Oyster Creek
3Q/2004 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Green NCV was identified for failure to correct a condition adverse to quality affecting IRMs causing a reactor scram
A self-revealing non-cited violation of 10 CFR 50 Appendix B Criterion XVI was identified for failure to adequately correct a condition adverse to quality affecting the Intermediate Range Monitor (IRM) System which resulted in a reactor scram while at 2% power operations. The reactor protection system processed IRM Hi-Hi/INOP on channels 13, 14, and 18 IRMs, while operators were driving the Source Range Monitor (SRM) detectors into the core. AmerGen initiated an investigation into the issue and CAP O2004-1314 was written in order to document the associated corrective actions to prevent recurrence.
Inspection Report# : 2004004*(pdf)*

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 Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
NCV was identified for an inadequate procedure that resulted in a loss of shutdown cooling
A self-revealing non-cited violation of Technical Specification 6.8.1 was identified because procedures for restoration of the shutdown cooling system were not adequate. This resulted in the loss of shutdown cooling while removing trip logic bypass jumpers in order to restore the shutdown cooling system to power operation standby readiness requirements in the plant technical specifications. Upon realization of the loss

of shutdown cooling system, plant operators returned the shutdown cooling system to operation.
Inspection Report# : 2004004*(pdf)*

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 SDP 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
Inadequate ESW Procedure due to poor operability evaluation
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. This NOV closed in IR2004007, by Neil Della Greca.

Inspection Report# : 2003005*(pdf)*
Inspection Report# : 2004007*(pdf)*

Barrier Integrity

Significance: G Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
A self-revealing Green NCV was identified for failure to adequately correct a condition adverse to quality affecting a Main Steam Isolation Valve.affecting a Main Steam Isolation Valve.
A self-revealing Green NCV was identified for failure to adequately correct a condition adverse to quality affecting MSIV, NS04A, which resulted in the failure of the MSIV to close during testing. Contrary to 10 CFR 50 Appendix B, AmerGen failed to timely implement the installation of the back-seat modification provided in the 1993 GE SIL 568 and take proper action to reduce the MSIV susceptibility to rib guide wear and subsequent failure to close. This was entered into the AmerGen corrective action program under CAP O2004-2499.
Inspection Report# : 2004004*(pdf)*

Significance: G Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
NCV was identified for failure to maintain the core thermal power below the licensed limit
A self-revealing non-cited violation of Operating License No. DPR-16, Section 2.C.(1) was identified because operators exceeded the licensed thermal power limit of 1930 MWt by approximately 0.4% for a period of approximately 19 hours. When identified, Oyster Creek operators reduced power until steady state core thermal power was below 1930 MWt.
Inspection Report# : 2004004*(pdf)*

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)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G 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)*

Significance: G 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)*

Significance: G 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)*

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : December 29, 2004