Pilgrim 1
4Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Inadequate Design Control of MSIV Nitrogen Supply Line Support leads to Scram
A self-revealing Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50, Appendix B, Criterion III, "Design Control," was identified because Entergy did not use the correct work planning and design controls to repair the support for the nitrogen supply line for the 1C inboard main steam isolation valve (MSIV). Specifically, inadequate design controls led to a failed horizontal unistrut support for the nitrogen supply line to the 1C MSIV, resulting in the header resting on the main steam line. This caused vibration-induced cyclic failure of the nitrogen supply line, closure of 1C MSIV, and a plant scram. The damaged line was modified and repaired using an additional unistrut for support as determined by the engineering change process. Entergy entered the issue into the corrective action program (CAP) under condition report (CR) 2015-07285.

This finding is more than minor because it is associated with the Initiating Events cornerstone attribute of equipment performance and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the failure of the pneumatic supply header support resulted in a plant scram due to the vibration induced cyclic failure of the nitrogen supply line and subsequent closure of 1C MSIV. In accordance with IMC 0609.04 and Exhibit 1 of IMC 0609, Appendix A, the inspectors determined that this finding was of very low safety significance (Green) because the finding did not involve the complete or partial loss of a support system that contributes to the likelihood of, or cause, an initiating event and affect mitigation equipment. The inspectors determined this finding does not have a cross-cutting aspect because the performance deficiency occurred in 2001 and is not indicative of current performance.
Inspection Report# : 2015004 *(pdf)*

Significance: G Aug 20, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate Procedures for Placing Main Turbine in Service
The inspectors identified a self-revealing Green non-cited violation of Technical Specification 5.4.1, "Procedures," because Entergy did not provide adequate procedures in that appropriate operator actions to recover systems and components important to safety were not included within operating procedures 2.1.1, "Startup from Shutdown," and 2.2.93, "Main Condenser Vacuum System," as well as abnormal operating procedure 2.4.36, "Decreasing Condenser Vacuum." Entergy entered this issue into their corrective action program as condition report CR-PNP-2015-5197.

This finding was more than minor because it was associated with the procedure quality attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding using IMC 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions." The inspectors determined this finding was of very low safety significance (Green) because it did not cause a loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. This finding

had a cross-cutting aspect in the area of Human Performance, Design Margins, because Entergy did not operate equipment within design margins. Specifically, Entergy staff's lack of awareness of the limitations of offgas system during startup and while placing the main turbine in service resulted in operators establishing conditions that were outside those limitations. [H.6]
Inspection Report# : 2015010 *(pdf)*

Significance: G Jun 30, 2015
Identified By: Self-Revealing
Item Type: FIN Finding
Ineffective Corrective Action Leads to of Cavitation of Residual Heat Removal Pump
A self-revealing Green finding was identified when residual heat removal pump (RHR) 'B' experienced cavitation during refueling and maintenance outage (RFO) 20 that was a result of inadequate corrective actions associated with equipment used to determine flow rate. Specifically, prior to placing augmented fuel pool cooling mode in service on April 26, 2015, Entergy did not ensure that the temporary flow transmitter was properly setup and calibrated because corrective actions from 2011 were not adequate to ensure proper setup in the future. As a result, when operators went to raise flow in accordance with their procedural requirement, residual heat removal pump 'B' experienced cavitation and operators secured the pump because the flow transmitter was inaccurately reading low. Entergy's immediate corrective actions included entering the issue into the corrective action program (CAP) as CR-2015-3724, re-calibrating and setting up the ultrasonic flow meter, and establishing a second ultrasonic flow meter to ensure proper flow.

The finding is more than minor because it is associated with the equipment performance attribute of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the 'B' RHR pump was secured from AFPC mode 2 on April 26, 2015 when the installed ultrasonic flow meter did not read properly, leading to operation of the 'B' RHR pump outside of flow limits specified in procedure 2.2.85.2 and cavitation of the pump. This finding was evaluated in accordance with Exhibit 2, Section C.6 of IMC 0609 Appendix G, Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Initial Screening and Characterization of Findings." The inspectors determined that this finding is of very low safety significance (Green) because while the performance deficiency resulted in the 'B' RHR pump being secured due to cavitation, it did occur when the refuel canal/cavity was flooded and did not increase the likelihood of a fire or internal/external flood that could cause an shutdown initiating event. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Evaluation, because Entergy staff did not thoroughly evaluate the issues associated with the ultrasonic flow meter in 2011 and 2013 to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. (P.2)

Inspection Report# : 2015002 *(pdf)*

Significance: G Mar 20, 2015
Identified By: Self-Revealing
Item Type: FIN Finding
Inadequate Testing of the Diesel-Driven Air Compressor
A self-revealing Green finding was identified for Entergy's failure to verify that the diesel-driven air compressor (K-117) was available for service prior to the January 27, 2015 winter storm. Specifically, although K-117 was tested prior to the winter storm, the test methodology did not reveal that the capacity of the starting battery was inadequate. Entergy entered the issue into the corrective action program as condition report (CR)-PNP-2015-00559 and initiated actions to supply instrument air with a temporary air compressor. Entergy also revised the operability test for K-117 air compressor to remove the alternating current (AC) power source prior to starting the air compressor.

This issue was more than minor because it is associated with the procedure quality and design control attributes of the Initiating Events cornerstone and adversely impacted the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, failure of K-117 resulted in loss of instrument air, which adversely impacted the plant response during the January 27, 2015 winter storm. Additionally, this issue is also associated with the procedure quality and design control attributes of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating event to prevent undesirable consequences. The inspectors screened the issue using Attachment 4 and Exhibit 1 of Appendix A to IMC 0609, "Significance Determination Process," and concluded that a detailed risk evaluation would be required because the finding involved the complete loss of a support system (instrument air) that contributes to the likelihood of an initiating event and affects mitigation equipment. The issue was determined to be of very low risk significance (Green).

The finding had a cross-cutting aspect in the area of Human Performance, Design Margins, because Entergy failed to ensure that the K-117 battery was designed with adequate margin. This finding is reflective of current performance because the inadequate design margin of the battery should have been discovered through proper testing [H.6].

Inspection Report# : 2015007 *(pdf)*

Mitigating Systems

Significance: G Dec 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Properly Implement Procedure Changes in accordance with TS 5.4.1a
The inspectors identified an NCV of TS 5.4.1, "Procedures," because Entergy was not adequately maintaining procedures listed in Regulatory Guide (RG) 1.33, Revision 2, Appendix A, February 1978. Specifically, the inspectors identified several examples where Entergy staff inappropriately used Entergy procedure EN-OP-112, "Night and Standing Orders," to implement procedure changes instead of PNPS quality assurance procedure NOP98A1, "Procedure Process." Entergy entered the issue into the CAP as CR 2015-09233.

The performance deficiency was determined to be more than minor because if left uncorrected it has the potential to lead to a more significant safety concern. Specifically, the inspectors determined the issue was similar to Example 4.a of IMC 0612, Appendix E, which states that an insignificant procedure error would be more than minor if the licensee routinely failed to adhere to the applicable procedure. The inspectors evaluated the finding using IMC 0609, Attachment 4 and Appendix A. Using Exhibit 2 of Appendix A, the inspectors determined this finding was of very low safety significance (Green) because it did not involve a design or qualification deficiency, it would not lead to a potential or actual loss of system or safety functions, it did not involve the loss or degradation of equipment or a function specifically designed to mitigate a seismic, flooding, or severe weather initiating event, and it did not involve the total loss of any safety function as identified in Exhibit 4. The inspectors determined that the finding had a cross-cutting aspect in Problem Identification and Resolution, Resolution, because, contrary to station procedure requirements, the standing order (SO) process was consistently inappropriately used to implement procedure changes for degraded equipment without the required evaluations.
Inspection Report# : 2015004 *(pdf)*

Significance: G Dec 31, 2015
Identified By: NRC

Item Type: NCV Non-Cited Violation
Failure to Identify the Cause of a Significant Condition Adverse to Quality
The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Actions,” when Entergy did not determine the cause of a significant condition adverse to quality (SCAQ). Specifically, a causal evaluation was not performed for a failed safety-related relay that ensured the automatic operation of the low pressure coolant injection (LPCI) system injection valves in a degraded voltage condition. Entergy replaced the failed relay and restored LPCI to an operable status on May 10, 2015. Entergy entered the issue into the CAP as CR 2015-9762.

This finding is more than minor because it is associated with the Mitigating System cornerstone attribute of equipment performance and adversely 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). The failure to identify the cause and extent of condition of the relay failure as directed by site procedures could result in repeat events which adversely affect safety system availability. In accordance with IMC 0609.04 and Exhibit 2 of IMC 0609, Appendix A, the inspectors determined that this finding was of very low safety significance (Green) because the finding did not involve the design of a mitigating structure, system, or component (SSC) or a loss of function of a train or system for greater than the technical specification (TS) allowed outage time. The inspectors determined this finding has a cross-cutting aspect in Human Performance, Procedure Adherence, because individuals did not recatergorize the CR to a higher level requiring a causal evaluation, as required by EN-LI-102 when a licensee event report (LER) was issued. The site also did not retain the failed safety-related part, as required by EN-MA-101-02.
Inspection Report# : 2015004 *(pdf)*

Significance: G Nov 19, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Analyze Reactor Recirculation System Motor Operated Valves for the Post-fire Cold Shutdown Function
The team identified a finding of very low safety significance involving a non-cited violation of Pilgrim Operating License Condition 3.F for failure to implement and maintain all aspects of the approved Fire Protection Program. Specifically, Entergy's post fire safe shutdown analysis did not adequately evaluate system requirements necessary to achieve cold shutdown conditions when the 'A' Reactor Recirculation System motor operated valves are damaged by fire. As a result, Entergy may not have been able to establish cold shutdown within 72 hours, as required by their safe shutdown analysis and regulatory requirements for this scenario. Entergy entered this issue into their corrective action program as condition reports CR-PNP-2015-09136 and CR-PNP-2015-09400, and implemented fire watches in the affected fire areas as an interim compensatory measure.

The finding was more than minor because it was similar to example 3.k of the NRC Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," and was associated with the Protection Against External Factors (e.g., fire) attribute of the Mitigating Systems Cornerstone and adversely affected the objective to ensure the availability and reliability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The team evaluated this issue in accordance with IMC 0609, Appendix F, "Fire Protection SDP." This finding screened to very low safety significance (Green) because it did not affect the ability to reach and maintain a hot shutdown condition (i.e., it only affected the ability to reach or maintain cold shutdown conditions). This finding had a cross-cutting aspect in the area of Problem Identification & Resolution, Evaluation, because, in 2013, Entergy incorrectly assumed that the 'B' RRS MOVs would be available during any fire that could damage the 'A' MOV cables without thoroughly evaluating whether the routing for the 'B' MOV cables ensured they would remain undamaged and available. [P.2]
Inspection Report# : 2015008 *(pdf)*

Significance: G Sep 30, 2015

Identified By: NRC
Item Type: NCV Non-Cited Violation
Main Control Room Annunciators 10 CFR 50.65(a)(2) Not Met
Green. Inspectors identified a Green NCV of 10 CFR 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants, paragraph (a)(2), because Entergy did not adequately demonstrate that the main control room annunciators (a)(2) performance was effectively controlled through performance of appropriate preventative maintenance. Specifically, Entergy did not identify and properly account for functional failures of the main control room (MCR) annunciators in February 2015 and May 2015, and did not recognize that the train exceeded its performance criteria and required a Maintenance Rule (a)(1) evaluation. Entergy entered the issue into the corrective action program under condition report 2015-7986 and CR 2015-7988 and is performing the Maintenance Rule (a)(1) evaluation.

The finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affects 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, following the three failures of the main control annunciator panel in February 2015 and May 2015, Entergy did not identify the failures as functional failures, and consequently, did not establish goals and monitoring criteria in accordance with 10 CFR 50.65(a)(1). The inspectors evaluated the significance of this finding using IMC 0609 Appendix A, The Significance Determination Process (SDP) for Findings at Power." The finding is of very low safety significance because the finding was not a design or qualification deficiency and did not represent a loss of safety function.

The inspectors determined that the finding has a cross cutting aspect in the area of Problem Identification and Resolution, Evaluation, in that the organization thoroughly evaluates issues to ensure that resolution addresses causes and extent of conditions commensurate with their safety significance. Specifically, Entergy identified all of the failures of the MCR annunciator system, however, Entergy did not include maintenance rule monitoring functions in the evaluation of the MCR annunciator system failures (P.2).

Inspection Report# : 2015003 *(pdf)*

Significance:  Sep 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate EDG Common Cause Determinations Result in TS Violation
Green. The inspectors identified a Green Non-Cited Violation (NCV) of TS 3.5.F, "Minimum Low Pressure Cooling and Diesel Generator Availability," for failure to adequately perform technical specification (TS) surveillance requirement (SR) 4.5.F.1 to determine that the 'B' Emergency Diesel Generator (EDG) was not inoperable due to a common cause failure, or to perform the TS-specified EDG monthly surveillance test, within 24 hours of the time that operators determined that the 'A' EDG was inoperable. Specifically, on July 1, 2015 after the 'A' EDG was declared inoperable due to unexpected annunciator response during engine pre-start checks, and again on July 28, 2015, when the 'A' EDG was declared inoperable due to reactive load oscillations during a routine surveillance, Entergy performed an inadequate common cause failure determination that did not address the failure mechanism of the inoperable EDG, which had not yet been determined. This issue has been entered into the corrective action program as condition report CR-PNP-2015-8073, and additional guidance has been provided to the operations crew in the form of an operations section standing order, pending permanent corrective actions.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the operability of the 'B' EDG was not verified as required, either through determination that it was not inoperable due to

a common cause failure or through performance of the monthly TS-required surveillance. In accordance with Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent actual loss of function of a single train for greater than its technical specification allowed outage time, 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, Conservative Bias, because Entergy did not use decision making practices that emphasized prudent choices over those that are simply allowed, or in this case those choices that were perceived to be allowed. Specifically, Entergy's credited SR 4.5.F.1 based on an administrative review instead of more deliberate actions or evaluations that would be necessary to confirm that a common cause condition did not exist. (H.14)

Inspection Report# : 2015003 *(pdf)*

Significance:  Sep 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate Operability Assessment of the Shutdown Transformer
Green. The inspectors identified a Green NCV of 10 CFR 50, Appendix B, "Instructions, Procedures, and Drawings," when Entergy failed to adequately assess the operability of the shutdown transformer as required by EN-OP-104, "Operability Evaluation Process". Specifically, Entergy failed to evaluate changes to the 23KV line supplying the shutdown transformer that resulted in the shutdown transformer incorrectly being called operable. This issue has been entered into the corrective action program under CR 2015-7787. Entergy is conducting a causal analysis and operators have been given interim guidance to declare the shutdown transformer inoperable under similar conditions.

This finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, a modification was made to the site, as described in the UFSAR that was unrecognized by Entergy during the operability determination process and resulted in the incorrect operability determination for the shutdown transformer. In accordance with Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding is of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, and did not represent an actual loss of function of a single train for greater than its TS allowed outage time.

This finding has a cross cutting aspect in the area of Human Performance, Avoid Complacency, in that individuals did not recognize and plan for the possibility of mistakes, latent problems, or inherent risk, even while expecting successful outcomes. Specifically, personnel did not fully evaluate the change to the 23KV line, and instead relied on a previous incorrect operability determination to justify declaring the shutdown transformer operable. (H.12)

Inspection Report# : 2015003 *(pdf)*

Significance: N/A Sep 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Provide 10 CFR 50.59 Evaluation Associated with Offsite Power Alignment
Inspectors identified a Severity Level IV, NCV of 10CFR 50.59 "Changes, Tests and Experiments" in that Entergy

failed to perform a written evaluation to provide the basis for a change to the facility that required a license amendment. Specifically, the inspectors identified that contrary to 10 CFR 50.59, Entergy failed to evaluate whether the placement of a 23KV line aboveground required a license amendment pursuant to 10 CFR 50.59 (c)(1). Entergy is performing a causal analysis, updating required procedures, and issued a standing order to ensure the site remains in TS compliance with only the 23 kV line 108 able to supply power to maintain the shutdown transformer operable.

The performance deficiency was dispositioned using the traditional enforcement process because it could potentially impede or impact the regulatory process. In accordance with the NRC Enforcement Manual, Revision 9, Part II, Enforcement of 10 CFR 50.59 and Related FSAR, Sections 2.1.3.E.1 and 2.1.3.E.6, this violation was determined to be more than minor because Entergy failed to conduct a safety evaluation when required and there was a reasonable likelihood that the change requiring 10 CFR 50.59 evaluation would have required Commission review and approval prior to implementation. Because this violation involves the traditional enforcement process and does not have an underlying technical violation that would be considered more than minor, the inspectors did not assign a cross-cutting aspect, in accordance with IMC 0612.

Inspection Report# : 2015003 *(pdf)*

Significance: G Jun 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate Operability Determination for the X-107B EDG Results in TS Violation
The inspectors identified a Green NCV 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," when Entergy staff performed an inadequate operability determination that assessed the X-107B emergency diesel generator (EDG) following cylinder head leakage indications during pre-start checks for a planned monthly operability run. Specifically, after engine coolant had been observed spraying from one of the open cylinder test cocks during X-107B EDG pre-start checks, operators determined that the EDG remained operable because the volume of leakage that had been observed would not have precluded a successful start of the engine. Operators did not consider that potential sources of leakage, such as a crack in the cylinder or cylinder head, could reasonably worsen during operation, such that the engine would not be able to complete its 30-day mission time, and therefore should be declared inoperable. Entergy's immediate corrective actions included replacement of the X-107B EDG 9L cylinder head and sending out the damaged cylinder head for analysis by a vendor. The completion of the analysis by the vendor is being tracked by CR-2015-2109.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, Entergy staff inadequately determined that the X-107B EDG was operable, which resulted in the operability of the X-107A EDG not being verified, either through determination that it was not inoperable due to a common cause failure or performing TS SR 4.5.F.1 in its entirety. This finding was evaluated using Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power." The inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent actual loss of a safety function of a single train for greater than its TS allowed outage time, 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, Conservative Bias, because Entergy staff did not use decision making practices that emphasized prudent choices over those that are simply allowed. Specifically, Entergy staff's operability determination for the X-107B EDG was based on the conclusion that the asfound condition would not have caused the engine to be inoperable because it would not have created a hydraulic lock; they did not consider that the condition would likely worsen during EDG operation, nor did their operability determination consider EDG mission time [H.14].
Inspection Report# : 2015002 *(pdf)*

Significance: G Mar 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Perform Testing of Safety-Related Undervoltage Alarm Relays
The inspectors identified an NCV of very low safety significance (Green) of 10 CFR 50, Appendix B, Criterion XI, "Test Control," because Entergy did not establish requirements in accordance with their test program for safety related 4160 V degraded voltage relays in accordance with Updated Final Safety Analysis Report (UFSAR) Section 8.4.7. Specifically, 4160V switchgear relays 127-509/1 & 2 undervoltage setpoints were not tested for the first time until March 2015, which identified the relays were out of calibration by 23 percent. This impacted operators ability to perform alarm response procedure, ARP-C3L, which directs operators to trip the X107A emergency diesel generator (EDG) when the alarm for relay 127-509/1 & 2 is received. Entergy entered CR-PNP-2015-1614 and CR-PNP-2015-1623 into the corrective action program to address the degraded condition. Corrective actions included an immediate operability determination and re-calibration of the relays to their required set points prior to restoration of the X107A EDG.

This finding is more than minor because it impacted the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, the finding is similar to example 1.a in Appendix E of IMC 0612, because no record of testing had ever been recorded or performed; and that testing in 2015 determined that relays 127-509/1 & 2 were degraded and would have impacted the operators ability to take alarm response procedure actions. In accordance with Exhibit 2 of IMC 0609 Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that the finding was of very low safety significance (Green) because it did not represent a loss of a safety system, did not represent a loss of a safety function of a system or a single train greater than its allowed outage time, and did not screen as potentially risk significant due to external events. Specifically, although testing was not being performed to ensure proper relay response, inspectors confirmed relay protection was available to ensure that at a minimum ECCS injection valves would not have been impacted if the X107A EDG voltage regulator failed during a LOOP/LOCA. This finding had a cross-cutting aspect in the area of problem identification and resolution related to identification because Entergy did not implement the CAP with a low threshold for identifying issues. Specifically, Entergy had multiple opportunities to identify that relays 127-509/1 & 2 undervoltage dropout settings were not being tested during establishment of the test setup or through periodic trending against similar relays in other systems [P.1].

Inspection Report# : 2015001 *(pdf)*

Significance: G Mar 20, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate Past Operability Assessment of 'C' Safety Relief Valve
The team identified a Green NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," when Entergy staff performed an inadequate past operability determination that assessed performance of the 'C' safety/relief valve (SRV), which did not open as expected when called upon to function. Specifically, following the January 27, 2015 reactor scram, operators placed an open demand for the 'C' SRV twice during post-scram recovery operations, but the valve did not respond as expected and did not perform its pressure reduction function on both occasions. Entergy's subsequent past operability assessment for the valve's operation incorrectly concluded that the valve was fully capable of performing its required functions during its installed service. In response to the team's past operability concerns, Entergy subsequently re-evaluated the past operability of 'C' SRV and concluded that it was inoperable and placed the issue into the corrective action program as CR-PNP-2015-02051.

This performance deficiency is more than minor because it is associated with the equipment performance attribute of

the Mitigating Systems cornerstone and affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent core damage. The team evaluated the finding using IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, and determined this finding was not a design or qualification deficiency and was not a potential or actual loss of system or safety function, and was therefore of very low safety significance (Green).

The finding had a cross-cutting aspect in Human Performance, Conservative Bias, because Entergy did not use decision making practices that emphasized prudent choices over those that are simply allowable. Specifically, Entergy did not appropriately evaluate unexpected and unsatisfactory performance of the 'C' SRV in consideration of the entire pressure range that the SRV, including its automatic depressurization system function, was required to be operable [H.14].

Inspection Report# : 2015007 *(pdf)*

Significance: W Mar 20, 2015
Identified By: NRC
Item Type: VIO Violation
Failure to Identify, Evaluate, and Correct 'A' SRV Failure to Open Upon Manual Actuation
A self-revealing preliminary White findIing and Violation (VIO) of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," and Technical Specification (TS) 3.5.E, "Automatic Depressurization System," was identified for the failure to identify, evaluate, and correct a significant condition adverse to quality associated with the 'A' SRV. Specifically, Entergy failed to identify, evaluate, and correct the 'A' SRV's failure to open upon manual actuation during a plant cooldown on February 9, 2013. In addition, the failure to take actions to preclude repetition resulted in the 'C' SRV failing to open due to a similar cause following the January 27, 2015, LOOP event. Entergy entered this issue in to the corrective action program (CAP) as CR-PNP-2015-01983, CR-PNP-2015-00561, and CR-PNP-2015-01520. Immediate corrective actions included replacing the 'A' and 'C' SRVs and completing a detailed operability analysis of the installed SRVs which concluded that a reasonable assurance of operability existed. This finding does not present a current safety concern because the 'A' and 'C' SRVs were replaced during the outage following the January 27, 2015 LOOP and reactor trip event. Also, Entergy performed a detailed operability analysis of the installed SRVs which concluded that a reasonable assurance of operability existed.

This performance deficiency is more than minor because it could reasonably be viewed as a precursor to a significant event if two of the four SRVs failed to open when demanded to depressurize the reactor, following the failure of high pressure injection systems or torus cooling, to allow low pressure injection systems to maintain reactor coolant system inventory following certain initiating events. In addition, it is associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

The inspectors screened this issue for safety significance in accordance with IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions." The screening determined that a detailed risk evaluation was required because it was assumed that for a year period, two of the four SRVs were in a degraded state such that they potentially would not have functioned to open at some pressure lower than rated pressure and would not fulfill their safety function for greater than the TS allowed outage time. Specifically, the assumptions of failures to open were based on: a failed actual opening demand at 200 psig reactor pressure on January 27, 2015, for the 'C' SRV; examination of the valve internals at the testing vendor (National Technical Systems); and a previous failed actual opening demand at 114 psig reactor pressure on February 9, 2013, for the 'A' SRV. The risk evaluation was performed using IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria," issued April 12, 2012. The NRC made a preliminary determination that the finding was of low to moderate safety significance (White) based on quantitative and qualitative evaluations.

This finding had a cross-cutting aspect in Problem Identification and Resolution, Evaluation, because Entergy did not thoroughly evaluate issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. Specifically, Entergy staff did not thoroughly evaluate the operation of the 'A' SRV during the February 9, 2015 plant cooldown and should have reasonably identified that the 'A' SRV did not open upon three manual actuation demands [P.2].

Update: The Preliminary White finding and AV was documented in IR 05000293/2015007, dated May 27, 2015.

Update: The final significance of the finding was determined to be White and was documented in Inspection Report 05000293/2015011, dated September 1, 2015.

Inspection Report# : 2015007 *(pdf)*
Inspection Report# : 2015011 *(pdf)*

Significance: G Mar 20, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Inadequate Loss of Instrument Air Abnormal Operating Procedure
A self-revealing Green NCV of TS 5.4.1, "Procedures," was identified because Entergy failed to include appropriate operator actions to both recognize the effects of and recover systems and components important to safety within Procedure 5.3.8, "Loss of Instrument Air," abnormal operating procedure. Entergy entered this issue into the CAP as PNP-CR-2015 0888 and issued a revision to Procedure 5.3.8 to provide additional guidance to operators during a loss of instrument air.

The finding was more than minor because it was associated with the procedure quality attribute of the Mitigating System cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesired consequences. The lack of adequate instructions in the procedure adversely affected several operator actions and plant equipment on January 27, 2015, during the LOOP and loss of instrument air. The team evaluated the finding using IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions." The team determined this finding was of very low safety significance (Green) because it was not a design or qualification deficiency, did not result in a loss of function of a TS required system, and did not represent an actual loss of function of one or more non-TS trains of equipment designated as a high safety-significant system.

This finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy leaders did not ensure that personnel, equipment, procedures, and other resources were available and adequate to support nuclear safety [H.1].

Inspection Report# : 2015007 *(pdf)*

Significance: G Mar 20, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Failure to Follow RCIC System Manual Restart Procedure
A self-revealing Green NCV of TS 5.4.1, "Procedures," was identified because the operating crew failed to implement a procedure step to open the reactor core isolation cooling (RCIC) system cooling water supply valve during a manual startup of the system. As a result, the RCIC system was operated for over 2 ½ hours with no cooling water being

supplied to the lubricating oil cooler or to the barometric condenser. Entergy entered the issue into the CAP as CR-PNP-2015-0566, CR-PNP-2015-0570, and CR-PNP-2015-0952 and conducted a human performance review of the Control Room operators involved with the issue.

This finding was more than minor because it was associated with the human performance 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 undesired consequences. Specifically, on January 27, 2015, reactor operators failed to open MO-1301-62, cooling water supply valve, during a manual restart of the RCIC system in accordance with procedure 5.3.35.1, “RCIC Injection – Manual Alignment Checklist.” Additionally, the operating crew failed to identify the valve was out of position even after the Vacuum Tank Pressure Hi Alarm, C904L-F3, was received two minutes after the system was re-started and the alarm response procedure identified “Improper Valve Lineup” as a probable cause. The team evaluated the finding using IMC 0609, Appendix A, Exhibit 2, “Mitigating Systems Screening Questions.” The team determined this finding was not a design or qualification deficiency and was not a potential or actual loss of system or safety function, and is therefore of very low safety significance (Green). During the period when the RCIC system was operated in this condition, no temperature limits were exceeded. In the event of a RCIC system automatic start, the cooling water supply valve would have opened automatically.

This finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because Entergy licensed personnel did not implement procedure 5.3.35.1, “RCIC Injection – Manual Alignment Checklist”, to open MO-1301-62. Additionally, Entergy licensed personnel did not implement the Vacuum Tank Pressure Hi Alarm, C904L-F3, response procedure to check for an improper valve line-up [H.8].

Inspection Report# : 2015007 *(pdf)*

Significance: G Mar 20, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Identify Condition Adverse to Quality Associated with Core Spray Discharge Header Voiding
The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Action,” because PNPS staff failed to identify and correct conditions adverse to quality associated with the partial voiding of the ‘A’ core spray (CS) discharge header on January 27, 2015, following the loss of the keepfill system due to a LOOP. PNPS entered the issue into the CAP as CR-PNP-2015-01406 and planned procedural changes that would provide guidance to operate the affected pumps in order to prevent pump discharge piping from voiding if keepfill pressure is lost.

This issue is more than minor because it is associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using IMC 0609, Appendix A, “The Significance Determination Process for Findings At-Power." This finding was determined to be of very low safety significance (Green) because it was not a deficiency affecting the design or qualification of a mitigating system and did not represent an actual loss of at least a single train system or two separate safety systems for greater than the TS allowed outage time.

The finding had a cross-cutting aspect in Problem Identification and Resolution, Identification, because PNPS personnel did not implement a CAP with a low threshold for identifying issues. Individuals did not identify the issue completely, accurately, and in a timely manner in accordance with the program [P.1].

Inspection Report# : 2015007 *(pdf)*

Barrier Integrity

Significance: G Dec 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate Implementation of Corrective Action following Winter Storm Juno
The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," because Entergy did not adequately implement corrective actions for an identified condition adverse to quality. Specifically, Entergy did not implement all of the procedure changes needed to ensure shutdown cooling was placed in service in a timely matter after plant shutdown in preparation for or during a severe winter storm. Entergy entered this issue into the CAP as CR 2016-0120 and updated procedure 2.1.42 to meet the requirements of the corrective actions in CR 2015-0558. Inspectors verified that the new procedure revision included the required actions.

The inspectors determined this performance deficiency is more than minor because it is associated with the procedure quality attribute of the Barrier Integrity cornerstone, and adversely affected its objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors determined that this finding is of very low safety significance (Green) in accordance with IMC 0609, Attachment 4 and Exhibit 3 of Appendix A, because it did not represent an actual open pathway in the physical integrity of reactor containment, containment isolation system, and heat removal components. The inspectors determined that this finding has a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because Entergy staff did not ensure procedure revisions were made in accordance with the requirements of EN-LI-102, "Corrective Action Program."
Inspection Report# : 2015004 *(pdf)*

Emergency Preparedness

Significance: G Aug 20, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate Guidance and Invalid Compensatory Measures for Out-of-Service EAL Instrumentation
The inspectors identified a Green non-cited violation of 10 CFR 50.54(q)(2) because Entergy did not follow and maintain an emergency plan that meets the requirements of planning standards 10 CFR 50.47(b) and Appendix E. Specifically, the Emergency Plan Implementing Procedure specified insufficient equipment as the primary method of emergency action level assessment, and directed invalid compensatory measures to be used when the primary method of emergency action level assessment for reactor coolant system leakage was unavailable. Entergy entered these issues into the corrective action program as condition reports CR-PNP-2015-7183 and CR-PNP-2015-7394. Additionally, since the time of this inspection, Entergy completed and issued the new procedure governing equipment important to emergency response.

This finding was more than minor because it was associated with the emergency response organization performance attribute of the Emergency Preparedness cornerstone and affected the cornerstone objective of ensuring that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Specifically, the incomplete procedural guidance and the inadequate compensatory measure could have led to an emergency not being declared in a timely manner. The inspectors evaluated the finding using IMC 0609, Appendix B, "Emergency Preparedness Significance Determination Process," and determined the finding was of very low safety significance (Green). The finding had a cross-cutting aspect in the area of Problem

Identification and Resolution, Identification, because Entergy did not ensure that the issues were promptly reported and documented in the corrective action program at a low threshold. Specifically, while performing the extent of condition review of emergency plan implementing procedure EP-IP-100.1, “Emergency Action Levels,” Entergy did not effectively utilize the corrective action program to identify and correct newly identified deficiencies with the guidance for emergency action level assessment and the invalid compensatory measures. This resulted in the associated degradation of the emergency plan assessment capability remaining in effect. [P.1]
Inspection Report# : 2015010 *(pdf)*

Significance: G Aug 20, 2015
Identified By: NRC
Item Type: VIO Violation
NOV for Untimely Actions to Restore Station Meteorological Towers
The inspectors identified a Green cited violation 10 CFR 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, in December 2011, Entergy cancelled preventative maintenance of the 160’ back-up meteorological tower, and that tower became non-functional. As a result, on eight occasions between March 18, 2012, and August 15, 2015, when the 220’ primary meteorological tower was also non-functional for various reasons, Pilgrim did not have instrumentation available on either tower for continuous reading of the wind speed, wind direction, air temperature, and delta air temperature. At the time of this inspection in August 2015, Entergy was in the process of obtaining necessary permits for construction of the new tower.

This finding 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, Resolution, because Pilgrim did not take effective corrective actions to address issues in a timely manner commensurate with their safety significance. Specifically, numerous delays and extensions of corrective actions resulted in a period of approximately two years in which the adverse condition identified by the inspectors had not been corrected, during which additional outages of the primary meteorological tower have resulted in additional unnecessary degradation of the Pilgrim Emergency Plan. [P.3]

Inspection Report# : 2015010 *(pdf)*

Significance: G Mar 20, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Implement Compensatory Measures for Out-of-Service Emergency Action Level Instrumentation
The inspectors identified a Green NCV of 10 CFR 50.54(q)(2) for failing to follow and maintain an emergency plan that meets the requirements of planning standards 10 CFR 50.47(b) and Appendix E. Specifically, on January 27, 2015, following a loss of instrument air, the indications in the Control Room for Sea Water Bay level were lost, and Entergy did not implement compensatory measures, as directed by an Emergency Plan Implementing Procedure, to determine whether a Sea Water Bay level emergency action level (EAL) threshold had been exceeded. Entergy entered this issue into the CAP as CR-PNP-2015-00948 and initiated corrective actions to identify alternative means for assessing this EAL in the event of a loss of Sea Water Bay level instruments.

This performance deficiency was more than minor because it was associated with the emergency response organization performance (program elements not meeting 50.47(b) planning standards) attribute of the Emergency Preparedness cornerstone and affected the cornerstone objective of ensuring that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Specifically, the out-of-service Sea Water Bay level instrumentation could have led to an emergency not being declared in a timely manner. The inspectors evaluated the finding using IMC 0609, Appendix B, “Emergency Preparedness Significance Determination Process." The inspectors determined the finding was associated with risk significant planning standard 10 CFR 50.47(b)(4), “Emergency Classification System,” and corresponded to the following Green Finding example in Table 5.4-1: an EAL has been rendered ineffective such that any Alert or Unusual Event would not be declared, or declared in a degraded manner for a particular off-normal event. Therefore, using Figure 5.4-1, “Significance Determination for Ineffective EALs and Overclassification,” and the example in Table 5.4-1, the inspectors determined the finding was of very low safety significance (Green).

The finding had a cross-cutting aspect in the area of Human Performance, Documentation, because Entergy did not maintain complete and accurate documentation. Specifically, compensatory measures associated with out-of-service EAL instrumentation are not governed by comprehensive and high-quality programs, processes, and procedures [H.7].

Inspection Report# : 2015007 *(pdf)*

Significance: N/A Mar 20, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Report a Major Loss of Emergency Assessment Capability
The NRC identified a SL IV NCV of 10 CFR Part 50.72(b)(3)(xiii) when Entergy failed to make a required event notification within eight hours for a major loss of assessment capability. Specifically, an unplanned loss occurred of all emergency action level (EAL) instrumentation associated with Sea Water Bay level that resulted in an inability to evaluate all EALs for an abnormal water level condition. Entergy entered the issue into the corrective action program as CR-PNP-2015-00949. Compliance was restored on February 5, 2015, when Entergy reported the major loss of assessment capability under Event Notification (EN) 50790.

Since the failure to submit a required event report impacts the regulatory process, the violation was evaluated using Section 2.2.4 of the NRC’s Enforcement Policy, dated July 9, 2013, instead of the SDP. Using the example listed in Section 6.9.d.9, “A licensee fails to make a report required by 10 CFR 50.72 or 10 CFR 50.73,” the issue was evaluated and determined to be a SL IV violation. The inspectors reviewed the condition for reactor oversight process significance. Because this NRC-identified violation involves the traditional enforcement process and does not have an underlying technical violation that would be considered more-than-minor, the inspectors did not assign a cross-cutting aspect to this violation in accordance with IMC 0612.

Inspection Report# : 2015007 *(pdf)*

Occupational Radiation Safety

Significance: G Sep 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation

Failure to Comply with RWP Instructions to Contact RP Prior to Dogbone Gasket Removal
The inspector identified a self-revealing Green NCV of Technical Specification 5.4.1, Regulatory Guide 1.33, Appendix "A" Procedures. Procedure EN RP 100 Radiation Worker Expectations, Section 5.4 Radiological Work Permit (RWP), requires radiation workers to comply with verbal and written instructions. RWP 2015530, Task 1 requires workers to "Contact Radiation Protection prior to entry to discuss work scope" and to allow for "RP survey when accessible surfaces are exposed." Contrary to these requirements, on April 28, 2015, several workers failed to inform RP when performing condenser dogbone gasket removal activity, which resulted in Radiation Protection (RP) not conducting the necessary contamination surveys. Performing this work without notifying RP resulted in five workers receiving unintended internal exposures. When identified, Entergy immediately stopped work on this project, conducted a safety meeting between RP and the Entergy contractors, performed the RP surveys on the accessible surfaces and enforced the RWP respiratory protection requirements for the remaining work. This issue was entered into the Entergy corrective action program (CR-PNP-2015-07577).

The inspectors determined that the performance deficiency was more than minor because it affected the Radiation Safety – Occupational Radiation Safety Cornerstone attribute of Program and Process associated with exposure/contamination controls and because it resulted in the unintended internal exposure of five workers. It was determined to be of very low safety significance (Green) because it was not related to ALARA, it did not involve an overexposure or a potential for an overexposure and because the licensees ability to assess dose was not compromised. A cross-cutting aspect of Procedure Adherence in the area of Human Performance was assigned for individuals failing to follow processes, procedures and work instructions, in that workers did not follow the verbal and written instructions on the RWP to discuss the scope of work with RP prior to beginning the work. [H.8]
Inspection Report# : 2015003 *(pdf)*

Public Radiation Safety

Significance: G Jun 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Conduct Operations to Miniimze the Introduction of Residual Radioactivity to the Site
The inspectors identified a Green NCV of 10 CFR 20.1406(c) in that Entergy did not conduct operations to minimize the introduction of residual radioactivity on site. Entergy did not take action to reduce residual radioactive waste from the site in a timely manner over fourteen years. Entergy entered this issue into the corrective action program as CR-2015-05745 with actions to characterize and evaluate the adverse conditions identified by the inspector

The issue is more than minor because it is associated with the program and process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure the licensee's ability to prevent inadvertent release and/or loss of control of licensed material to an unrestricted area. In accordance with IMC 0609, Appendix D, "Public Radiation Safety Significance Determination Process," the finding was determined to be of very low safety significance (Green) because Entergy had an issue involving radioactive material control, but did not involve: (1) transportation; or (2) public exposure in excess of 0.005 Rem. The finding has a cross-cutting aspect in the area of problem identification and resolution, Resolution, in that Entergy did not adequately address the radioactive waste in a fourteen year time period (P.3).

Inspection Report# : 2015002 *(pdf)*

Significance: G Jun 30, 2015

Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Properly Ship Category 2 Radioactive Material - Quantity of Concern
The inspectors identified a Green NCV of 10 CFR 71.5, "Transportation of Licensed Material," and 49 CFR 172, Subpart I, "Safety and Security Plans." Specifically, Entergy shipped a category 2 RAM-QC on public highways to a waste processor without adhering to a transportation security plan. Prior to shipment, Entergy's staff failed to recognize that the quantity of radioactive material met the definition RAM QC. Entergy entered the issue into their corrective action program as CR-2015-05746 to address changes in Department of Transportation requirements.

The issue is more than minor because it is associated with the program and process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure the safe transport of radioactive material on public highways in accordance with regulations. The finding was determined to be of very low safety significance (Green) because Entergy had an issue involving transportation of radioactive material, but it did not involve: (1) a radiation limit that was exceeded; (2) a breach of package during transport; (3) a certificate of compliance issue; (4) a low level burial ground nonconformance; or (5) a failure to make notifications or provide emergency information. The finding had a cross-cutting aspect in the area of problem identification and resolution, Identification, in that the licensee did not have a low threshold for identifying issues. Specifically, the security transportation plan requirements became effective in March 2003, had not been effectively identified by Entergy (P.1).

Inspection Report# : 2015002 *(pdf)*

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.

Miscellaneous

Significance: N/A Jun 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Submit an LER
The inspectors identified a Severity Level IV NCV because Entergy personnel did not provide a written report to the NRC within 60 days after discovery of the event as required by 10 CFR 50.73(a)(2)(i)(B) for a condition which was prohibited by TS 3.5.E, "Automatic Depressurization System (ADS)." Specifically, on January 27, 2015, Pilgrim experienced a loss of offsite power and reactor scram during a winter storm. While operators performed a reactor cooldown with manual operation of safety relief valves (SRVs), the 3C SRV twice failed to open upon demand by the operations crew. Entergy staff initiated condition report CR-PNP-2015-0561 to document SRV 3C's failure to open, and the valve was immediately declared inoperable. The inspectors determined that the improper operation of SRV 3C was reportable in accordance with 10 CFR 50.73(a)(2)(i)(B). Entergy has captured this issue in condition report CR-2015-6191.

Because this issue had the potential to affect the NRC's ability to perform its regulatory function, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (a failure of a licensee to make a report required by 10 CFR 50.72 or 10 CFR 50.73) violation. Because this violation involves the traditional enforcement process and does not have an underlying technical violation, inspectors did not assign a cross-cutting aspect to this violation in accordance with IMC 0612, Appendix B.

Inspection Report# : 2015002 *(pdf)*

Last modified : March 01, 2016