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NRC FINALIZES “WHITE” FINDING FOR OYSTER CREEK NUCLEAR PLANT OVER CLASSIFICATION OF EMERGENCY

The Oyster Creek nuclear power plant will receive additional oversight from the Nuclear Regulatory Commission based on an inspection finding involving the classification of an emergency. The finding, which has now been finalized, stems from a failure by plant operators to properly use the plant’s emergency action level matrix during an event in August.

Oyster Creek is located in Lacey Township (Ocean County), N.J., and operated by AmerGen.

The NRC uses a color-coded system to categorize inspection findings. It ranges from “green,” for a very low safety issue, to “red,” for a high safety issue. In this case, the Oyster Creek finding has been determined by the NRC staff to be “white,” or a safety issue of low to moderate safety significance.

Because this was the second “white” inspection finding in the Emergency Preparedness cornerstone for the plant during the last year, Oyster Creek moved from the Regulatory Response Column to the Degraded Cornerstone Column of the NRC’s Action Matrix for the third quarter of 2005, resulting in a higher level of scrutiny in the emergency preparedness area. The matrix is available on the agency’s web site at:

http://www.nrc.gov/NRR/OVERSIGHT/ASSESS/actionmatrix_summary.html .

During an event at the plant on Aug. 6, a large amount of sea grass built up on screens on the north side of the plant’s water intake structure, which is used to draw water from a canal and pump it into the plant for cooling purposes. The clogging caused by the grass led to decreases in the amount of water taken into the structure between 2:35 and 3:40 a.m., meeting the values for the declaration of an Unusual Event and subsequently an Alert. (The NRC uses four levels of emergency classification: Unusual Event, Alert, Site Area Emergency and General Emergency.) While an Unusual Event was declared at 4:03 a.m. – even though conditions had returned to normal – an Alert was never declared.

“Since an Alert was not declared, AmerGen personnel did not activate their emergency response organization to assist (control room) operators in mitigating the event,” NRC Region I Administrator Samuel J. Collins wrote to AmerGen in a letter regarding the enforcement action.

“Additionally, had the event degraded further, state and local agencies, who rely on information provided by the facility licensee, might not have been able to take initial offsite response measures in as timely a manner.”

AmerGen responded to the NRC’s finding in writing on Dec. 9. In that reply, the company said an analysis of the event had identified two root causes: 1.) A shift manager’s assessment of the emergency plan’s applicability was incorrect and the classification of the event was not based solely on emergency action level threshold values; and 2.) the operating crew did not implement all applicable steps of the procedure relevant to this type of event.

In addition, AmerGen listed numerous corrective actions that had either already been implemented or were planned. These include enhanced training for control room operators and emergency response organization personnel, the assignment of a manager as a full-time human performance manager for operations and staffing improvements throughout the site.

The NRC will conduct a supplemental inspection at a future date to evaluate the company’s corrective actions.

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