

June 25, 2002

Mr. Robert M. Bellamy  
Site Vice President  
Entergy Nuclear Operations, Inc.  
Pilgrim Nuclear Power Station  
600 Rocky Hill Road  
Plymouth, Massachusetts 02360-5599

SUBJECT: PILGRIM NUCLEAR POWER STATION - NRC INSPECTION  
REPORT 50-293/02-03

Dear Mr. Bellamy:

On May 11, 2002, the NRC completed an inspection at your Pilgrim reactor facility. The enclosed report documents the inspection findings which were discussed on May 21, 2002, with Mr. C. Dugger and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel. No findings of significance were identified.

Immediately following the terrorist attacks on the World Trade Center and the Pentagon, the NRC issued an advisory recommending that nuclear power plant licensees go to the highest level of security, and all promptly did so. With continued uncertainty about the possibility of additional terrorist activities, the Nation's nuclear power plants remain at the highest level of security and the NRC continues to monitor the situation. This advisory was followed by additional advisories, and although the specific actions are not releasable to the public, they generally include increased patrols, augmented security forces and capabilities, additional security posts, heightened coordination with law enforcement and military authorities, and more limited access of personnel and vehicles to the sites. The NRC has conducted various audits of your response to these advisories and your ability to respond to terrorist attacks with the capabilities of the current design basis threat (DBT). On February 25, 2002, the NRC issued an Order to all nuclear power plant licensees, requiring them to take certain additional interim compensatory measures to address the generalized high-level threat environment. With the issuance of the Order, we will evaluate Entergy Nuclear Generation Company compliance with these interim requirements.

Robert M. Bellamy

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Sincerely,

/RA/

Clifford Anderson, Chief  
Projects Branch 5  
Division of Reactor Projects

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

Enclosure: Inspection Report 50-293/02-03

Attachment: Supplemental Information

cc w/encl: M. Krupa, Director, Nuclear Safety & Licensing  
W. Riggs, Director, Nuclear Assessment Group  
D. Tarantino, Nuclear Information Manager  
B. Ford, Regulatory Affairs Department Manager  
J. Fulton, Assistant General Counsel  
R. Hallisey, Department of Public Health, Commonwealth of Massachusetts  
The Honorable Therese Murray  
The Honorable Vincent deMacedo  
Chairman, Plymouth Board of Selectmen  
Chairman, Duxbury Board of Selectmen  
Chairman, Nuclear Matters Committee  
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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No: 50-293

License No: DPR-35

Report No: 50-293/02-03

Licensee: Entergy Nuclear Operations, Inc.

Facility: Pilgrim Nuclear Power Station

Location: 600 Rocky Hill Road  
Plymouth, MA 02360

Inspection Period: March 31, 2002, through May 11, 2002

Inspectors: R. Arrighi, Acting Senior Resident Inspector  
W. Raymond, Senior Resident Inspector  
L. Cheung, Senior Reactor Inspector  
T. Walker, Senior Reactor Inspector  
S. Chaudhary, Reactor Inspector  
F. Paul Bonnett, Project Engineer  
J. Furia, Senior Health Physicist

Approved By: Clifford Anderson, Chief  
Projects Branch 5  
Division of Reactor Projects

## **SUMMARY OF FINDINGS**

IR 05000293-02-03; on 03/31-05/11/2002; Entergy Nuclear Operations, Inc.; Pilgrim Nuclear Power Station, Resident Inspection Report.

The inspection was conducted by resident inspectors, reactor inspectors, a project engineer and a health physicist. This inspection identified no significant findings. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at <http://www.nrc.gov/reactors/operating/oversight.html>

A. Inspector Identified Findings

None

B. Licensee Identified Violations

None

## Report Details

### **SUMMARY OF PLANT STATUS**

On March 31, 2002, the licensee was in the process of returning the unit to 100 percent core power following the March 28, 2002, planned down power. Power had been reduced to 55 percent to perform a thermal backwash of the main condenser. On April 1, 2002, power was temporarily reduced to 75 percent to perform a control rod pattern exchange.

#### **1. REACTOR SAFETY (Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity)**

##### 1R04 Equipment Alignment

###### a. Inspection Scope

The inspector conducted a partial system walk down of the standby gas treatment system. This included reviewing applicable plant and information drawings and normal operating procedures. The inspector reviewed valve static mimics in the control room and walked down accessible portions of the systems to ensure proper system alignment. The inspector confirmed that the systems were properly aligned to support normal and emergency plant operations.

###### b. Findings

No findings of significance were identified.

##### 1R05 Fire Protection

###### a. Inspection Scope

The inspector toured the standby gas treatment system area to observe conditions related to: (1) transient combustibles and ignition sources; (2) the material condition and readiness of fire protection systems and equipment; and (3) the condition and status of readiness of fire barriers used to prevent fire damage or fire propagation. The inspector verified that any identified degraded conditions were compensated by compensatory measures until appropriate corrective actions could be taken.

###### b. Findings

No findings of significance were identified.

##### 1R11 Licensed Operator Requalification

###### a. Inspection Scope

The inspector observed the performance of an operating crew in the simulator on April 22, 2002. The inspector verified that the crew met the training scenario objectives and performed the critical tasks. The scenario involved a loss of torus level and emergency depressurization. The inspector verified proper use of the system operating

procedures and emergency operating procedures. The inspector also verified that the post-scenario critique discussed any relevant lessons learned. The inspector verified that the identified discrepancies during the scenario were discussed with the crew to enhance future performance.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspector reviewed the implementation of the maintenance rule (10 CFR 50.65) for selected systems and components. The review included applicable maintenance rule basis documents and the Updated Final Safety Analysis Report (UFSAR) and included the following specific equipment issues:

- Proper classification of equipment failures for the residual heat removal system, control room high efficiency air filtration system and the 125 VDC system. The inspector reviewed problems reports (PR) issued within the last two years for the selected systems.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

The inspector reviewed the following on-line maintenance work plans/activities to assess the adequacy of the licensee's risk assessment process. The inspector reviewed the plan against the criteria contained in licensee procedures 1.5.21, "Integrated Scheduling Guidelines," and 1.5.22, "Risk Assessment Process." The inspection included a review of the risk assessments and contingencies established, and verification that the increase in plant risk and protected equipment was conveyed during the licensee's morning meeting and that the plan was posted throughout the site.

The inspector reviewed the risk associated with performing preventive maintenance on the standby gas treatment system and the 345 KV switch yard line 342.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspector reviewed the following operability evaluations to verify that continued operability was justified. The Pilgrim Updated Final Safety Evaluation Report (UFSAR), technical specifications, and licensee procedure 1.3.34.5, "Operability Evaluations," were used as a reference to assess the adequacy of the evaluations. The inspector also verified that the identified corrective actions to correct the degraded conditions were adequate and scheduled in the licensee's work control process.

- OE 02-11, Preliminary calculations determined the trip settings for breaker B603 may be challenged with certain load combinations. The licensee assessed this issue in condition report 2002-09746 and engineering evaluation 02-017. The interim compensatory measures were to assure that operation of certain non-safety related backup loads were limited to one component at a time.

b. Issues and Findings

No findings of significance were identified.

1R17 Permanent Plant Modification

a. Inspection Scope

The inspector selected one risk-significant plant modification package for review to verify that the design bases, licensing bases, and performance capability of the risk significant system had not been degraded through the modification.

For the selected modification, the inspector reviewed the design inputs, assumptions, and design calculations, such as time delay set-point and uncertainty calculations, to determine the design adequacy. In addition, the inspector reviewed the associated 10 CFR 50.59 safety evaluation to verify that the safety issue pertinent to the changes were properly resolved or adequately addressed. The inspector also reviewed: (1) field change notices that were issued during the installation to determine proper installations of the time delay relays; and, (2) post-modification functional testing and time delays setting records to determine the readiness for operations. Finally, the inspector reviewed the affected procedures, drawings, and vendor manuals to verify that the affected documents were appropriately updated.

The inspector also walked-down the time delay relays in the control cabinets to detect possible abnormal installation conditions.

The modification package selected for review was:

MR E0000059	Replace Degraded Voltage Agastat EDSC Timers with E70000 Series time delay Relays
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b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspector reviewed the following post maintenance testing activities:

- P9600467, Rebuild standby gas treatment outlet damper actuator, AO-N-108.

The review included ensuring that the effect of the test on plant had been evaluated adequately, verifying that the test was properly performed and the test data met the required acceptance criteria, and that the test activity was adequate to verify system operability and functional capability following maintenance.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testinga. Inspection Scope

The inspector reviewed the results of the following surveillance tests:

- 8.7.2.6, SBGT single train operability test.
- 2.8.87.3, Control Rod Drive Venting, Timing and Adjustment.
- 8.M.1-20, SDIV Level Switch Functional Test.
- 8.M.2-1.5.3.1 Primary Containment Isolation Logic Channel Test

The inspector verified that the test acceptance criteria was consistent with technical specifications and Updated Final Safety Analysis Report requirements, the test was performed in accordance with the written procedure, the test data was complete and met procedural requirements, and the system was properly returned to service following testing.

b. Findings

No findings of significance were identified.

## 1R23 Temporary Plant Modification

### a. Inspection Scope

The inspector selected three risk-significant temporary modifications for review to verify that the design bases, licensing bases, and performance capability of the associated risk significant systems had not been degraded through the modification.

The temporary modifications selected for review were:

- TM 00-44 Replacement of Pressure Switch PS-3986 Associated with Screen-wash Pump 213A;
- TM 01-28 Rerouting of LPRM 28-29B and 12-21B Cable Under Vessel;
- TM 98-32 CRHEAF System Jumpering of the Relative Humidity Switches (RHS-1A & RHS-1B) for VSF103A & VSF 103B Fans.

For the selected temporary modifications, the inspector reviewed the design inputs, assumptions, and design calculations to determine the design adequacy. In addition, the inspector reviewed the associated 10 CFR 50.59 safety evaluations and safety evaluation screening to verify that the safety issue pertinent to the changes were properly resolved or adequately addressed. The inspector also reviewed the post-installation testing records to determine the readiness for operations. Finally, the inspector reviewed the control room logs to verify that selected temporary modifications were properly recorded.

Further, the inspector reviewed a sample of condition reports (CRs) related to temporary modifications to verify that identified problems were appropriately resolved. The inspector also walked-down the pressure switch associated with Screen-wash Pump 213A in the Intake Structure to detect possible abnormal installation conditions.

### b. Findings

No findings of significance were identified.

## 1EP6 Drill Evaluation

### .1 Drill Observations

#### a. Inspection Scope

The inspector observed portions of the April 23, 2002, annual emergency planning exercise to evaluate the drill and licensee critique. The inspector focused on event classification and notification, communication of priorities, and command and control among the emergency response organizations. Initially, the inspector observed the operating crew response in the simulator; and after the Alert notification was declared, the remainder of the drill from the Technical Support Center/Operational Support Center. The inspector also observed the on-station critique/debrief held between the controllers and players held immediately following the drill and the licensee's presentation of exercise findings to site management.

b. Findings

No findings of significance were identified.

.2 Prompt Alert and Notification System

a. Inspection Scope

The inspector reviewed the licensee actions in response to the April 17, 2002, determination that the Prompt Alert and Notification System (PANS) was inoperable (reference condition report 2002-09884). The PANS became inoperable because the ability to activate the system was prevented by the failure of one siren. The inspector reviewed the compensatory actions taken which included the notification to the local town Emergency Management Directors to be prepared to implement route alerting if needed. The licensee identified and isolated the failed siren, and restored the PANS to an operable status within two hours. The inspector reviewed the licensee's assessment of the PANS performance, and the long term plans to improve the system. The licensee reported this event to the NRC per 10 CFR 50.72(b)(1)(v) as Event Notification 38859.

b. Findings

No findings of significance were identified.

**3. RADIATION SAFETY**

2OS1 Access Control (7112101)

a. Inspection Scope

The inspector identified exposure significant work areas (e.g., high radiation areas, and potential airborne radioactivity areas) in the turbine and reactor buildings and reviewed associated controls and surveys of these areas to determine if the controls (i.e., radiological surveys, postings, barricades) were adequate to identify and control radiation exposures. For these areas, the inspector: reviewed radiological job requirements and attended job briefings; determined if radiological conditions in the work area were adequately communicated to workers through briefings and postings; verified the implementation of radiological job coverage and contamination controls; and verified the accuracy of surveys and applicable posting and barricade requirements. The inspector determined if prescribed radiation work permit (RWPs) controls were in-place, procedure and engineering controls were in place, whether licensee surveys and postings were complete and accurate, and whether air samplers were properly located. The inspector reviewed electronic pocket dosimeter alarm set points (both integrated dose and dose rate) for conformity with survey indications and plant policy. Ongoing work activities reviewed included repairs to the cation resin tank on Turbine Building 3' elevation. Plant technical specification (TS) 5.7 and the requirements contained in 10 CFR 20, Subpart G were utilized as the standard for necessary barriers.

b. Findings

No findings of significance were identified.

2OS2 ALARA Planning and Controls (7112102)

a. Inspection Scope

The inspector reviewed ALARA job evaluations, reviewed exposure estimates and exposure mitigation requirements, and reviewed ALARA plans. The inspector conducted a review of: the integration of ALARA requirements into work procedures and RWP documents; the accuracy of person-hour estimates and person-hour tracking; and the generation of shielding requests including their effectiveness in dose rate reduction. The inspector also attended the May 6, 2002, meeting of the station's ALARA Oversight Committee, which is chaired by the Plant Operations General Manager, and whose membership is made up of the various station Managers and Directors. Topics discussed by this committee included: ALARA planning for top decile performance; establishment of a revised (lowered) calendar year 2002 exposure goal; and, station ownership of RP issues, including ALARA.

For the work areas identified in section 2OS1 (above), the inspector: evaluated the licensee's use of engineering controls to achieve dose reductions; determined if workers utilized the low dose waiting areas and were effective in maintaining their doses ALARA; determined if workers received appropriate on-the-job supervision to ensure ALARA requirements were met; and reviewed individual exposures of selected work groups.

The inspector conducted a review of actual exposure results versus initial exposure estimates including comparison of estimated and actual dose rates and person-hours expended; determination of the accuracy of estimations to actual results; and determination of the level of exposure tracking detail, exposure report timeliness and exposure report distribution. The review was against requirements contained in 10 CFR 20.1101(b).

b. Findings

No findings of significance were identified.

2OS3 Radiation Monitoring Instrumentation (7112103)

a. Inspection Scope

The inspector reviewed field instrumentation utilized by health physics technicians and plant workers to measure radioactivity including; portable field survey instruments, friskers, portal monitors and small article monitors. The inspector conducted a review of instruments observed, specifically verification of proper function and certification of appropriate source checks for these instruments, which were utilized to ensure that occupational exposures were maintained in accordance with 10 CFR 20.1201.

The inspector also reviewed documentation related to the annual full system calibration of the whole body counters (chair and Fastscan), conducted in July 2001.

b. Findings

No findings of significance were identified.

**4. OTHER ACTIVITIES [OA]**

4OA2 Identification and Resolution of Problems

a. Inspection Scope

During three events in 2001, safety-related reactor vessel water level instruments exhibited inaccurate indications. The causes of the level indication errors were different in each case: air intrusion in April 2001; reference leg drain down in August 2001; and non-condensable gas migration (level notching) in December 2001. However, in all cases, the errors were non-conservative (actual water level was lower than indicated level). The licensee's actions to address the reactor water level indication issues were selected for review because non-conservative level indication could delay or prevent automatic safety functions such as emergency core cooling system initiation, and could mislead plant operators.

The inspector reviewed the root cause analysis for the level errors observed in December 2001, as well as the reactor vessel level traces recorded during the shutdown. The inspector also reviewed reference leg external leakage inspection procedures and results, and discussed the results of equalizing valve testing with licensee personnel. These activities were performed to determine whether the licensee's analysis was of sufficient detail and scope to identify root and contributing causes, and considered extent of condition, generic implications, common cause, and previous occurrences.

The inspector reviewed engineering evaluations that provided justification for intermittent operation of the level instrument reference leg backfill system, as well as the temporary modification and engineering evaluation for continuous operation of the backfill system for the 'B' reference leg. The inspector also reviewed historical information (licensee event reports, problem reports, reactor vessel water level traces, etc.) and engineering evaluations that supported the licensee's operability determinations for the safety-related reactor vessel water level instruments. The purpose of these reviews was to assure that the level instruments could be expected to perform their intended safety functions. The inspector also confirmed, by review of reactor vessel water level traces from previous shutdowns, that level notching did not occur on the safety-related level instruments when the backfill system was in continuous operation.

The inspector reviewed corrective action program documents (condition reports and problem reports) for the level instrument issues to assure that identified corrective actions were appropriately focused to correct the problems and considered the identified causes of level indication errors. The inspector confirmed that corrective actions were completed or scheduled commensurate with the significance of the problems.

b. Issues and Findings

The licensee determined that off-gassing of dissolved gases in the 'B' instrument reference leg, while the reactor depressurized, caused the non-conservative reactor water level indications (level notching) observed in December 2001. The licensee believed that leakage from one of the safety-related instrument racks allowed the dissolved gases to migrate into the reference legs, but was unable to identify the leakage location. The inspector considered the licensee's actions to identify the root cause and the source of the reference leg leakage reasonable considering the difficulties in testing for internal leakage, the low safety significance of the condition, and the licensee's plans for long term corrective actions that would address non-condensable gas migration, as well as air intrusion and reference leg drain down.

The licensee determined that the 'B' reference leg level instruments would remain operable with intermittent backfill every 14 days based on a leakage rate that bounded the non-condensable gas migration necessary to cause the level notching observed in December 2001. The 'A' reference leg level instruments were determined to be operable with intermittent backfill every 90 days based on evaluations performed following the August 2001 event. The determinations were supported by historical performance of the level instruments without continuous backfill system operation. These operability determinations also relied on evaluations performed prior to installation of the backfill system in 1993.

The licensee had revised procedures to address the causes of all three events and had established compensatory measures to minimize the potential for level errors due to causes other than migration of dissolved gases with the backfill system in continuous operation. At the time of the inspection, the licensee was carefully evaluating several options for long term corrective actions that would eliminate the possibility of reference leg drain down, minimize or eliminate the potential for air intrusion, and minimize the potential for non-condensable gas migration.

No findings of significance were identified.

4OA3 Event Followup

(Open) LER 50-293/2001-07: Automatic Scram During Transient Caused by Failure of Calibrating Unit. This event occurred on December 27, 2001, and was previously documented in section 1R14 of NRC Inspection Report 50-293/2001-08. Short term corrective actions for the level instrument anomalies observed during this event are also discussed in section 1R15 of NRC Inspection Report 50-293/2001-012 and in section 4OA2 of this inspection report. The LER will remain open pending implementation of long term corrective actions to address the level instrument anomalies.

4OA6 Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. C. Dugger and other members of licensee management at the conclusion of the inspection on May 21, 2002. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered propriety. No propriety information was identified.

**ATTACHMENT****SUPPLEMENTAL INFORMATION**a. Key Points of Contact

S. Bethay  
 P. Dietrich  
 B. Ford  
 J. Hurley  
 K. Kampschneider  
 W. Lobo  
 W. Mauro  
 J. McClellan  
 F. McGinnis  
 W. Perks  
 D. Perry  
 P. Smith

b. List of Items Opened, Closed and DiscussedDiscussed

LER 50-293/2001-007	Automatic Scram During Transient Caused by Failure of Calibrating Unit
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Open

LER 50-293/2001-07	Automatic Scram During Transient Caused by Failure of Calibrating Unit
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c. List of Documents Reviewed

NOP83E1 Control of Modifications at Pilgrim Station  
 No.1.5.9 Temporary Modifications  
 CR-PNP-2002-10054  
 CR-PNP-2000-09459  
 CR-PNP-2000-09460  
 CR-PNP-2002-10039  
 PR00.3040,00  
 PR01.9739  
 Calculation M-1185, "Reactor Water Level Reference Leg Backfill System Design Evaluation," Rev. 0, 10/15/01  
 CDI Report No. 93-06, "Testing of Boiling Water Reactor Water Level Instrumentation Reference Leg Backfill Modification Concept," August 1993  
 Condition Report CR-PNP-2001-08152, initiated 12/31/01  
 Condition Report CR-PNP-2001-09385, initiated 4/24/01  
 Condition Report CR-PNP-2001-09774, initiated 8/15/01

Condition Report CR-PNP-2002-09042, initiated 1/24/02  
Engineering Evaluation EE 02-06, 2/15/02  
Engineering Evaluation EE 02-11, 3/25/02  
F&MR 90-52, "Momentary Spike in Rx Level (From Condensing Chamber 12B) Causing Group I Isolation," April 18, 1990  
Final Report on Contract #NPS00742, "Review of SCRAM Event of August 13, 2001," Continuum Dynamics Inc., 01/08/2002  
LER 90-003-00, "Automatic Closing of the Group 1 Isolation Valves Due to a False High Reactor Water Level Signal During Shutdown," April 6, 1990  
LER 90-016-00, "Automatic Closing of the Group 1 Isolation Valves While Shutdown Due to High Reactor Water Level," October 16, 1990  
LER 91-008-001, "Three Automatic Group 1 Isolations Due to False High Reactor Water Level Signals While Shutdown," February 24, 1992  
LER 92-004-00, "Three Automatic Group 1 Isolations During Plant Shutdown," April 27, 1992  
LER 92-013-01, "Automatic Closing of Group 1 Containment Isolation Valves Due to False Reactor Vessel High Water Level Signal," March 29, 1993  
LER 93-026-00, "Low Reactor Vessel Water Level While Shutdown Resulting in Automatic Scram Signal and Containment System Isolations," December 1993  
LER 94-003-00, "False Low Reactor Vessel Water Level Signal While Shutdown During Control Rod Drive System Venting," May 26, 1994  
LER 96-009-00, "Group 3 Isolation Due to False High Reactor Vessel Pressure Signal During Backfill While Shutdown," October 1996  
PNPS Procedure 2.1.1, "Startup From Hot Shutdown," Rev. 118  
PNPS Procedure 2.1.6, "Reactor Scram," Rev. 49  
PNPS Procedure 2.2.80, "Reactor Vessel Level, Temperature, and Internal Pressure Instrumentation," Rev. 34  
PNPS Procedure 2.2.87, "Control Rod Drive System," Rev. 82  
PNPS Procedure 2.4.4, "Loss of CRD Pumps," Rev. 16  
PNPS Procedure 3.M.2-12.3, "Backfilling Condensing Chambers 12B and 13B, Active Leg and Instrument Lines From Racks 2206, 2276, 2252," Rev. 8  
PNPS Procedure 3.M.2-12.6, "Reactor Level Reference Line and Backfill System Inspection," Rev. 1  
PNPS Procedure 5.3.23, "Alternate Rod Insertion," Rev. 19  
Problem Report PR 92.9203, initiated 10/25/92  
Problem Report PR 95.9145, initiated 3/27/95  
Problem Report PR 95.9316, initiated 5/31/95  
Problem Report PR 01.9838, initiated 8/29/01  
Quality Assurance Surveillance Report 01-079, "Review of Field Complete Exhibit 1 Forms Per NOP83A1," 12/11/01  
SUDDS/RF#93-136, "Investigation of Level Indication Anomalies at Pilgrim Nuclear Power Station," BEC-002-R-01(Q), Rev. 0, S. Levy Inc., November 1992  
Temporary Modification TM02-09, "Reactor Level Reference Leg Backfill System," Rev. 0  
Traces for shutdowns on 3/13/93, 3/25/95, 2/14/97, 5/8/99

d. List of Acronyms

ALARA	As Low As Reasonable Achievable
CFR	Code of Federal Regulations
CR	Condition Reports
CRHEAF	Control Room High Efficiency Air Filter
DBT	Design Basis Threat
LER	Licensee Event Report
MR	Maintenance Request
OE	Operability Evaluations
PANS	Prompt Alert and Notification System
PARS	Publically Available Records
PR	Problem Report
RP	Radiation Protection
RWP	Radiation Work Permit
SBGT	Standby Gas Treatment
SDIV	Scram Discharge Instrument Volume
SDP	Significant Determination Process
TS	Technical Specifications
UFSAR	Updated Final Safety Analysis Report