



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
2100 RENAISSANCE BOULEVARD, SUITE 100  
KING OF PRUSSIA, PENNSYLVANIA 19406-2713

November 20, 2013

Mr. John Dent  
Site Vice President  
Entergy Nuclear Operations, Inc.  
Pilgrim Nuclear Power Station  
600 Rocky Hill Road  
Plymouth, MA 02360-5508

SUBJECT: PILGRIM NUCLEAR POWER STATION – NRC PROBLEM IDENTIFICATION  
AND RESOLUTION INSPECTION REPORT 05000293/2013008

Dear Mr. Dent:

On October 3, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution biennial inspection at your Pilgrim Nuclear Power Station. The inspectors discussed the results of this inspection with you and other members of your staff, and documented the results of this inspection in the enclosed inspection report.

This inspection examined activities conducted under your license as they relate to identification and resolution of problems and compliance with the Commission's rules and regulations and conditions of your license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

Based on samples selected for review, the inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving issues. Entergy identified problems and entered them into the corrective action program at a low threshold. Entergy prioritized and evaluated issues commensurate with the safety significance of the problems, and corrective actions were generally implemented in a timely manner.

The inspectors concluded that, in general, Entergy adequately identified, reviewed, and applied relevant industry operating experience to Pilgrim Nuclear Power Station operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were thorough.

Enclosure 2 contains Sensitive Unclassified Non-Safeguards Information. When separated from Enclosure 2, the transmittal document is DECONTROLLED.

J. Dent

2

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

NRC inspectors documented three findings of very low safety significance (Green) in this report. Two of these findings are documented in Enclosure 1. The third finding contains security-related information and is documented in Enclosure 2. This deficiency was promptly corrected or compensated for, and the plant was in compliance with applicable physical protection and security requirements within the scope of this inspection before the inspectors left the site. Additionally, this security-related finding has a cross-cutting aspect in the area of Human Performance, Decision Making, because Entergy did not use conservative assumptions in decision making and adopt a requirement to demonstrate a proposed action was safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disprove an action [H.1(b)].

The inspectors determined that all three of these findings involved a violation of NRC requirements. However, because of the very low safety significance and because they were entered into your corrective action program, the NRC is treating these findings as non-cited violations, consistent with Section 2.3.2.a of the Enforcement Policy. If you contest these non-cited violations, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Pilgrim Nuclear Power Station. In addition, if you disagree with the cross-cutting aspect assigned to any finding in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region I, and the NRC Resident Inspector at Pilgrim Nuclear Power Station.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390, "Public Inspections, Exemptions, Requests for Withholding," of the NRC's "Rules of Practice," a copy of this letter, any non-security-related information, such as Enclosure 1, and your response (if any) to Enclosure 1, will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC website at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

However, the material enclosed herewith contains security-related information in accordance with 10 CFR 2.390(d)(1), and its disclosure to unauthorized individuals could present a security vulnerability. Therefore, the material in Enclosure 2 will not be made available electronically for public inspection in the NRC Public Document Room or from the PARS component of NRC's ADAMS. If you choose to provide a response and security-related information is necessary to

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3

provide an acceptable response, please mark your entire response “Security-Related Information – Withhold from Public Disclosure under 10 CFR 2.390” in accordance with 10 CFR 2.390(d)(1), and follow instructions for withholding in 10 CFR 2.390(b)(1). In accordance with 10 CFR 2.390(b)(1)(ii), the NRC is waiving the affidavit requirements for your response.

Sincerely,

*/RA/*

Raymond R. McKinley, Chief  
Reactor Projects Branch 5  
Division of Reactor Projects

Docket No: 50-293  
License No: DPR-35

Enclosure 1 (Public):  
Inspection Report 05000293/2013008  
w/Attachment: Supplementary Information

Enclosure 2 (Non-Public):  
Inspection Report 05000293/2013008  
w/Attachment: Supplementary Information

**(CONTAINS OFFICIAL USE ONLY – SECURITY-RELATED INFORMATION (OUO-SRI))**

cc w/Enclosure 1; w/Enclosure 2; w/OUO-SRI  
D. Burke, Protective Services Department Section Manager  
J. Giarrusso, SLO, Massachusetts Emergency Management Agency (MEMA)

cc w/Enclosure 1; w/o Enclosure 2; w/o OUO-SRI  
Distribution via ListServ

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3

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Enclosure 2 (Non-Public):  
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DATE	11/19/13	11/19/13	11/21/13	11/20/13	

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**U.S. NUCLEAR REGULATORY COMMISSION**

REGION I

Docket No: 50-293

License No: DPR-35

Report No: 05000293/2013008

Licensee: Entergy Nuclear Operations, Inc.

Facility: Pilgrim Nuclear Power Station

Location: Plymouth, MA 02360

Dates: September 16, 2013 – October 3, 2013

Team Leader: Carey Bickett, Senior Project Engineer, Division of Reactor Projects

Inspectors: Juan Ayala, Reactor Inspector, Division of Reactor Safety  
Jeffrey Bream, Physical Security Inspector, Division of Reactor Safety  
Elizabeth Keighley, Project Engineer, Division of Reactor Projects

Approved by: Raymond McKinley, Branch Chief  
Reactor Projects Branch 5  
Division of Reactor Projects

## SUMMARY

IR 05000293/2013008; 09/16/2013 – 10/03/2013; Pilgrim Nuclear Power Station; Biennial Baseline Inspection of Problem Identification and Resolution. The inspectors identified one finding in the area of problem evaluation and two findings in the area of effectiveness of corrective actions.

This NRC team inspection was performed by four regional inspectors. The inspectors identified three Green non-cited violations during this inspection. The significance of inspection findings is indicated by their color (i.e., greater than Green, or Green, White, Yellow, Red) and determined using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process," dated June 2, 2011. Cross-cutting aspects are determined using IMC 0310, "Components Within Cross-Cutting Areas," dated October 28, 2011. All violations of NRC requirements are dispositioned in accordance with the NRC's Enforcement Policy, dated July 9, 2013. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4.

### Problem Identification and Resolution

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. Entergy personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. In most cases, Entergy appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Entergy typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner. However, the inspectors identified one violation in the area of problem evaluation, and two violations in the area of effectiveness of corrective actions.

The inspectors concluded that, in general, Entergy adequately identified, reviewed, and applied relevant industry operating experience to Pilgrim Nuclear Power Station (Pilgrim) operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were thorough.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

### **Cornerstone: Initiating Events**

- Green. The inspectors identified a Green non-cited violation of 10 CFR 26.207(a) for Entergy's failure to issue waivers that were necessary to mitigate or prevent conditions adverse to safety, and only to address circumstances that could not have been reasonably controlled. Specifically, Entergy issued multiple fatigue waivers during planned and forced outages that were determined to be inappropriate based on plant conditions. Additionally, the inspectors identified other waivers of the fatigue rule that Entergy issued during non-outage periods that were inappropriate based on plant conditions. Entergy's immediate

corrective action was to enter this issue into their corrective action program as condition reports CR-PNP-2013-06706 and CR-PNP-2013-06707 for further evaluation.

The inspectors determined that Entergy's failure to grant waivers in accordance with regulatory requirements was a performance deficiency that was within Entergy's ability to foresee and correct. This performance deficiency is more than minor because it was associated with the human performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the resulting increased likelihood of human error could adversely affect the station's defense-in-depth. Additionally, the finding was similar to IMC 0612, Appendix E, "Examples of Minor Issues," Example 9.a and is more than minor because this inappropriate use of work hour control waivers was not an isolated incident (e.g., one or two instances). The finding has been reviewed by NRC management in accordance with IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." The violation was determined to be of very low significance because no significant events or human performance issues were directly linked to personnel fatigue as a result of the hours worked. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because Entergy did not thoroughly evaluate problems such that the resolutions address causes and extent conditions. Specifically, Entergy previously identified that waivers were inappropriately granted for conditions that were not necessary to mitigate or prevent conditions adverse to safety. However, because the previous evaluations were limited in scope and focus, Entergy did not develop corrective actions to address the deficient condition. [P.1(c)] [Section 4OA2.c.(1)]

### **Cornerstone: Emergency Preparedness**

- Green. The inspectors identified a Green non-cited violation of 10 CFR Part 50.54(q)(2) because Entergy did not ensure that the Pilgrim Emergency Plan met the planning standards in 10 CFR 50.47(b). Specifically, on various occasions in 2012 and 2013, Pilgrim failed to maintain both meteorological towers as necessary to support emergency response. Entergy entered this issue into their corrective action program as condition report CR-PNP-2013-06829 for further evaluation. Additionally, as of the date of this inspection, the 220' meteorological tower was functional and the National Weather Service is still available as an alternate data source.

The inspectors determined that failure to maintain the 160' and 220' meteorological towers resulting in both towers being out of service concurrently for three separate periods in 2012 and 2013 was a performance deficiency that was within Entergy's ability to foresee and correct. This performance deficiency is more than minor because it is associated with the facilities and equipment attribute of the Emergency Preparedness cornerstone and adversely affected the cornerstone objective of ensuring the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. In accordance with IMC 0609, Appendix B, "Emergency Preparedness Significance Determination Process," Table 5.8-1, the inspectors determined the finding to be of very low safety significance (Green) because the planning standard function was degraded. Specifically, a significant amount of equipment necessary to implement the emergency plan was not functional to the extent that an emergency response organization member could not perform assigned functions, in the absence of compensatory measures. However, Pilgrim was able to make adequate dose assessments at all times

using the National Weather Service to obtain necessary data. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because Pilgrim did not take appropriate corrective actions to address safety issues and trends in a timely manner. Specifically, the station did not take timely corrective actions to correct deficiencies associated with both meteorological towers resulting in both towers being simultaneously non-functional on multiple occasions. [P.1(d)] [Section 4OA2.c.(2)]

**Cornerstone: Physical Protection**

- This finding has a cross-cutting aspect in the area of Human Performance, Decision Making, because Entergy did not use conservative assumptions in decision making and adopt a requirement to demonstrate a proposed action was safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disprove an action. [H.1(b)]. Refer to Enclosure 2, Section 4OA2.c(3) for full documentation of the violation.



**REPORT DETAILS**

**4. OTHER ACTIVITIES (OA)**

4OA2 Problem Identification and Resolution (71152B)

This inspection constitutes one biennial sample of problem identification and resolution as defined by Inspection Procedure 71152. All documents reviewed during this inspection are listed in the Attachment to this report.

.1 Assessment of Corrective Action Program Effectiveness

a. Inspection Scope

The inspectors reviewed the procedures that described Entergy's corrective action program at Pilgrim. To assess the effectiveness of the corrective action program, the inspectors reviewed performance in three primary areas: problem identification, prioritization and evaluation of issues, and corrective action implementation. The inspectors compared performance in these areas to the requirements and standards contained in 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," and Entergy procedure EN-LI-102, "Corrective Action Process," Revision 21. For each of these areas, the inspectors considered risk insights from the station's risk analysis and reviewed condition reports selected across the seven cornerstones of safety in the NRCs Reactor Oversight Process. Additionally, the inspectors attended multiple Condition Review Group and Operations Focus Meetings. The inspectors selected items from the following functional areas for review: engineering, operations, maintenance, emergency preparedness, radiation protection, chemistry, physical security, and oversight programs.

(1) Effectiveness of Problem Identification

In addition to the items described above, the inspectors reviewed system health reports, maintenance rule documents, and various system drawings. The inspectors also completed field walkdowns of various systems on site, including the emergency diesel generators and the safety-related batteries. Additionally, the inspectors reviewed a sample of condition reports written to document issues identified through internal self-assessments, audits, emergency preparedness drills, and the operating experience program. The inspectors completed this review to verify that Entergy entered conditions adverse to quality into their corrective action program as appropriate.

(2) Effectiveness of Prioritization and Evaluation of Issues

The inspectors reviewed the evaluation and prioritization of a sample of condition reports issued since the last NRC biennial problem identification and resolution inspection, completed in March 2011. The inspectors also reviewed condition reports that were assigned lower levels of significance that did not include formal cause evaluations to ensure that they were properly classified. The inspectors' review included the appropriateness of the assigned significance, the scope and depth of the causal analysis, and the timeliness of resolution. The inspectors assessed whether the evaluations identified likely causes for the issues and developed appropriate corrective

actions to address the identified causes. Further, the inspectors reviewed equipment operability determinations, reportability assessments, and extent-of-condition reviews for selected problems to verify these processes adequately addressed equipment operability, reporting of issues to the NRC, and the extent of the issues.

(3) Effectiveness of Corrective Actions

The inspectors reviewed Entergy's completed corrective actions through documentation review and, in some cases, field walkdowns to determine whether the actions addressed the identified causes of the problems. The inspectors also reviewed condition reports for adverse trends and repetitive problems to determine whether corrective actions were effective in addressing the broader issues. The inspectors reviewed the station's timeliness in implementing corrective actions and effectiveness in precluding recurrence for significant conditions adverse to quality. The inspectors also reviewed a sample of condition reports associated with selected non-cited violations and findings to verify that Entergy personnel properly evaluated and resolved these issues. In addition, the inspectors expanded the corrective action review to five years for the 'A' emergency diesel generator, the high pressure coolant injection system, and the station meteorological towers.

b. Assessment

(1) Effectiveness of Problem Identification

Based on the selected samples, plant walkdowns, and interviews of site personnel in multiple functional areas, the inspectors determined that Entergy identified problems and entered them into the corrective action program at a low threshold. Entergy staff at Pilgrim initiated approximately 18,000 condition reports between January 2011 and October 2013. The inspectors observed staff at the Operations Focus and the Condition Review Group meetings appropriately questioning and challenging condition reports to ensure clarification of the issues. Based on the samples reviewed, the inspectors determined that Entergy trended equipment and programmatic issues, and appropriately identified problems in condition reports. The inspectors verified that conditions adverse to quality identified through this review were entered into the corrective action program as appropriate. Additionally, inspectors concluded that personnel were identifying trends at low levels. In general, inspectors did not identify any issues or concerns that had not been appropriately entered into the corrective action program for evaluation and resolution.

(2) Effectiveness of Prioritization and Evaluation of Issues

The inspectors determined that, in general, Entergy appropriately prioritized and evaluated issues commensurate with the safety significance of the identified problem. Entergy screened condition reports for operability and reportability, categorized the condition reports by significance, and assigned actions to the appropriate department for evaluation and resolution. The condition report screening process considered human performance issues, radiological safety concerns, repetitiveness, adverse trends, and potential impact on the safety conscious work environment.

Based on the sample of condition reports reviewed, the inspectors noted that the guidance provided by Entergy's corrective action program implementing procedures appeared sufficient to ensure consistency in categorization of issues. Operability and reportability determinations were generally performed when conditions warranted and in most cases, the evaluations supported the conclusion. Causal analyses appropriately considered the extent of condition or problem, generic issues, and previous occurrences of the issue. However, the inspectors did note some observations in Entergy's evaluation of the following issues:

Weaknesses in Documentation of Extent of Condition Reviews

The inspectors assessed Entergy's extent of condition reviews for selected apparent cause evaluations. The inspectors noted a couple of observations related to weaknesses in documentation of extent of condition reviews for the following issues:

The inspectors reviewed condition report CR-PNP-2011-04877 related to failure of the emergency operations facility diesel generator to run during loss of power to the facility. Specifically, when the emergency operations facility lost power during a storm, the diesel generator ran and tripped on low oil pressure due to water in the fuel oil tank. Upon further evaluation of the issue, Entergy identified water in both the above ground day tank and below ground storage tank. During review of the station's apparent cause evaluation, the inspectors noted that the extent of condition focused only on above ground tanks. The inspectors questioned whether Entergy had considered all fuel storage tanks on site, especially for the plant emergency diesel generators, considering that water had been identified in the underground tank for the emergency operations facility diesel generator. Inspectors interviewed Entergy's staff and determined that all underground fuel storage tanks were considered in the extent of condition review. Also, the inspectors reviewed Entergy's fuel oil sampling procedure, and determined that the procedure was adequate to identify moisture in the underground fuel oil storage tanks for the plant emergency diesel generators.

The inspectors also reviewed CR-PNP-2011-02160 related to the high pressure coolant injection system exhaust vacuum breaker check valve failing to close after it was tested. Specifically, vacuum breaker check valve 23-CK-233 failed when the internal counterweight mispositioned due to internal valve corrosion. The extent of condition review evaluated the upstream check valve that made up the rest of the vacuum breaker system, but did not describe Entergy's efforts to identify the potential for similar conditions in other check valves. Through interviews and system schematic reviews, the inspectors determined that the high pressure coolant injection system check valves were the only two check valves at the station that would be subjected to similar operating conditions.

The inspectors evaluated these observations related to extent of condition reviews for significance in accordance with IMC 0612, Appendix B, "Issue Screening." Because the inspectors were able to verify that Entergy did perform adequate extent of condition reviews, and the weaknesses were limited to documentation of the reviews, these observations are of minor significance and, as a result, not subject to enforcement action in accordance with the NRC's Enforcement Policy.

The inspectors also identified one additional minor observation and one Green violation where Pilgrim personnel were not effective in evaluation of plant issues. These issues are documented in Enclosure 2.

(3) Effectiveness of Corrective Actions

The inspectors concluded that corrective actions for identified deficiencies were generally timely and adequately implemented. For significant conditions adverse to quality, Entergy identified actions to prevent recurrence. The inspectors concluded that corrective actions to address the sample of NRC non-cited violations and findings since the last problem identification and resolution inspection were timely and effective.

However, the inspectors identified two examples of more than minor significance where Pilgrim staff were not effective in evaluating and implementing corrective actions. These findings are documented in Section 4OA2.1.c.

c. Findings

(1) Inappropriate Fatigue Rule Waivers

Introduction. The inspectors identified a Green non-cited violation of 10 CFR 26.207(a) for Entergy's failure to issue waivers that were necessary to mitigate or prevent conditions adverse to safety, and only to address circumstances that could not have been reasonably controlled. Specifically, Entergy issued multiple fatigue waivers during planned and forced outages that were determined to be inappropriate based on plant conditions. Additionally, the inspectors identified other waivers of the fatigue rule that Entergy issued during non-outage periods that were inappropriate based on plant conditions.

Description. As part of the selected sample, the inspectors reviewed condition report CR-PNP-2011-05677, dated December 11, 2011. The station wrote this condition report to document that fatigue waivers had been issued inappropriately during a forced outage in December 2011. Specifically, the condition report identified that multiple waivers for work hour limits that were issued to Entergy personnel were not for situations that were necessary to mitigate or prevent conditions adverse to safety. Entergy identified limited corrective actions to raise awareness of conditions where a waiver is warranted with Entergy management personnel that request and approve waivers.

The inspectors performed a limited effectiveness review of the corrective actions associated with CR-PNP-2011-05677, and identified CR-PNP-2013-00245, dated January 14, 2013, which documented that the station issued multiple fatigue waivers inappropriately during a forced outage in January 2013. Entergy performed an apparent cause evaluation to determine the cause of the performance deficiency and identify appropriate corrective actions. Entergy determined that the apparent cause was that "the Fatigue Management Procedure, EN-OM-123, was not followed." Again, the corrective actions were to raise awareness of conditions where a waiver is warranted with Entergy management personnel that request and approve waivers. The inspectors determined that this apparent cause evaluation and resultant corrective actions were narrowly focused. The evaluation did not explore other potential causes such as outage schedule pressure or manpower limitations. Additionally, the apparent cause evaluation

failed to identify that this was a repeat occurrence of the condition evaluated in CR-PNP-2011-05677. Finally, the inspectors determined that the corrective actions identified in CR-PNP-2011-05677 and CR-PNP-2013-00245 were deficient in that no programmatic or procedural changes were implemented to address inappropriate fatigue rule waivers.

The inspector's effectiveness review also identified numerous waivers that were issued during the recent forced outage in September 2013. The inspectors reviewed a sample of the waivers and determined that multiple waivers were issued inappropriately. Entergy entered this issue into the corrective action program as CR-PNP-2013-06707.

Additionally, the inspectors identified multiple instances of deficiencies in the face-to-face assessments associated with waiver requests. In some instances, workers were discovered to have violated work hour requirements after the fact. Other examples included face-to-face assessments being performed outside of the 4-hour window before the employee began performing the work under the waiver.

Analysis. The inspectors determined that Entergy's failure to grant waivers in accordance with regulatory requirements was a performance deficiency that was within Entergy's ability to foresee and correct. This performance deficiency is more than minor because it was associated with the human performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the resulting increased likelihood of human error could adversely affect the station's defense-in-depth. Additionally, the finding was similar to IMC 0612, Appendix E, "Examples of Minor Issues," Example 9.a, and is more than minor because this inappropriate use of work hour control waivers was not an isolated incident (e.g., one or two instances). The finding has been reviewed by NRC management in accordance with IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." The violation was determined to be of very low significance because no significant events or human performance issues were directly linked to personnel fatigue as a result of the hours worked.

This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because Entergy did not thoroughly evaluate problems such that the resolutions address causes and extent conditions. Specifically, Entergy previously identified that waivers were inappropriately granted for conditions that were not necessary to mitigate or prevent conditions adverse to safety. However, because the previous evaluations were limited in scope and focus, Entergy did not develop corrective actions to address the deficient condition. [P.1(c)]

Enforcement: 10 CFR 26.207(a) states, in part, that to grant a waiver, the licensee shall determine that the waiver is necessary to mitigate or prevent a condition adverse to safety and that licensees shall rely on the granting of waivers only to address circumstances that could not have been reasonably controlled. Contrary to the above, on multiple instances in December 2011, January 2013, and September 2013, Entergy issued waivers of the work hours requirements for instances that were not necessary to mitigate or prevent conditions adverse to safety and were within Entergy's ability to control. Entergy's immediate corrective action was to enter this issue into their corrective action program as condition reports CR-PNP-2013-06706 and CR-PNP-2013-06707 for further evaluation. Because the violation was determined to be of very low

safety significance and was entered into the corrective action program, it is being treated as a non-cited violation, consistent with Section 2.3.2 of the NRC's Enforcement Policy. **(NCV 05000293/2013008-01, Inappropriate Fatigue Rule Waivers)**

(2) Failure to Maintain Station Meteorological Towers

Introduction. The inspectors identified a Green non-cited violation of 10 CFR Part 50.54(q)(2) because Entergy did not ensure that the Pilgrim Emergency Plan met the planning standards in 10 CFR 50.47(b). Specifically, on various occasions in 2012 and 2013, Pilgrim failed to maintain both meteorological towers as necessary to support emergency response.

Description. Per 10 CFR 50.54(q)(2), licensees are required to follow and maintain the effectiveness of an emergency plan that meets the planning standards of 10 CFR 50.47(b). One of these standards, 10 CFR 50.47(b)(8), requires licensees to provide and maintain adequate equipment to support emergency response. Pilgrim has two meteorological towers onsite, both of which are credited in the Pilgrim's Emergency Plan. The meteorological towers are used to provide data on the wind speed, wind direction, air temperature, and delta air temperature to perform offsite dose assessments during a radiological emergency condition. The 220' meteorological tower provides data remotely, and is the primary source used to gather this data. The 160' meteorological tower is the back-up, local data source. The local National Weather Service station is available as an alternate source of data in the event that the meteorological towers are unavailable.

In December 2011, Entergy stopped performing preventative maintenance on the 160' meteorological tower. Subsequent to the 160' meteorological tower becoming non-functional, the 220' meteorological tower was out of service from March 18, 2012, through July 19, 2012, due to a broken aspirator fan; February 8, 2013, through March 13, 2013, due to effects from winter storm Nemo, and April 26, 2013, through April 30, 2013, due to power being secured for an outage. During these periods, the 160' and 220' meteorological towers were no longer capable of providing a continuous reading of the parameters mentioned above, and therefore did not have the capability to provide accurate data necessary to perform assessment of offsite dose consequences during a radiological emergency condition, as required by Pilgrim's Emergency Plan. As a result, Entergy was relying on the information from the National Weather Service as an alternate data source.

The inspectors reviewed procedures and processes in place that allow Entergy to perform dose assessment using data obtained from the National Weather Service. In addition to being credited in the Emergency Plan as an alternate source of data, Entergy also has appropriate procedures in place to ensure that station personnel can perform dose assessment calculations accurately and in a timely manner during an event. Therefore, during the periods where both meteorological towers were out-of-service, Pilgrim would still have been able to make adequate dose assessments using National Weather Service information.

Analysis. The inspectors determined that failure to maintain the 160' and 220' meteorological towers resulting in both towers being out of service concurrently for three separate periods in 2012 and 2013 was a performance deficiency that was within

Entergy's ability to foresee and correct. This performance deficiency is more than minor because it is associated with the facilities and equipment attribute of the Emergency Preparedness cornerstone and adversely affected the cornerstone objective of ensuring the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. In accordance with IMC 0609, Appendix B, "Emergency Preparedness Significance Determination Process," Table 5.8-1, the inspectors determined the finding to be of very low safety significance (Green) because the planning standard function was degraded. Specifically, a significant amount of equipment necessary to implement the emergency plan was not functional to the extent that an emergency response organization member could not perform assigned functions, in the absence of compensatory measures. However, Pilgrim was able to make adequate dose assessments at all times using the National Weather Service to obtain necessary data.

This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because Pilgrim did not take appropriate corrective actions to address safety issues and trends in a timely manner. Specifically, the station did not take timely corrective actions to correct deficiencies associated with both meteorological towers resulting in both towers being simultaneously non-functional on multiple occasions. [P.1(d)]

Enforcement. 10 CFR 50.54(q)(2), states, in part, that a holder of a nuclear power reactor operating licensee shall follow and maintain the effectiveness of an emergency plan that meets the standards of 10 CFR 50.47(b) and the requirements in Appendix E of this part. 10 CFR 50.47(b)(8) requires, in part, that adequate equipment to support the emergency response are provided and maintained. The Pilgrim Nuclear Power Station Emergency Plan states, in part, that Pilgrim has two meteorological towers, a 220' primary and a 160' back-up, equipped with instrumentation for continuous reading of the wind speed, wind direction, air temperature, and delta air temperature. Contrary to the above, in December 2011, the licensee failed to maintain in effect a provision of its emergency plan in that emergency equipment needed to support emergency response was not provided when the station cancelled preventative maintenance for the 160' meteorological tower and the 220' meteorological tower was non-functional for extended periods of time. Entergy entered this issue into their corrective action program for further evaluation. Additionally, as of the date of this inspection, the 220' meteorological tower was functional and the National Weather Service is still available as an alternate data source. Because this finding is of very low safety significance and was entered into Entergy's corrective action program (condition report CR-PNP-2013-06829), this violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy. **(NCV 05000283/2013008-02, Failure to Maintain Station Meteorological Towers)**

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

The inspectors reviewed a sample of condition reports associated with review of industry operating experience to determine whether Entergy appropriately evaluated the operating experience information for applicability to Pilgrim and had taken appropriate actions, when warranted. The inspectors also reviewed evaluations of operating

experience documents associated with a sample of NRC generic communications to ensure that Entergy adequately considered the underlying problems associated with the issues for resolution via their corrective action program. In addition, the inspectors observed various plant activities to determine if the station considered industry operating experience during the performance of routine and infrequently performed activities.

b. Assessment

The inspectors determined that Entergy appropriately considered industry operating experience information for applicability, and used the information for corrective and preventive actions to identify and prevent similar issues when appropriate. The inspectors determined that operating experience was appropriately applied and lessons learned were communicated and incorporated into plant operations and procedures when applicable. Additionally, based on interviews with station personnel, the inspectors concluded that industry operating experience is routinely discussed during pre-job briefs and various other meetings at the site.

c. Findings

No findings were identified.

3. Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors reviewed a sample of audits, including the most recent audit of the corrective action program, departmental self-assessments, and assessments performed by independent organizations. Inspectors performed these reviews to determine if Entergy entered problems identified through these assessments into the corrective action program, when appropriate, and whether Entergy initiated corrective actions to address identified deficiencies. The inspectors evaluated the effectiveness of the audits and assessments by comparing audit and assessment results against self-revealing and NRC-identified observations made during the inspection.

b. Assessment

The inspectors concluded that self-assessments, audits, and other internal assessments were generally critical, thorough, and effective in identifying issues. The inspectors observed that station personnel knowledgeable in the subject completed these audits and self-assessments in a methodical manner. Entergy completed these audits and self-assessments to a sufficient depth to identify issues which were then entered into the corrective action program for evaluation. In general, the station implemented corrective actions associated with the identified issues commensurate with their safety significance.

c. Findings

No findings were identified.



.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

During interviews with station personnel, the inspectors assessed the safety conscious work environment at Pilgrim. Specifically, the inspectors interviewed personnel to determine whether they were hesitant to raise safety concerns to their management and/or the NRC. The inspectors also interviewed the station Employee Concerns Program coordinator to determine what actions are implemented to ensure employees were aware of the program and its availability with regards to raising safety concerns. The inspectors also reviewed Employee Concerns Program files, anonymous condition reports, and results of the most recent station safety culture survey to ensure that Entergy entered issues into the corrective action program when appropriate.

b. Assessment

During interviews, Pilgrim staff expressed a willingness to use the corrective action program to identify plant issues and deficiencies, and stated that they were willing to raise safety issues. All persons interviewed demonstrated an adequate knowledge of the corrective action program and the Employee Concerns Program. Based on these limited interviews, the inspectors concluded that there was no evidence of an unacceptable safety conscious work environment and no significant challenges to the free flow of information.

c. Findings

No findings were identified.

40A6 Meetings, Including Exit

On October 3, 2013, the inspectors presented the inspection results to Mr. John Dent, Site Vice President, and other members of the Pilgrim staff. The inspectors verified that no proprietary information was retained by the inspectors or documented in this report.

**ATTACHMENT: SUPPLEMENTARY INFORMATION**

**SUPPLEMENTARY INFORMATION**

**KEY POINTS OF CONTACT**

Licensee Personnel

J. Dent, Site Vice President  
R. Blagbrough, Engineer  
G. Blankenbiller, Chemistry Manager  
T. Bordelon, Corrective Action and Assessment Manager  
P. Broaken, Standby Liquid Control System Engineer  
S. Burgess, Radiation Protection Superintendent  
S. Cook, Emergency Operations Facility Supervisor  
M. Faunce, System Engineer  
M. Gastlick, Senior Security Compliance Supervisor  
K. Kampschneider, System Engineer  
K. Larson-Sullivan, Emergency Preparedness Specialist  
J. Leonardi, Emergency Preparedness Specialist  
K. Lowther, Employee Concerns Program Coordinator  
J. MacDonald, Operations Director  
D. Noyes, Director Regulatory and Performance Improvement  
D. Oberist, Engineer  
J. O'Donnell, High Pressure Coolant Injection System Engineer  
R. O'Neill, Operations Shift Manager  
D. Peyvan, Component Engineer  
J. Priest, Emergency Preparedness Manager  
J. Sabina, In-Service Testing Program Engineer  
K. Sejkora, Chemistry Specialist  
T. White, Contractor  
M. Williams, Licensing Specialist

NRC Personnel

M. Schneider, Senior Resident Inspector

**LIST OF ITEMS OPENED, CLOSED, DISCUSSED, AND UPDATED**

Opened and Closed

05000293/2013008-01	NCV	Inappropriate Fatigue Rule Waivers
05000293/2013008-02	NCV	Failure to Maintain Station Meteorological Towers
05000293/2013008-03	NCV	Security Finding

**LIST OF DOCUMENTS REVIEWED**

**Section 40A2: Problem Identification and Resolution**

Audits and Self-Assessments

Assessment of Pilgrim Station Employee Concerns Program, March 2013  
LO-PNPLO-2011-00030, Snapshot Assessment on Quality of Higher Tier Apparent Cause Evaluations  
LO-PNPLO-2011-00126, Snapshot/Benchmark Assessment on Internal – Operability Determinations  
LO-PNPLO-2011-00145, Snapshot Assessment on Emergency Response Organization and Everbridge  
LO-PNPLO-2012-00009, Snapshot Assessment on the Motor Operated Valve Program  
LO-PNPLO-2012-00011, Snapshot Assessment on 2011 ESP PSCT  
LO-PNPLO-2012-00023, Snapshot Assessment on Key System Health  
LO-PNPLO-2012-00027, Focused Self-Assessment on Single Point Vulnerabilities  
LO-PNPLO-2012-00034, Benchmarking Assessment on Engineering Work Management  
LO-PNPLO-2012-00062, Focused Self-Assessment on the Preventive Maintenance Program  
LO-PNPLO-2012-00103, Snapshot Assessment on EQRT  
LO-PNPLO-2012-00124, Focused Self-Assessment on Security Equipment Maintenance  
LO-PNPLO-2013-00030, Focused Self-Assessment on the Corrective Action Program  
QA-03-2011-PNPS-1, Corrective Action Program Audit  
QA-03-2012-PNPS-1, Corrective Action Program Audit  
QA-04-2012-PNP-1, Engineering (Design Control)  
QA-07-2011-PNP-1, Emergency Plan  
QA-07-2013-PNP-1, Emergency Preparedness  
QA-08-2011-PNP-1, Engineering Programs  
QA-08-2013-PNP-1, Engineering Programs

Condition Reports (\* indicates that condition report was generated as a result of this inspection)

CR-PNP-2008-00070	CR-PNP-2011-02303	CR-PNP-2011-03986
CR-PNP-2010-03289	CR-PNP-2011-02381	CR-PNP-2011-04077
CR-PNP-2011-00272	CR-PNP-2011-02475	CR-PNP-2011-04387
CR-PNP-2011-00511	CR-PNP-2011-02538	CR-PNP-2011-04484
CR-PNP-2011-00980	CR-PNP-2011-02609	CR-PNP-2011-04595
CR-PNP-2011-00989	CR-PNP-2011-02664	CR-PNP-2011-04601
CR-PNP-2011-01049	CR-PNP-2011-02715	CR-PNP-2011-04877
CR-PNP-2011-01171	CR-PNP-2011-02751	CR-PNP-2011-05044
CR-PNP-2011-01188	CR-PNP-2011-02802	CR-PNP-2011-05066
CR-PNP-2011-01432	CR-PNP-2011-02926	CR-PNP-2011-05154
CR-PNP-2011-01461	CR-PNP-2011-02989	CR-PNP-2011-05200
CR-PNP-2011-01510	CR-PNP-2011-03018	CR-PNP-2011-05201
CR-PNP-2011-01521	CR-PNP-2011-03056	CR-PNP-2011-05677
CR-PNP-2011-01636	CR-PNP-2011-03210	CR-PNP-2011-05738
CR-PNP-2011-01736	CR-PNP-2011-03236	CR-PNP-2011-05939
CR-PNP-2011-02012	CR-PNP-2011-03368	CR-PNP-2012-00115
CR-PNP-2011-02160	CR-PNP-2011-03598	CR-PNP-2012-00155
CR-PNP-2011-02181	CR-PNP-2011-03629	CR-PNP-2012-00171
CR-PNP-2011-02252	CR-PNP-2011-03809	CR-PNP-2012-00197

CR-PNP-2012-00229	CR-PNP-2013-00147	CR-PNP-2013-03322
CR-PNP-2012-00230	CR-PNP-2013-00157	CR-PNP-2013-03335
CR-PNP-2012-00355	CR-PNP-2013-00245	CR-PNP-2013-03432
CR-PNP-2012-00715	CR-PNP-2013-00262	CR-PNP-2013-03457
CR-PNP-2012-00774	CR-PNP-2013-00589	CR-PNP-2013-03520
CR-PNP-2012-00860	CR-PNP-2013-00610	CR-PNP-2013-04231
CR-PNP-2012-00872	CR-PNP-2013-00651	CR-PNP-2013-04302
CR-PNP-2012-01045	CR-PNP-2013-00666	CR-PNP-2013-04697
CR-PNP-2012-01154	CR-PNP-2013-00700	CR-PNP-2013-04755
CR-PNP-2012-01296	CR-PNP-2013-00731	CR-PNP-2013-04758
CR-PNP-2012-01332	CR-PNP-2013-00872	CR-PNP-2013-04789
CR-PNP-2012-01490	CR-PNP-2013-00916	CR-PNP-2013-04808
CR-PNP-2012-01518	CR-PNP-2013-00919	CR-PNP-2013-04841
CR-PNP-2012-01594	CR-PNP-2013-01029	CR-PNP-2013-05018
CR-PNP-2012-02764	CR-PNP-2013-01078	CR-PNP-2013-05054
CR-PNP-2012-02884	CR-PNP-2013-01176	CR-PNP-2013-05106
CR-PNP-2012-02980	CR-PNP-2013-01215	CR-PNP-2013-05154
CR-PNP-2012-03564	CR-PNP-2013-01254	CR-PNP-2013-05164
CR-PNP-2012-03637	CR-PNP-2013-01320	CR-PNP-2013-05457
CR-PNP-2012-03866	CR-PNP-2013-01360	CR-PNP-2013-05737
CR-PNP-2012-04058	CR-PNP-2013-01569	CR-PNP-2013-05777
CR-PNP-2012-04123	CR-PNP-2013-01570	CR-PNP-2013-06096
CR-PNP-2012-04235	CR-PNP-2013-01575	CR-PNP-2013-06186
CR-PNP-2012-04362	CR-PNP-2013-01708	CR-PNP-2013-06195
CR-PNP-2012-04446	CR-PNP-2013-01924	CR-PNP-2013-06276
CR-PNP-2012-04467	CR-PNP-2013-01966	CR-PNP-2013-06485*
CR-PNP-2012-04759	CR-PNP-2013-02154	CR-PNP-2013-06519*
CR-PNP-2012-04806	CR-PNP-2013-02190	CR-PNP-2013-06623*
CR-PNP-2012-05076	CR-PNP-2013-02522	CR-PNP-2013-06706*
CR-PNP-2012-05336	CR-PNP-2013-02700	CR-PNP-2013-06707*
CR-PNP-2012-05405	CR-PNP-2013-02774	CR-PNP-2013-06829*
CR-PNP-2012-05682	CR-PNP-2013-02965	CR-PNP-2013-06830*
CR-PNP-2012-05727	CR-PNP-2013-02976	CR-PNP-2013-13672
CR-PNP-2012-05809	CR-PNP-2013-03081	

Drawings

M223, P&ID Diesel Oil Storage & Transfer System, Revision 33  
M243, P&ID HPCI System, Revision 54  
M244, P&ID HPCI System, Sheet 1, Revision 31  
M244, P&ID HPCI System Turbine Lube and Control Oil Subsystem, Sheet 2, Revision 10  
M288, Turbine Building Air Flow Diagram, Revision 15  
M227, Containment Atmospheric Control System, Sheet 1, Revision 60

Non-Cited Violations and Findings

FIN 05000293/2011003-02, Submerged Medium Voltage Cables  
FIN 05000293/2012005-03, Inadequate Design Control for Station Blackout Battery  
NCV 05000293/2011003-05, Failure to Enter Technical Specifications after Loss of Control Rod Indication  
NCV 05000293/2011004-01, Failure to Verify the Adequacy of the Design for the 'C' Salt Service Water Pump

NCV 05000293/2011007-02, Inadequate Test Control of Safety-Related Batteries  
NCV 05000293/2012403-01, Security Finding  
NCV 05000293/2012403-02, Security Finding

Procedures

2.4.11.1, CRD System Malfunctions, Revision 23  
2.4.153, Loss of Turbine Building/Aux Bay Area Ventilation, Revision 21  
3.M.3-61.2, General and Preventive Maintenance Corrective Actions – Critical Maintenance, Revision 37  
6.1-220, Radiological Controls for High Risk Evolutions, Revision 12  
7.1.87, Diesel Fuel Oil Storage Tank Sampling, Revision 19  
8.5.5.1, RCIC Pump Quarterly and Biennial Operability Flow Rate and Valve Test at Approximately 1000 PSIG, Revision 76  
8.9.1, Emergency Diesel Generators on Site Fuel Oil Quantity, Attachment 3, Revision 126  
8.A.1, Drywell to Torus Vacuum Breaker Monthly/Quarterly Operability, Revision 47  
8.E.71, Surveillance, Maintenance, and Calibration of 160' MET Tower, Revision 14  
EN-EC-100, Guidelines for Implementation of the Employee Concerns Program, Revision 6  
EN-EC-100-01, Employee Concern Coordinator Training Program, Revision 1  
EN-EP-202, Equipment Important to Emergency Preparedness, Revision 1  
EN-FAP-LI-001, Condition Review Group (CRG), Revision 4  
EN-FAP-LI-003, Corrective Action Review Board (CARB) Process, Revision 11  
EN-FAP-LI-004, Corrective Action Program Performance Indicators, Revision 3  
EN-FAP-LI-006, Self-Assessment Review Board (SARB) Process, Revision 4  
EN-FAP-OP-006, Operator Aggregate Impact Index Performance Indicator, Revision 0  
EN-LI-102, Corrective Action Process, Revision 21  
EN-LI-104, Self-Assessment and Benchmark Process, Revision 9  
EN-LI-118, Root Cause Evaluation Process, Revision 18  
EN-LI-119, Apparent Cause Evaluation (ACE) Process, Revision 16  
EN-LI-121, Trending and Performance Review Process, Revision 13  
EN-OE-100, Operating Experience Program, Revision 19  
EN-OM-123, Fatigue Management Program, Revision 4  
EN-OP-104, Operability Determination Process, Revision 6  
EN-OP-111, Operational Decision-Making Issue (ODMI) Process, Revision 11  
EN-PL-100, Nuclear Safety and Management Expectations, Revision 2  
EN-PL-187, Safety Conscious Work Environment (SCWE) Policy, Revision 1  
EN-PL-190, Maintaining a Strong Safety Culture, Revision 2  
EN-QV-109, Audit Process, Revision 25  
EN-QV-135, Nuclear Oversight Performance Assessments, Revision 3  
EN-QV-136, Nuclear Safety Culture Monitoring, Revision 1  
EP-IP-100.1, Emergency Action Levels (EALs), Revision 8  
EP-IP-300, Offsite Radiological Dose Assessment, Revision 9

Miscellaneous

Climatronics Job No. 10105, Boston Edison Company, Purchas Order No. 67559  
Facility Operating License DPR-35: Annual Radioactive Effluent Release Report, January 1 through December 31, 2012  
Facility Operating License DPR-35: Annual Radioactive Effluent Release Report, January 1 through December 31, 2011  
Facility Operating License DPR-35: Annual Radioactive Effluent Release Report, January 1 through December 31, 2010

Licensed Operator Requalification, 2010-2012 PSU Cycle 9  
Maintenance Rule (a)(1) Evaluation: System 50 – Primary Containment System  
Maintenance Rule Document, Primary Containment System Spreadsheet – 1 Scoping  
Maintenance Rule Document, Primary Containment System Spreadsheet – 2 Risk Significance  
Maintenance Rule Document, Primary Containment System Spreadsheet – 3 Performance  
Criteria Levels  
Maintenance Rule Document, Primary Containment System Spreadsheet – 5 PC Value  
MRAP-2011-004, Maintenance Rule (a)(1) Action Plan: Primary Containment – System 50,  
Revision 0  
Pilgrim Condition Review Group Pre-Screen Report, 09/19/2013  
Pilgrim Condition Review Group Summary Agenda Report, 09/17/2013  
Pilgrim Condition Review Group Summary Agenda Report, 09/19/2013  
Pilgrim Nuclear Power Station Offsite Dose Calculation Manual, Revision 10  
Pilgrim Nuclear Power Station Updated Final Safety Analysis Report, Revision 28  
Reactor Core Isolation Cooling System Health Report, 2Q-2013

### LIST OF ACRONYMS

ADAMS	Agency-wide Documents Access and Management System
BSSDP	Baseline Security Significance Determination Process
CFR	Code of Federal Regulations
IMC	Inspection Manual Chapter
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records System