

## Oyster Creek 2Q/2004 Plant Inspection Findings

### Initiating Events

**Significance:** G Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Correct a Condition Adverse to Quality - RRCS Voltage Control Circuit**

The inspectors identified a non-cited violation of 10 CFR part 50 Appendix B, Criterion XI for failure to adequately correct a condition adverse to quality affecting the recirculation pump voltage regulator card which resulted in the trip of the 'D' recirculation pump during four loop full power operations. The licensee replaced the failed components on the voltage regulator cards of all five recirculation loops and have returned them to service. This finding is greater than minor because it had an actual impact on the operations of the plant. It increased the likelihood of a plant transient, therefore it had an impact on effect on initiating events. The finding is of very low safety significance because the finding does not contribute to a primary or secondary system LOCA initiator, the finding does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and the finding does not contribute to the likelihood of a fire or internal/external flood. This finding has a cross-cutting aspect of PI&R in that engineering evaluation of External Operating Experience and corrective action implementation was inadequate to prevent a similar condition at the site.

Inspection Report# : [2004003\(pdf\)](#)

**Significance:** N/A May 21, 2004

Identified By: Self Disclosing

Item Type: FIN Finding

#### **Identification and Resolution of Problems**

The team determined that AmerGen was generally effective at identifying discrepant conditions at an appropriate threshold and entering them into the corrective action program. Identified issues were typically prioritized appropriately and in a timely fashion and were properly evaluated commensurate with the potential safety significance. Overall, the evaluations reasonably identified the causes of the problem, the extent of the condition, and provided for corrective actions to address the causes. However, in some cases, the corrective action program was not effectively used to evaluate, resolve and prevent problems. There were also some examples where issue evaluations were not complete, and corrective actions were not effective at resolving problems. Audits and self-assessments identified adverse conditions and negative trends, and were generally self-critical and consistent with the team's findings. On the basis of interviews conducted, the team determined that plant staff personnel were familiar with and utilized the corrective action program to identify problems.

Inspection Report# : [2004006\(pdf\)](#)

### Mitigating Systems

**Significance:** G Jun 30, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

#### **Inadvertent Loss of Shutdown Cooling**

A self-revealing event involving an inadvertent loss of shutdown cooling resulted in a Green finding and non-cited violation (NCV) for failure to establish and maintain appropriate procedural requirements for the operation of the shutdown cooling system, as prescribed by Technical Specification 6.8.1 and the Oyster Creek Operation Quality Assurance Plan. The finding was more than minor because the procedural control deficiency actually led to a trip of the shutdown cooling system isolation actuation logic and a resultant loss of the normal shutdown decay heat removal capability. Therefore, this deficiency affected the availability of the decay heat removal function during shutdown operational conditions.

Inspection Report# : [2004003\(pdf\)](#)

**Significance:** TBD Jun 30, 2004

Identified By: Self Disclosing

Item Type: AV Apparent Violation

#### **Human Performance Event Failure to Follow Procedures Led to Failure of Cooling System for EDG #1 on May 17, 2004.**

A self-revealing event involving an inadvertent loss of the #1 Emergency diesel generator (EDG) cooling fan resulted in identifying a preliminary White finding and apparent violation for failure to implement appropriate procedural requirements for the maintenance of the #1 EDG system during an overhaul conducted April 26 - 30, 2004, as prescribed by Technical Specification 6.8.1. The finding was more than minor because it affected the mitigation system cornerstone objective to ensure the availability, reliability, and capability of systems (emergency AC power) that respond to initiating events to prevent undesirable consequences and the related attributes of equipment performance, human performance, and procedure quality. A Phase 1 SSDP determined that the finding represented a degradation in both the mitigating systems and barrier integrity cornerstones, because both core spray and containment spray systems were affected. Since the #1 EDG was inoperable for a period of 17 days (April 30 - May 17), exceeding the Technical

Specification Allowed Outage Time of 7 days, the finding required a Phase 2 approximation. The Phase 2 evaluation of this finding resulted in a White finding based on a Loss of Offsite Power and failure to recover power. Also, this finding has a cross-cutting aspect of human performance in that technicians failed to follow written procedures when replacing the fan belts for the #1 emergency diesel generator during a two-year overhaul in April 2004.

Inspection Report# : [2004003\(pdf\)](#)

**Significance:** **G** May 21, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Perform Corrective Actions for Mode Switch Failure on August 14, 2003**

The finding was determined to be more than minor because it negatively affected the mitigating systems cornerstone attribute of human performance. Failure to place the reactor mode switch into the shutdown position following a reactor scram would be expected to result in a loss of the normal heat sink and complicate the event response. The finding was of very low safety significance (Green), because it was not a design or qualification deficiency, and it did not result in an actual loss of safety function for risk-significant equipment with respect to internal or external events. Additionally, the team noted that the heat sink would be recoverable from an event of this type.

Inspection Report# : [2004006\(pdf\)](#)

**Significance:** **G** Mar 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Operability Evaluations**

A Green NCV was identified for failure to adequately maintain the ESW Pump Trouble alarm response procedure as required by Technical Specification (TS) 6.8.1., due to an erroneous operability evaluation compensatory action.

Closed in IR OC0402

Inspection Report# : [2004002\(pdf\)](#)

**Significance:** **W** Jan 22, 2004

Identified By: NRC

Item Type: VIO 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:** **G** 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\(pdf\)](#)

## **Barrier Integrity**

**Significance:** **G** Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Operator Failure to Recognize Degraded Secondary Containment Airlock**

The inspectors identified a Green finding and non-cited violation (NCV) for failure to identify a condition adverse to quality when a secondary containment airlock door was found open resulting in a momentary violation of Technical Specification 3.5.B and Procedure 312.10, "Secondary Containment Control," Rev. 8. The airlock doors function to ensure secondary containment integrity and to support the SGTS capability to maintain a negative pressure in the reactor building and minimize ground level releases of radioactive materials. The finding was more than minor because the failure to timely identify the condition adverse to quality for the airlock door led to inappropriate controls being used to override the interlock. If left

uncorrected this condition could have led to a more significant event involving a failure of airlock because of interlock failure. Also, this condition is associated with the Reactor Safety Barrier Integrity Cornerstone and affects the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radio nuclide releases from accidents or events. In addition to the PI&R cross-cutting aspect in failing to identify a condition adverse to quality, this finding has a cross-cutting aspect of human performance, in that operators failed to adhere with procedures and expectations in response to the degraded secondary containment airlock door.

Inspection Report# : [2004003\(pdf\)](#)

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## 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\(pdf\)](#)

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## Occupational Radiation Safety

**Significance:**  Mar 31, 2004

Identified By: Self Disclosing

Item Type: FIN Finding

### ALARA Planning and Controls

A self-revealing finding having very low safety significance associated with occupational radiation exposure reduction was identified. During the Fall 2002 refueling outage, conduct of reactor vessel reassembly activities resulted in 12.4 person-rem of collective radiation exposure on an exposure estimate of 6.5 rem. This work activity was 90% above its estimate. FIN opened in IR OC0402

Inspection Report# : [2004002\(pdf\)](#)

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**Significance:**  Mar 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### Access Control to Radiologically Significant Areas

On March 18, 2004, the inspector determined that secondary keys for locked High Radiation Areas were not maintained under the administrative control of operations and/or radiation protection supervision on duty to prevent unauthorized entry. The keys were accessible to unauthorized personnel. This is a violation of Technical Specification 6.13.2. closed in IR OC0402

Inspection Report# : [2004002\(pdf\)](#)

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**Significance:**  Mar 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### Radiation Monitoring Instrumentation and Protective Equipment

On March 18, 2004, the inspector identified that AmerGen was not functionally testing self-contained breathing apparatus (SCBAs) in accordance with the manufacturer's recommendations. This is a violation of 10 CFR50.47(b)(10) associated with failure to maintain protective measures for emergency workers. closed in IR OC0402

Inspection Report# : [2004002\(pdf\)](#)

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## Public Radiation Safety

## **Physical Protection**

[Physical Protection](#) information not publicly available.

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## **Miscellaneous**

Last modified : September 08, 2004