January 17, 2002

Mr. Ron J. DeGregorio
Vice President Oyster Creek
AmerGen Energy Company, LLC
P.O. Box 388
Forked River, New Jersey 08731

SUBJECT: OYSTER CREEK GENERATING STATION - NRC INTEGRATED INSPECTION REPORT 50-219/01-10

Dear Mr. DeGregorio:

On December 30, 2001, the NRC completed an integrated inspection at your Oyster Creek reactor facility. The enclosed report documents the inspection findings which were discussed on January 15, 2002, with you and other members of your staff.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, the inspectors identified one issue of very low safety significance (Green). This finding was determined to involve a violation of NRC requirements. However, because of the very low safety significance and because the issue has been entered into your corrective action program, the NRC is treating this issue as a Non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Oyster Creek facility.

Immediately following the terrorist attacks on the World Trade Center and the Pentagon, the NRC issued an advisory recommending that nuclear power plant licensees go to the highest level of security, and all promptly did so. With continued uncertainty about the possibility of additional terrorist activities, the Nation's nuclear power plants remain at the highest level of security and the NRC continues to monitor the situation. This advisory was followed by additional advisories, and although the specific actions are not releasable to the public, they generally include increased patrols, augmented security forces and capabilities, additional security posts, heightened coordination with law enforcement and military authorities, and more limited access of personnel and vehicles to the sites. The NRC has conducted various audits of your response to these advisories and your ability to respond to terrorist attacks with the capabilities of the current design basis threat (DBT). From these audits, the NRC has concluded that your security program is adequate at this time.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. (the Public Electronic Reading Room).

Sincerely,

/RA Curtis J. Cowgill for/

John F. Rogge, Chief
Projects Branch No. 7
Division of Reactor Projects

Docket No. 50-219
License No. DPR-16

Enclosure: Inspection Report 50-219/01-10
Attachment: Supplemental Information

cc w/encl:
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U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Report No.	50-219/01-10
Docket No.	50-219
License No.	DPR-16
Licensee:	AmerGen Energy Company, LLC (AmerGen)
Facility:	Oyster Creek Generating Station
Location:	Forked River, New Jersey
Dates:	November 11 - December 30, 2001
Inspectors:	Laura A. Dudes, Senior Resident Inspector Steve Dennis, Resident Inspector David M. Silk, Senior Emergency Preparedness Inspector, November 20-21, 2001 Jason Jang, Senior Radiation Specialist, December 10-14, 2001
Approved By:	John F. Rogge, Chief Projects Branch 7 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000219-01-10, on 11/11-12/30/01, AmerGen, Oyster Creek Generating Station, resident inspector report. Emergent work.

The inspection was conducted by resident and regional inspectors. This inspection identified one Green finding. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/reactors/operating/oversight.html .

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

- Green. The inspectors identified a Non-Cited Violation for failure to follow procedures (Technical Specification 6.8.1). The inspectors observed multiple examples of failure to follow a maintenance work order during an emergent 4160 volt safety related electrical cable replacement. Additionally, quality verification witness points were established but not verified by qualified inspectors. However, this failure was considered to have very low safety significance using the SDP phase 1 assessment since the post maintenance testing was successfully completed which indicated the cable in-service performance was satisfactory. **(NCV 50-219/01-10-02)**

B. Licensee-Identified Findings

A violation of very low safety significance which was identified by the licensee has been reviewed by the inspector. Corrective actions taken or planned by the licensee appear reasonable. This violation is listed in Section 4OA7 of this report.

Report Details

Summary of Plant Status:

Oyster Creek began the inspection period at full power. On November 11, 2001, a safety related electrical cable failure resulted in a technical specification (TS) required plant shutdown. The licensee conducted a maintenance outage to replace portions of the electrical cable and perform other maintenance activities on plant equipment. A reactor startup commenced on November 17, 2001, and criticality was achieved November 18, 2001. Full power was achieved on November 20. A planned power reduction occurred on December 8, 2001, in order to perform core maneuvers for reactivity flux shaping. Reactor power was reduced to 50 percent and returned to 100 percent after approximately 12 hours. The plant remained at full power for the duration of the inspection period.

1. REACTOR SAFETY

Initiating Events, Mitigating Systems, Barrier Integrity (REACTOR-R)

1R01 Adverse Weather Protection

Winterization

a. Inspection Scope

The inspectors reviewed plant procedures, system readiness reviews, action requests, and the status of corrective actions identified during the previous cold weather season to verify the ability of systems to function in the winter climate. Additionally, the inspectors walked down portions of the Emergency Service Water, Service Water, Fire Water, Circulating Water, and Plant Heating systems to verify that the maintenance work performed on heat tracing, insulation and other portions of those systems was completed in accordance with the sampled associated work packages. The following documents were reviewed.

- Exelon Seasonal Readiness Procedure
- Winter Readiness Plan - 2000-PLN-3000.02
- Action Request - A2009785
- CAPs: 1999-1469, 2000-0072, 2000-0035, 2000-0082, 2000-0137, 2000-0181, 2000-2028, 2000-2154, 2001-0091, and 2001-1865.
- Matrix of Heating Steam work requests.

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment

a. Inspection Scope

Partial walkdown inspections were performed on the systems listed below. A random sampling of valve positions in the field were verified to be properly aligned in accordance with operating procedures. Control room indications and controls were verified to be appropriate for the standby or operating status of the system and system maintenance action requests were reviewed to assure no degraded conditions existed to adversely affect operability.

- Shutdown Cooling
- Core Spray Systems 1 and 2

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors conducted fire protection inspection activities consisting of plant walkdowns, discussions with fire protection personnel, and reviews of procedure 333, “Plant Fire Protection System,” and the Oyster Creek Fire Hazards Analysis Report to verify that the fire program was implemented in accordance with all conditions stated in the facility license. Plant walkdowns included observations of combustible material control, fire detection and suppression equipment availability, and compensatory measures. The inspectors conducted fire protection inspections in the following areas due to the potential to impact mitigating systems:

- Main Control Room
- Lower Cable Spreading Room
- Diesel Fire Pump building
- Switchyard Blockhouse
- Station Blackout Transformer Deluge System
- General Area Tour Reactor Building 95' Elevation

b. Findings

No findings of significance were identified.

1R07 Heat Sink Performance

a. Inspection Scope

The inspector reviewed heat transfer calculations for the emergency condenser system. The inspector also reviewed calculations C-1302-211-5300-046, C-1302-211-E540-099 and C-1302-211-E540-124 associated with the potential effects of non-condensible gases on the heat transfer coefficient for the emergency condensers. In addition, the inspector reviewed procedure 2400-SMM-3216.03, "Isolation Condenser Inspection and Maintenance." The inspector verified that the isolation condensers were capable of meeting the requirements specified in TS 3.8 and the design heat removal capacity as described in the Updated Final Safety Analysis Report (UFSAR) section 6.3.1.1.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors selected the following safety significant systems in (a)(1) and (a)(2) status to verify that: (1) failed structures, systems and components (SSCs) were properly characterized, (2) goals and performance criteria were appropriate, (3) corrective action plans were appropriate, and (4) performance was being effectively monitored:

- Cask Drop Protection System (a)(2)
- Reactor Building Ventilation System (a)(1)
- 125v DC System (Station Battery 'B', CAP 2001-1735) (a)(2)
- Fire Barriers (fire barrier penetration leak, CAP 2001-1678) (a) (2)

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation

Installation of Safety Related 4160 volt cable

a. Inspection Scope

On November 11, 2001, a safety related 4160 volt electrical cable failed, resulting in a technical specification required shutdown of the plant. Troubleshooting revealed the failure was located in one portion of the primary 4160 volt feeder cable and a replacement plan was developed. The inspector observed maintenance activities surrounding the emergent 4160 volt cable replacement and also reviewed the following documents.

- Action Request (A/R) A2019176 - Direction for 1B2 Cable Splicing.
- Work Order (WO) C20011833 - Replace the 1B2 Primary Feeder Cables.
- Corrective Action Process (CAP) No. 2001-1753 & 2001-1754 - Electrical Termination Taping and Raychem Splicing.
- CAP N0. 2001- 1770 - Issues affecting ability to execute cable repair and splice.
- Cable Failure Matrix.

b. Findings

The inspector identified a finding of very low safety significance (GREEN) associated with the licensee's failure to follow maintenance and quality assurance procedures while splicing a 4160 volt safety related cable.

The inspector observed portions of the cable splice jacketing work performed on the "C" phase of the cable and noted the following: The inspector observed the use of an oxy-acetylene torch to heat shrink the outer jacket on the splice, however, the use of the torch was not authorized by the work order. Engineering evaluation number seven associated with the parent WO C2001833, provides specific details for the splice kits to be used and methods for performing the work. The work was performed outside of this engineering instruction. The method was later approved by licensee engineering after their discussions with the jacket material manufacturer and further engineering evaluation. Nevertheless, maintenance personnel deviated from a safety related maintenance WO without proper direction from the engineering staff.

The inspector also observed the cable splice crimping work activities and noted the following discrepancies which deviated from the original WO. Neither the tool nor the die used to perform the crimp on the first phase ("C") was recorded in the work package. The lug manufacturer specifies unique hydraulic tool and dies for the various lugs produced. WO #C2001833, states that the crimp should be performed in accordance with manufacturer's instructions. The inspector noted that a hydraulic tool that was not specified in the work order, the manufacturers instructions or any other licensee controlled maintenance procedure was used to perform the crimp on the cable splice, although the manufacturer outlined the appropriate type of tool to be used with different size dies. In addition, the die used to perform the crimp was also not specified in the work package. After the inspector raised these issues, the licensee performed an engineering evaluation to specify the equipment used for the splice. The evaluation provided more details about the work activity and documented the tools used during the crimping process. This is a second example of maintenance personnel deviating from the safety related WO without appropriate engineering direction.

Corrective maintenance WO #C2001833, activity 16, specifically states quality verification (QV) personnel must witness the installation of the cable splice in accordance with the work order and the manufacturers instructions. Procedure 2000-PLN-7200.01, "Oyster Creek Operational Quality Assurance Plan," requires individuals who perform quality inspections are knowledgeable of the activity performed and are qualified to perform the work.

Contrary to the above, during the splicing of the second phase of the cable, a QV inspector who did not have the electrical training or qualifications to inspect medium

voltage cable splices was present and verified the acceptance of the second splice. Procedure 2000-PLN-7200.01, "Oyster Creek Operational Quality Assurance Plan," requires individuals who perform quality inspections are knowledgeable of the activity performed and are qualified to perform the work. The inspector determined that a qualified QV inspector had verified the first cable phase splicing activity. The licensee indicated that verification of all of the splices was unnecessary once the maintenance crew demonstrated proficiency with the splicing process. However, the work crew performing the splices had changed and therefore the second cable splice was performed by a maintenance crew that had not demonstrated proficiency performing any portion of the splicing process for a qualified QV inspector.

This issue is considered to be more than minor since multiple deviations from a safety related maintenance WO and inadequate QV verifications could be a precursor to a significant degradation in the quality of a safety related electrical cable. The issue affects the mitigating system cornerstone since the reliability of nuclear safety related electrical cable and its associated safety related equipment could be affected. However, the failure to follow the manufacturers instructions as described in the work order and the failure to have a qualified QV inspector verify the second crimp was considered to have very low safety significance using the Significance Determination Process (SDP) phase 1 assessment since the post maintenance testing (PMT) was successfully completed which indicated the cable in-service performance was satisfactory.

The above stated multiple deviations from safety related maintenance procedures and inadequate QV verification of a safety related 4160 volt cable splice is a violation of TS 6.8.1 which requires, in part, that written procedures shall be implemented as recommended in Appendix "A" of Regulatory Guide 1.33. Regulatory Guide 1.33 Appendix A.9 identifies the requirement for having a procedure for safety related maintenance. In addition, procedure 2000-PLN-7200.01, "Oyster Creek Operational Quality Assurance Plan," section 6.0 establishes criteria for quality verification personnel to establish witness points for safety related activities and be appropriately qualified to perform these inspections. This violation is being treated as a Non-Cited Violation (NCV) consistent with section VI.A.1 of the NRC Enforcement Policy. The licensee entered this issue into the CAP (2001-1770). **(NCV 50-219/01-10-02)**

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed operability evaluations associated with the following plant equipment deficiencies to verify that all equipment was capable of performing its design basis function and in order to determine that operability justifications were performed in accordance with procedures OC-2, "Operability Review and Analysis," and 2000-ADM-7216.01, "Corrective Action Process." In addition, where a component was determined to be inoperable, the inspectors verified the TS Limiting Condition for Operation (LCO) implications were properly addressed.

- A/R A2019811, No power to fans which provide cooling to the 1B2 Transformer
- CAP 2001-1735, Main Station Battery, untimely return of battery to equalize

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspector reviewed and observed portions of the PMT associated with the following maintenance activities because of their function as mitigating systems and their potential role in increasing plant transient frequency. The inspectors reviewed the post maintenance test documents to verify that they were in accordance with the licensee's procedures and that the equipment was restored to an operable state.

- Core Spray Booster Pump 3B breaker, trip shaft and under voltage checks (WO R080729101). Performed 610.4.002, "Core Spray Pump Operability Test" as the PMT.
- "A" Recirculation Pump Motor Generator (MG) Set, inspection, oil samples, 4160V breaker preventive maintenance (PM) (WOs R080552402, R080552401, R080530801). The pump was returned to service following maintenance and a visual inspection was satisfactory.
- Containment Spray Pump 1-1, 480V breaker maintenance (WO R080726701). Performed 607.4.004, "Containment Spray/ESW System 1 Pump Operability Test" as the PMT.
- Standby Gas Treatment System Exhaust Fan 1-8, motor bearing replacement (WO C2002067). Performed portions of 651.4.001, "Standby Gas Treatment System Test" as the PMT.

b. Findings

No findings of significance were identified.

1R20 Refueling and Outage Activities

Maintenance Outage to Replace 4160 Primary Cable after In-Service Failure

a. Inspection Scope

The inspectors observed portions of the plant shutdown and startup and verified those activities were in accordance with Plant Operating Procedures (POP) 201 and 203 respectively. In addition, during the outage the inspectors reviewed the daily outage risk assessments and verified the equipment alignments used to support the assessments. Lastly, the inspectors monitored the availability of the decay heat removal system due to limited electrical power for shutdown cooling pumps.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspector observed pre-test briefings and portions of the surveillance test (ST) performance for procedural adherence, and verified that the resulting data associated with the test met the requirements of TSs. The inspector also reviewed the results of past performances of the ST to verify that degraded or non-conforming conditions were identified and corrected. The following STs were observed:

- Procedure 619.3.011, "Scram Discharge Instrument Volume Calibration and Test"
- Procedure 610.4.003, "Core Spray Valve Operability and In-Service Test"

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed temporary modification OC-2001-E-0012 and the associated technical and safety evaluations. The modification was prepared in response to the 1B2 cable failure event and was a contingency to be used in the event that power was lost to the 1B2 loads during the cable repair. The review included a verification that the change did not adversely impact the design functions of the 4160V and 480V systems and was performed in accordance with licensee procedure 108.8, "Temporary Modification Control." The inspectors also reviewed system procedures, walked down the temporary modification, and conducted interviews with the system engineer, 10 CFR 50.59 evaluators, and operations department staff.

b. Findings

No findings of significance were identified.

2. RADIATION SAFETY

Public Radiation Safety (PS)

2PS1 Radioactive Gaseous and Liquid Effluent Treatment and Monitoring Systems

a. Inspection Scope

The inspector reviewed the following documents to evaluate the effectiveness of the licensee's radioactive gaseous and liquid effluent control programs. The requirements of the radioactive effluent controls are specified in the station's TSs and Offsite Dose Calculation Manual (TS/ODCM).

- the 1999 and 2000 Radiological Annual Effluent Release Reports including projected public dose assessments;
- review of the ODCM (Revision 13, March 6, 2001), including technical justifications for ODCM changes made;
- selected 2001 analytical results for charcoal cartridge, particulate filter, and noble gas samples;
- selected 2000 and 2001 radioactive liquid (one batch release in 2000) and gaseous release permits;
- implementation of the compensatory sampling and analysis program when an effluent radiation monitoring system (RMS) is out of service;
- associated effluent control procedures, including analytical laboratory procedures;
- calibration results for chemistry laboratory measurements equipment (gamma and liquid scintillation counters);
- implementation of the measurement laboratory quality control program, including effluent inter-laboratory comparisons and control charts;
- review of Corrective Action Processes (CAPs) and corrective actions [CAP Nos. O2001-0698, O2001-0895, O2001-1126, O2001-1579, O2001-1881 (related to the effluent RMS availability), and O2001-1883 (related to the ODCM upgrading process)];
- the 2001 Nuclear Oversight Assessment (NOA-OC-01-1Q) for the implementations of the radioactive liquid and gaseous effluent controls and the ODCM;
- review of the year 2002-2003 Nuclear Oversight Assessment Schedule;
- Most recent Channel Calibration and Channel Functional Test results for the radioactive liquid and gaseous effluent radiation monitoring system(RMS) and its flow measurement devices listed in ODCM Attachments 2000-ADM-4532.04-16 and 2000-ADM-4532.04-17.

RMS:

- Reactor Building Service Water Monitor;
- Turbine Building Sump No.1-5 Monitor;
- Turbine Building Ventilation Noble Gas Monitor (Low and High Ranges);
- Main Stack Noble Gas Monitor (Low and High Ranges); and

- Augmented Offgas Building Exhaust Noble Gas Monitor.

Flow Rate Measuring Device:

- Main Stack Effluent Flow Measuring Device; and
- Turbine Building Ventilation Effluent Flow Measuring Device.

Most recent surveillance testing results (visual inspection, pressure difference, in-place testings for high efficiency particulate air (HEPA) and charcoal filters, air capacity test, and laboratory test for iodine collection efficiency) for the following air treatment systems:

- TS 4.5.H Standby Gas Treatment System;
- UFSAR 9.4.4.2.2 New Radwaste Building Ventilation System (HEPA filter test only); and
- UFSAR 9.4.4.2.3 Offgas Building Ventilation System (HEPA filter test only).

- review of the Response Letter to the NRC Generic Letter 99-02, "Laboratory Testing of Nuclear-Grade Activated Charcoal."

The inspector also toured and observed the following activities to evaluate the effectiveness of the licensee's radioactive gaseous and liquid effluent control programs.

- walkdown to determine the availability of radioactive liquid/gaseous effluent RMS and to determine the material condition of the equipment;
- walkdown to determine operability of air cleaning systems and to determine the material condition of the equipment; and
- observation of radioactive filter and charcoal cartridge sampling and preparation for gamma spectrometry measurements.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES (OA)

4OA1 Performance Indicator Verification

.1 Emergency Preparedness

a. Inspection Scope

The inspector reviewed the licensee's process for identifying the data that is utilized to determine the values for the three emergency preparedness performance indicators (PIs) which are: 1) Drill and Exercise Performance (DEP), 2) Emergency Response Organization Participation, and 3) Alert and Notification System (ANS) Reliability. The inspectors reviewed data from the fourth quarter of 2000 through the third quarter of

2001 using the criteria of Nuclear Energy Institute (NEI) 99-02, Revision 1, "Regulatory Assessment Performance Indicator Guideline." Attendance records for drill and exercise participation were reviewed, selected scenarios were reviewed to confirm DEP opportunities, and ANS test data was reviewed for completeness and accuracy.

b. Findings

No findings of significance were identified.

.2 Radiological Effluent Technical Specification (RETS) /ODCM Radiological Effluent Occurrences

a. Inspection Scope

The inspector reviewed the following documents to ensure the licensee met all requirements of the performance indicator from the third quarter 2000 to the third quarter 2001:

- monthly projected dose assessment results due to radioactive liquid and gaseous effluent releases;
- quarterly projected dose assessment results due to radioactive liquid and gaseous effluent releases; and
- associated procedures.

The information contained in these records was compared against the criteria contained in NEI 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 1, to verify that conditions that met the applicable NEI criteria were recognized, identified, and reported as a PI occurrence.

b. Findings

No findings of significance were identified.

4OA3 Event Follow-up

Manual Reactor Scram, November 11, 2001

a. Inspection Scope

On November 11, 2001, with the plant at 100 percent power, a fault occurred on the electrical cable supplying power to Unit Substation (USS) 1B2 from 4160V Bus 1D. The electrical loads lost due to the cable failure resulted in operations performing a TS required shutdown, followed by a manual scram, plant cooldown to cold shutdown, and entry into shutdown cooling (SDC). Once in SDC, the licensee performed repairs on the faulty cable and performed other scheduled forced outage maintenance. The inspectors reviewed technical specifications relating to the required plant shutdown and observed operations performance during the plant cooldown and entry into cold shutdown and SDC. The inspectors also reviewed documentation relating to the electrical cable failure and repair (discussed previously in Section 1R13 and 1R20), other forced outage

maintenance, equipment performance during and after the shutdown, corrective actions identified by the licensee during the shutdown, and shutdown risk assessment. The following documents were reviewed.

- CAP No. 2001-1718 - documents TS entries and Limiting Conditions for Operation (LCO) requirements due to the loss of 480 USS 1B2.
- CAP No. 2001-1721 - documents components that failed to operate properly during the forced shutdown.
- CAP No. 2001-1727 - Post-Transient Review Checklist
- Procedure 2000-ABN-3200.13A/B - Loss of DC Distribution Center A and/or B.
- Procedure 338 - 480V Electrical System.
- Procedure 305 - Shutdown Cooling Operation.
- Procedure EPIP-OC-.01 - Classification of Emergency Conditions.
- Procedure 2000-OPS-3024.27 - SDC diagnostic and restoration.
- Oyster Creek 18U2 Outage Risk Assessment.
- Forced outage maintenance schedule.

b. Findings

No findings of significance were identified.

4OA5 Other

Inspector Follow-up Item (IFI) Review and Closure

a. Inspection Scope

The inspector reviewed licensee corrective action for IFI 50-219/99-06-01 regarding a weakness identified during the October 5, 1999, full-participation exercise. Specifically, due to communications problems, the licensee did not initiate mitigation activities in a timely manner to respond to a simulated breach of the reactor coolant system. The licensee had conducted specific training for key emergency response members to address this issue. In 2001 drill reports reviewed by the inspector, there were no repeats of untimely mitigation actions, however, there remained instances of communication problems. During the next full-participation exercise, the licensee's communications will be evaluated. This item has been identified in the licensee's CAP and is being administratively closed in this report.

b. Findings

No findings of significance were identified.

4OA6 Meetings, including Exit

Exit Meeting Summary

On, January 15, 2002, the resident inspectors presented the inspection results to Mr. Ron DeGregorio and other members of licensee management. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

4OA7 Licensee Identified Violations

The following findings of very low significance were identified by the licensee and are violations of NRC requirements which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as a Non-Cited Violation (NCV).

NCV Tracking Number	Requirement Licensee Failed to Meet
50-219/01-10-01	TS 6.8.1 requires, in part, that written procedures shall be implemented as recommended in Appendix "A" of Regulatory Guide 1.33. Regulatory Guide 1.33 Appendix A.1.c lists a procedure for equipment control. Oyster Creek procedure 108P, "Clearance and Tagging," describes equipment control requirements. Step 5.2.2 of procedure 108P states, in part, that components with danger tags attached shall not be manipulated. Contrary to these requirements, the ESW Heat Trace System Breaker LP1A31 19 was manipulated "closed" despite being listed as danger tagged "open" on clearance 01001225. However, the issue was determined to be of very low significance (GREEN) because the associated maintenance work had been completed and emergency service water system operability was unaffected. This issue is documented in the licensee's corrective action program as CAP No. 02001-1865.

ATTACHMENT

SUPPLEMENTAL INFORMATION

a. Key Points of Contact

Licensee
V. Aggarwal, Director, Engineering
R. DeGregorio, Vice President
E. Harkness, Plant Manager
R. Hillman, Manager, Chemistry & Radwaste
J. Magee, Director, Maintenance
M. Massaro, Director, Work Management
D. McMillan, Director, Training
M. Newcomer, Senior Manager, Design
D. Slear, Manager, Regulatory Assurance
C. Wilson, Senior Manager, Operations

b. List of Items Opened, Closed, and Discussed

Opened and Closed

50-219/01-10-01	NCV	Violation of Technical Specification 6.8.1 for failure to follow procedures for clearance and tagging of the ESW Heat Trace System. (Section 4OA7)
50-219/01-10-02	NCV	Violation of Technical Specification 6.8.1 for failure to follow procedures regarding the qualifications of QV inspectors who inspect safety related work. (Section 1R13)

Closed

50-219/99-06-01	IFI	Untimely mitigation during an emergency preparedness exercise due to communication problems. (section 4OA5)

c. List of Acronyms

ADAMS	Agencywide Documents Access and Management System
AmerGen	AmerGen Energy Company, LLC
ANS	Alert and Notification System
A/R	Action Request
CAP	Corrective Action Process
CFR	Code of Federal Regulations
DEP	Drill and Exercise Performance
HEPA	High Efficiency Particulate Air
IFI	Inspector Follow-up Item
LCO	Limiting Condition for Operation
MG	Motor Generator
NCV	Non-Cited Violation
NEI	Nuclear Energy Institute
NRC	Nuclear Regulatory Commission
NOA	Nuclear Oversight Assessment
ODCM	Offsite Dose Calculation Manual
PI	Performance Indicator
PM	Preventive Maintenance
PMT	Post Maintenance Testing
POP	Plant Operating Procedure
QV	Quality Verification
RCA	Radiologically Controlled Area
RETS	Radiological Effluent Technical Specification
RMS	Radiation Monitoring System
SDC	Shutdown Cooling
SDP	Significance Determination Process
SSC	Systems, Structures, Components
ST	Surveillance Test
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report
USS	Unit Substation
WO	Work Order