nuclear Engineer, Bureau of Nuclear Engineering (BNE)
D. Zannoni, Supervisor, Nuclear Engineering, BNE

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened/Closed

05000219/2004009-01	URI	Inconsistencies in Table B-1 Staffing (Section 1EP3)
05000219/2004009-02	AV	Incorrect EAL Due to EOP Change. (Section 1EP4)
05000219/2004009-03	URI	FEMA Approval of Siren Testing Change (Section 1EP2)

Discussed

None

LIST OF DOCUMENTS REVIEWED

Section 1EP3: ERO Augmentation

Exelon Standardized Emergency Plan
Oyster Creek Annex Emergency Plan
Oyster Creek Emergency Plan Implementing Procedures

Section 1EP4: Emergency Action Level and Emergency Plan Changes

Oyster Creek Generation Station Prompt Investigation Report
Table D-2: OCNS EAL Technical Basis, Recognition Category Fission Product Barrier
Regulatory Analysis, OCNS Failure to Revise EALs with Corresponding EOP Revision
Exelon Nuclear Procedure CC-AA-102, Design Input and Configuration Change Impact Screening, Rev. 8
Exelon Nuclear Procedure AD-AA-101-1002, 50.54(q) analysis
PORC Meeting (04-28) Report dated July 27, 2004
PORC Meeting (04-30) Minutes

Section 1EP5: Correction of Emergency Preparedness Weaknesses and Deficiencies

Augmentation Drill Report, Dated 11/24/03
OC April 30, 2003 Drill Evaluation Report
OC July 30 and August 6, 2003 Drill Evaluation Reports
OC September 9, 2003 Graded Exercise Evaluation Report
OC November 12, 2002 Training Drill Evaluation Report
OC May 6, 2004 Drill Findings and Observation Report
Memorandum dated August 16, 2004, Ineffective or Declining Functional Area Performance at the Oyster Creek Station
Memorandum dated August 19, 2004, pager test response needs continued improvement
CAP No. 02004-1986, Recent Changes to the EOP were not incorporated in the associated EAL.
CAP No. 02004-0346, Potential non-conservative value for EOP limit due to error in GE calculation
CAP No. 02004-0346-5, If EOF Changes, submit a change to the E-Plan if required, 8/2/04
CAP No. 02004-1986-7, Identify the RAC computer issues associated with recent EOP change
CAP No.02004-1986-5, Review what guidance exists relative to changes in critical plant parameters and their impact to Plans and Programs
CAP No. 02004-2098, Significance of EAL not being changed with EOP
CAP No. 02004-1120, ERO participation PI value less than station's expectations
CAP No. 02004-1099, Trend in on-duty ERO members not responding to pager tests
CAP No. 02004-1817, ERO qualification status in ETUDE does not agree with LOTUS notes
CAP No. 02004-1057, ERO qualification documentation deficiencies
CAP No. 02004-1042, 2002 50.54(t) audit not provided to State in accordance to regulation
CAP No. 02004-1168, 2003 50.54(t) audit not provided to state in accordance to regulation
CAP No. 02004-2296, NRC Inspection Unresolved Item, Table B-1 staffing
CAP No. 02004-2357, NRC Inspection Observation, ERO pager responses
CAP No. 02004-2399, NRC Inspection Observation, PI record keeping
CR No. 00248572, NRC Inspection Unresolved Item, FEMA not informed of siren testing change

LIST OF ACRONYMS

ANS	Alert and Notification System
AV	Apparent Violation
CAP	Corrective Action Process
DER	Deviation/Evaluation Report
DEP	Drill and Exercise Performance
EAL	Emergency Action Level
EP	Emergency Preparedness
E-Plan	Emergency Plan
EOP	Emergency Operating Procedure
ERO	Emergency Response Organization
FAQ	Frequently Asked Question
FEMA	Federal Emergency Management Agency
GE	General Emergency
MSCRWL	Minimum Steam Cooling RPV Water Level
PI	Performance Indicator
RP	Radiation Protection
RPV	Reactor Pressure Vessel
RSPS	Risk Significant Planning Standard
SAE	Site Area Emergency
SDP	Significant Determination Process
TAF	Top of Active Fuel
URI	Unresolved Item