



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PA 19406-1415

September 22, 2008

Mr. Charles G. Pardee
Chief Nuclear Officer (CNO) and Senior Vice President
Exelon Generation Company, LLC
Chief Nuclear Officer (CNO)
AmerGen Energy Company, LLC
200 Exelon Way
Kennett Square, PA 19348

**SUBJECT: OYSTER CREEK GENERATING STATION – PROBLEM IDENTIFICATION
AND RESOLUTION REPORT 05000219/2008009**

Dear Mr. Pardee:

On August 8, 2008, the U.S. Nuclear Regulatory Commission (NRC) completed a team inspection at your Oyster Creek Generating Station. The enclosed inspection report documents the inspection findings, which were discussed with Mr. Timothy Rausch, Site Vice President, and members of his staff at an exit meeting on August 8, 2008.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and the conditions of your license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

There were no findings of significance identified during this inspection. The inspectors concluded that, in general, problems were properly identified, evaluated, and corrected. AmerGen personnel identified problems and entered them into the Corrective Action Program (CAP) at a low threshold. AmerGen prioritized and evaluated issues commensurate with the safety significance of the issues. The CAP processes and management reviews in place to review issue reports were comprehensive. The team noted, however, that this same level of rigor was not consistently applied when corrective actions for equipment issues were transferred to your work management process (PIMS). In general, corrective actions were effective and implemented in a timely manner.

C. Pardee

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Sincerely,

/RA/

Raymond Powell, Chief
Technical Support and Assessment Branch
Division of Reactor Projects

Docket Nos. 50-219
License Nos. DPR-16

Enclosure: Inspection Report No. 05000219/2008009
w/Attachment: Supplemental Information

cc w/encl:

C. Crane, Executive Vice President, Exelon, Chief Operating Officer, Exelon Generation
M. Pacilio, Chief Operating Officer, Exelon
T. Rausch, Site Vice President, Oyster Creek Nuclear Generating Station
J. Randich, Plant Manager, Oyster Creek Generating Station
J. Kandasamy, Regulatory Assurance Manager, Oyster Creek
R. DeGregorio, Senior Vice President, Mid-Atlantic Operations
K. Jury, Vice President, Licensing and Regulatory Affairs
P. Cowan, Director, Licensing
B. Fewell, Associate General Counsel, Exelon
Correspondence Control Desk, AmerGen
Mayor of Lacey Township
P. Mulligan, Chief, NJ Dept of Environmental Protection
R. Shadis, New England Coalition Staff
E. Gbur, Chairwoman - Jersey Shore Nuclear Watch
E. Zobian, Coordinator - Jersey Shore Anti Nuclear Alliance
P. Baldauf, Assistant Director, NJ Radiation Protection Programs

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Sincerely,
/RA/
Raymond Powell, Chief
Technical Support and Assessment Branch
Division of Reactor Projects

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U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No.: 50-219

License No.: DPR-16

Report No.: 05000219/2008009

Licensee: AmerGen Energy Company, LLC (AmerGen)

Facility: Oyster Creek Generating Station

Location: Forked River, New Jersey

Dates: July 21, 2008 – August 8, 2008

Team Leader: S. Barber, Senior Project Engineer

Inspectors: J. Kulp, Resident Inspector
B. Fuller, Operations Engineer
J. Cherubini, Reactor Inspector (Security)

Approved By: Raymond Powell, Chief
Technical Support and Assessment Branch
Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000219/2008009; 07/21/2008 - 08/08/2008; AmerGen Energy Company, LLC, Oyster Creek Generating Station; Biennial Baseline Inspection of the Identification and Resolution of Problems.

This team inspection was performed by three NRC region-based inspectors, and one resident inspector stationed at Oyster Creek. There were no findings or violations identified during this inspection.

Identification and Resolution of Problems

The inspectors concluded that AmerGen was generally effective in identifying, evaluating and resolving problems. AmerGen personnel identified problems and entered them into the Corrective Action Program (CAP) at a low threshold. The inspectors determined that, in general, AmerGen appropriately screened issues for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Causal analyses appropriately considered extent of condition, generic issues and previous occurrences. Corrective actions for high priority issues were appropriate; however, issues that were forwarded to the work management system (PIMS) for resolution did not consistently receive the same level of rigor and attention that the CAP provided. AmerGen staff exhibited difficulty in following corrective actions through this process and were unable to clearly state how a variety of issues were addressed in PIMS.

AmerGen's audits and focused area self-assessments were generally very thorough and probing. The inspectors concluded that AmerGen adequately identified, reviewed, and applied relevant industry operating experience (OE). Based on interviews and other field observations and discussions, the inspectors concluded that site personnel were willing to raise safety issues and to document them in the CAP.

A. NRC-Identified and Self-Revealing Findings

None.

B. Licensee-Identified Violations

None.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (PI&R) (Biennial - 71152B)

a. Assessment of the Corrective Action Program (CAP)

1. Inspection Scope

The inspectors reviewed the procedures that describe AmerGen's CAP at the Oyster Creek Generating Station (OC). AmerGen personnel identified problems for evaluation and resolution by initiating issue reports (IRs) that were entered into the issue reporting system (Passport). IRs are evaluated for operability, categorized by significance, assigned a level of evaluation and tracked and trended. The Station Operations Committee (SOC) reviews the initial evaluation and adjusts the categorization and investigation class and makes additional changes or clarifications when appropriate. Issues requiring work are entered into the work management system (PIMS) as action requests (ARs). Work orders (WOs) are developed that are implemented in the work week schedule or during refueling outages.

The inspectors evaluated the process for assigning and tracking issues to ensure they were screened for operability and reportability, prioritized for evaluation and resolution in a timely manner commensurate with their safety significance, and tracked to identify adverse trends and repetitive issues. In addition, the inspectors interviewed plant staff and management to determine their understanding of, and involvement with, the CAP.

The inspectors reviewed IRs selected across the seven cornerstones of safety in the NRC's Reactor Oversight Process (ROP) to determine if AmerGen personnel properly identified, characterized, and entered problems into the CAP for evaluation and resolution. The inspectors selected items from functional areas that included operations, maintenance, engineering, radiation safety, emergency preparedness, physical security, and oversight programs to ensure that AmerGen appropriately addressed problems identified in these functional areas. The inspectors selected a risk-informed sample of IRs that had been issued since the last NRC PI&R inspection conducted in May 2006. The inspectors considered risk insights from the station's risk analyses to focus the sample selection and plant tours on risk-significant systems and components. Inspectors' samples focused on, but were not limited to, these systems. The corrective action review was expanded to five years for evaluation of issues associated with the containment spray system and the startup transformers.

The inspectors selected items from other processes at OC to verify that they were appropriately considered for entry into the CAP. Specifically, the inspectors reviewed a sample of ARs in the work management system, operator workaround conditions, operability determinations and WOs.

The inspectors observed daily IR screening meetings, conducted by the SOC and Maintenance Review Committee (MRC), where AmerGen personnel reviewed new IRs for prioritization, investigation class and assignment. The IRs reviewed encompassed the full range of evaluations, including root cause analyses (RCAs), apparent cause evaluations (ACEs), and common cause analyses (CCAs). IRs that were assigned

lower levels of significance which did not include formal cause evaluations were also reviewed by the inspectors to ensure they were appropriately classified. The inspectors' review included the appropriateness of the assigned significance, the scope and depth of the causal analysis, and the timeliness of resolution. The inspectors assessed whether the evaluations identified likely causes for the issues and developed appropriate corrective actions (CAs) to address the identified causes. Further, the inspectors reviewed equipment operability determinations, reportability assessments, extent-of-condition reviews and follow up work assignments for selected problems to verify these processes adequately addressed equipment operability and reportability of issues to the NRC.

The inspectors reviewed IRs for adverse trends and repetitive problems to determine whether CAs were effective in addressing broader issues. The inspectors reviewed AmerGen's timeliness in implementing CAs and evaluated their actions to prevent recurrence for issues that involved significant conditions adverse to quality. The inspectors also reviewed IRs associated with selected NRC non-cited violations (NCVs) and findings since May 2006 to determine whether AmerGen personnel properly evaluated and resolved issues, including the timeliness and adequacy of corrective actions. The IRs and other documents reviewed, as well as key personnel contacted, are listed in the Attachment.

2. Assessment

Identification of Issues

The inspectors concluded that AmerGen personnel identified problems and entered them into the CAP at a low threshold. Most OC departments effectively identified and documented issues in IRs. However, the inspectors noted that the Security Department use of the CAP was below the level that would be expected. Based upon analysis of security related IRs and interviews with security officers (SOs) and the Security Manager, the inspectors determined that this issue appears to be a legacy issue related to the recent change from a contracted security force to an in-house force which occurred in May 2008. Prior to the changeover, SOs would report deficiencies to supervisors who were tasked with documenting the issue into either the contractor's corrective action program or the station's CAP. SOs were not tasked with documenting any deficiencies. After the changeover, SOs have been tasked with entering problems directly into the station's CAP. The inspectors interviewed SOs to assess their familiarity with the CAP. Many SOs stated that they were briefed on the use of the CAP by supervisors, but believed that additional training was planned to increase their understanding of the process and how to enter an issue. SOs also indicated that they would willingly identify items of safety or security significance to their supervisor with the expectation that they would be adequately addressed. Although the use of supervisors to enter issues may have been an acceptable practice in the past, AmerGen acknowledged that this old practice is undesirable and expressed the need to have individual SOs enter issues into the CAP. AmerGen initiated IR 00805024 to document this concern.

The inspectors concluded that AmerGen personnel were identifying trends at low levels and did not identify trends or repetitive issues that AmerGen had not self-identified. Although the descriptions in most IRs was generally good, there were several examples where the subject of the IR was either too general or did not reflect the underlying

condition which made trending of similar events and issues challenging. The inspectors noted that many IRs (approximately one-third) did not have a system number assigned. Although the inspectors determined that this challenged AmerGen's staff's ability to trend issues, no deficiencies in trending were identified during the inspection.

Prioritization and Evaluation of Issues

The inspectors determined that, in general, AmerGen appropriately prioritized and evaluated issues commensurate with the safety significance of the underlying issue. IRs were initially screened for operability and reportability, categorized by significance, and assigned to a department for evaluation and resolution. The SOC and MRC were effective at reviewing IRs for significance and adjusting categorization and departmental assignments, when warranted.

The inspectors noted that AmerGen's ACEs and RCAs were generally thorough. The inspectors observed a MRC review of an ACE and noted that the members provided insightful comments which were indicative of thorough preparation.

The inspectors assessed AmerGen's prioritization and evaluation of the operations procedure change backlog. The backlog of procedure changes for operations has decreased from approximately 720 in 2007 to 320 in 2008. In 2008, there have been about 15 change requests submitted each week with about the same number being resolved. The inspectors sampled five changes and noted that four of them were improperly prioritized as enhancements vice correcting setpoints or procedural steps. The inspectors evaluated this issue as minor as it has not had an adverse effect on system operation or performance.

The inspectors noted that one of the change requests involved operation of the reactor water cleanup system pumps and valves has been open for 18 months and involved a technical disagreement on system operation between operations and engineering. The inspectors noted, and AmerGen acknowledged, that they do not have a process in place to resolve differing professional views or opinions. AmerGen initiated IR 808546 to document this concern.

Effectiveness of CAs

The inspectors concluded that CAs for identified deficiencies were typically timely and adequately implemented. AmerGen conducted in-depth effectiveness reviews for significant issues to determine if CAs were effective in resolving the issue. The inspectors identified a few minor instances where CAs were not fully effective in addressing underlying deficiencies. For significant conditions adverse to quality, the inspectors concluded that AmerGen's actions were comprehensive and successful at preventing recurrence.

The inspectors expanded the scope of review to five years during the review of the identification and resolution of issues associated with the containment spray system and the startup transformers. These systems have components where degradation may be age dependent, such as aging of electrical components or having components that may incur degradation due to interactions with raw water. Walkdowns of these systems did

not identify any new deficiencies. The inspectors noted that there were very few outstanding deficiencies associated with either system and that actions were underway to either monitor or correct the underlying conditions.

For IRs that involved equipment issues, ARs are placed into the work management system to drive the correction of the identified deficiency. IRs that have been assigned ARs are closed out as "complete" in the CAP, even if the work required to address the deficiency is not done. The expectation is that any actions taken to address the underlying conditions will be tracked and documented under the AR. Although this is permissible under AmerGen procedures, the inspectors determined that this process makes tracking the timely completion of corrective actions within the CAP challenging. The number of IRs that are open at any given point in time does not provide a true indication of how successful the station is at resolving corrective actions because, in these instances, the CAP does not track corrective actions beginning to end. For example, IR 772816 was listed as "complete" and the associated AR was "Routed." A status of "Routed" means that the work has yet to be scheduled. In another example, IR 781438 was listed as complete in the CAP and the associated PIMS AR is "Planned" but not yet worked. A status of "Planned" means that the work has been scheduled. This approach can create personal accountability issues because the PIMS AR process does not receive the same management and/or process rigor that IRs do through the CAP. In general, the inspectors noted that plant staff had difficulty showing that corrective actions generated in response to CAP IRs had been completed in a timely manner. The inspectors noted that similar concerns were documented in NRC Inspection Report 05000219/2008003.

In another example, deficiencies (loose keyway, pillow block problem) were identified in the spring of 2007 with the reactor building (RB) crane in WO R2085532. The crane is used to move highly radioactive waste and irradiated fuel in the spent fuel pool. Documentation in the WO indicated that these deficiencies were to be corrected during the performance of the spring 2008 inspection. These items were not corrected during this inspection and an additional set of deficiencies was identified in IR 761184. The RB crane was characterized in WO R2105552 as being in poor working condition and CAs were scheduled to take place prior to the next refueling outage. These CAs were not scheduled to occur prior to the next heavy load lift. In July 2008, the RB crane malfunctioned while moving a cask that contained highly radioactive components. Specifically, crane motion stopped while the cask was underwater and there was no change in radiation levels on the refueling floor as a result of this malfunction. The cause of the motion stoppage appeared to be related to limit switch malfunction which was identified during the spring 2008 inspection. AmerGen wrote an IR to acknowledge lack of timely corrective action for this condition. The inspectors reviewed this performance deficiency against the Occupational Radiation Safety cornerstone to determine if a single reasonable minor alteration in circumstances could have led to an unintended increase in worker dose. The inspectors considered a circumstance in which cask motion stopped with the cask out of the water at the worst case location along its intended travel path and determined that there would not have been any significant increase in worker dose. Based on this conclusion, this issue was not considered to be more than minor.

b. Assessment of the Use of Operating Experience

1. Inspection Scope

The inspectors reviewed a sample of industry operating experience (OE) issues to confirm that AmerGen evaluated the OE information for applicability to OC and took appropriate actions when warranted. The inspectors reviewed OE documents to determine that AmerGen appropriately considered the underlying problems associated with the issues for resolution via the CAP. The inspectors also observed plant activities to determine if industry OE was considered during the performance of routine and infrequently performed activities. A list of the documents reviewed is included in the Attachment to this report.

2. Assessment

The inspectors determined that AmerGen appropriately considered industry OE information for applicability, and used the information for corrective and preventive actions to identify and prevent similar issues. Industry OE was incorporated into the daily routine at OC as part of management meetings, as part of pre-job briefs and as part of pre-evolution briefs. The inspectors assessed that, in general, OE was appropriately applied and lessons learned were effectively communicated and incorporated into plant operations.

c. Assessment of Self-Assessments and Audits

1. Inspection Scope

The inspectors reviewed a sample of Quality Assurance (QA) audits, including the most recent audit of the CAP, focused area self-assessments (FASAs), and assessments conducted by independent organizations. These reviews were performed to determine if problems identified through these assessments were entered into the CAP when appropriate, and whether CAs were initiated to address identified deficiencies. A list of documents reviewed is included in the Attachment to this report.

2. Assessment

The inspectors concluded that self-assessments, QA audits, and other assessments were generally critical, probing, thorough and effective in identifying issues. The inspectors noted that audits and FASAs were completed in a methodical manner by personnel knowledgeable in the subject. The FASAs were generally comprehensive. However, the inspectors noted that the FASAs completed by the Security Department did not have external members on the team. AmerGen acknowledged this comment and will ensure that future security FASAs have external members. In general, the actions proposed for identified issues were commensurate with their safety significance.

d. Assessment of Safety Conscious Work Environment

1. Inspection Scope

During interviews with AmerGen personnel, the inspectors assessed whether there were issues that could have challenged the free flow of information or other factors that could

have resulted in a reluctance to raise safety concerns. The inspectors also assessed whether the plant staff was willing to enter issues into the CAP or raise safety concerns to their management and/or to the NRC. The inspectors interviewed the station employee concerns program investigator (ECI) and representative (ECR) to determine the number and types of issues being raised and entered into the employee concerns program (ECP). The inspectors reviewed a sample of the ECP files to assess the program's effectiveness in addressing potential safety issues.

2. Assessment

All persons interviewed demonstrated adequate knowledge of the CAP and ECP. Based on these interviews, the inspectors did not identify any reluctance to raise safety issues or any significant challenges to the free flow of information. The inspectors determined that site personnel were willing to raise safety issues and to document them in the CAP.

4OA6 Meetings, Including Exit

On August 8, 2008, the inspectors presented the inspection results to Mr. T. Rausch, Site Vice President, and to other members of the OC staff. The inspectors verified that no proprietary information is documented in the report.

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee personnel

J. Dent, Director, Work Management
J. Dostal, Shift Operations, Superintendent
S. Dupont, Regulatory Assurance Specialist
R. Ewart, Security Supervisor
J. Frank, Manager NSSS
T. Keenan, Site Security Manager
J. Kandasamy, Manager, Regulatory Assurance
G. Ludlam, Director, Training
P. Orphanos, Director, Operations
R. Peak, Director, Engineering
D. Pfeiffer, Manager Nuclear Oversight
J. Raby, Radiation Protection
J. Randich, Plant Manager
T. Rausch, Site Vice President
H. Ray, Manager, Engineering Programs
T. Schuster, Manager, Environmental/Chemistry Manager
T. Sexsmith, Manager Corrective Action Program
J. Vaccaro, Director, Maintenance
C. Williams, NSSS System Engineer

Others

R. Pinney, State of New Jersey, Bureau of Nuclear Engineering

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

None

LIST OF DOCUMENTS REVIEWED

Section 40A2: Identification and Resolution of Problems

Audits and Self-Assessments

NOSA-Audit- NOSA-OYS-08-03, 4/2008
NOSA-Audit- NOSA-OYS-06-03, 4/2006
NOSA-Audit- NOSA-OYS-07-04, 4/2007
NOSA-Audit- NOSA-OYS-06-05, 8/2006
NOSA-Audit- NOSA-OYS-08-02, Feb 2008
NOSA Audit- NOSA-OYS-07-03, Jan 2007
NOSA Audit- NOSA-OYS-06-02, Feb 2006

FASA 566867 OC Environmental Qualification
FASA 369728 Review NOS Identified Deficiencies from audit NOSA-OYS-05-06
FASA 513129 Review of Turnover of Records to Records Management
FASA 711832 Pre-NRC RETS Inspection
FASA 673565 Triennial Fire Protection Inspection Preparatory
FASA 713052 Pre-NRC PI&R
FASA 490540 Appendix J Program at OC
FASA 588029 BWRVIP Review Visit
FASA 583689 RP Pre-NRC Inspection
FASA 546944 OCNCS Thermal Performance Program Compliance
FASA 600161 GL 89-13 Safety-Related Service Water Program
FASA 673517 Configuration Changes and 10CFR50.59
FASA 600559 OC ISI Program
FASA 590856 OC 2006 AFI Identified Weakness in Contamination Control
FASA 709476 RP Pre-NRC Inspection
FASA 656857 Maintenance Rule Triennial Inspection
FASA 708733 System Manager Performance Monitoring
FASA 748943 EP Gaps to Excellence
FASA- NRC TI, 5-08-08
FASA- Security Equipment Aging Issue, 12-13-07
FASA- Shift Turnover, 10/24/07
FASA- NRC Nuclear Security Inspection, 5-24-07
FASA- NRC Protective Strategy Inspection, 9-26-08
FASA- Use of Corrective Action Process, 8-8-06
FASA- Annual NRC Inspection, 5-22-06
FASA- Implementation of MRM
Operations Department Audit (IR 627777)
OCNCS Operations Fundamentals FASA (IR 274824-10)
Operability Determination Assessment (IR 753010)
Oyster Creek Operations Shift Team Crew Rotation and Reassignment (IR 06522)
Maintenance Functional Area Audit (IR 441348/717288)
Pre-NRC PI&R Self Assessment (IR 713052)
Work Package Planning FASA (IR 478748)

<u>Issue Reports</u>	518098	581996	679066
274824	520272	583257	683499
348082	520272	588200	684762
350802	521070	591343	685170
350901	521448	600598	685385
354648	523632	601643	692898
380153	525820	606516	693434
388056	525934	613095	693664
427972	526403	613095	693693
431028	526540	613383	693746
435025	527010	618930	696955
441511	527354	619526	698258
446035	530357	622074	698887
446216	530716	622905	702125
450851	530995	622978	705651
453495	533865	623115	705914
456211	533909	623231	706579
461452	536990	623372	708301
478748	537785	630284	708309
485153	538498	630894	712360
486965	538851	631071	712803
487737	538852	631529	712984
487961	539100	634607	713052
488494	540059	635709	713248
490026	540235	636337	713652
491196	541475	637269	714001
491198	542375	646890	714203
492333	543809	648497	714539
492846	547173	650344	715412
492900	547452	650654	718763
493002	548555	653321	724107
494356	548830	653351	725612
494356	550164	654058	725687
495210	550437	655640	729035
495515	555536	655805	729449
498341	558072	656299	729704
498761	558975	657526	730440
500946	562382	659042	731707
503300	566768	659257	735153
50354	567038	660972	744793
503548	567406	661126	745133
504275	567913	661647	745761
505137	569463	664344	749568
507677	569753	664583	753010
508367	573229	668413	753895
508561	575493	669949	756045
511368	576533	671907	759293
511894	577200	673988	762054
513786	578193	675296	
514747	579111	676082	
515502	579363	677342	
517345	580144	678533	

762335	779599	795814
768799	780478	796851
771438	781786	796851
771926	781820	804975*
772915	783580	800158*
773248	786376	800166*
776035	787139	804871*
776539	789529	808546*
777254	793677	2099090
777334	794100	O2002-0758
777470	794100	O2004-3917
778233	795814	

*NRC Identified During Inspection

Drawings

DWG 302-650, Reactor Coolant System, Revision 55

Miscellaneous

C-1302-826-5360-001, Control Room/Cable Spreading Room Loss of Chilled Cooling Water, Rev. 4

C57.104-1991, IEEE Guide for the Interpretation of Gases Generated in Oil-Immersed Transformers, dated 06/27/91

NUREG-1482, Guidelines for Inservice Testing at Nuclear Power Plants, Rev. 1

OC-06-00926, ECP Isolation Condenser Heat Capacity Calculation, dated 11/10/2006

OCP-060522-1, Oyster Creek Operations Shift Team Crew Rotations and Reassignments

Planner Checklist

UFSAR Fig 8.2-1, 230-34.5 kV Substation – One Line Diagram

System Health Report, System 724 – Startup Transformers, dated 6/30/08

System Health Report, System 724 – Startup Transformers, dated 11/30/07

Bank 5 “A” Phase Voltage Regulator Investigation Results, dated 3/10/05

OpEval OC-2005-OE-0010, “Bank 5 - “A” Phase Voltage Regulator

Business Case Memorandum: “PD# 129171 – Bank 6 S/U Transformer Stabilization Plan – OC”, Rev. 1

Security Quarterly Safeguards log entries 2006-2008

Security Department 2006, 2007, 2008 OSHA Recordable Incidents

Action Requests

209909	619526	725612	2127878
354648	622074	745133	2145953
446216	630894	753985	2151327
468887	650344	756045	2151328
499515	655640	786386	2165966
581996	685170	793677	2173914
588200	693664	794100	2183631
611881	696955	795814	2183632
613095	713052	796851	2184773
618930	724107	2105304	40206012

Non-Cited Violations

NCV 2006006-01 Failure to Identify That an MSIV Did Not Close Within TS Surveillance Acceptance Criteria (IR 491198)

NCV 2007002-02 Improper Identification of an Inoperable fire Barrier Door (IR 578193)

NCV 2007002-02 'D' EMRV Adverse Trend Not Properly Identified (IR 567038)

NCV 2007003-01 Identification of Quality Assurance Test results for Effluent Monitoring Not Meeting Acceptance Criteria (IR 622978)

NCV 2007006-01 Inadequate Acceptance Criteria in Emergency Diesel Generator Battery Service Test procedure (IR 630284)

NCV 2007502-01 Failure to Require State PAR Notifications within 15 Minutes of Emergency Declaration (IR 671907)

NCV 2006007-03 Inservice Test Failure Not Identified and Evaluated for Containment Isolation Check Valve (IR 444055) (example –only)

NCV 2006003-01 Untimely Corrective Actions for the Standby Gas Treatment System (IR 495210)

NCV 2006003-02 Inadequate Scaffold Disassembly Results in Core Spray BoosterPump Unavailability (IR 504275)

NCV 2006003-03 Failure to Follow Procedures Results in a Hydrogen Detonation in Augmented Offgas System (IR 453495)

NCV 2006004-01 Fire Protection Plan Requirements Not Implemented (IR 521448)

NCV 2006004-04 Untimely Corrective Actions for the 'A' ESW Pump Breaker (IR 508367)

NCV 2006005-01 Inadequate Operability Determination Associated With Elevated Isolation Condenser Shell Temperatures (IR 540059)

NCV 2006005-02 Clearance Activity Performed Out of Sequence And Causes Trip of 'A'
Shutdown Cooling Pump (IR 547452)

NCV 2007004-02 Degraded Condition on the Remote Shutdown Panel Not Properly Identified
(IR 654058)

NCV 2007004-03 Improper Repair of a Fire Rated Penetration Seal (IR 646890 and 653351)

NCV 2007004-04 Inadequate Procedure Implementation during Response to a Reactor
Feedpump Trip and Reactor Scram (IR 653321)

NCV 2007005-03 Operations Personnel did not Appropriately Implement Reactor Startup
Procedure (IR 718763)

Findings

FIN 2006006-02 Failure to Take Timely Corrective Actions to Ensure the Availability and
Reliability of the Augmented Off-Gas System (IR 491196)

FIN 2007006-02 Inadequate Containment Hardened vent Valve Accumulator Test Criteria (IR
631071)

Operating Experience Issue Reports (IR)

772915	771926	685385
692898	776035	693746
508561	606516	693434
762054	684762	

NRC Information Notice 2005-14, Fire Protection Finding on Loss of Seal Cooling to
Westinghouse Reactor Coolant Pumps (example –only)

Procedures

- EI-AA-101, Employee Concerns Program, Revision 7
- EI-AA-101-1001, Employee Concerns Program Process, Revision 6
- EI-AA-101-1002, Employee Concerns Program Trending Tool, Revision 4
- EI-AA-100-1103, Employee Issues Advisory Committee Notification, Revision 0
- LS-AA-115, Operating Experience Procedure, Revision 11
- LS-AA-120, Issue Identification and Screening Process, Revision 7
- LS-AA-125, CAP Procedure, Revision 11
- LS-AA-125-1001, Root Cause Analysis Manual, Revision 6
- LS-AA-125-1002, Common Cause Analysis Manual, Revision 5
- LS-AA-125-1003, Apparent Cause Evaluation Manual, Revision 7
- LS-AA-125-1004, Effectiveness Review Manual, Revision 2
- LS-AA-125-1005, Coding and Analysis Manual, Revision 5

LS-AA-126, Self-Assessment Program, Revision 6
 LS-AA-126-1001, Focused Area Self-Assessments, Revision 5
 LS-AA-126-1005, Check-In Self-Assessments, Revision 4
 LS-AA-127, Passport Action Tracking Management Procedure, Revision 7
 131, Oyster Creek Load Lift Management Procedure, Rev. 3
 323, Main Condenser Circulating Water System Filling and Startup, Rev. 86
 323.3, Normal Operation of the Main Condenser Circulating Water System, Rev. 1
 323.6, Backwashing Condensers, Rev. 0
 331.1, Control Room and Old Cable Spreading Room Heating, Ventilation and Air Conditioning System, Rev. 23
 654.4.003, Control Room HVAC System Operability Test, Rev. 13
 EA-AA-2030, Conduct of Plant Engineering Manual, Rev. 7
 ER-AA-302-1006, Generic Letter 96-05 Program Motor-Operated Valve Maintenance and Testing Guidelines, Rev. 5
 ER-AA-302-1006, Generic Letter 96-05 Program Motor-Operated Valve Maintenance and Testing Guidelines, Rev. 6
 LS-AA-115, Operating Experience Procedure, Rev. 12
 MA-AA-716-021, Rigging and Lifting Program, Rev. 9
 MA-AA-716-022, Control of Heavy Loads Program, Rev. 4
 SY-OC-101-122-1003, Revision 1, "Explosive Detector and Walk Through Metal Detector Testing"
 SY-AA-101-112, Revision 14, "Searching Personnel, Vehicles, Packages, and Cargo"

Work Orders (WO)

C2009450	R0800786	R0802208	R2004854	R2094389	R2113921
A2166889	A2185706	A2147377	A2186890	A2196171	A2185573
A2186299	A2187183	A2189461	A2187184	A2187182	A2195166
A2201724	A2201727	A2201725			

LIST OF ACRONYMS

ACE	Apparent Cause Evaluations
ADAMS	Agencywide Documents Access and Management System
AmerGen	AmerGen Energy Company, LLC
AR	Action Request
CA	Corrective Action
CAP	Corrective Action Program
CCE	Common Cause Evaluations
ECI	Employee Concerns Investigator
ECP	Employee Concerns Program
ECR	Employee Concerns Representative
FASA	Focused Area Self Assessments
IMC	Inspection Manual Chapter
IR	Issue Report
MRC	Management Review Committee
NCV	Non-Cited Violation
NRC	U.S. Nuclear Regulatory Commission
OC	Oyster Creek Generating Station
OE	Operating Experience
PARS	Publicly Available Records
P&IR	Problem Identification and Resolution
QA	Quality Assurance
RB	Reactor Building
RCA	Root Cause Analysis
ROP	Reactor Oversight Program
SDP	Significance Determination Process
SO	Security Officer
SOC	Station Ownership Committee
WO	Work Order