July 25, 2006

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 SUPPLEMENTAL INSPECTION REPORT NO. 05000219/2006010

Dear Mr. Crane:

During May 15 to June 12, 2006, the U.S. Nuclear Regulatory Commission (NRC) completed an emergency preparedness (EP) supplemental inspection pursuant to Inspection Procedure 95002 at your Oyster Creek Generating Station. The enclosed inspection report documents the inspection results, which were discussed on June 12, 2006, with Mr. T. Rausch and other members of your staff. The NRC had been informed of your readiness for the inspection on April 21, 2006.

The supplemental inspection examined your root cause evaluations, extent of condition and extent of cause determinations, and corrective actions associated with two White findings in the emergency preparedness (EP) cornerstone. The two findings had placed the EP functional area for Oyster Creek into the Degraded Cornerstone Column of the NRC's Action Matrix for the third quarter 2005. The first White finding involved an inaccurate Emergency Action Level (EAL) threshold value for making a General Emergency (GE) declaration. The second White finding involved operators not recognizing during an actual event on August 6, 2005, that plant parameters met the EAL thresholds for declaring an Unusual Event (UE) and a subsequent Alert. A prior NRC inspection, Supplemental Inspection Report 05000219/2005007, had reviewed and accepted your followup of the first White finding; therefore, this inspection focused primarily on the second White finding and the combined assessment of the two White findings. This inspection also included an independent NRC review of the extent of condition and extent of causes of issues related to the two findings.

Based on the results of this inspection, the inspectors determined that you had adequately addressed the performance issues related to EP. However, the inspectors determined that, despite the fact that you had completed a number of relevant corrective actions, operators continued to demonstrate weaknesses associated with understanding of management expectations and site requirements for procedural use and adherence. Thus, your progress, in the area of procedural use and adherence, was less than what should be reasonably expected in light of the time period between the event and our supplemental inspection. Your root cause report identified the operator performance deficiency as a primary causal factor for the August 2005 event response problems. Therefore, the NRC has determined that the second White finding will remain open until we can perform another follow-up inspection to review additional corrective actions that you plan to implement to improve licensed operators' knowledge of and

use of procedures. Please inform us when you believe that your follow-up actions to improve in this area have been sufficient to support our follow-up inspection.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publically Available Records (PARS) component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC Website at http://www.nrc.gov/reading-rm/adams.html (The Public Electronic Reading Room).

Sincerely,

/RA/

A. Randolph Blough, Director
Division of Reactor Safety

Docket No: 50-219
License Nos: DPR-16

Enclosure: Supplemental Inspection Report No. 05000219/2006010

cc w/encl:
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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
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Manager Licensing - Oyster Creek, AmerGen
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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No.	50-219
License No.	DPR-16
Report No.	05000219/2006010
Licensee:	AmerGen Energy Company, LLC (AmerGen)
Facility:	Oyster Creek Generating Station
Location:	Forked River, New Jersey
Dates:	May 15 - June 12, 2006
Inspector:	Nancy T. McNamara, Team Leader Peter Presby, Operator Licensing Examiner Neil Perry, Senior Emergency Response Manager Stephen LaVie, Senior Emergency Preparedness Specialist
Observer:	Ron Cureton, Reactor Engineer
Approved by:	Raymond K. Lorson, Chief Plant Support Branch 1 Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

IR 05000219/2006-010; 05/15/2006 - 06/12/2006; Oyster Creek Generating Station; Supplemental Inspection Report.

The report covers a supplemental inspection by three regional inspectors and one senior specialist from the NRC Headquarters Office. No findings were identified. 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.

Cornerstone: Emergency Preparedness (EP)

The NRC performed this supplemental inspection, in accordance with Inspection Procedure 95002, to assess the licensee's evaluation and corrective actions associated with two White findings. This inspection also included an independent extent of condition and extent of cause review of issues related to the White findings. The two findings, which were in the EP Cornerstone, placed the performance of Oyster Creek into the Degraded Cornerstone Column of the NRC's Action matrix for the third quarter 2005. The first White finding involved an inaccurate EAL threshold value used for making a GE declaration. That White finding was evaluated and closed in Supplemental Inspection Report 05000219/2005007.

The second White finding involved operators not recognizing during an actual event that plant parameters met the EAL thresholds for declaring a UE and a subsequent Alert. In consideration of the NRC work already completed in the above listed prior inspection, this supplemental inspection primarily focused on the second White finding, and the combined assessment of the two White findings that resulted in the Degraded EP Cornerstone.

August 2005 Event Analysis and Corrective Actions (Second White Finding)

AmerGen determined that the root cause of the event was that operations senior management failed to consistently reinforce strict compliance with human performance and EP fundamentals. AmerGen also identified several causal factors and contributing causes associated with EP and issued corrective actions to prevent recurrence. The completed corrective actions associated with the EP deficiencies appeared to be effective.

However, the human performance issues related to procedural compliance were determined to be a primary causal factor that led to the performance problems identified during the August 2005 event response. The inspectors determined, despite the corrective actions taken and the time available for the actions to become effective, that licensed operators continued to demonstrate weaknesses associated with understanding of management expectations and site requirements for procedural use and adherence. The inspectors based this conclusion on information obtained during interviews with multiple licensed operators and on review of NRC-identified procedural usage issues during recent operating events. (Section 02.03)

As a result, the White finding associated with the August 2005 event will remain open pending completion of an additional follow-up NRC inspection to review additional AmerGen corrective actions to improve the licensed operators' knowledge of and adherence to procedural usage requirements.

Summary of Combined Review

The inspectors performed a collective assessment of the July 2004 event and the August 2005 event to determine if a commonality existed between the two events. For the first event, a process was not used; whereas for the second event, the procedure was used, but not strictly followed. Though somewhat similar, AmerGen determined the causes for the events were different; therefore, no additional corrective actions were necessary. The team reviewed the two events, discussed the root causes with AmerGen personnel, and concluded that AmerGen's collective evaluation for the multiple performance issues was adequate.

Report Details

01. INSPECTION SCOPE

The NRC performed this supplemental inspection to assess the licensee's evaluation associated with a degraded EP Cornerstone due to two White findings in the third quarter 2005. The first White finding was evaluated and closed in Supplemental Inspection Report 05000219/2005007. This inspection focused primarily on the second White finding and the combined assessment of the two White findings.

This supplemental inspection involved a review of the licensee's root cause evaluation, extent of condition and extent of cause evaluations, and associated corrective actions. The inspection also consisted of interviews with a selected number of licensed operators and department managers. It also involved an independent NRC team review of the extent of condition and extent of cause for the two White findings.

02. EVALUATION OF INSPECTION REQUIREMENTS

02.01 Problem Identification

a. Determination of who identified the issue and under what conditions.

The NRC identified that the operators failed to recognize that the plant was in an Alert Condition for an extended period of time during the August 6, 2005 event. This was the issue that prompted the White finding. Prior to the NRC's Inspection, the licensee reviewed the event and identified several other performance deficiencies.

b. Determination of how long the issue existed, and prior opportunities for identification.

For approximately 60 minutes, the intake structure water level had decreased, meeting the EAL values expected for a UE and then an Alert. Had the control room operators monitored the intake water level at the designated frequency as required by abnormal operating procedure (ABN) No-32, "Abnormal Intake Level," there would have been several prior opportunities to identify when they were approaching and had exceeded the EAL thresholds.

Additionally, there were sixteen previous occasions in which Oyster Creek experienced problems at the intake structure due to excessive grassing and Procedure ABN-32 was entered. In 2004, AmerGen did not make a timely UE classification due to decreased intake water level. It was determined that the root cause of the event was the lack of a specific requirement for the frequency of level readings at the intake. A requirement was added to Procedure ABN-32 to periodically monitor the intake level as part of the corrective actions. However, during the August 6, 2005 event, the operators failed to monitor the intake level readings as required by the abnormal operating procedure.

c. Determination of the plant-specific risk consequences (as applicable) and compliance concerns associated with the issue.

Due to the nature of this issue, the potential consequences were that the failure to declare an Alert prevented the activation of both onsite and offsite emergency responders during an actual event. Had the event degraded further, the onsite responders would not have been readily available to assist in the mitigation of the event. Additionally, state and local agencies, which rely on information provided by the facility licensee, could have been prevented from taking initial offsite response measures. AmerGen acknowledged they had not utilized the EAL matrix and consequently missed declaring a UE and subsequent Alert as required by the Oyster Creek Annex emergency plan (E-Plan) and 10 CFR 50.47(b)(4). Following the licensee's identification of this issue, AmerGen retrained operators on the implementation of E-Plan requirements during transient events to restore compliance with NRC regulations. The NRC staff determined this was an issue of low to moderate significance (White) as documented in NRC Inspection Report No. 05000219/05-011.

However, as of this inspection, corrective actions related to the procedural compliance issues had not been sufficiently effective to address these performance deficiencies as discussed in Section 02.03.

02.02 Root Cause and Extent of Condition and Extent of Cause Evaluation

a. Evaluation of methods used to identify the root causes and contributing causes.

AmerGen used a "Tap Root" Event and Causal Factor chart to analyze the information leading up to the event and to develop the root and contributing causes and associated corrective actions. This included barrier, change and event and causal factor analysis. The evaluation considered information gathered from several sources including: the control room logs, station procedures, and interviews with station personnel. The inspectors found the evaluation method used by the licensee to be acceptable.

b. Level of detail of the root cause evaluation.

During the NRC's review of the event, it was identified that the initial root cause evaluation did not correctly identify the amount of time that the plant was in an Alert condition. The NRC issued a green finding for the inadequate root cause evaluation (IR 05000219/2005011). This led to AmerGen issuing a subsequent revision (2) to the initial root cause evaluation on December 30, 2005.

In March and April 2006, several levels of corporate personnel and station management conducted subsequent reviews of the root cause evaluation in preparation for this supplemental inspection and identified that Revision 2 of the root cause report was not adequate. Specifically, AmerGen determined that Revision 2 of the root cause evaluation: (1) did not provide sufficient information to support one of the identified root causes; (2) a collective evaluation of the multiple performance issues was not performed; and, (3) did not provide adequate supporting information for the extent of

cause. These reviews resulted in substantial changes and enhancements to the root cause evaluation, including identification of a new primary causal factor which stated, "Operations senior management failed to consistently reinforce strict compliance with human performance (procedure adherence) and ERO fundamentals."

Revision 3 of the root cause evaluation was issued just prior to this supplemental inspection. AmerGen issued a condition report to review the problems identified with the initial and subsequent revision of the root cause evaluation. The inspectors determined that Revision 3 of the root cause evaluation of the August 2005, sea grass event, was thorough and the identified corrective actions were commensurate with the significance of the problem.

c. Consideration of prior occurrences of the problem and knowledge of prior operating experience.

As stated in Section 2.01.b, the licensee identified 16 previous occurrences in which Oyster Creek experienced a problem with excessive grassing at the intake structure. On one of those occasions in 2004, a UE classification was missed due to operators not monitoring the intake water level on a scheduled frequent basis. As discussed, following the 2004 event AmerGen improved the abnormal operating procedure to improve the response to this type of event. The failure to recognize that the plant was in an Alert Condition for an extended period of time during the August 2005 event occurred when the operators did not properly implement the revised abnormal operating procedure.

d. Consideration of potential common causes and extent of condition of the problem.

AmerGen immediately conducted an extent of condition review specific to the EP issues and found weaknesses in the training of the ERO personnel. The confusion during the event with respect to the use of the EALs and its basis document was found to be limited to the shift managers and on-shift operators. However, AmerGen performed a comprehensive review of their EAL basis document and identified several EALs where the EAL basis statements needed to be enhanced and/or improved to provide additional guidance. A focused area self-assessment (FASA) identified weaknesses in management and leadership fundamentals in the Operations Department particularly with respect to following procedures. AmerGen determined this applied to other plant departments which led to a station-wide reassessment of all personnel in leadership positions and individual department improvement plans. The inspector determined the licensee adequately considered the common causes and the extent of condition for identifying the corrective actions.

02.03 Corrective Actions

a. Appropriateness of corrective actions.

EP Issues

Following the event, AmerGen took immediate actions to prevent recurrence. These included: (1) briefed all operating shifts on E-plan event termination and on communicator expectations; (2) issued standing orders regarding intake monitoring and E-plan implementation; (3) made personnel reassignments and changes in senior operations and training department management; and, (4) provided additional maintenance support for the intake structure.

A number of follow-up corrective actions were developed subsequent to the event. These follow-up actions included extensive training on the E-plan and procedural implementation and EAL thresholds. Additionally, remedial training was conducted on the use of abnormal operating procedure, ABN-32, “Abnormal Intake Level.” The licensee also installed a remote intake bay level indicator in the control room make the intake bay level more readily available to control room operators. The inspectors determined that the corrective actions related to the EP deficiencies were appropriate and appeared to adequately address the identified causal factors.

Knowledge of and Adherence to Procedural Usage Requirements

The inspectors determined that, despite the corrective actions taken to address the procedural adherence issues, licensed operators continued to demonstrate weaknesses associated with understanding managements’ expectations for procedure use and adherence.

The inspectors interviewed eight licensed operators from several different operating crews. In order to gain a better understanding of the event and causal factors, inspectors asked each operator to describe the event and the actions taken or planned by their organization to prevent recurrence. All operators explained, in detail, actions taken to correct problems associated with the EP performance issues. However, with respect to the operator performance issues, responses were mixed. Specifically, most believed the primary cause was due to complacency because of frequent entry into Procedure ABN-32. While this was a contributing cause, a majority of the operators believed that they did not have a problem with placekeeping and verbatim procedure compliance. This did not align with the root cause evaluation’s conclusions or with management’s directives, standing orders, simulator training sessions and completed corrective actions for this issue.

To gain insight into the operator’s understanding of step-by-step compliance requirements, operators were asked to explain what actions they would take to implement a particular step in Procedure ABN-32. The step directed a power reduction and shutdown of the pumps following a drop in intake water level. Rather than follow the step as required, some of the operators answered that they would not take the directed action in the procedure unless they had indication of pump cavitation. Several operators explained that they are required to follow Procedure ABN-32, a Level 1

procedure, in a step-by-step manner. However, if they needed to stop a pump due to cavitation, they would jump ahead in the procedure and perform subsequent steps to stop the pump. There also appeared to be confusion as to the definition of “step by step” and that it was okay to skip around in the procedure as long as the subset steps of a particular section were performed in sequence. Several operators conveyed that performance of the step could be a judgment or subjective call.

These responses indicated that operators, while using personal knowledge and insight, could miss key procedural steps by not following the procedural adherence requirements as AmerGen intended. Oyster Creek Operations Expectation HU-AA-104-101, "Procedure Use and Adherence" states that Level 1 - Continuous Use is defined as "reading each step of the procedure prior to performing that step, performing each step in the sequence specified, and where required, signing off each step as complete before proceeding to the next step." Exelon Nuclear HU-AA-104-101, "Procedure Use and Adherence" has the same definition and further elaborates on expectations by stating that Level 1 procedures will be performed in sequence unless otherwise specified within the procedure.

The inspectors reviewed other occasions since the August 2005, grassing event regarding procedural compliance issues. On November 1, 2005, operators had entered Procedure ABN-32 and were observed by the NRC to not follow the procedure step by step as required. The operators skipped the final step to perform a risk assessment of the plant condition following the event. AmerGen issued IR No. 39303 to address the performance deficiency associated with this issue.

On February 13, 2006, AmerGen experienced a hydrogen detonation in the augmented offgas (AOG) system which resulted in an isolation of the AOG system. AmerGen's initial evaluation of the event determined that the hydrogen detonation in the AOG system was due to an equipment related issue and that no personnel performance issues contributed to causing the event. However, prior to the detonation, the control room had received and reset the high hydrogen alarm seven times in a two-hour period without complying with the alarm response procedure step to determine the underlying cause. Although AmerGen identified the number of times the alarm was received and reset, the NRC resident inspectors identified the procedure compliance problems as a contributing cause. The assessment of the operator performance deficiencies identified during this event is further discussed in NRC Inspection Report 05000219/2006003.

Based on operator interviews and two actual events since August 2005, it is apparent that, while corrective actions have been taken to strengthen crew procedural response, knowledge deficiencies and inconsistencies continue to exist regarding procedural use and adherence by licensed operators. The licensee has additional reviews and actions planned to improve operator performance, however, the inspectors noted that there has been a significant amount of time to address this issue since the August 2005 event, and the completed actions prior to the inspection were not as effective as could have been reasonably expected.

b. Prioritization of corrective actions.

As noted above, AmerGen implemented immediate corrective actions following the event, performed an immediate event evaluation and a root cause evaluation. The root cause evaluation and its three revisions identified root causes and contributing causes and corrective actions. The inspectors determined that these corrective actions were appropriately prioritized.

c. Establishment of a schedule for implementing and completing the corrective actions.

AmerGen implemented immediate corrective actions following the event, performed a prompt investigation and a root cause evaluation. The root cause evaluation and its three revisions identified root causes, contributing causes and a schedule for completing the corrective actions. At the time of the inspection, 69 out of 82 corrective action assignments had been completed. This included the additional corrective actions assigned as a result of the review prior to this inspection. With the exception of four assignments to perform effectiveness reviews on the four corrective action assignments (due in April 2007), all remaining corrective actions are scheduled to be completed prior to December 2006.

d. Establishment of quantitative or qualitative measures of success for determining the effectiveness of the corrective actions to prevent recurrence.

AmerGen has assigned four effectiveness reviews to be completed in April 2007, and a collective effectiveness review, to be completed in May 2007. According to the root cause evaluation, quantitative and qualitative measures have been put in place to which success will be achieved when performance trends show improvement over the 2006-2007 time-frame. Some of the ongoing actions which the licensee used to measure effectiveness were:

- Management reviewed crew performance to ensure they met managements' expectations and that consistent performance was apparent.

- Management observed simulator training and the training staff added an emergency classification component to the simulator training scenarios.

- An audit program was established to allow the Exelon Corporate EP staff to periodically audit all Exelon site EP programs to ensure that program commitments were being met.

- An Operations Excellence Plan was developed to address gaps in leadership and human performance fundamentals and to include metrics for evaluation.

02.04 Independent Assessment of Extent of Condition and Extent of Cause

The inspectors independently assessed the validity of the licensee's conclusions regarding the extent of the issues that contributed to the August 5, 2005 event and resultant White finding.

One of the causal factors of the event was determined to be related to the Shift Manager's wrong assumptions with respect to his assessment of the E-Plan and the EAL threshold values. As a result, remedial training was conducted of all shift managers. The inspectors reviewed a selected number of training lesson plans and determined the content addressed the identified EP performance problems.

The inspectors questioned whether there were other situations where EAL thresholds could be exceeded without indication available in the control room. One such alarm was identified involving on-site radiation readings. The team also questioned if there were other abnormal procedures that were frequently entered and could result in complacency. AmerGen had identified one other procedure which involved high wind conditions. The team verified that AmerGen was appropriately addressing these issues.

The inspectors performed a collective assessment of the July 2004, event and the August 2005, event to determine if a commonality existed between the two events. For the first event, a process was not used; whereas for the second event, the procedure was used, but not strictly followed. Though somewhat similar, AmerGen determined the causes for the events were different; therefore, no additional corrective actions were necessary. The team reviewed the two events, discussed the root causes with AmerGen personnel, and concluded that AmerGen's collective evaluation for the multiple performance issues were adequate.

03. MANAGEMENT MEETINGS

Exit Meeting Summary

The inspector presented the inspection results to Mr. Rausch and other licensee personnel on June 12, 2006. The inspector confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT 1

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Persons Contacted

J. Kandasamy, Regulatory Assurance Manager
K. Poletti, Site EP Manager
R. Zacholski, Operations Director
J. Vaccaro, Training Director
J. Dostal, Shift Operations Superintendent
P. Cervenka, Root Cause Team Leader
G. Waldup, Operations Service Manager

New Jersey State Department of Environmental Protections

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

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Open/Closed

None

LIST OF DOCUMENTS REVIEWED

Root Cause Reports

Incident Report 360630 Grassing Event August 6, 2005, Rev. 1
Incident Report 360630 Grassing Event August 6, 2005, Rev. 2
Incident Report 360630 Grassing Event August 6, 2005, Rev. 3

Procedures:

OP-OC-100, Oyster Creek Conduct of Operations, Rev. 5
LS-AA-125-1001, Root Cause Analysis Manual, Rev. 5
LS-AA-125, Corrective Action Program Procedure, Rev. 10
LS-AA-126, Self-Assessment Program, Rev. 4
LS-AA-125-1003, Apparent Cause Evaluation Manual, Rev. 6
LS-AA-126-1001, Focused Area Self-Assessments, Rev. 3
LS-AA-125-1004, Effectiveness Review Manual, Rev. 2
HU-AA-102, Technical Human Performance Practices, Rev. 1
HU-AA-104-101, Procedure Use and Adherence, Rev. 1

OP-AA-101-111, Roles and Responsibilities of On-shift Personnel, Rev. 1
EP-AA-1103, Conduct of Corporate EP Oversight, Rev. 0
EP-OC-112-100, Control Room Operations, Rev. 8
FASA #449126, OC NRC Inspection (95002) Degraded Cornerstone - EP
HU-AA-1212, Technical Task Risk/Rigor Assessment, Pre-Job Brief, Rev. 0
Oyster Creek Station Procedure No. 344, Screen Wash System Evolutions, Rev. 47

Miscellaneous

Document Based Instruction Guide, Licensed Operator Requal, Guide #: 2612.811, DBIG1
Document Based Instruction Guide, Licensed Operator Requal, Guide #: 2612.811, DBIG2
Document Based Instruction Guide, Licensed Operator Requal, Guide #: 2612.811, DBIG3
Document Based Instruction Guide, Licensed Operator Requal, Guide #: 2612.811, DBIG4
Emergency Response Organization Required Reading Package OC-2006-01
Oyster Creek Nuclear Safety Review Board Meeting Report, dated 5/8/06
Nuclear Oversight Monthly Reports (2005 and January -March, 2006)
2005 Emergency Preparedness Security Notice
Training Advisory Committee Meeting Minutes, dated 10/14/05
Oyster Creek Operations Expectations, Procedure Use and Adherence
Oyster Creek Operations Expectations, Response to Transient and Abnormal Operations
PORC Meeting (05-20) Report, dated 1/3/06
Letter to NRC, dated 1/4/06, Revision of E-Plan EALS
Operation's Standing Order, Number 70
Operation's Standing Order, Number 81
Operation's Standing Order, Number 88
Operation's Standing Order, Number 93
2005 Control Room Logs
2006 Control Room Logs

Corrective Action Reports:

AR No. 00360630, Low Intake Level Results in EAL Declaration, Assignments No. 1 thru 82
IR No. 449126, Focus Area Self-Assessment Report, dated 3/24/06
AR No. 486787, Nuclear Oversight Identified Errors in the Notice of Violation
AR No. 468393, Low Intake Event Root Cause No. 2 was Inadequate
AR No. 384615, Root Cause Report Missing Data Point

LIST OF ACRONYMS

AOG	Augmented Offgas
AR	Action Report
CAP	Corrective Action Process
EAL	Emergency Action Level
EP	Emergency Preparedness
E-Plan	Emergency Plan
ERO	Emergency Response Organization
FASA	Focused Area Self Assessment
GE	General Emergency
IMC	Inspection Manual Chapter
IR	Incident Report
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records
UE	Unusual Event