



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION I
2100 RENAISSANCE BLVD.
KING OF PRUSSIA, PA 19406-2713

November 15, 2016

Mr. David Lochbaum
1825 K Street NW, Suite 800
Washington, DC 20006-1232

Dear Mr. Lochbaum:

I am responding to your June 27, 2016, email to Ms. Diane Screnci and Mr. Neil Sheehan that included several questions about an event discussed in Pilgrim Licensee Event Report (LER) 05000293/2016001-001. The LER described an April 12, 2016, event that caused both the 'A' and 'B' emergency diesel generators (EDGs) to be inoperable at the same time. You questioned the adequacy of Entergy performance during the event and the extent of its impact on the plant's safety.

As of September 30, 2016, we completed our inspection of this event per Inspection Procedure 71153, Event Response. The results of the inspection are documented in NRC Inspection Report 05000293/2016003 (ADAMS Accession No. ML16319A206). Because the inspectors did not identify any findings or violations during the inspection, per NRC Inspection Manual Chapter 0612, the report will not contain the additional detail that you requested in your June 27, 2016, letter. In the following paragraphs we hope to provide you the answers to your questions.

As you stated in your email, according to the LER, to prevent recurrence of this event, Entergy enhanced site procedures by adding steps to inspect the instrument cabinets for the opposite train EDG before performing scheduled maintenance on either EDG. You asked whether this meant that on April 12, 2016, Entergy had removed the 'B' EDG from service without knowing whether it was likely that the 'A' EDG was operable. You also asked how often, by procedure, Pilgrim workers enter the 'A' EDG room and if they had exceeded any applicable technical specification action statements as a result of the leak.

The inspectors reviewed logs and procedures and also conducted interviews with Entergy staff who operate and maintain the EDGs. During normal operations, once-per-shift and weekly walkdowns and monthly loaded-run periodic surveillance tests confirm the EDGs remain operable. During the once-per-shift walkdowns, Pilgrim procedures direct operators to review start system air pressures, fuel tank levels, and lube oil levels. During the weekly walkdowns, operators monitor EDG support system pressures and temperatures, check ventilation damper positions, and look for abnormal leakage indications. Deficiencies identified during these activities require immediate corrective action to ensure the EDGs are functioning properly. In addition, to maintain the plant in a safe condition, the plant's technical specifications direct specific actions to be taken if an EDG is discovered to be inoperable until the affected EDG can be restored.

Before removing an EDG from service for maintenance, Pilgrim procedures did not require a physical walkdown to verify the operability condition of the other EDG. A walkdown of the other EDG was only required, per the plant's technical specifications, after one EDG was discovered inoperable, to ensure the second EDG is not subject to the same condition. On April 10, the 'B' EDG was removed from service for planned maintenance, therefore, a physical walkdown of the 'A' EDG was not required prior to removing the 'B' EDG from service. However, before the other EDG was removed from service, site procedures directed operators to perform an administrative review of testing and walkdown documentation to confirm required surveillance testing and once-per-shift and weekly walkdowns were completed. The inspectors confirmed that on April 10 all walkdowns and surveillance testing had been completed in accordance with procedure requirements before the 'B' EDG was removed from service for maintenance.

Through staff interviews, the inspectors confirmed that a night-shift non-licensed operator identified water leaking from the instrument cabinet during a once-per-shift walkdown at 10:30 pm on April 11. The operator estimated that there was less than a gallon of water on the floor and that it had not yet reached the floor drain. The previous shift operator, who had entered the room at approximately 2:30 pm on April 11, did not report any evidence of leaks. The inspectors also determined that the EDG jacket water system expansion tank low-level alarm, at 24 gallons, was not alarming at the time of discovery, and the tank was at the normal level of about 32 gallons. The inspectors concluded that Pilgrim operators were performing EDG walkdowns in accordance with procedure requirements, and that neither the weekly nor the once-per-shift walkdown directed operators to open the instrument cabinet where the leakage was eventually discovered on April 12.

Following the event, the inspectors conducted independent EDG room walkdowns, which included opening the instrument cabinet where the leak occurred. Based on the walkdown and how the leak was identified on April 11, they determined that a leak inside the cabinet would be visible outside the cabinet shortly after it started because of the location of the leak inside the cabinet and the fact that the cabinet was not watertight. Additionally, there was less than one gallon of water in the vicinity of the leak. This suggests that the time that this leak had existed before it was discovered was likely only a few hours. Therefore, the inspectors concluded that it was not likely that the 'A' EDG was inoperable when Entergy removed the 'B' EDG from service on April 10 and that Pilgrim did not operate for longer than the maximum time permitted (24 hours) by the operating license for both EDGs to be inoperable.

As a result of this event, because Pilgrim recognized that this type of leak might not be immediately visible to operators and could result in placing the plant in a condition where both EDGs were inoperable when performing maintenance, Pilgrim added steps to inspect the instrument cabinets for the opposite train EDG before performing scheduled maintenance on either EDG.

The inspectors concluded that Pilgrim had complied with all technical specification action statement and procedure requirements and that no performance deficiencies were identified related to the event discussed in Pilgrim LER 05000293/2016001-001, Both Emergency Diesels Inoperable.

D. Lochbaum

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The inspectors also concluded that procedure changes completed following the event should ensure it does not occur again. We hope that this addresses your concerns regarding this Pilgrim LER. However, if you have additional questions or concerns regarding this issue, please feel free to contact me at 610-337-5373.

Sincerely,

/RA/

Leonard M. Cline, Senior Project Engineer
Reactor Projects Branch 5
Division of Reactor Projects

D. Lochbaum

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Leonard M. Cline, Senior Project Engineer
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