



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION I
2100 RENAISSANCE BLVD.
KING OF PRUSSIA, PA 19406-2713

December 14, 2016

Mr. Bryan Hanson
Senior Vice President, Exelon Generation Co., LLC
President and Chief Nuclear Officer, Exelon Nuclear
4300 Winfield Rd.
Warrenville, IL 60555

**SUBJECT: OYSTER CREEK NUCLEAR GENERATING STATION –
PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT
05000219/2016008**

Dear Mr. Hanson:

On November 18, 2016, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution inspection at the Oyster Creek Nuclear Generating Station. The NRC inspection team discussed the results of this inspection with Mr. M. Gillin, Plant Manager, and other members of your staff. The results of this inspection are documented in the enclosed report.

The NRC inspection team reviewed the station's corrective action program and the station's implementation of the program to evaluate its effectiveness in identifying, prioritizing, evaluating, and correcting problems, and to confirm that the station was complying with NRC regulations and licensee standards for corrective action programs. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

The team also evaluated the station's processes for use of industry and NRC operating experience information and the effectiveness of the station's audits and self-assessments. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

Finally, the team reviewed the station's programs to establish and maintain a safety-conscious work environment, and interviewed station personnel to evaluate the effectiveness of these programs. Based on the team's observations and the results of these interviews, the team found no evidence of challenges to your organization's safety-conscious work environment. Your employees appeared willing to raise nuclear safety concerns through at least one of the several means available.

In all of the areas reviewed, the NRC inspectors did not identify any findings or violations of more than minor significance.

B. Hanson

-2-

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Sincerely,

/RA/

Silas Kennedy, Chief
Reactor Projects Branch 6
Division of Reactor Projects

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

Enclosure:
Inspection Report 05000219/2016008
w/Attachment: Supplementary Information

cc w/encl: Distribution via ListServ

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket Nos. 50-219

License No. DPR-16

Report Nos. 05000219/2016008

Licensee: Exelon Nuclear

Facility: Oyster Creek Nuclear Generating Station

Location: Forked River, New Jersey

Dates: October 31, 2016 - November 4, 2016, and
November 14 - 18, 2016

Team Leader: S. Barber, Senior Project Engineer

Inspectors: E. Andrews, Resident Inspector
N. Floyd, Reactor Inspector
R. Vadella, Project Engineer

Approved By: Silas R. Kennedy, Chief
Reactor Projects Branch 6
Division of Reactor Projects

Enclosure

SUMMARY

Inspection Report 05000219/2016008; 10/31/16 - 11/4/2016 and 11/14 – 18, 2016, Oyster Creek Nuclear Generating Station Biennial Baseline Inspection of Problem Identification and Resolution.

This NRC team inspection was performed by three regional inspectors and one resident inspector. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 5.

Problem Identification and Resolution

The inspectors concluded that Exelon was generally effective in identifying, evaluating, and resolving problems. Exelon personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. In most cases, Exelon appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Exelon typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Exelon adequately identified, reviewed, and applied relevant industry operating experience to Oyster Creek operations. In addition, based on those items selected for review, the inspectors determined that Exelon's self-assessments and audits were generally acceptable.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

No findings were identified.

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution (71152B)

This inspection constitutes one biennial sample of problem identification and resolution as defined by Inspection Procedure 71152. All documents reviewed during this inspection are listed in the Attachment to this report.

.1 Assessment of Corrective Action Program Effectiveness

a. Inspection Scope

The inspectors reviewed the procedures that described Exelon's corrective action program at Oyster Creek. To assess the effectiveness of the corrective action program, the inspectors reviewed performance in three primary areas: problem identification, prioritization and evaluation of issues, and corrective action implementation. The inspectors compared performance in these areas to the requirements and standards contained in Title 10 *Code of Federal Regulations* 50, Appendix B, Criterion XVI, "Corrective Action," and PI -AA-120, "Issue Identification and Screening." For each of these areas, the inspectors considered risk insights from the station's risk analysis and reviewed issue reports (IRs) selected across the seven cornerstones of safety in the NRCs Reactor Oversight Process. Additionally, the inspectors attended multiple Plan-of-the-Day, Station Ownership Committee, and Management Review Committee meetings. The inspectors selected items from the following functional areas for review: engineering, operations, maintenance, emergency preparedness, radiation protection, chemistry, physical security, and oversight programs.

(1) Effectiveness of Problem Identification

In addition to the items described above, the inspectors reviewed system health reports, a sample of completed corrective and preventative maintenance work orders, completed surveillance test procedures, operator logs, and periodic trend reports. The inspectors also completed field walkdowns of various systems on site, such as the safety related electrical and instrument air systems. Additionally, the inspectors reviewed a sample of issue reports written to document issues identified through internal self-assessments, audits, emergency preparedness drills, and the operating experience program. The inspectors completed this review to verify that Exelon entered conditions adverse to quality into its corrective action program, as appropriate.

(2) Effectiveness of Prioritization and Evaluation of Issues

The inspectors reviewed the evaluation and prioritization of a sample of issue reports issued since the last NRC biennial Problem Identification and Resolution inspection completed in October 2014. The inspectors also reviewed issue reports that were assigned lower levels of significance that did not include formal cause evaluations to ensure that they were properly 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 to address the identified causes.

Further, the inspectors reviewed equipment operability determinations, reportability assessments, and extent-of-condition reviews for selected problems to verify these processes adequately addressed equipment operability, reporting of issues to the NRC, and the extent of the issues.

(3) Effectiveness of Corrective Actions

The inspectors reviewed Exelon's completed corrective actions through documentation review and, in some cases, field walkdowns to determine whether the actions addressed the identified causes of the problems. The inspectors also reviewed issue reports for adverse trends and repetitive problems to determine whether corrective actions were effective in addressing the broader issues. The inspectors reviewed Exelon's timeliness in implementing corrective actions and effectiveness in precluding recurrence for significant conditions adverse to quality. The inspectors also reviewed a sample of issue reports associated with selected non-cited violations and findings to verify that Exelon personnel properly evaluated and resolved these issues. In addition, the inspectors expanded the corrective action review to five years to evaluate Exelon actions related to instrument air system deficiencies to ensure that they were adequately addressed for this risk significant system.

b. Assessment

(1) Effectiveness of Problem Identification

Based on the selected samples, plant walkdowns, and interviews of site personnel in multiple functional areas, the inspectors determined that Exelon identified problems and entered them into the corrective action program at a low threshold. Exelon staff at Oyster Creek initiated approximately 15,900 IRs between January 2015 and October 2016. The inspectors observed supervisors at the Plan-of-the-Day, Station Ownership Committee, and Management Review Committee meetings appropriately questioning and challenging issue reports to ensure clarification of the issues. Based on the samples reviewed, the inspectors determined that Exelon trended equipment and programmatic issues, and appropriately identified problems in issue reports. The inspectors verified that conditions adverse to quality identified through this review were entered into the corrective action program, as appropriate. Additionally, inspectors concluded that personnel were identifying trends at low levels. In general, inspectors did not identify any issues or concerns that had not been appropriately entered into the corrective action program for evaluation and resolution. In response to several questions during this inspection, Exelon personnel promptly initiated issue reports and/or took immediate action to address these issues.

(2) Effectiveness of Prioritization and Evaluation of Issues

The inspectors determined that, in general, Exelon appropriately prioritized and evaluated issues commensurate with the safety significance of the identified problem. Exelon screened issue reports for operability and reportability, categorized the issue reports by significance, and assigned actions to the appropriate department for evaluation and resolution. The IR screening process considered human performance issues, radiological safety concerns, repetitiveness, adverse trends, and potential impact on the safety conscious work environment.

Based on the sample of issue reports reviewed, the inspectors noted that the guidance provided by Exelon's corrective action program implementing procedures appeared sufficient to ensure consistency in categorization of issues. Operability and reportability determinations were generally performed when conditions warranted and in most cases, the evaluations supported the conclusion. Causal analyses appropriately considered the extent of condition or problem, generic issues, and previous occurrences of the issue. However, the inspectors did note an observation in Exelon's prioritization and evaluation of the following issue:

Categorization of NRC Non-Cited Violations

The inspectors reviewed a sample of 11 IRs associated with previously issued NRC non-cited violations (NCVs) and findings and determined that Exelon did not follow its own procedures for six of these IRs. PI-AA-120, "Issue Identification and Screening Process," requires that IRs documenting issues associated with the receipt of an NRC violation or finding be classified with significance level 3. Additional follow-up, such as a work group evaluation or apparent cause evaluation, is required for IRs designated as significance level 3. Six IRs were inappropriately categorized as significance level 4, and did not receive this additional level of scrutiny. This represents a missed opportunity for Exelon to understand the underlying performance issues that resulted in adverse conditions. Exelon documented this performance deficiency in IR 2737186.

The inspectors evaluated the deficiencies noted above for significance in accordance with the guidance in Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," and Appendix E, "Examples of Minor Issues." Although the significance level for these six IRs was not properly categorized, the inspectors noted that the underlying technical issues that resulted in the findings or NCVs were adequately addressed. Thus, the inappropriate categorization of these issue reports was considered to be a performance deficiency of minor significance and, therefore, not subject to enforcement action in accordance with NRC's Enforcement Policy.

(3) Effectiveness of Corrective Actions

The inspectors concluded that corrective actions for identified deficiencies were generally timely and adequately implemented. For significant conditions adverse to quality, Exelon identified actions to prevent recurrence. The inspectors concluded that corrective actions to address selected NRC non-cited violations and findings since the last problem identification and resolution inspection were timely and effective. The inspectors did observe some observations in Exelon's resolution of degraded conditions for the following two issues:

Missed Surveillance Tests

IR 2739733 documented that the completed surveillance tests for Core Spray System 1 Testable Check Valve, Core Spray System 2 Testable Check Valve, and Intermediate Range Monitor Range 9 could not be found and were presumed to be misplaced. This IR also stated that the Core Spray System 1 Testable Check Valve indicated open during the surveillance when the valve was verified shut locally, a potentially non-conservative condition. Although operator logs and a work tracking data base indicated that all three surveillance tests had been satisfactorily completed, the inspectors questioned the operability of these three systems because of a lack of quality assurance records documenting these activities.

The inspectors informed Exelon of these concerns. Subsequently, Exelon produced completed work documentation that showed that the indication for the Core Spray System 1 Testable Check Valve was successfully repaired, and post-maintenance testing was completed satisfactorily. The post-maintenance test for this repair included completing applicable portions of the surveillance test that would have been performed during the outage (i.e., the missed surveillance test). The inspectors reviewed both work documents and considered them to be acceptable. Therefore, there was reasonable assurance that the Core Spray System 1 Testable Check Valve remained operable.

Regarding the other two surveillances, Exelon implemented RM-AA-101-1008, "Processing and Storage of Records," Section 4.5, "Replacing Lost, Damaged, or Contaminated Documents (Records)." This section required reviewing operator logs and incident reports and conducting interviews with individuals who performed, reviewed, and approved the completion of the surveillance tests to verify that the remaining two surveillances were completed satisfactorily. The inspectors reviewed Exelon's actions for these two missed surveillance tests and considered them to be acceptable. Exelon entered this issue into the corrective action program as IRs 2742129 and 2742131

The inspectors evaluated this issue for significance in accordance with IMC 0612, Appendix B, "Issue Screening," and IMC 0612, Appendix E, "Examples of Minor Issues." Although three surveillance tests were not adequately documented, the inspectors noted that Exelon's documented actions provided reasonable assurance that all three systems remained operable. Thus, the inspectors determined this issue was minor, and, as a result, was not subject to enforcement action in accordance with NRC's Enforcement Policy.

Delayed Corrective Actions for Scram Discharge Volume Valve Vent Valves

In 2012, scram discharge volume (SDV) vent valve, V-15-119, failed during in-service testing. Exelon performed an equipment apparent cause evaluation (EACE) which determined the cause to be the air pressure regulator (APR) not bleeding air as a result of a 2010 modification when an APR with internal soft seats was installed. At that time, Exelon also determined that there were three SDV vent and drain valves with this susceptible design and that the non-safety related pressure regulator classifications should be reevaluated. Subsequently, Exelon generated engineering change request (ECR) 13-00358 to replace the APRs for these three scram discharge vent and drain valves, but only one of these APRs was replaced during the next refueling outage (1R25) in October 2014. Later, in early 2015, an NRC modifications team inspection reviewed these circumstances and issued a non-cited violation (NCV 2015008-02) for untimely corrective actions because Exelon did not restore design conformance for the other SDV vent and drain valves. This violation noted the APRs for the other two valves were not replaced at the first opportunity of sufficient duration, nor was the basis for deferral of corrective actions beyond plant restart from 1R25 documented, reviewed, and approved by site management and/or oversight organizations.

During a recent refueling outage (1R26) in October 2016, Exelon discovered that the SDV drain valve did not have an associated pressure regulator, and therefore, was acceptable per design. The inspectors noted that the pressure regulator replacement for the remaining SDV vent valve was de-scoped from the outage, but Exelon did not explicitly justify the deferral consistent with the operability procedure, OP-AA-108-115, "Operability Determinations." The inspectors determined that the failure to replace the remaining SDV vent valve was a performance deficiency that appeared similar to the previous NCV, but with several key exceptions.

Specifically, the inspectors noted that station management did review and approve the deferral of the pressure regulator replacement as documented in the outage scope reduction form 1R26-162 and in a supporting valve scope spreadsheet. Thus, the basis for deferral of corrective actions beyond plant restart from 1R26 was documented, reviewed, and approved by site management; however, not all of the criteria in OP-AA-108-115 were fully addressed. OP-AA-108-115 states, in part, that the justification should address the timing of corrective actions, the identified cause including contributing factors and proposed corrective actions, the existing conditions, and the basis for why the repair or replacement will not be accomplished prior to restart after a planned outage. Although not all of these criteria were satisfied, the inspectors noted that a sufficient number were satisfied to adequately address this issue. Exelon initiated IR 2742750 to document this performance deficiency.

The inspectors evaluated this issue for significance in accordance with IMC 0612, Appendix B, "Issue Screening," and IMC 0612, Appendix E, "Examples of Minor Issues." The inspectors noted that Exelon had an operability evaluation in the original issue report that showed that this non-conforming condition did not adversely impact the plant operation. Although the remaining SDV vent valve was not replaced, its failure would not result in a loss of safety function but merely a loss of redundancy, and therefore would not have a significant impact on plant operations. The inspectors determined this issue was minor, and, as a result, it was not subject to enforcement action in accordance with NRC's Enforcement Policy.

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

The inspectors reviewed a sample of issue reports associated with review of industry operating experience to determine whether Exelon appropriately evaluated the operating experience information for applicability to Oyster Creek and had taken appropriate actions, when warranted. The inspectors also reviewed evaluations of operating experience documents associated with a sample of NRC generic communications to ensure that Exelon adequately considered the underlying problems associated with the issues for resolution via its corrective action program. In addition, the inspectors observed various plant activities to determine if the station considered industry operating experience during the performance of routine and infrequently performed activities.

Assessment

The inspectors determined that Exelon appropriately considered industry operating experience information for applicability, and used the information for corrective and preventive actions to identify and prevent similar issues when appropriate. The inspectors determined that operating experience was appropriately applied and lessons learned were communicated and incorporated into plant operations and procedures, when applicable. The inspectors also observed that industry operating experience was routinely discussed and considered during the conduct of Plan-of-the-Day meetings and pre-job briefs.

b. Findings

No findings were identified.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors reviewed a sample of audits, including the most recent audit of the corrective action program, departmental self-assessments, and assessments performed by independent organizations. Inspectors performed these reviews to determine if Exelon entered problems identified through these assessments into the corrective action program, when appropriate, and whether Exelon initiated corrective actions to address identified deficiencies. The inspectors evaluated the effectiveness of the audits and assessments by comparing audit and assessment results against self-revealing and NRC-identified observations made during the inspection.

Assessment

The inspectors concluded that self-assessments, audits, and other internal Exelon assessments were generally critical, thorough, and effective in identifying issues. The inspectors observed that Exelon personnel knowledgeable in the subject completed these audits and self-assessments in a methodical manner. Exelon completed these audits and self-assessments to a sufficient depth to identify issues which were then entered into the corrective action program for evaluation. In general, the station implemented corrective actions associated with the identified issues commensurate with their safety significance.

b. Findings

No findings were identified.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

During interviews with station personnel, the inspectors assessed the safety conscious work environment at Oyster Creek. Specifically, the inspectors interviewed personnel to determine whether they were hesitant to raise safety concerns to their management and/or the NRC. The inspectors also interviewed the station Employee Concerns Program coordinator to determine what actions are implemented to ensure employees are aware of the program and its availability with regards to raising safety concerns. The inspectors reviewed the Employee Concerns Program files to ensure that Exelon entered issues into the corrective action program, when appropriate.

Assessment

During interviews, Oyster Creek staff expressed a willingness to use the corrective action program to identify plant issues and deficiencies and stated that they were willing to raise safety issues. The inspectors noted that no one interviewed stated that they personally experienced or were aware of a situation in which an individual had been retaliated against for raising a safety issue. All persons interviewed demonstrated an adequate knowledge of the corrective action program and the Employee Concerns Program. Based on these limited interviews, the inspectors concluded that there was no evidence of an unacceptable safety conscious work environment and no significant challenges to the free flow of information.

b. Findings

No findings were identified.

4OA6 Meetings, Including Exit

On November 18, 2016, the inspectors presented the inspection results to Mr. M. Gillin, Plant Manager, and other members of the Oyster Creek staff. The inspectors verified that no proprietary information was retained by the inspectors or documented in this report.

SUPPLEMENTARY INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

G. Stathes, Site Vice President
M. Gillin, Plant Manager
M. Arnao, Outage Manager
A. Beard, Senior Maintenance Program Specialist
M. Capone, Engineering Manager
D. Chernesky, Maintenance Director
J. Clark, Chemistry Manager
R. Dutes, Regulatory Assurance Specialist
R. Fitts, Senior Regulatory Specialist, CAP Manager
J. Jimenez, Senior Regulatory Assurance Specialist
T. Keenan, Site Security Manager
A. Krukowski, Shift Operations Superintendent (Acting)
M. McKenna, Regulatory Assurance Manager
H. Ray, Engineering Senior Manager
W. Sacareno, Engineering Manager
S. Schwartz, System Manager
J. Stanley, Engineering Director
E. Swain, Shift Operations Superintendent
T. Trettel, Instrument Air System Manager
J. Weissinger, Operations Director

LIST OF DOCUMENTS REVIEWED

Section 40A2: Problem Identification and Resolution

Audits and Self-Assessments

2403535, Infield Work Control, dated March 25, 2015
2410814, PM Program Check-In Self-Assessment, dated October 13, 2015
2410833, Operational Decision Making (ODM) Check-In, dated October 8, 2015
2411117, Plant Engineering KT&R Check-In Self-Assessment, dated December 30, 2015
2411365, Pre-NRC Force on Force Inspection Focused Area Self-Assessment, dated
January 26, 2015
2414882, Operating Experience (OPEX) Program Check-In Self-Assessment, dated
November 8, 2015
2414885, Oyster Creek Welding Activities Focused Area Self-Assessment, dated October 15,
2015
2414969, Equipment Important to Chemistry Reliability, dated March 31, 2015
2414989, Radworker Performance, dated June 10, 2015
2419972, 2015 NEI Force-on-Force Workshop, dated December 31, 2015
2441215, Fleet Maintenance and Test Equipment (M&TE) Process Check-In Self-Assessment,
dated July 2, 2015
2455539, Operation Fundamentals, dated December 17, 2015
2615273, Maintenance KT&R, dated October 28, 2016
2615741, Security Work Control & Project Analyst KT&R Check-In Self-Assessment, dated
October 25, 2016

Issue Reports

1172382	2471069	2567167
1180238	2474110	2568200
1182369	2474119	2568767
1221224	2474619	2585773
1339697	2475167	2587088
1430051	2478305	2594848
1438798	2481615	2598480
1516599	2482851	2600694
1523294	2483560	2607730
1537120	2486278	2612195
1647696	2489986	2612200
1661753	2491444	2612206
1670170	2493515	2612214
1697823	2495993	2615176
2390111	2496406	2618827
2394374	2497353	2665764
2407926	2498378	2665992
2409459	2498392	2670180
2411135	2505379	2671084
2423574	2507389	2671093
2431263	2513013	2674289
2438396	2514484	2696770
2438485	2515063	2698395
2439583	2515070	2701603
2440643	2515072	2702781
2441538	2515076	2702789
2447883	2522756	2702792
2448599	2528435	2706750
2449768	2533648	2714672
2450343	2536453	2720404
2450928	2538923	2733079
2451826	2542891	2733691
2451960	2542893	2733722
2453957	2543589	2737186*
2454436	2556385	2738660*
2454461	2560515	2742129*
2454466	2562493	2742131*
2454810	2563163	2742749*
2455504	2563651	2742750*
2458846	2566057	2742753*
2460874	2566064	
2468380	2566458	

*These IRs were generated from this inspection

Non-Cited Violations and Findings

05000219/2015001-01, Post Maintenance Test Results were not Evaluated to Assure that Technical Specifications Requirements were Satisfied
 05000219/2015001-02, Inadequate Post-Maintenance Testing for Emergency Service Water Pump Breaker
 05000219/2015002-01, Inadequate Assessment of Degraded 4k Emergency Switchgear Roll-Up Door Floor Gasket
 05000219/2015002-03, Reactor Water Cleanup Procedure Not Followed Resulting in a Level Transient 05000219/2015002-04, Reset of Automatic Voltage Regulator Controllers Led to an Automatic Reactor Scram
 05000219/2015003-01, Non-Conservative Temperature Input in the Electromatic Relief Valve Voltage Drop Calculation
 05000219/2015004-02, Inadequate Problem Identification and Resolution Leading to Degradation of EPR Causing a Reactor Scram
 05000219/2015008-02, Untimely Corrective Actions to Restore Design Conformance of Two SDV Vent & Drain Valves Pressure Regulator Valves
 05000219/2016001-001, Failure to Identify a Slower than Normal Scram Time of a Control Rod Drive
 05000219/2016001-02, Failure to Use Respiratory Protection as Required by Radiation Worker Permit/As Low as Reasonably Achievable Plan for Drywell Head Reassembly
 05000219/2016002-01, Inadequate Maintenance Procedure associated with Reactor Recirculation Pump Seal

Procedures

203, Plant Shutdown, Revision 88
 401.2, Nuclear Instrumentation SRM Channels Operation during Startup, Revision 16
 610.4.008, Core Spray Testable Valve Operability Test, Revision 16
 651.4.001, Standby Gas Treatment System Auto Actuation Test, Revision 72
 651.4.002, Standby Gas Treatment System 15-Minute Run – System 1, Revision 16
 ABN-1, Reactor Scram, Revision 13
 ABN-6, Control Rod Malfunctions, Revision 15
 EI-AA-101, Employee Concerns Program, Revision 11
 EI-AA-101-1001, Employee Concerns Program Process, Revision 9
 EI-AA-101-1002, Employee Concerns Program Trending Tool, Revision 5
 EP-011, Methodology for Assigning and Maintaining the Quality Classification of Components, Revision 15
 HR-AA-501, Exelon Nuclear Knowledge Transfer and Retention (KT&R) Process, Revision 8
 LS-AA-1003, NRC Inspection Preparation and Response, Revision 20
 LS-AA-1012, Safety Culture Monitoring, Revision 0
 LS-AA-120, Issue Identification and Screening Process, Revision 6
 LS-AA-125, Corrective Action Program, Revision 4
 NO-AA-210, Nuclear Oversight Regulatory Audit Procedure, Revision 7
 OP-AA-101-111-1001, Operations Standards and Expectations, Revision 18
 OP-AA-101-113, Operator Fundamentals, Revision 10
 OP-AA-108-115, Operability Determinations (CM-1), Revision 17
 PI-AA-115, Operating Experience Program, Revision 1
 PI-AA-120, Issue Identification and Screening Process, Revision 6
 PI-AA-125, Corrective Action Program (CAP) Procedure, Revision 4
 PI-AA-125-1004, Effectiveness Review Manual, Revision 1
 PI-AA-126, Self-Assessment and Benchmark Program, Revision 1
 PI-AA-126-1001, Focused Area Self-Assessment,
 PI-AA-126-1005, Check-In Self-Assessments, Revision 1
 PI-AA-1012, Safety Culture Monitoring, Revision 0

RAP-B6e, System 1 Temp Hi, Revision 2
 RAP-B6f, System 2 Temp Hi, Revision 2
 RM-AA-101-1008, Process and Storage of Records, Revision 8
 RP-AA-401, Operational Alara Planning and Controls, Revision 21
 WC-AA-106, Work Screening and Processing, Revision 16
 WC-AA-111, Surveillance Program Requirements, Revision 5

Work Orders

A2379492	C2030149	M2413348
A2404334	C2034491	R2111873
A2404335	C2034492	R2111873
A2404586	C2035783	R2245476

Miscellaneous

E-43746, AREVA Letter to NRC Follow-up Notification of Non-reportable Condition per 10 CFR Part 21, dated November 5, 2015
 ECR 13-00358, Replacement of Pressure Regulator on SDV Valves, Revision 0
 Management Review Committee Meeting Package, dated November 2, 2016
 Management Review Committee Meeting Package, dated November 3, 2016
 Management Review Committee Meeting Package, dated November 11, 2016
 Operations Log, dated November 1-17, 2016
 Oyster Creek Nuclear Generating Station Plan of the Day Package, dated November 2, 2016
 Plan of the Day Meeting Package, dated November 1, 2016
 Scope Change Request Form 1R26-162, dated August 12, 2016
 Scope Change Request Form 1R26-213, dated September 19, 2016
 Service, Instrument and Breathing Air Nuclear Plant Operator Initial Training, dated January 11, 2013
 Station Ownership Committee Meeting Package, dated November 1, 2016
 Station Ownership Committee Meeting Package, dated November 2, 2016
 Station Ownership Committee Meeting Package, dated November 14, 2016
 Station Ownership Committee Meeting Package, dated November 15, 2016

Surveillances

609.3.022, A Isolation Condenser Isolation Test and Calibration - A1 Sensors First, performed May 8, 2015
 609.3.023, B Isolation Condenser Isolation Test and Calibration - B1 Sensors First, performed May 8, 2015
 610.4.008, Core Spray Testable Check Valve Operability Test, performed October 8, 2016
 619.4.022, Scram Discharge Volume Vent and Drain Valve Functional Test, performed September 19, 2016
 634.2.307, Main Station C Battery Service Test, performed September 23, 2016

Drawings

BR 2013, Instrument (Control) Air System Flow Diagram, Sheet 6, Revision 89
 BR 2013, Service Air System Flow Diagram, Sheet 1, Revision 76
 GE885D781, Core Spray System Flow Diagram, Sheet 1, Revision 76

Evaluations

1575590, ESW Pump 52A Failure to Start, Breaker Failed to Close, dated December 2, 2013
 2412093, Reactor Re-criticality During Soft Shutdown, dated February 20, 2015
 2448320, Unexpected Half SCRAM on Reactor Protection System 1 Equipment Apparent Cause Evaluation, dated March 20, 2015
 2457598, Gaps in Maintenance Preparation for Work Execution, dated April 8, 2016
 2513715, Maintenance Response to Red Rating CPA 15-2, dated July 13, 2015
 2522667, LORT Biennial Requalification Exam Crew Failures, dated July 10, 2016
 2526892, Loss of Oyster Creek Siren System, dated August 20, 2015
 2537535, 1C 4160V Bus Protective Relay Surveillances Missed Apparent Cause Investigation Report, dated September 4, 2015
 2537994, Security Search Performance Not Meeting Expectations Apparent Cause Investigation Report, dated August 31, 2015
 2548558, Diesel-driven Fire Pump 1-1 Failure Apparent Cause Investigation Report, dated October 6, 2015
 2611369, Operating Crew Failure of EP Drill, dated February 10, 2016
 2636983, 2016 Operations WANO AFI – Ineffective Teamwork during Actual and Simulated Transients Apparent Cause Report, dated April 2, 2016
 2636999, 2016 WANO peer review AFI MA.1 Tools and Test Equipment, dated April 8, 2016
 2663436, 'D' Reactor Recirculating Pump Shaft Seal Failure, dated June 2, 2016
 2664038, Underlying Causes of Human Performance Trend, dated May 2, 2016
 2678195, 'D' Recirc Seal Inter-stage Leakage, dated July 8, 2016

Safety Conscious Work Environment

1Q16 & 2Q16 SCMP - Semi-Annual Senior Leadership Team Nuclear Safety Culture Health Review
 1Q16 & 2Q16 SCMP Report - Nuclear Safety Culture Monitoring Panel
 3Q15 & 4Q15 - Semi-Annual Senior Leadership Team Nuclear Safety Culture Health Review
 4Q15 SCMP Report - Nuclear Safety Culture Monitoring Panel
 3Q15 SCMP Report - Nuclear Safety Culture Monitoring Panel
 1Q15 & 2Q15 SCMP Report - Nuclear Safety Culture Monitoring Panel
 2Q15 SCMP Report - Nuclear Safety Culture Monitoring Panel
 1Q15 SCMP Report - Nuclear Safety Culture Monitoring Panel

LIST OF ACRONYMS

APR	air pressure regulator
IMC	Inspection Manual Chapter
IR	issue report
NRC	Nuclear Regulatory Commission
NCV	non-cited violation
PARS	Publicly Available Records System
SDV	scram discharge volume