AmerGen Energy Company
Oyster Creek
US Route 9 South, P.O. Box 388
Forked River, NJ 08731-0388

www.exeloncorp.com

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10CFR 2.201

May 11, 2006
2130-06-20333

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Oyster Creek Generating Station
Facility Operating License No. DPR-16
NRC Docket No. 50-219

Subject: Supplemental Response to Notice of Violation EA-05-199

References: (1) Oyster Creek NRC Event Follow-up Inspection Report 05000219/2005011; Preliminary White Finding (November 4, 2005)
(2) Oyster Creek Response to Apparent Violation EA-05-199 (December 8, 2005).

By letter dated November 4, 2005, the NRC docketed a Preliminary White Finding (NRC Inspection Report 05000219/2005011) for the Oyster Creek Generating Station sea grass intrusion event of August 6, 2005. By letter dated December 8, 2005, AmerGen Energy Company, LLC (AmerGen) submitted a response to the Preliminary White Finding. On January 9, 2006 the NRC issued the Final Significance Determination for the White Finding and Notice of Violation.

Attachment 1 to this cover letter provides the revised response to the Notice of Violation based upon further review of the original root cause evaluation. Attachment 2 lists the revised regulatory commitments made in this response. Change bars have been added to the right-hand margin where text has been modified.

If you have any questions regarding this submittal, please contact Kathy Barnes, Regulatory Assurance at 609-971-4970 or Jeff Dostal, Operations, at 609-971-4572.

Sincerely,

Timothy S. Rausch
Vice President, Oyster Creek Generating Station

Attachment 1 – Response to the Notice of Violation
Attachment 2 – Summary of Commitments

cc: Administrator, USNRC Region I
USNRC Project Manager, Oyster Creek
USNRC Senior Resident Inspector, Oyster Creek
File No. 05050

IE14
IE35

ATTACHMENT 1

AmerGen Energy Company, LLC
Oyster Creek Generating Station

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

Restatement of Notice of Violation EA-05-199

During an NRC inspection conducted from August 25, 2005 through September 23, 2005, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is listed below:

10CFR 50.54(q) states, in part, that a licensee authorized to possess and operate a nuclear power reactor shall follow and maintain in effect emergency plans which meet the standards in 10CFR 50.47(b).

10CFR 50.47(b)(4) requires the facility licensee to have a standard emergency classification and action level scheme in use, and State and local response plans call for reliance on information provided by facility licensees for determinations of minimum initial offsite response measures.

The Oyster Creek Emergency Plan Emergency Action Level (EAL) matrix requires, in part, the declaration of an Unusual Event when the intake canal water level differential pressure drops below 0.94 pounds per square inch gauge (psig) and the declaration of an Alert when the intake canal water level differential pressure drops below 0.50 psig.

Contrary to the above, on August 6, 2005, between 2:35 and 3:40 a.m., licensed operators did not properly utilize the Oyster Creek Emergency Plan EAL matrix during an actual event to determine that plant conditions warranted declaration of an Unusual Event and a subsequent Alert. Specifically, when the intake canal water level differential pressure dropped below 0.94 psig, an Unusual Event was not declared, and when the intake canal water level differential pressure dropped below 0.50 psig, an Alert was not declared. During the event, the intake canal water level differential pressure decreased to 0 psig. Since an Alert was not declared, AmerGen personnel did not activate their emergency response organization to assist operators in mitigating the event. Additionally, State and local agencies, who rely on information provided by the facility licensee, might not have been able to take initial offsite response measures in as timely a manner had the event degraded further.

This violation is associated with a WHITE significance determination process finding.

AmerGen Reply to Notice of Violation EA-05-199

AmerGen concurs with the violation as written.

Reason for the Notice of Violation

This finding involved the failure to properly utilize the Oyster Creek Emergency Plan (E-Plan) emergency action level (EAL) matrix during an actual event.

A root cause analysis was completed that determined the following:

There were two root causes associated with the operators not recognizing that plant parameters met the EAL thresholds for declaring an Unusual Event (UE) and a subsequent Alert:

- The first root cause was determined to be the Shift Manager assessment of E-Plan Applicability was incorrect and Event Classification was not based solely on EAL threshold values.

- The second root cause was determined to be the Operating crew did not implement and follow all applicable steps of ABN-32 Abnormal Intake Level.

Initially there were two root causes identified for this event. Upon further review, we have identified the causal factors for two terminal events: classification and notification. The root cause for both events is as follows:

Operations Senior Management failed to consistently reinforce strict compliance with Human Performance and ERO fundamentals.

Corrective Steps

Following identification of this issue, AmerGen took immediate corrective actions that included:

- A Shift Brief was issued to cover classification of events when criteria are reached and recovered before declarations are made, discussion on termination and recovery, and communicator and notifications requirements.

- Operations Standing Order 69 "Standing Order for Intake Monitoring" was issued to communicate expectation of keeping the Intake systems in a high state of readiness and monitoring for conditions that would lead to entry into ABN-32, "Abnormal Intake Level".

- Operations Standing Order 70 "Strategy for E-Plan Implementation" was issued to reinforce expectations and outline actions to be taken upon plant entry into an abnormal or transient condition, requirements for entry into the appropriate abnormal operating procedure, critical parameter monitoring, review of EALs, role of the Shift Technical Advisor, and responsibilities of communicators.

- The Shift Operations Superintendent (SOS) conducted one-on-one discussions with each Shift Manager on their EP duties and responsibilities. This included following the E-Plan process and procedures, for declarations and notifications.

- An environmental impact evaluation was performed, which concluded that there were no adverse environmental impacts as a result of this event.

In addition, the following actions were taken to address Human Performance issues:

1. The SM involved in the event was removed from shift duty.
2. A manager was assigned as a full time Human Performance Manager for Operations.
3. Two additional SROs were assigned to support the Human Performance Manager for Operations to mentor, observe and provide feedback for continuous improvement.
4. A Common Cause analysis (CCA) was performed on the Human Performance events in operations.
5. Leadership Assessments were initiated for the First Line Supervisors (FLS) and above for the site and Operations Management personnel.
6. Leadership assignments were evaluated and individuals were reassigned based on strengths identified in the leadership assessments.
7. The Operations Human Performance Improvement plan was reevaluated with input from the Operations CCA and the grassing event.
8. The Emergency Preparedness Improvement plan was updated with Human Performance actions and training requirements.
9. Training was provided by Corporate SME and INPO to improve the use of Human Performance tools.
10. Staffing improvements were made throughout the site.
11. Corrective Action Program trending of Human Performance issues has been improved.
12. Various station teambuilding sessions to improve site personnel alignment were conducted.
13. Fundamental Management System (FMS) Refresher Training was provided to site personnel.
14. Operations Human Performance Improvement plan was updated to heighten standards and performance in Operations.

Interviews and investigation of this event revealed that operators involved considered the impact of nuclear safety and industrial safety.

Planned Corrective Steps

1. Revise initial and recurring training for Emergency Response Organization (ERO) personnel on the inappropriate behaviors and the following expectations for E-Plan implementation:

   - Emphasize the need to utilize and review the E-Plan and EAL matrix when any procedure or condition indicates the potential of meeting or approaching an EAL threshold value.
   - Emphasize the danger and potential impacts of making knowledge-based decisions without validating the knowledge base.
   - Emphasize the value of obtaining a peer check whenever possible in making classifications.
   - Emphasize the importance and the need for strict compliance with E-Plan requirements to make classifications within fifteen minutes of identifying conditions that require classification and the required notifications within fifteen minutes of the classification.

   These actions are tracked in the Corrective Action Program as AR 360630-49.

2. Revise licensed operator training program to provide a minimum of ten ABN/EOP simulator scenarios during each biennial requalification cycle. In addition to the existing expectations and attributes include the following:

   - Communications of ABN/EOP entry to all crew members.
   - Complete and thorough execution, verbatim compliance and proper place keeping and maintenance of procedure documentation for subsequent review.
   - Appropriate log entries for initial entry and other entries as required by procedures.
   - Establishing and maintaining command and control and oversight by the Shift Manager (SM) and the Unit Supervisor (US).
   - Establishment of roles and responsibilities for execution of steps and critical parameter monitoring, including frequency of updates to SM and US.
   - Forward looking and anticipating potential E-Plan entry.
   - Implementation of E-Plan when appropriate, including classifications and notifications and review of documentation for attention to detail.

   These actions are tracked in the Corrective Action Program as AR 360630-21.

3. Revise EP training to provide initial and continuing classroom and periodic tabletop exercises to Shift Emergency Directors that emphasize classification based solely on EAL thresholds and how to handle situations where plant conditions have improved before classifications and notifications are made. Some of these exercises shall provide challenges to making the classification as well as realistic obstacles in meeting the fifteen-minute classification and notification time requirements. Also incorporate the requirement to complete and review all completed forms for accuracy and attention to detail.

   These actions are tracked in the Corrective Action Program as AR 360630-50.

4. Revise licensed operator training program to integrate E-Plan training into all applicable simulator scenarios, not just evaluated simulator exercises. E-Plan training should present challenges in both classification and notifications so any weaknesses in the E-Plan and implementation of the E-Plan can be identified and corrected. Emphasis should be placed on making classifications solely based on EAL thresholds and also include some scenarios involving improving plant conditions that would challenge classifications and notifications. Also incorporate requirement to complete and review all completed forms for accuracy and attention to detail.

   These actions are tracked in the Corrective Action Program as AR 360630-20

Date When Full Compliance Achieved

Full compliance was achieved when the Unusual Event was exited at 07:55 on 8/06/05.

ATTACHMENT 2

SUMMARY OF COMMITMENTS

The following table identifies commitments made in this document. (Any other actions discussed in the submittal represent intended or planned actions. They are described to the NRC for the NRC's information and are not regulatory commitments.)

COMMITMENT	COMMITTED DATE OR "OUTAGE"	COMMITMENT TYPE	
		ONE-TIME ACTION	PROGRAMMATIC
Revise EP training to provide initial and continuing classroom and periodic tabletop exercises to Shift Emergency Directors that emphasize classification based solely on EAL thresholds and how to handle situations where plant conditions have improved before classifications and notifications are made. Also incorporate the requirement to complete and review all completed forms for accuracy and attention to detail.	January 31, 2006		Yes