

# Pilgrim 1

## 2Q/2012 Plant Inspection Findings

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### Initiating Events

**Significance:** **W** Jul 20, 2011

Identified By: Self-Revealing

Item Type: VIO Violation

#### **Failure to Implement Conduct of Operations and Reactivity Control Procedures during Reactor Startup**

A self-revealing finding was identified involving the failure of Pilgrim personnel to implement conduct of operations and reactivity control standards and procedures during a reactor startup, which contributed to an unrecognized subcriticality followed by an unrecognized return to criticality and subsequent reactor scram.

The significance of the finding has been determined to be White, or of low to moderate safety significance. The finding is also associated with one apparent violation of NRC requirements specified by Technical Specification 5.4, "Procedures." There was no significant impact on the plant following the transient because the event itself did not result in power exceeding license limits or fuel damage. Additionally, interim corrective actions were taken, which included removing the Pilgrim control room personnel involved in the event from operational duties pending remediation, providing additional training for operators not involved with the event, and providing increased management oversight presence in the Pilgrim control room while long term corrective actions were developed. Entergy staff entered this issue, including the evaluation of extent of condition, into its corrective action program (CR-PNP-2011-2475) and performed a Root Cause Evaluation (RCE).

The finding is more than minor because it was associated with the Human Performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Specifically, the failure of Pilgrim personnel to effectively implement conduct of operations and reactivity control standards and procedures during a reactor startup caused an unrecognized subcriticality followed by an unrecognized return to criticality and subsequent reactor scram. Because the finding primarily involved multiple human performance errors, probabilistic risk assessment tools were not well suited for evaluating its significance. The inspection team determined that the criteria for using IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria," were met, and the finding was evaluated using this guidance, as described in Attachment 4 to this report. Based on the qualitative review of this finding, the NRC has concluded that the finding was of low to moderate safety significance (White).

The inspection team determined that multiple factors contributed to this performance deficiency, including: inadequate enforcement of operating standards, failure to follow procedures, and ineffective operator training. The Entergy RCE determined that the primary cause was a failure to adhere to established Entergy standards and expectations due to a lack of consistent supervisory and management enforcement. The inspection team concluded that the finding had a cross-cutting aspect in the Human Performance cross-cutting area, Work Practices component, because Entergy did not adequately enforce human error prevention techniques, such as procedural adherence, holding pre-job briefs, self and peer checking, and proper documentation of activities during a reactor startup, which is a risk significant evolution. Additionally, licensed personnel did not effectively implement the human performance prevention techniques mentioned above, and they proceeded when they encountered uncertainty and unexpected circumstances during the reactor startup [H.4(a)]. (Section 2)

Inspection Report# : [2011012](#) (*pdf*)

Inspection Report# : [2011013](#) (*pdf*)

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### Mitigating Systems

**G****Significance:** Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Verify the Adequacy of the Design of MCC-B18 with Respect to Internal Flooding**

The inspectors identified a finding of very low safety significance (Green) involving a non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control", because Entergy did not verify the adequacy of the design of the Motor Control Center (MCC) B-18 enclosure. Specifically, Entergy had not previously evaluated the susceptibility of MCC B-18 to internal flooding from a potential pipe break by the use of calculational methods or by the performance of design reviews. Entergy entered this issue in the corrective action program (CR-PNP-2012-1351).

The performance deficiency was determined to be more than minor because it is associated with the Design Control attribute of the Mitigating Systems cornerstone, and adversely affected the cornerstone's objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. The inspectors used IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings" and IMC 0609 Appendix A, Exhibit 2, "Mitigating Systems Screening." The finding was determined to be of very low safety significance (Green) because the finding was a design deficiency and did not represent a loss of system and/or function or the loss of a single train for greater than its Technical Specification outage time. The finding does not have a cross-cutting aspect since the verification of the MCC B18 design is not indicative of current licensee performance. Entergy's current design change procedures require an evaluation of flooding vulnerabilities for new modifications. (Section 1R06)

Inspection Report# : [2012003](#) (*pdf*)**G****Significance:** Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Scope the Rod Worth Minimizer into the Maintenance Rule**

The inspectors identified an NCV of very low safety significance (Green) of 10 CFR Part 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy did not include the Rod Worth Minimizer (RWM) system into the scope of Maintenance Rule (MR) systems. Specifically, Entergy did not include the RWM system into the scope of the MR monitoring program as required by 10 CFR 50.65 (b)(2)(i) as a non-safety related system that is relied upon to mitigate accidents or transients. Entergy entered this issue in the corrective action program (CR-PNP-2012-0394).

The inspectors performed a review of IMC 0612, Appendix E, "Examples of Minor Issues," and determined the issue was more than minor because it was similar to example 7.d; in that, the RWM system was not within the scope of the Maintenance Rule and that equipment performance problems were such that effective control of performance could not be demonstrated. The finding was also determined to be more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and affected the availability of the RWM to provide its mitigation function for a control rod drop accident (CRDA). This finding had a cross-cutting aspect in the Problem Identification and Resolution cross-cutting area, Self Assessment component, because previous assessments performed by Entergy did not include Maintenance Rule scoping attributes nor did they identify scoping issues such as the RWM system. [P.3(a)] (Section 1R12)

Inspection Report# : [2012002](#) (*pdf*)**G****Significance:** Dec 31, 2011

Identified By: NRC

Item Type: FIN Finding

**Written NRC Biennial Written Examinations did not meet Qualitative Standards**

Green. The inspectors identified a Green finding of 10 CFR 55.59, "Requalification," based on a determination that greater than 20 percent of the biennial requalification written exam questions administered to licensed operators during weeks three and four of the 2010 examination cycle were unacceptable. Entergy entered this issue into the corrective action program (CR-PNP-2011-04561).

The inspectors determined that the finding was more than minor because it was associated with the Human Performance attribute of the Mitigation Systems cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the finding affected the quality and level of difficulty of biennial written exams which potentially impacted Entergy's ability to appropriately evaluate licensed operators. The risk importance of this issue was evaluated using IMC 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)." Appendix I was entered using the number of written exam questions that did not meet the qualitative standard for the written exam questions. The qualitative standard used by the inspectors is defined in NUREG-1021, Rev. 9, ES-602, Attachment 1, "Guidelines for Developing Open-Reference Examinations," and Appendix B, "Written Examination Guidelines." Since 28.6 percent of the questions reviewed did not meet the guidance, Block 16 of Appendix I applied, specifically, "Were more than 20 percent of the written questions sampled by the inspectors unacceptable?" Based on this screening criteria, the finding was characterized by the SDP as having very low safety significance (greater than 20 percent unacceptable), or Green. A review of the cross-cutting aspects was performed and no cross-cutting aspect was identified that would be considered a contributor to the cause of the finding. (Section 1R11)

Inspection Report# : [2011005](#) (pdf)

**Significance:** TBD Dec 31, 2011

Identified By: NRC

Item Type: AV Apparent Violation

**Licensed Operators Stood Watch Without Being Medically Qualified**

TBD. The inspectors identified an apparent violation (AV) of Title 10 of the Code of Federal Regulations (10 CFR) 55.53 and 10 CFR 55.21 related to Entergy's medical examinations of licensed operators. Specifically, at various times over a period of almost four years, ten operators did not meet certain medical requirements (for stamina and/or blood pressure) for performing NRC-licensed operator activities, and the operators continued to perform NRC-licensed activities. Additionally, Entergy did not perform complete medical testing of its licensed operators, in that five of those licensed operators had not been administered stamina tests for more than two years and therefore did not complete their NRC-required biennial medical exam. Immediately after the NRC identified the issue, Entergy restricted operators from watch until they could pass the requirements of their medical testing. Entergy entered this issue into their corrective action program (CR-PNP-2011-04554).

The inspectors determined that Entergy's failure to ensure that licensed operators met the license conditions associated with medical testing prior to performing license activities was a performance deficiency that was within Entergy's ability to foresee and correct and should have been prevented. The inspectors determined that Traditional Enforcement applies, as the issue had the potential to impact the NRC's ability to perform its regulatory function because the NRC relies upon the accurate certification by the licensee's medical examiner to ensure all licensed operators meet the medical conditions of their license. Specifically, ten operators had not taken the stamina test during their annual physical, but were certified by the medical examiner and licensee as being fit to safely perform their watch-standing duties. Additionally, five of those operators had not taken the stamina test during their biennial physical, but were certified by the medical examiner and licensee as being fit to safely perform their watch-standing duties. Lastly, an individual who had not passed their blood pressure examination, and required a license condition to take medication, was placed back on watch-standing duty without such a license condition. The performance deficiency was screened against the Reactor Oversight Process (ROP) per the guidance of Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening." No associated ROP finding was identified and no cross-cutting aspect was assigned. These issues are being characterized as an apparent violation in accordance with the NRC's Enforcement Policy, and its final significance will be dispositioned in separate future correspondence. (Section 1R11)

Inspection Report# : [2011005](#) (pdf)

**Significance:** TBD Dec 31, 2011

Identified By: NRC

Item Type: AV Apparent Violation

**Entergy did not Provide Complete and Accurate Medical Information for Licensed Operator Renewal Applications**

TBD. The inspectors identified an AV of 10 CFR 50.9, "Completeness and Accuracy of Information," related to Entergy's medical examinations of licensed operators. Specifically, Entergy did not provide information to the NRC that was complete and accurate in all material respects, in that Entergy submitted two NRC licensed operator renewal applications which certified that the applicants met the medical requirements for license renewal when in fact they did not complete the required stamina tests. Entergy entered this issue into their corrective action program (CR-PNP-2011-04554).

The inspectors determined that Entergy's failure to provide complete and accurate information to the NRC was a performance deficiency that was within Entergy's ability to foresee and correct and should have been prevented. The inspectors determined that Traditional Enforcement applies, as the issue had the potential to impact the NRC's ability to perform its regulatory function. Specifically, Entergy did not provide information to the NRC that was complete and accurate in all material respects, in that although Entergy had not administered complete medical examinations of licensed operators in accordance with American National Standards Institute/American Nuclear Society (ANSI/ANS) 3.4-1983 (because it had not conducted stamina testing), it submitted two NRC Form 396s for renewal of operator licenses which certified that the applicants met the medical requirements of ANSI/ANS 3.4-1983. Subsequently, the NRC made a licensing decision based on this information that was not complete and accurate in all material respects. The performance deficiency was screened against the ROP per the guidance of IMC 0612, Appendix B, "Issue Screening." No associated ROP finding was identified and no cross-cutting aspect was assigned. This issue constitutes an apparent violation in accordance with the NRC's Enforcement Policy, and its final significance will be dispositioned in separate future correspondence. (Section 1R11)

Inspection Report# : [2011005](#) (pdf)

**Significance: TBD** Dec 31, 2011

Identified By: NRC

Item Type: AV Apparent Violation

**Entergy did not Notify the NRC Within 30 Days of Discovering Changes in Medical Conditions**

TBD. The inspectors identified an AV of 10 CFR 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, Entergy did not notify the NRC within 30 days of discovering a change in medical condition for two licensed operators. Subsequently, Entergy submitted notifications for both operators on November 10, 2011, and entered the issue into their corrective action program (CR-PNP-2011-04554).

The inspectors determined that Entergy's failure to notify the NRC within 30 days of discovering the change in medical condition for two licensed operators was a performance deficiency that was within Entergy's ability to foresee and correct and should have been prevented. The inspectors determined that Traditional Enforcement applies, as the issue had the potential to impact the NRC's ability to perform its regulatory function because if a licensed operator has a change in medical condition, the NRC may need to perform a review for consideration of a licensing action. Specifically, Entergy had not notified the NRC within 30 days of learning of a change in medical condition for two licensed operators for which a license condition was required. The performance deficiency was screened against the ROP per the guidance of IMC 0612, Appendix B, "Issue Screening." No associated ROP finding was identified and no cross-cutting aspect was assigned. This issue constitutes an apparent violation in accordance with the NRC's Enforcement Policy, and its final significance will be dispositioned in separate future correspondence. (Section 1R11)

Inspection Report# : [2011005](#) (pdf)

**Significance: SL-IV** Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Entergy Incorrectly Credited Operators Proficiency Watch-Standing Experience and the Operators Subsequently Stood Watch**

SL-IV. The inspectors identified a Severity Level IV NCV of 10 CFR 55.53 (e) and (f), "Conditions of Licenses," because Entergy incorrectly credited two individuals for proficiency watch-standing experience and then these operators subsequently stood watch without meeting the minimum proficiency requirements necessary to maintain an active license. Entergy implemented immediate corrective action that included discontinuing the practice of crediting the emergency core cooling system (ECCS) and Extra Balance of Plant (BOP) positions for proficiency. Entergy entered this issue into their corrective action program (CR-PNP-2011-04649).

The inspectors determined that Entergy incorrectly credited two individuals for proficiency watch-standing experience and then these operators subsequently stood watch in the control room. This error constitutes a performance deficiency that was within Entergy's ability to foresee and correct and should have been prevented. The inspectors determined that Traditional Enforcement applies, as the issue had the potential to impact the NRC's ability to perform its regulatory function because if a licensed operator fails to meet the conditions of their license, the NRC may need to perform a review for consideration of a licensing action, and if the information regarding an individual's qualifications is not accurately presented, the NRC could potentially make an incorrect licensing decision based on the inaccurate information. Specifically, Entergy did not ensure that two reactor operator (RO) licensed individuals maintained their RO licenses in an active status in the 2nd quarter 2011, prior to standing RO watches in the 3rd quarter 2011 which violated a license condition as specified in 10 CFR 55.53 (e) and (f). The performance deficiency was screened against the ROP per the guidance of IMC 0612, Appendix B, "Issue Screening." No associated ROP finding was identified and no cross-cutting aspect was assigned. This issue is similar to violation example 6.4.c.1(c) in the NRC Enforcement Policy for a Severity Level III violation because it involves noncompliance with a condition stated on an individual's license. However, since there were no adverse impacts to nuclear safety, the NRC has determined that this issue constitutes a Severity Level IV NCV in accordance with the NRC's Enforcement Policy. (Section 1R11)

Inspection Report# : [2011005](#) (pdf)

**G**

**Significance:** Oct 06, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Evaluation of the Adequacy of the 4160 Volt Emergency Bus 95% Voltage Alarm and Load Shed Relay Design**

Green: The team identified a finding of very low safety significance involving a non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, Design Control, because Entergy had not verified the adequacy of the 4160 volt emergency bus 95% voltage alarm/load shed relay design regarding the potential for multiple starts of the salt service water (SSW) and reactor building closed cooling water (RBCCW) pump motors. Additionally, Entergy had not verified the adequacy of design with respect to the ability of the SSW pump motors to restart following a load shed of the motors without tripping the motor control center (MCC) thermal overload (TOL) relays at design basis degraded voltage conditions. Entergy entered the issue into their corrective action program and implemented measures to bypass the SSW pump motor TOL relay motor trips based on their initial review of TOL margin. The team determined this to be a conservative action which ensured under all conditions including degraded voltage, that the SSW pump motors would not be inadvertently tripped due to TOL margin concerns.

The performance deficiency was determined to be more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Significance Determination Process, Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of findings." The finding was determined to be of very low safety significance because it was a design deficiency confirmed not to result in a loss of operability. This finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance. (Section 1R21.2.1.1)

Inspection Report# : [2011007](#) (pdf)

**G**

**Significance:** Oct 06, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Test Control of Safety Related Batteries**

Green: The team identified a finding of very low safety significance involving a non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XI, Test Control, because Entergy did not adequately perform battery discharge testing and assure that the battery discharge test procedures incorporated requirements contained in applicable design

documents for multiple cycles of Technical Specification (TS) required surveillance testing of the station batteries. Specifically, test results have been negatively impacted because of improper use of battery test equipment and tests had errors with load profiles. Entergy entered these issues into the corrective action program to evaluate and correct the deficiencies in the battery testing program and ensure any future testing requirements are met.

The performance deficiency was determined to be more than minor because it was associated with the procedure quality attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Significance Determination Process, Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings." The team determined the finding was of very low safety significance because it was not a design or qualification deficiency, did not represent a loss of system safety function, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Human Performance, Resources Component, because Entergy did not ensure that complete, accurate, and up-to-date procedures were available and adequate to assure nuclear safety. Specifically, the battery discharge test procedures did not ensure that capacities were correctly measured and service test profiles were correctly translated from the battery design calculations. (IMC 0310, Aspect H.2(c)) (Section 1R21.2.1.2)

Inspection Report# : [2011007](#) (pdf)

**Significance:**  Oct 06, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Evaluaton of the Affect of Non Class I Equipment Internal Flooding on Redundant Safety Related Equipment**

Green: The team identified a finding of very low safety significance involving a non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, Design Control, because Entergy did not verify the adequacy of the design with respect to ensuring that safety-related equipment would be adequately protected from a postulated flood originating in the turbine building. Specifically, Entergy did not correctly evaluate a failure of seawater system piping or equipment that could challenge the doors separating the turbine building from the reactor building auxiliary bay, which would require timely operator identification and action to secure the seawater pumps to prevent the common mode failure of redundant safety-related components. Entergy entered the issue into their corrective action program, evaluated the immediate operability of systems potentially affected by the postulated flooding scenario, and provided interim guidance to operators.

The performance deficiency was determined to be more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and completed a Phase 3 risk evaluation using the Pilgrim Standardized Plant Analysis Risk (SPAR) model, Revision 8.15 and SAPHIRE 8. Based upon the Phase 3 evaluation, the finding was determined to be of very low safety significance. The finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance. (Section 1R21.2.2.3)

Inspection Report# : [2011007](#) (pdf)

**Significance:**  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Verify the Adequacy of the Design for the 'C' Salt Service Water Pump**

Green. The inspectors identified a Green NCV of 10 CFR Part 50, Appendix B, Criterion III, Design Control, because Entergy's design control measures did not ensure two-over-one seismic protection of the 'C' Salt Service Water (SSW) Pump. Specifically, Entergy did not ensure that a Class I to Class II interface would not result in a failure of a

Class I component ('C' SSW Pump). Corrective actions included installing a temporary modification (i.e., water shield), to protect the pump motor from potential spray effects of a Class II piping failure and performing an extent of condition review.

The inspectors performed a review of Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," and did not find a similar more than minor example. The finding was determined to be more than minor because it was associated with the Protection Against External Events (i.e., seismic) attribute of the Mitigating Systems Cornerstone, and adversely affected the cornerstone's objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the 'C' SSW pump motor was vulnerable to water spray from a failed Class II pipe during a seismic event which could have rendered the pump inoperable. The inspectors used IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and determined that further evaluation was required since the finding was potentially risk significant due to a seismic initiating event. As a result of this screening, a Phase 3 evaluation was conducted by a regional Senior Reactor Analyst (SRA). The condition was assessed as Green, with a change in core damage frequency (CDF) calculated to be 1.29E-8. Since the finding was assessed to have a CDF of less than 1E-7, large early release frequency was not required to be assessed. The finding does not have a cross-cutting aspect since the failure to verify the adequacy of design with respect to ensuring two-over-one seismic protection for the 'C' SSW pump is not indicative of current licensee performance. In addition, current Entergy design procedures require rigorous Class II-over-I criteria for all new modifications. (Section 1R06)

Inspection Report# : [2011004](#) (pdf)

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## Barrier Integrity

**Significance:**  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Identify a Primary Containment System Maintenance Rule Functional Failure and Thereby Establish Monitoring Requirements for the System**

Green. The inspectors identified a Green NCV of 10 CFR 50.65, paragraph (a)(1) and (a)(2), "Requirements for Monitoring the Effectiveness of Maintenance of Nuclear Power Plants," because Entergy did not monitor the performance of the Primary Containment System (Drywell to Torus Vacuum Breaker Components) against license-established goals to provide reasonable assurance that these components are capable of fulfilling their intended functions. Specifically, Entergy did not identify a functional failure of the Drywell to Torus Vacuum Breaker Component portion of the Primary Containment System and thereby did not recognize that the system exceeded its unavailability performance criteria, requiring a Maintenance Rule (a)(1) evaluation. Entergy subsequently conducted an (a)(1) evaluation and concluded that the system should be classified as (a)(1), corrective actions specified, and system monitoring completed.

The finding is more than minor because it is associated with the Barrier Performance attribute of the Barrier Integrity cornerstone, in that the issue affected the Primary Containment System reliability due to the failure to recognize the need to evaluate the system for goals, corrective actions, and monitoring. The inspectors determined the significance of the finding using IMC 0609-04, "Phase 1 - Initial Screening and Characterization of Findings." The finding was determined to be of very low safety significance (Green) because the degraded condition had been corrected by the time of the failure to accurately evaluate the maintenance rule functional failure. As a result, this finding did not involve a design or qualification deficiency, did not result in a loss of system safety function, and did not screen as potentially risk significant due to external initiating events. The finding has a cross-cutting aspect in the Human Performance cross-cutting area, Decision Making component; in that, Entergy did not use conservative assumptions when evaluating the degraded Drywell to Torus Vacuum Breakers condition to correctly conclude that a functional failure had occurred. Specifically, Entergy did not consider that the function of these vacuum breakers would be required as soon as plant conditions exceeded 212F, and therefore, the procedural guidance for Technical Specification applicability not being exceeded was an incorrect basis for this decision [H.1(b)]. (Section 1R12)

Inspection Report# : [2011004](#) (pdf)

**G****Significance:** Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Accurately Assess Risk of Maintenance on Standby Gas and Secondary Containment**

Green. The inspectors identified a Green NCV of 10 CFR 50.65(a)(4) because Entergy did not assess and manage risk during elective maintenance for both 'A' and 'B' trains of the StandBy Gas Treatment (SBGT) system. Specifically, Entergy did not consult qualitative guidance in their risk assessment process procedures before removing both trains of SBGT from service and, therefore, removing the Secondary Containment key safety function while online. Corrective actions planned include evaluating and revising risk assessment procedures, and communicating qualitative risk assessment guidance to Senior Reactor Operators and Work Week Managers.

A review of NRC Inspection Manual Chapter (IMC) 0612, Appendix E, "Minor Examples," identified that Section 7, Maintenance Rule, Example e, reflected a similar more than minor example. This finding was determined to be more than minor because Entergy's risk assessment failed to account for the loss or significant uncompensated impairment of a key operating safety function. In addition, the finding affected the Human Performance attribute of the Barrier Integrity cornerstone's objective to ensure that physical design barriers (containment) protect the public from radionuclide releases caused by accidents or events. The inspectors performed an evaluation in accordance with IMC 0609, "Significance Determination Process," Attachment 4, "Phase 1 -Initial Screening and Characterization of Findings," and determined that the finding was of very low safety significance (Green) because the finding only represented a degradation of the radiological barrier function provided for the SBGT system. The inspectors determined that this finding had a cross-cutting aspect in the Human Performance cross-cutting area, Work Control component, because Entergy did not plan work activities by incorporating appropriate risk insights [H.3(a)]. (Section 1R13)

Inspection Report# : [2011004](#) (*pdf*)

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

Last modified : September 12, 2012