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10CFR 2.201

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2130-05-20216

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Oyster Creek Generating Station
Facility Operating License No. DPR-16
NRC Docket No. 50-219

Subject: Apparent Violation (EA-05-199)

Reference: Oyster Creek NRC event follow up Inspection Report
05000219/2005011; Preliminary White Finding (November 4, 2005)

By letter dated November 4, 2005, the NRC docketed a Preliminary White Finding and Apparent Violation (NRC Inspection Report 05000219/2005011) for the Oyster Creek Generating Station. Attachment 1 to this cover letter provides a reply to the preliminary finding.

If any further information or assistance is needed, please contact Kathy Barnes at 609-971-4970.

Sincerely,



C. N. Swenson
Vice President, Oyster Creek Generating Station

CNS/KB
Attachment 1 – Reply to Apparent Violation

cc: S. J. Collins, Administrator, USNRC Region I
G. Miller, USNRC Project Manager, Oyster Creek
Marc Ferdas, USNRC Senior Resident Inspector, Oyster Creek
File No. 05050

IE01

ATTACHMENT 1

AmerGen Energy Company, LLC
Oyster Creek Generating Station

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

Restatement of Apparent Violation EA-05-199

During an NRC inspection conducted between August 25 and September 23, 2005, for which an exit meeting was held on September 23, 2005, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

- A. This report documents one finding that appears to have low to moderate safety significance. This finding involved the failure to properly utilize the Oyster Creek Emergency Plan (E-Plan) emergency action level (EAL) Matrix during an actual event. This finding was assessed using the emergency preparedness significance determination process dated March 6, 2003, as a potentially safety significant finding that has preliminary determined to be White (i.e., a finding with some increased importance to safety which may require additional inspection). This finding is an apparent violation of NRC requirements (10CFR 50.54(q) and 50.47(b)(4)) and is being considered for escalated enforcement action in accordance with the NRC Enforcement policy.

Reason for the Apparent Violation

This finding involved the failure to properly utilize the Oyster Creek Emergency Plan (E Plan) emergency action level (EAL) matrix during an actual event.

A root cause analysis was completed that determined the following:

There were two root causes associated with the operators not recognizing that plant parameters met the EAL thresholds for declaring an Unusual Event (UE) and a subsequent Alert:

- The first root cause was determined to be the Shift Manager assessment of E-Plan Applicability was incorrect and Event Classification was not based solely on EAL threshold values
- The second root cause was determined to be the Operating crew did not implement and follow all applicable steps of ABN-32 Abnormal Intake Level.

Corrective Steps

Following identification of this issue, AmerGen took immediate corrective actions that included:

- A Shift Brief was issued to cover classification of events when criteria are reached and recovered before declarations are made, discussion on termination and recovery, and communicator and notifications requirements.
- Operations Standing Order 69 "Standing Order for Intake Monitoring" was issued to communicate expectation of keeping the Intake systems in a high state of readiness and monitoring for conditions that would lead to entry into ABN-32, "Abnormal Intake Level".

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- Operations Standing Order 70 "Strategy for E-Plan Implementation" was issued to reinforce expectations and outline actions to be taken upon plant entry into an abnormal or transient condition, requirements for entry into the appropriate abnormal operating procedure, critical parameter monitoring, review of EALs, role of the Shift Technical Advisor, and responsibilities of communicators.
- The Shift Operations Superintendent (SOS) conducted one-on-one discussions with each Shift Manager on their EP duties and responsibilities. This included following the E-Plan process and procedures, for declarations and notifications.
- An environmental impact evaluation was performed, which concluded that there were no adverse environmental impacts as a result of this event.

In Addition, The following actions were taken to address Human Performance issues:

1. The SM involved in the event was removed from shift duty.
2. A manager was assigned as a full time Human Performance Manager for Operations
3. Two additional SROs were assigned to support the Human Performance Manager for Operations to mentor, observe and provide feedback for continuous improvement.
4. A Common Cause analysis (CCA) was performed on the Human Performance events in operations.
5. Leadership Assessments were performed for the First Line Supervisors (FLS) and above for the site and all personnel in operations.
6. Leadership assignments were evaluated and individuals were reassigned based on strengths identified in the leadership assessments.
7. The Operations Human Performance Improvement plan was reevaluated with input from the Operations CCA and the grassing event.
8. The Emergency Preparedness Improvement plan was updated with Human Performance actions and training requirements.
9. Training was provided by Corporate SME and INPO to improve the use of Human Performance tools.
10. Staffing improvements were made throughout the site.
11. Corrective Action Program trending of Human Performance issues has been improved.
12. Various station teambuilding sessions to improve site personnel alignment were conducted.
13. Fundamental Management System (FMS) Refresher Training was provided to site personnel.
14. Operations Human Performance Improvement plan was update to heighten standards and performance in Operations.

Interviews and investigation of this event revealed that operators involved considered the impact of nuclear safety and industrial safety.

Planned Corrective Steps

1. Revise initial and recurring training for Emergency Response Organization (ERO) personnel on the inappropriate behaviors and the following expectations for E-Plan implementation:

- Emphasize the need to utilize and review the E-Plan and EAL matrix when any procedure or condition indicates the potential of meeting or approaching an EAL threshold value.
- Emphasize the danger and potential impacts of making knowledge-based decisions without validating the knowledge base.

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- Emphasize the value of obtaining a peer check whenever possible in making classifications.
- Emphasize the importance and the need for strict compliance with E-Plan requirements to make classifications within fifteen minutes of identifying conditions that require classification and the required notifications within fifteen minutes of the classification.

Action – AR 360630-49.

2. Revise licensed operator training program to provide a minimum of ten ABN/EOP simulator scenarios during each biennial requalification cycle. In addition to the existing expectations and attributes include the following:

- Communication of ABN/EOP entry to all crew members
- Complete and thorough execution, verbatim compliance and proper place keeping and maintenance of procedure documentation for subsequent review.
- Appropriate log entries for initial entry and other entries as required by procedures
- Establishing and maintaining command and control and oversight by the Shift Manager (SM) and the Unit Supervisor (US)
- Establishment of roles and responsibilities for execution of steps and critical parameter monitoring, including frequency of updates to SM and US
- Forward looking and anticipating potential E-Plan entry
- Implementation of E-Plan when appropriate, including classifications and notifications and review of documentation for attention to detail

Action – AR 360630-21.

3. Revise EP training to provide initial and continuing classroom and tabletop exercises to appropriate ERO personnel (as a minimum Shift, Station, and Corporate Emergency Directors) that emphasize classification based solely on EAL thresholds and how to handle situations where plant conditions have improved before classifications and notifications are made. Exercises should provide challenges to making the classification as well as realistic obstacles in meeting the fifteen-minute classification and notification time requirements. Also incorporate the requirement to complete and review all completed forms for accuracy and attention to detail.

Action – AR 360630-50.

4. Revise licensed operator training program to integrate E-Plan training into all applicable simulator scenarios, not just evaluated simulator exercises. E-Plan training should present challenges in both classification and notifications so any weaknesses in the E-Plan and implementation of the E-Plan can be identified and corrected. Emphasis should be placed on making classifications solely based on EAL thresholds and also include some scenarios involving improving plant conditions that would challenge classifications and notifications. Also incorporate requirement to complete and review all completed forms for accuracy and attention to detail.

Action – AR 360630-20.

Date When Full Compliance Achieved

Full compliance was achieved when the Unusual Event was exited at 07:55 on 8/06/05.