

**U. S. NUCLEAR REGULATORY COMMISSION
REGION I**

Report No. 99-08

Docket No. 50-219
72-1004

License No. DPR-16

Licensee: GPU Nuclear Incorporated
1 Upper Pond Road
Parsippany, New Jersey 07054

Facility Name: Oyster Creek Nuclear Generating Station

Location: Forked River, New Jersey

Inspection Period: September 27, 1999 - November 7, 1999

Inspectors: Laura A. Dudes, Senior Resident Inspector
Joseph G. Schoppy, Senior Resident Inspector
Thomas R. Hipschman, Resident Inspector
Joseph T. Furia, Senior Radiation Specialist,
October 12-15, 1999

Approved By: Peter W. Eselgroth, Chief
Projects Branch 7

EXECUTIVE SUMMARY

Oyster Creek Nuclear Generating Station Report No. 99-08

This integrated inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers about a six-week period of inspection.

Plant Operations

- Operations demonstrated attention to detail to intervene when work management processes did not meet management's expectations. (Section M3.1)
- A control room senior reactor operator performed a less than adequate review of a control rod clearance. An operator demonstrated attention to detail to identify the discrepancy and stop the evolution. (Section E4.1)

Maintenance

- Work week schedules, maintenance planning and incomplete job orders presented several challenges to plant operations. (Section M3.1)

Engineering

- Engineering provided a less than thorough evaluation of a degraded core spray pump motor heater to operations. The informal communication did not include a firm technical basis regarding what conditions could cause the degraded motor heater to impact the safety function of the core spray system. Subsequently, engineering adequately addressed the degraded motor heaters in engineering evaluation 0161-99. Additionally, the licensee missed two opportunities to identify the fact that the potential safety impact of the degraded motor heaters had not been evaluated properly. (Section E2.1)
- Engineering challenged operators and provided less than adequate support in the development of an inaccurate core maneuvering plan to be used for planned maintenance on the control rod system. Specifically, informal communications and inattention to detail caused the core engineering group to issue an inaccurate core maneuvering plan to operations. A control room SRO performed a less than adequate review of a control rod tagging outage. An operator demonstrated attention to detail and provided the final barrier to prevent potential reactivity challenges when he identified the discrepancy and stopped the evolution. (Section E4.1)

Plant Support

- Postings and controls for high and locked high radiation areas were appropriate. Use of informational postings aided in maintaining occupational exposures as low as is reasonably achievable. (Section R1.1)
- Calibration of radiological instrumentation was appropriately conducted and documented. Sources used in the radiological instrument calibration program were properly utilized and traceable. (Section R1.1)
- Dosimetry records, both year-to-date and lifetime, were appropriately documented and maintained. An effective program for calibration of the whole body counters was implemented. (Section R1.1)
- GPUN failed to obtain approval, in accordance with 10 CFR 20.2002, for a procedure to dispose of trace concentrations of licensed material on property owned by General Public Utilities Corporation, but not previously analyzed for the disposition of such materials. This is a violation of 10 CFR 20, Subpart K, 20.2001, "General Requirements," which requires the licensee to obtain approval for the disposal procedure in accordance with 10 CFR 20.2002, "Method for obtaining approval of proposed disposal procedures." This Severity Level IV violation is being treated as a Non-cited Violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This matter is in the licensee's corrective action program as CAP 1999-1405. (Section R8.1)
- A security patrol demonstrated attention to detail when a maintenance technician left a running vehicle unattended in the protected area. The driver's failure to properly secure the vehicle in accordance with OSEC-IMP-1530.06, *Inspection and Search of Personnel, Vehicles, Packages and Materials*, is a violation of License Condition 2.C(4), which requires that the licensee fully implement and maintain in effect all provisions of the Commission-approved physical security plan. The NRC-approved Oyster Creek Nuclear Generating Station Physical Security Plan specifies inspection and search of vehicles, etc. in procedure OSEC-IMP-1530.06, *Inspection and Search of Personnel, Vehicles, Packages and Materials*. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. Security documented this issue in CAP 1999-1436. (Section S1.2)

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Report Details

Summary of Plant Status

Oyster Creek operated at or near full power for the duration of the period. From September 30 through October 3, operators reduced reactor power to less than 70 percent to perform planned maintenance on the feedwater and control rod systems.

I. OPERATIONS

O1 Conduct of Operations

O1.1 General Comments (71707)

The inspectors conducted frequent reviews of ongoing plant activities and operations, using the guidance in NRC inspection procedure 71707. The inspectors conducted routine plant tours to assess equipment conditions, indications of operator work-arounds, procedural adherence, and compliance with regulatory requirements.

Operators conducted control room activities in a professional manner with staffing levels above those required by technical specifications (TS). The inspectors verified operator knowledge of ongoing plant activities, the reason for any lit annunciators, and the adequacy of existing fire watches. The inspectors also routinely performed independent verification of safety system status, from the control room indications and in the plant observation of equipment operation/position, for the plant operational mode.

II. MAINTENANCE

M1 Conduct of Maintenance

M1.1 Maintenance Activities

a. Inspection Scope (62707)

The inspectors reviewed selected maintenance work activities and supporting work documentation. Activities were selected based on the systems, structures, or components contained within the scope of the maintenance rule.

b. Observations and Findings

The inspectors observed selected maintenance activities on risk significant safety-related and non safety-related equipment to ascertain that the licensee conducted these activities in accordance with approved procedures, TS, and appropriate industrial codes and standards. The inspectors observed all or portions of the following job orders (JO):

- JO 533374 Station Battery B M-G Charger Lubrication and Visual Inspection

- JO 534256 GE AK 480V SWGR BRK Trip Shaft and Undervoltage Operability Checks for Core Spray Booster Pump 1-C
- JO 534112 Reactor Protection System HFA Relay Inspection
- JO 534083 Reactor Building Railroad Inner and Outer Airlock Doors and Associated Personnel Access Hatch Inspection

Maintenance activities were conducted satisfactorily and in accordance with applicable maintenance procedures. Personnel were knowledgeable of the activities and observed appropriate safety precautions and radiological practices. The licensee appropriately monitored performance of equipment within the scope of the maintenance rule.

M1.2 Surveillance Activities

a. Inspection Scope (61726)

The inspectors performed technical procedure reviews, witnessed in-progress surveillance testing, and reviewed completed surveillance packages. They verified that the surveillance tests were performed in accordance with TS, approved procedures, and NRC regulations. The activities selected were based on the systems, structures or components contained within the scope of the maintenance rule.

b. Observations and Findings

The inspectors reviewed all or portions of the following surveillance tests:

- 607.4.005 Containment Spray & ESW Pump System 2 Operability and In-Service Test.
- 609.4.001 Isolation Condenser Valve Operability and In-Service Test
- 617.4.002 CRD Exercise and Flow Test and IST Cooling Water Header Check
- 636.4.003 Diesel Generator Load Test
- 651.4.001 Standby Gas Treatment System Test - System I
- 680.4.007 Safety Related Equipment Verification

Personnel used the appropriate procedure, obtained prior approval, and completed applicable surveillance testing prerequisites. Personnel used properly calibrated test instrumentation, observed good radiological practices, and properly documented test results to ensure that equipment met TS requirements. Qualified technicians conducted the tests and appeared knowledgeable about the test procedure.

M3 Maintenance Procedures and Documentation**M3.1 Work Management and Maintenance Planning****a. Inspection Scope (62707, 71707, 37551)**

The inspector reviewed the maintenance work management process for several maintenance activities.

b. Observations and Findings

Although GPUN appropriately identified the following work management issues, the inspector noted that these aggregate issues presented several challenges to plant operations due to changes in work week schedules, maintenance planning and incomplete job orders (JO).

- During a power reduction with the 'B' feed string out of service, the re-packing of the 'B' feed regulating valve (V-2-0733) was missed, despite a significant packing leak and existing JO. This is a work management control issue (corrective action process (CAP) 1999-1274).
- Following the trip of the No. 1 emergency diesel generator (EDG) during a scheduled surveillance test, the core spray system 1 work window was appropriately postponed while the EDG was out of service. Subsequently, the core spray window schedule needed several revisions due to conflicting resources. Operations appropriately demanded a revised schedule to ensure they could effectively control plant operations.
- Instrumentation and Control (I&C) technicians tasked with inserting new local power range monitor (LPRM) currents did not have sufficient data to perform a calibration. The Group Operating Supervisor (GOS) appropriately intervened to stop the work and initiated CAP 1999-1345.
- A JO on the cleanup system included a troubleshooting control sheet and a safety determination that was not reviewed. An operations supervisor had to perform the review in order to start the work which required additional research since there was no supporting documentation (CAP 1999-1387).

The inspector noted that operations demonstrated attention to detail to identify work schedule, maintenance planning and JOs that did not meet management's expectations.

c. Conclusions

Work week schedules, maintenance planning and incomplete job orders presented several challenges to plant operations. Operations demonstrated attention to detail to intervene when work management processes did not meet management's expectations.

III. ENGINEERING

E2 Engineering Support of Facilities and Equipment

E2.1 Core Spray Pump Motor Heater Engineering Evaluation

a. Inspection Scope (37551)

Following a walkdown of the core spray system pumps, the inspector questioned the operability of the core spray pump due to inoperable motor heaters. The inspector reviewed corrective action documents and plant procedures to determine the quality of the licensee's actions.

b. Observations and Findings

During a routine walkdown of plant equipment on November 2, the inspector noticed that the 'C' core spray pump motor housing was cool to the touch. The inspector noted that similar pump motor housings were warm to the touch. The inspector questioned the Group Operating Supervisor (GOS) about the pump's motor heater condition. The GOS informed the inspector that operations was monitoring the heater. The previous day GOS initiated a work request (WR) to troubleshoot the heater. When the inspector asked the GOS about the status of the work request, he was informed that it was canceled. Maintenance planning canceled the work request stating that a planned preventative maintenance (PM) activity would correct any heater deficiencies. The inspector questioned this activity and further review by the GOS and the maintenance planning supervisor determined that the PM would not correct any existing heater problems and the GOS initiated a new job order (JO) (536967).

Operations documented a similar concern with the heater in April 1999 (CAP 1999-0491). At that time, the Group Shift Supervisor (GSS) determined the system was operable based on the system engineer's recommendation. The engineer's recommendation was based on an electronic mail (e-mail) message sent to him in June 1998, by a component engineer. The inspector reviewed the e-mail document and noted that it was inadequate as an engineering evaluation in that it did not provide sufficient technical basis for motor performance as a function of the environmental conditions in the pump room. Specifically, it did not indicate the bounding temperature and humidity conditions that could impact the operability of the motor windings if the heaters were not properly functioning. In addition, the e-mail document was not a controlled engineering document. The inspector determined that this e-mail did not meet the requirements of procedure 125, *Oyster Creek Tasking and Technical Evaluations*. This procedure, section 4.6.1, requires that technical evaluations shall be documented on form 125-1, including engineering evaluations that provide engineering direction to implementing organizations. Engineering's failure to provide an engineering evaluation in accordance with Procedure 125, *Oyster Creek Tasking and Technical Evaluations*, Section 4.6.1, constitutes a violation of minor significance and is not subject to formal enforcement action.

On November 9, engineering performed an engineering evaluation and a safety determination (125-1, 0161-99) to determine that the core spray pump is operable with the motor heater inoperable. The inspector reviewed the engineering evaluation and determined that it adequately addressed the core spray pump's operability.

Licensee management missed two opportunities to identify the lack of a proper engineering evaluation. This first opportunity occurred in June 1998 when the e-mail which discussed core spray pump operability was sent to several directors, managers, senior reactor operators and engineers. Secondly, the Oyster Creek corrective action management review team missed an opportunity to identify the problem when they decided to close CAP 1999-0491 with no further action, based on the system engineer's note to operations. The inspector concluded that the licensee did not pursue actions to correct the cause of the heater inoperability and relied on a less than thorough evaluation by engineering to assess the potential safety impact of degraded core spray pump motors.

c. Conclusions

Engineering provided a less than thorough evaluation of a degraded core spray pump motor heater to operations. The informal communication did not include a firm technical basis regarding what conditions could cause the degraded motor heater to impact the safety function of the core spray system. Subsequently, engineering adequately addressed the degraded motor heaters in engineering evaluation 0161-99. Additionally, the licensee missed two opportunities to identify the fact that the potential safety impact of the degraded motor heaters had not been evaluated properly.

E4 Engineering Staff Knowledge and Performance

E4.1 Engineering Human Performance Error During Control Rod System Maintenance

a. Inspection Scope (37551, 71707)

The inspector reviewed the apparent cause evaluation following a human performance error which resulted in an inadequate core maneuvering plan issued to operations during planned maintenance of the control rod system.

b. Observations and Findings

On October 1, maintenance planning issued a job order (JO) which identified that control rod 38-47 was to be tagged out for maintenance. To support this work activity, engineering had developed a core maneuvering plan on September 30, to insert three rods to position 00. Rod 38-47 was supposed to be one of the rods inserted by the plan; however, the core maneuvering plan incorrectly identified 34-47 instead of 38-47 as the third rod to be inserted. Engineering's apparent cause evaluation Core Engineering inappropriately developed the core maneuvering plan using an e-mail message from the system engineer as a reference for identifying the control rods that were to be worked. The e-mail incorrectly listed control rod 34-47 vice 38-47 to be inserted into the core.

Engineering did not demonstrate attention to detail when they referenced the e-mail rather than the controlled JO to develop the core maneuvering plan.

During the preparation for the maintenance activity, the control room senior reactor operator (SRO) authorized the hanging of tags without verifying that the rods listed on the tagging outage were consistent with those listed by the core maneuvering plan, or that the rods to be tagged out of service were in the required position. The operator assigned to hang the tags checked the control rod display and noted that rod 38-47 was not at 00 and questioned the inconsistency with the tagging outage as written.

The inspector noted that the apparent cause evaluation was appropriate. The actions by the operator to identify the discrepancy and stop the evolution demonstrated a questioning attitude. Operations documented this issue in CAP 1999-1266. Because the error was detected before any control rods were valved out of service, shutdown margin requirements were not violated.

c. Conclusions

Engineering challenged operators and provided less than adequate support in the development of an inaccurate core maneuvering plan to be used for planned maintenance on the control rod system. Specifically, informal communications and inattention to detail caused the core engineering group to issue an inaccurate core maneuvering plan to operations. A control room SRO performed a less than adequate review of a control rod tagging outage. An operator demonstrated attention to detail and provided the final barrier to prevent potential reactivity challenges when he identified the discrepancy and stopped the evolution.

E8 Miscellaneous Engineering Issues

E8.1 Year 2000 Readiness (TI 2515/141)

On July 1, 1999, GPUN responded to NRC Generic Letter 98-01 to provide information concerning Year 2000 (Y2K) readiness at OCNGS Generating Station. The inspector verified completion of the REM/AACS/CICO, integrated software for managing personnel radiation exposure and controlling access to radiologically controlled areas (EP-034 Y2K-186-990210, Y2K-185-990210, and Y2K-135-980625).

IV. PLANT SUPPORT

R1 Radiological Protection and Chemistry (RP&C) Controls

R1.1 General Observations (71750)

During radiologically controlled area (RCA) tours the inspectors observed that technicians posted proper warning signs, conducted adequate radiological monitoring of personnel and materials leaving the RCA, maintained monitoring instrumentation functional and in calibration, and maintained radiation work permits (RWPs) and survey status boards up-to-date and accurate. Technicians observed activities in the RCA and verified that personnel complied with the requirements of applicable RWPs, and that workers remained aware of the radiological conditions in the area.

a. Inspection Scope (83750)

A health physics inspection during routine operations was conducted. Areas of inspection focus were based on the following regulatory requirements from 10 CFR Part 20:

20.1101	Radiation protection program
20.1601	Control of access to high radiation areas
20.1602	Control of access to very high radiation areas
20.1902	Posting requirements
20.1904	Labeling containers
20.2103	Records of surveys

The inspection was conducted via direct observation of in-process work in the radiologically controlled areas (RCA), review of pertinent documents including surveys, radiation work permits (RWPs) and as low as is reasonably achievable (ALARA) reviews, and discussions with cognizant personnel.

Specific emphasis during this inspection included reviewing calibration records for radiological instrumentation, including the whole body counter, and reviewing personnel dosimetry records maintained in accordance with 10 CFR 20.2106.

b. Observations and Findings

Tours of various portions of the RCA located in the turbine, reactor, old radwaste and new radwaste buildings indicated that the licensee had properly posted and controlled identified high and locked high radiation areas. Additional use of informational postings to maintain occupational exposures ALARA was also noted. One activity observed during this period involved the transfer of highly radioactive filter sludge. Appropriate postings and controls were in-place to handle this activity, which resulted in numerous areas of the new radwaste building having changing radiological conditions during the transfer. Use of informational postings, in addition to those required under 10 CFR 20.1902, aided in maintaining occupational exposures ALARA.

For 1999, the licensee established an exposure goal of not more than 45 person-rem. If achieved, this would be the lowest annual exposure ever at this facility. Through October 14, site exposure was less than 31 person-rem, and discussions with management indicated that their expectation was that for the year, exposures would be not more than 40 person-rem.

Calibration of radiological survey instrumentation, portable frisker equipment, electronic dosimeters and portal monitors was accomplished utilizing National Institute of Standards and Technology (NIST) traceable sources, with all calibration results reviewed appropriately documented and maintained. Survey meters were calibrated utilizing tertiary standards, as were electronic dosimeters. Records of standards traceability were appropriately maintained.

Personnel dosimetry records were maintained in a manner consistent with NRC requirements, and individual records, both year-to-date and lifetime, were readily retrievable from the licensee's computerized data base. Thermoluminescent dosimeters (TLDs) were used to determine dose-of-record, and were changed out and read on a quarterly basis. TLD processing was performed by a National Voluntary Laboratory Accreditation Program (NVLAP)-certified contract laboratory, located at Three Mile Island.

The licensee operates both a bed and stand-up type whole body counters, and maintains records of daily, monthly and annual source checks, background checks and calibrations. Additionally, control charts for manufacturer-recommended data points are maintained in a computerized data base, and were readily available for review. No internal uptakes of radioactive material have occurred at the site in 1999. The last measured internal uptake occurred during the 17R refueling outage in 1998.

c. Conclusions

Postings and controls for high and locked high radiation areas were appropriate. Use of informational postings aided in maintaining occupational exposures as low as is reasonably achievable.

Calibration of radiological instrumentation was appropriately conducted and documented. Sources used in the radiological instrument calibration program were properly utilized and traceable.

Dosimetry records, both year-to-date and lifetime, were appropriately documented and maintained. An effective program for calibration of the whole body counters was implemented.

R8 Miscellaneous RP&C Issues**R8.1 Disposal of Dredge Spoils at Finninger Farm (83750)**

Finninger Farm is a 600 acre-plus property located immediately to the east of the Oyster Creek Nuclear Generating Station (OCNGS). It is separated from OCNGS by State Route 9, and was part of the property originally purchased by Jersey Central Power and Light, which included what is now known as OCNGS, Finninger Farm and the Forked River site. Finninger Farm is bounded on the west by Route 9, on the east by the development known as Forked River Beach, on the south by Oyster Creek and on the north by the south branch of the Forked River. On the eastern and western (land-side) boundaries, the farm is bordered with a post and rail fence, which is posted "No Trespassing." Access into the property is along a dirt road which has a locked gate. Within the farm is a 17.5 acre area that was set aside in 1978 as a dewatering basin for dredging spoils.

The dewatering basin is bounded on all sides by a snowdrift type fence. At least one air sampler is located along each side of the basin, and two sides of the basin have air samplers under the control of the New Jersey Bureau of Nuclear Engineering. A remote direct radiation monitor, also under state control, is located along the western border of the basin.

In 1978, in accordance with the final environmental statement for the OCNGS and the New Jersey Board of Public Utilities, portions of Oyster Creek were dredged to remove sediment from the creek bottom which was causing shoaling. This material, about 100,000 cubic yards, was pumped to the dewatering basin, and allowed to dry. The basin was then covered over with top soil.

In 1984, a second dredging project, this time in the Forked River was commenced. The dewatering basin was reopened, with the top soil used to create a 4-6 foot high berm around the basin. Approximately 30,000 cubic yards of additional materials were deposited into the basin at this time. The basin was left uncovered, pending additional planned dredging. This additional dredging did not take place until 1997. At that time, an additional 50,000 cubic yards of sediment from the Forked River were deposited in the basin.

Sampling and analyses of these dredging spoils has indicated the presence of trace (detectable) concentrations of cobalt-60 and cesium-137. The licensing basis and safety evaluation for Oyster Creek considered exposure due to radiological effluents that were released within technical specification limits. Accordingly, the detection of trace concentrations in dredging spoils is not unexpected. These trace concentrations are deposited on GPU controlled property, are effectively monitored, secured against unauthorized removal and access, and are not expected to pose any health and safety consequence. Notwithstanding, the disposition of reacquired licensed materials (that were previously released in accordance with technical specifications), in a manner different than specified in 10 CFR 20, Subpart K, 20.2001, "General Requirements," requires the licensee to obtain approval for the disposal procedure in accordance with

10 CFR 20.2002, "Method for obtaining approval of proposed disposal procedures." Failure to obtain the required approval to accommodate the disposition of this material constitutes a violation of NRC requirements. Notwithstanding, this Severity Level IV violation is being treated as a Non-cited Violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This matter is in the licensee's corrective action program as CAP No. 01999-1405. (NCV 50-219/99-08-01)

Conclusion

A non-cited violation was identified with respect to the licensee's failure to obtain approval, in accordance with 10 CFR 20.2002, for a procedure to dispose of trace concentrations of licensed material on property owned by General Public Utilities Corporation, but not previously analyzed for the disposition of such materials. (NCV 50-219/99-08-01)

- R8.2 (Closed) Inspector Follow-up Item (50-219/98-05-03): Periodic Verification of Plant Isotopic Mix as it Applies to the Respiratory Protection Program. The licensee conducted and documented a review of the plant isotopic mix in September 1998, which indicated that the gross activity values in use at the time were still valid.
- R8.3 (Closed) Inspector Follow-up Item (50-219/99-03-01): Status of Certain Radwaste Equipment and Cubicles. The licensee initiated Corrective Action Process (CAP) 01999-0703 to document the need to determine the as left conditions of evaporator WC-E-1B, filter sludge hold-up tank SL-T-3A, filter sludge storage tank NV-09 and waste concentrator NV 230, and their associated cubicles.

S1 Conduct of Security and Safeguards Activities

S1.1 General Observations (71750)

During routine tours, the inspectors noted that security controlled vital and protected area access in accordance with the security plan, properly manned security posts, locked or guarded protected area gates, and maintained isolation zones free of obstructions.

S1.2 Vehicular Control in the Protected Area

a. Inspection Scope (71750)

The inspectors reviewed security force activities and observed vehicle control in the protected area.

b. Observations and Findings

On November 3, a security patrol discovered a GPUN vehicle unattended inside the protected area with the engine running. The security officer turned off the vehicle and took custody of the keys. Security determined that the individual and other personnel in his workgroup were aware of the requirements for vehicles left unattended in the

protected area. Security determined that the discussion with the individual and his workgroup was sufficient corrective action and documented the occurrence in CAP 1999-1436.

Security Procedure OSEC-IMP-1530.06, *Inspection and Search of Personnel, Vehicles, Packages and Materials*, Section 4.1.4 states that "positive control will be exercised of vehicles," and Sect. 4.1.5 requires that "when unoccupied vehicle ignition will be locked and the keys removed." Contrary to this requirement, a maintenance technician left the vehicle unattended, unlocked and running in the protected area. The driver's failure to properly secure the vehicle in accordance with OSEC-IMP-1530.06, *Inspection and Search of Personnel, Vehicles, Packages and Materials*, is a violation of License Condition 2.C(4), which requires that the licensee fully implement and maintain in effect all provisions of the Commission-approved physical security plan. The NRC-approved Oyster Creek Nuclear Generating Station Physical Security Plan specifies inspection and search of vehicles, etc. in procedure OSEC-IMP-1530.06, *Inspection and Search of Personnel, Vehicles, Packages and Materials*. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. Security documented this issue in CAP 1999-1436. (NCV 50-219/99-08-02)

A similar occurrence was documented in NRC Integrated Inspection Report No. 50-219/98-09. On October 14, 1998, the inspector observed a commercial trash truck approach the exit gate from inside the protected area. The driver left the unlocked running truck and stepped into the access building. The security escort followed close behind the driver, leaving the running truck unattended. The security guard did not properly conduct vehicle escort duties as he left a running vehicle unattended in the protected area. Additionally, security force members did not properly document the occurrence. When notified by the inspector, security management took prompt and appropriate corrective actions (CAP 1998-1459) (VIO 50-219/98-09-01)

In the most recent occurrence, the inspector noted that security identified the problem, and appropriately took corrective actions. The inspector observed that security's vehicle awareness inside the protected area and willingness to document problems has improved during the one year interval since the last occurrence. Additionally during walkdowns of the protected area, the inspector did not observe any instances of unattended vehicles with keys inside the protected area.

c. Conclusions

A security patrol demonstrated attention to detail when a maintenance technician left a vehicle unattended in the protected area. The driver's failure to properly secure the vehicle in accordance with OSEC-IMP-1530.06, *Inspection and Search of Personnel, Vehicles, Packages and Materials*, is a violation of License Condition 2.C(4), which requires that the licensee fully implement and maintain in effect all provisions of the Commission-approved physical security plan. The NRC-approved Oyster Creek Nuclear Generating Station Physical Security Plan specifies inspection and search of vehicles, etc. in procedure OSEC-IMP-1530.06, *Inspection and Search of Personnel, Vehicles, Packages and Materials*. This Severity Level IV violation is being treated as a Non-Cited

Violation, consistent with Appendix C of the NRC Enforcement Policy. Security documented this issue in CAP 1999-1436. (NCV 50-219/99-08-02)

V. MANAGEMENT MEETINGS

X1 Exit Meeting Summary

The inspectors provided a verbal summary of preliminary findings to senior licensee management at exit meetings on October 15, and November 15, 1999. During the inspection period, inspectors periodically discussed preliminary findings with licensee management. Inspectors did not provide any written inspection material to the licensee. The licensee did not indicate that any of the information presented at the exit meeting was proprietary.

PARTIAL LIST OF PERSONS CONTACTED**Licensee (in alphabetical order)**

G. Busch, Manager, Nuclear Safety & Licensing
B. DeMerchant, Licensing Engineer
E. Gregory, Supervisor, Dosimetry and Respirator Maintenance
A. Judson, Acting Manager, Radiological Engineering
S. Levin, Director, Operations and Maintenance
D. McMillan, Director, Equipment Reliability
K. Mulligan, Plant Operations Director
J. Perry, Plant Maintenance Director
M. Roche, Director, Oyster Creek
D. Slear, Director, Configuration Control
M. Slobedien, Health Physics Manager
R. Tilton, Manager, Assessment
J. Vouglitois, Manager, Environmental Affairs
K. Wolf, Radiological Controls Field Operations Manager

NRC (in alphabetical order)

L. Dudes, Senior Resident Inspector
T. Hipschman, Resident Inspector
J. Schoppy, Senior Resident Inspector

INSPECTION PROCEDURES USED

<u>Procedure No.</u>	<u>Title</u>
37551	Onsite Engineering
61726	Surveillance Observation
62707	Maintenance Observation
71707	Plant Operations
71750	Plant Support
83750	Occupational Radiation Exposure
TI 2515/141	Review of Year 2000 (Y2K) Readiness of Computer Systems at Nuclear Power Plants

ITEMS OPENED AND CLOSED**Opened\Closed**

<u>Number</u>	<u>Type</u>	<u>Description</u>
50-219/99-08-01	NCV	Disposal of Dredge Spoils at Finninger Farm. (Section R8.1)
50-219/99-08-02	NCV	Vehicular Control in the Protected Area. (Section S1.2)

Closed

<u>Number</u>	<u>Type</u>	<u>Description</u>
50-219/98-05-03	IFI	Periodic verification of plant isotopic mix as it applies to the respiratory protection program. (Section R8.2)
50-219/99-03-01	IFI	Status of certain radwaste equipment and cubicles. (Section R8.3)

LIST OF ACRONYMS USED

ALARA	As Low As Is Reasonably Achievable
CAP	Corrective Action Process
CFR	Code of Federal Regulations
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
e-mail	Electronic Mail
EDG	Emergency Diesel Generator
GOS	Group Operating Supervisor
GPUN	General Public Utilities (GPU) Nuclear
GSS	Group Shift Supervisor
I&C	Instrumentation and Control
IST	In-Service Test
JO	Job Order
LPRM	Local Power Range Monitor
NIST	National Institute of Standards and Technology
NRC	Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
NCV	Non-Cited Violation
NVLAP	National Voluntary Laboratory Accreditation Program
OCNGS	Oyster Creek Nuclear Generating Station
ODCM	Offsite Dose Calculation Manual
PDR	Public Document Room
PM	Preventive Maintenance
RCA	Radiologically Controlled Area
RWP	Radiation Work Permit
RP&C	Radiological Protection and Chemistry
SRO	Senior Reactor Operator
TLD	Thermoluminescent Dosimeter
TS	Technical Specifications
UFSAR	Updated Final Safety Analysis Report
WR	Work Request
Y2K	Year 2000