

Oyster Creek 4Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Service Water System Procedure Quality

The inspectors identified a non-cited violation of Technical Specification 6.8.1 for failure to adequately maintain the Service Water System procedure on April 17, 2003. Specifically, the main control room copy of the procedure was not the latest revision and therefore did not reference valves added to the system during a modification which occurred in November, 2002. The finding adversely impacted the ability to determine the appropriate Service Water System standby status.

Inspection Report# : [2003003\(pdf\)](#)

Mitigating Systems

Significance: TBD Dec 31, 2003

Identified By: Self Disclosing

Item Type: AV Apparent Violation

Finding Regarding the May 2003 4160 V Cable Fault & Loss of the 1C 4160 V Bus

On May 20, 2003, the 1C 4160 VAC vital bus was lost because of a fault on the feeder cable from the EDG 1 output breaker. The cable fault occurred because AmerGen Engineering failed to identify in Nov. 2001, following another 4160 V cable failure, that the cable in question was of a type and in an adverse environment that rendered it susceptible to an identical fault. As a result, AmerGen took no action to evaluate, test and/or replace this cable in spite of that event and an identical failure in 1996 of the same cable, subject to similar adverse environmental conditions, on EDG 2.

Inspection Report# : [2003005\(pdf\)](#)

Significance:  Sep 10, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Operator error causes loss of 480V vital bus 1A2

An operator failed to follow Procedure 610.3.115, "Core Spray System 1 Instrument Channel and Level Bistable Calibration and System Operability Test." As a result, the operator tripped the feeder breaker to Bus 1A2 as opposed to tripping the breaker for Core Spray Pump 1A. This resulted in de-energizing the bus and its associated equipment. This equipment included two of the four loops of core spray and containment spray systems. Control Room operators determined the cause of the failure and restored power to the bus approximately 1 hour and 15 minutes later. No plant transient occurred as a result of this evaluation.

Inspection Report# : [2003005\(pdf\)](#)

Significance:  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

No. 1 EDG Inop due to Weak Evaluation

The inspectors identified a non-cited violation for failure to promptly identify and correct a condition adverse to quality in accordance with 10 CFR 50 App. B. Criterion XVI. Specifically, inadequate corrective actions and evaluations led to the inoperability of Emergency Diesel generator #1 on May 13, 2003. The inadequate corrective actions were taken after a normally full fuel oil sight glass was found half full.

Inspection Report# : [2003003\(pdf\)](#)

Barrier Integrity

Significance:  Mar 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Correction Action for Failure of SBGTS Fan EF-1-8

Green. A non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI (Corrective Action) was identified. Licensee failed to adequately correct a significant condition adverse to quality such that a subsequent repeat problem occurred. This deficiency relates to the licensee's insufficient corrective actions following the trip of an exhaust fan in the standby gas treatment system (SBGTS). Two weeks after corrective actions were completed, the fan tripped again under similar circumstances. This finding is more than minor because the licensee failed to adequately identify and correct the cause of the fan trip, which resulted in the train not being capable of performing its intended function for its required 30 day mission time. This finding is similar to Example 4.f of NRC Manual Chapter 0612, Appendix E, in that the failure to implement adequate corrective action affected the function of the SBGTS train. However, this finding was determined to be of very low safety significance (Green) using Phase 1 of the At-Power Reactor Safety Significance Determination Process because the finding only represented a degradation of the radiological barrier function provided by the standby gas treatment system.

Inspection Report# : [2003002\(pdf\)](#)

Significance:  Mar 28, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

No. 1 SGTS Inop due to Wrong Damper Position in Operating Procedure

Green. A non-cited violation of Oyster Creek Technical Specification 6.8, Procedures and Programs, was identified for failure to have an adequate operating procedure for the Standby Gas Treatment System. The procedure did not ensure that system operability was maintained while the system was in a standby alignment.

A self-revealing finding was identified. The finding is considered greater than minor in that the issue was associated with Barrier Integrity Cornerstone due to the inadequate procedure leading to SGTS1 being inoperable for five days. The finding is of very low safety significance because it only represented a degradation of the radiological barrier function provided for by the standby gas treatment system. In addition, standby gas treatment system 2 was operable during the entire time period system 1 was inoperable. This NCV was closed in IROC0302.

Inspection Report# : [2003002\(pdf\)](#)

Emergency Preparedness

Significance:  Sep 11, 2003

Identified By: NRC

Item Type: FIN Finding

Failing to submit ANS system changes to FEMA for review and approval prior to making changes

The licensee made changes to their ANS sometime in the late 1980s without prior review and approval from FEMA as per 44 CFR 350.14. But because a violation of FEMA requirements is outside of the NRC's purview, no enforcement action is being taken the NRC. Due to FEMA's evaluation that the licensee's changes would have been acceptable, this finding does not present an immediate safety concern. This issue was entered into the licensee's corrective action program (CAP 2002-0955). The licensee is aware that this change, and future changes to the ANS, must be submitted to FEMA for review and approval.

Inspection Report# : [2003008\(pdf\)](#)

Occupational Radiation Safety

Significance:  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to relocate WB dosimetry per RC procedure

The inspectors identified a non-cited violation of Technical Specification 6.8.1(a) involving failure to implement a radiological controls procedure (RP-AA-210) for relocation of personnel whole-body dosimetry when working in radiation dose rate gradients. Specifically, on October 22, 2002, the primary/secondary dosimeters of four radiation workers, working in the reactor refueling cavity, were not relocated even though they worked in radiation dose-rate gradients requiring such relocation. Although the issue was documented in the licensee's dose assessment program, the issue had not been entered into the licensee's corrective action process and had not been identified as a Performance Indicator occurrence.

Inspection Report# : [2003003\(pdf\)](#)

Public Radiation Safety

Physical Protection

Significance:  Jun 28, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

License Violation Due to Security Officer Inattentive to Duty

A self-revealing was identified. A non-cited violation of the Order Modifying License, dated February 25, 2002, and

the prescribed "Interim Compensatory Measures for High Threat Environment (ICM)," relative to failure to maintain the Vehicle Barrier System as required by the ICM. Specifically, inattentiveness by security force personnel, who were assigned to a function that was prescribed by a specific ICM set forth by the Order Modifying License, resulted in a condition in which the Vehicle Barrier System (VBS) was not effectively maintained in accordance with the conditions of the Order Modifying License.

Inspection Report# : [2003003\(pdf\)](#)

Miscellaneous

Last modified : March 02, 2004