

September 30, 1999

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

SUBJECT: MID-CYCLE PLANT PERFORMANCE REVIEW - PILGRIM NUCLEAR
POWER STATION

Dear Mr. Bellamy:

On September 13, 1999, the NRC staff completed the mid-cycle Plant Performance Review (PPR) of Pilgrim Nuclear Power Station. The staff conducts these reviews for all operating nuclear power plants to integrate performance information and to plan inspection activities at your facility over the next six months. The focus of this performance review was to identify changes in performance over the last six months, and to allocate inspection resources accordingly. We provided our most recent summary of your performance (full PPR) in a letter dated April 9, 1999, which was discussed in a public meeting with you on August 31, 1999.

As discussed previously in our April letter, equipment and plant reliability continued to be good, and your corrective action program and independent review groups continued to function well. Our current review of Pilgrim identified that your performance was consistent with the full PPR. However, we note that your performance in some areas warrants additional NRC attention. We observed human performance problems during some routine plant evolutions, which included several tagging errors, a reactivity control error, and a configuration error while placing the residual heat removal system in the normal lineup to support power operations. We also observed several examples of deficient engineering support to operations and maintenance that contributed to a main transformer failure, an automatic reactor shutdown, and a feedwater system transient. Finally, while noting you have taken the initiative to reduce the plant source term in certain areas by chemical decontamination, managing occupational dose as low as reasonably achievable (ALARA) remains a challenge at the station.

Based on this mid-cycle review, we plan to conduct additional inspections beyond the core inspection program over the next six months to better assess the issues described above. As such, we plan an initiative inspection for resident inspector follow-up of your corrective actions for the increased human performance problems. We also plan an initiative inspection in the engineering area to better assess engineering support to operations and maintenance. Finally, we plan an initiative inspection to assess your occupational dose management program implementation and to review your actions to further reduce the plant source term. Further, we will continue to provide an increased inspection emphasis on the handling of degraded equipment and post-work test procedure adequacy as described in our April letter.

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Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated review of licensee performance trends. The PIM includes items summarized from inspection reports or other docketed correspondence between the NRC and Entergy - Pilgrim Station from September 1998 through August 1999. As noted above, we placed greater emphasis on those issues identified in the past six months during this performance review. The NRC does not attempt to document all aspects of licensee programs and performance that may be functioning appropriately. Rather, we only document issues that we believe warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may have also considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that have occurred since the last NRC inspection report was issued, but that have not yet received full review and consideration. This material will be placed in the Public Document Room as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our plans for future inspection activities at your facility so that you will have an opportunity to prepare for these inspections and to provide us with feedback on any planned inspections that may conflict with your plant activities. Enclosure 2 details our inspection plan through March 2000 to coincide with the scheduled implementation of the revised reactor oversight process in April 2000. Also included in the plan are NRC non-inspection activities. The rationale or basis for each inspection outside the core inspection program is discussed above so that you are aware of the reason for emphasis in these program areas. Resident inspections are not listed due to their ongoing and continuous nature.

If circumstances arise which cause us to change this inspection plan, we will contact you to discuss the change as soon as possible. Please contact me at 610-337-5227 with any questions you may have.

Sincerely,

Original Signed by:

Stephanie Coffin, Acting Chief
Projects Branch 5
Division of Reactor Projects

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

Enclosures:

1. Plant Issues Matrix
2. Inspection Plan

cc w/encls:

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D. Tarantino, Manager, Communications
S. Brennon, Regulatory Affairs Department Manager
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The Honorable Therese Murray
The Honorable Vincent DiMacedo
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DATE	09/30/99	09/30/99

ENCLOSURE 1:

PLANT ISSUES MATRIX

PILGRIM PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
7/9/99	Positive	IR 99-03	N	OPS	1A	Shift turnover briefings lead by the off going nuclear watch engineer were detailed and included a good discussion on equipment availability and shutdown risk.
7/9/99	Positive	IR 99-03	N	OPS	1A 1C	Reactor fuel movements were performed in a controlled manner with effective communications between contract fuel handlers, reactor engineers, control room operators and the SRO stationed on the refueling bridge.
7/9/99	Positive	IR 99-03	N	OPS	1A 2A	Operators stopped fuel movements when necessary to resolve degraded conditions such as poor reactor water quality and also when a source range monitor started to read erratically. This reflected a conservative nuclear safety approach by operators's personnel.
7/9/99	Positive	IR 99-03	N	OPS	1A 2A 5A	A new camera angle during core verification revealed a fuel support piece which was not fully seated. Also, a cap screw was removed from a control rod drive which had jammed the rod during the previous operating cycle. Good FME practices were observed during refueling activities. Refueling activities were conducted in a controlled manner with overall good performance.
7/9/99	Negative	IR 99-03	N	OPS	3A 3C	Several tagging errors resulted due to license operator errors both while hanging and verifying checking tags. These errors occurred early in RFO12 during the highest demand period for work release indicating that management involvement was lacking in the oversight and scheduling of tagouts. Interim corrective actions were implemented to improve future tagging performance.
7/9/99	Positive	IR 99-03	N	OPS	3B	Training provided to licensed operators on modifications implemented during the cycle 12 refueling outage was determined to be good. Simulator and job performance measures were used, as necessary, to ensure operators could properly operate the equipment and that they understood the modifications.
5/17/99	Positive	IR 99-02	N	OPS	1A 5A	The nuclear plant operator identified several equipment problems during a tour of the reactor building; and appeared to be very knowledgeable and experienced.
5/17/99	Negative	IR 99-02	L	OPS	1A	Operators incorrectly moved several control rods during a planned down power due to inattention-to-detail and poor communication. The licensee's immediate corrective actions to address this issue were determined to be good. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as PR 99.9108 (NCV 50-293/99-02-01).

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Date	Type	Source	ID	SFA	Code	Item Description
5/17/99	Positive	IR 99-02	N	OPS	1A 5A 2A	Operators promptly declared main steam isolation valve AO-220-2C inoperable due to a slow close test failure and followed technical specifications and other administrative requirements. Subsequently, operators responded well to a small power excursion when operating at 85% reactor power with one steam line isolated.
4/20/99	Positive	IR 99-01	N	OPS	1A	Operators completed operational activities well including a scheduled plant down power to perform control rod scram time testing. Good communication and procedure adherence was observed. The pre-evolutionary brief for this evolution was comprehensive which covered actions for a feed water malfunction. Members of the quality assurance staff were observed in the control room providing independent oversight.
4/20/99	Positive	IR 99-01	N	OPS	1A	Nuclear watch engineer (NWE) shift turnovers were generally good. In addition to reviewing current plant conditions, the NWEs discussed changes in plant status since the crew's last watch as well as scheduled plant activities.
4/20/99	Positive	IR 99-01	N	OPS	1A 5A 5B	Operators alertly identified that sample valves were left open out of the normally closed position in the SWC system. The root cause evaluation thoroughly reviewed the human performance aspects of this event.
4/20/99	Negative	IR 99-01	N	OPS	1A	The operations staff did not promptly inform the security staff or senior site management for an operational event which had the potential to involve security tampering issues. Subsequent licensee and NRC review determined that the event did not involve tampering.
4/20/99	Positive	IR 99-01	N	OPS	1C	The inspector concluded that the Nuclear Safety Review and Audit Committee effectively performed review and audit of station activities and met TS requirements.
2/19/99	Positive	IR 98-11	N	OPS	3A	Operators completed operational activities well including the recording and evaluation of technical specification readings. Members of plant management were periodically observed touring the control room and plant areas.
2/19/99	Negative	IR 98-11	N	OPS	3A	Two instances of minor weaknesses in the identification and initiation of corrective action for degraded equipment conditions in the control room were identified by the NRC. Also, two minor instances were noted where relevant operational information was not recorded in the NOS log or daily morning report. These conditions reflect lapses in operator awareness.
2/19/99	Negative	IR 98-11	N	OPS	2B	A weakness in the cold weather program was evident when temperatures in the intake structure went below an UFSAR specified design value of 60 degrees Fahrenheit.

PILGRIM PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
2/19/99	Positive	IR 98-11	N	OPS	1C	The high pressure coolant injection system was properly configured to support system operability. No operability concerns were identified during the walkdown of the system.
2/19/99	Negative NCV	IR 98-11 NCV 98-11-02 LER 98-19	N	OPS	5C	The standby liquid control system was declared inoperable due to low accumulator pressure. A leak had developed in a pressure instrument fitting.
12/22/98	Positive	IR 98-10	N	OPS	1A	The conduct of routine operations was professional and safety-conscious. An initiative to require newly licensed operators to serve under instruction watches prior to assuming full licensed duties was positive.
12/22/98	Positive	IR 98-10	N	OPS	1B	Reactor engineers prepared a thorough power maneuver plan to support a planned down power to 70% reactor power. Reactor fuel vendor recommendations were followed to minimize the chance to develop a reactor fuel leak.
12/22/98	Positive	IR 98-10	N	OPS	1B	Operators maneuvered the plant and performed individual control rod scram time testing in a competent manner. Test anomalies were promptly evaluated prior to proceeding.
12/22/985 22	Negative	IR 98-10	N	OPS	1A	Operators were slow to declare the "B" SBGT train inoperable. Operators troubleshot the cause of the "B" SBGT fan trip for one hour prior to entering the applicable technical specification action statement.
12/22/98	Negative NCV	IR 98-10 LER 97-28 NCV 98-10-01	L	OPS	1A	Screen house configuration was outside the design basis of the plant due to a door being removed that affected the tornado depressurization model.
11/24/98	Positive	IR 98-301	N	OPS	3B	All applicants passed all portions of the examination and performed well, overall.
11/24/98	Positive	IR 98-301	N	OPS	3B	The applicants were well prepared for the examination, indicating that the facility had thoroughly evaluated the knowledge and abilities of each applicant in an effort to determine their readiness to sit for an initial NRC examination. Crew communications and control board awareness were good.
11/24/98	Misc	IR 98-301	N	OPS	5B	An event involving a potential exam compromise was evaluated. The licensee was objective, thorough and timely in its investigations and in its actions taken to prevent similar events in the future. NRC staff agreed with the licensee that there was reasonable assurance that an exam compromise had not occurred and the control of the examination met the requirements of 10 CFR 55.49.

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Date	Type	Source	ID	SFA	Code	Item Description
11/24/98	Positive	IR 98-301	N	OPS	3B	The experience and qualifications of the RO and SRO applicants met the facility licensee program and NRC requirements. NRC questions on waivers to the program guidelines were adequately resolved. The licensee made enhancements to their program subsequent to the NRC questions.
11/24/98	Negative	IR 98-301	N	OPS	1C	Two procedure clarity problems were identified by the NRC examiners during the exam preparation week.
11/20/98	Positive	IR 98-08	N	OPS	1A	Routine plant operations were well performed including shift turnover and pre-evolutionary briefings.
11/20/98	Positive	IR 98-08	N	OPS	1A	Operators performed well during a power reduction to clean two main condenser waterboxes. Plant management developed a special procedure to provide specific criteria to address potential boundary valve leakage between the waterboxes. After mussel shells and other debris was removed from inside the condenser tubes, overall condenser performance significantly improved.
11/20/98	Negative	IR 98-08	N	OPS	1A 1C	A primary containment configuration control weakness was identified that resulted in not entering the related LCO requirements during chemical decontamination of the residual heat removal (RHR) loops. Several opportunities existed for the licensee's staff to identify this problem. Contributing to this issue was the improper interpretation of an UFSAR table and inadequate communications between operations and systems engineering personnel.
11/20/98	Positive	IR 98-08 LER 98-20	L	OPS	1A 5A	A control room shift staffing issue was properly identified, resolved and reported to the NRC.
7/9/99	Positive	IR 99-03	N	MAINT	3A	The disassembly and reassembly of the reactor vessel was performed well by the refueling crew. Good teamwork was noted between the craft and contract personnel.
7/9/99	Positive	IR 99-03	N	MAINT	2B	Several new initiatives were used during the outage including use of electronic logs which were accessible site wide, new reduced weight heavy-lifting slings, and a relocated outage work control center.
7/9/99	Positive	IR 99-03	N	MAINT	3A	Pre-job briefs for surveillance activities were determined to be good with proper oversight provided by the test engineer and quality assurance personnel.
7/9/99	Positive	IR 99-03	N	MAINT	2B	Post work testing for observed maintenance activities was determined to be good and in accordance with code requirements.

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Date	Type	Source	ID	SFA	Code	Item Description
7/9/99	Negative	IR 99-03	N	MAINT	3A	Several procedure usage problems were identified by the licensee and the inspector. One problem dealt with the mispositioning of LPCI throttle valve MO-10C1-28B during performance of the EDG load sequence test.
7/9/99	Positive	IR 99-03	N	MAINT	3A	The emergent replacement of the underground SSW discharge piping, replacement of the DC power panels and CRDM drive change-outs were well planned and executed.
7/9/99	Positive	IR 99-03	N	MAINT	2A	Deferred work items were properly tracked and dispositioned by the outage review board. No work items were removed from the outage scope that would adversely affect safe plant operations.
7/9/99	Positive	IR 99-03	N	MAINT	2B 5A	BEC Energy was implementing inservice inspection activities in accordance with their ISI program. NDE personnel were qualified, and adhered to procedures while performing examinations. Deficiencies identified during inspection activities were properly documented. HPCI system weld drawings accurately reflected the location of welds in the plant.
7/9/99	Negative	IR 99-03	N	MAINT	3B 3A	The failure to establish specific procedural guidance and human performance errors contributed to the cause of the transformer fire.
7/9/99	Positive	IR 99-03	N	MAINT	4B	Response to the main transformer fire by fire brigade members was good; their immediate response prevented any serious damage to the plant. The licensee properly classified the event in accordance with emergency classification guidelines.
5/17/99	Positive	IR 99-02	N	MAINT	2B 3A	Overall good pre-job briefs and procedure adherence was displayed during routine maintenance and surveillance activities.
5/17/99	Positive	IR 99-02	N	MAINT	3A 2A	Planned corrective maintenance to replace a fuel injector and high pressure tube on the station blackout (SBO) emergency diesel generator (EDG) was successfully completed by competent mechanics. Good attention to detail was evident by thorough cleaning of carbon residue where the injector seals insert inside the cylinder head.
5/17/99	Negative	IR 99-02	N	MAINT	3B	Two different maintenance work package quality issues resulted in wrong parts being sent to the job site for installation in safety related equipment. This was identified by maintenance field workers but reflected errors by planning personnel. In the first example, a work planner error resulted in sending a DC electrical relay coil instead of an AC relay. In the second example, a planner twice ordered the wrong top works for a hand operated valve in the EDG fuel oil transfer system. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as PR 99.0620 and PR 99.0626 (NCV 50-293/99-02-02).

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Date	Type	Source	ID	SFA	Code	Item Description
5/17/99	Negative	IR 99-02	N	MAINT	5B	The apparent cause evaluation for the wrong valve parts did not fully evaluate all aspects of how the work planner ordered the wrong parts twice.
5/17/99	Positive	IR 99-02	N	MAINT	3B	Extensive planning was evident for RFO12 with an emphasis on minimizing shutdown risk. Adequate administrative controls were in place to control in vessel activities such as repairing a stuck control rod drive and maintaining the reactor fuel offload rate within the capabilities of the decay heat removal systems.
5/17/99	Positive	IR 99-02	N	MAINT	3B	Quality assurance prepared an RFO12 inspection plan partly based on risk significance which included some nonsafety related systems.
4/20/99	Positive	IR 99-01	N	MAINT	1C	Operators were knowledgeable of the recently implemented diesel TS due to effective training and management oversight.
4/20/99	Positive	IR 99-01	N	MAINT	2B 3A	Good pre-job briefs and procedure adherence was displayed during routine maintenance and surveillance activities.
4/20/99	Positive	IR 99-01	N	MAINT	2A 2B	In response to an unplanned trip of an EDG, maintenance troubleshooting identified that the most likely cause involved calibration of the engine protector. The licensee interfaced well with the vendor and performed detailed troubleshooting of the trip setpoint in the I&C shop. Maintenance rule requirements regarding the diesel failure and unavailability were properly captured in the licensee's program.
4/20/99	Positive	IR 99-01	N	MAINT	2B	New fuel inspection training was good and covered all requirements contained in the fuel inspection procedure. The inspection of the fuel bundles was rigorous as demonstrated by the identification of some small foreign material. Good oversight was provided during the training and inspection activities.
4/20/99	Negative	IR 99-01	N	MAINT	5A 2B	A review of control room deficiencies revealed that there was a general increasing trend during 1998. This resulted primarily from a lower problem reporting threshold and also due to I&C staffing issues. Work control group self assessments noted the increasing trend but did not contain detailed analysis of possible barriers to reducing the overall number of control room deficiencies.
2/19/99	Negative	IR 98-11 URI 98-11-01	N	MAINT	4B	The licensee developed an alternate HPCI test method using a 1991 engineering evaluation but did not update the technical specifications to reflect the change. This item is unresolved pending further NRR review.

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Date	Type	Source	ID	SFA	Code	Item Description
2/19/99	Positive	IR 98-11	N	MAINT	3B	Good procedure usage was noted for maintenance activities observed. Probabilistic risk assessment was properly used to evaluate overall risk to the plant for an emergent work activity.
2/19/99	Negative	IR 98-11	N	MAINT	3C	Scaffolding erected to support motor operated valve work in the RHR quadrant did not provide complete access to perform the scheduled work. Electricians completed the work in a competent manner and took proper corrective actions when an actuator cover bolt broke.
2/19/99	Positive	IR 98-11	N	MAINT	5C	A condenser bay entry at power to perform temporary leak repair on a heating system valve was well coordinated and performed. An emphasis on ALARA was noted at the pre-work brief which was attended by the maintenance production manager.
2/19/99	Positive	IR 98-11	N	MAINT	3A	I&C technicians calibrated a LPCI loop select transmitter with no problems and used effective communications.
2/19/99	Positive	IR 98-11	N	MAINT	3A	Maintenance troubleshooting for control rod 34-35 was effective and operators took precautions during the post work test to minimize the significance of any potential problems.
2/19/99	Negative	IR 98-11	N	MAINT	3B	The licensee's post work test of the control room high efficiency air filtration system modification did not adequately prove the intent of the modification. This was considered a poor maintenance practice.
2/19/99	Negative NCV	IR 98-11 NCV 98-11-03 LER 98-17	N	MAINT	2B	The licensee was not performing a complete instrument loop calibration of the reactor water level instrument every refueling as required by tech specs. The proportional amplifiers were being calibrated on a 5 year frequency.
12/22/98	Positive	IR 98-10	N	MAINT	3A	A good questioning attitude was displayed by the electrical maintenance mechanics during work on motor operated valve actuators when they observed that the wiring was not in accordance with the internal wiring diagram.
12/22/98	Negative	IR 98-10	N	MAINT	2B	A procedure weakness was identified during the performance of the standby gas treatment surveillance involving the adequacy of the system retest. The licensee initiated a problem report to resolve this issue. Actual system response was not performed following disconnect/reconnect of temperature sensor grey boot.
12/22/98	Negative NCV	IR 98-10 LER 98-11 NCV 98-10-04	L	MAINT	1A 2B	Two concrete shield plugs were removed (in Nov., 1996) that affected the high energy line break analysis.

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Date	Type	Source	ID	SFA	Code	Item Description
12/22/98	Negative NCV	IR 98-10 LER 98-10 NCV 98-10-03	L	MAINT	2B	Inadequate surveillance performed for containment cooling flow rates. The system was tested at 4800 gpm vice 5100 gpm.
12/22/98	Negative	IR 98-10	N	MAINT	2A	Overall, the inspector observed that the licensee maintained continued attention to material condition deficiencies. The NRC did note some minor deficiencies that were not captured in the licensee's corrective action system.
12/22/98	Positive	IR 98-10	N	MAINT	2A	Operators used remote cameras to closely monitor valve leaks inside the condenser bay. Efforts to stop packing leakage from the "B" feed water regulating valve during a down power were not completed. Interim actions were taken to mitigate the effects of the steam leak.
11/20/98	Negative	IR 98-08 LER 98-22	L	MAINT	2B 5B 5C	An unplanned actuation of the 'A' Emergency Diesel Generator occurred during a surveillance test of related logic system testing.
11/20/98	Negative	IR 98-08	N	MAINT	1A 2A	Mechanical interference was identified between the control rod drive system solenoid directional control valve and the actuating arm of the valve position indicator for the inlet scram valve on four of the hydraulic control units (HCUs). HCU operability was not affected, but the solenoids could have been damaged by operation of the scram valve.
11/20/98	Positive	IR 98-08	L	MAINT	2B	Routine surveillance and maintenance activities were generally well controlled. Supervisory presence in the field was noted.
7/9/99	Positive	IR 99-03 LER 98-28 NCV 99-03-05	N	ENG	5A	inoperable control room high efficiency air filtration system.
7/9/99	Positive	IR 99-03 LER 98-23 NCV 99-03-04	N	ENG	5A	inoperable reactor building closed cooling water alternative shutdown panel
7/9/99	Positive	IR 99-03	N	ENG	4B	No safety concerns were noted concerning the open operability evaluations reviewed.

PILGRIM PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
7/9/99	Negative	IR 99-03	N	ENG	4B	Two minor problems were noted during the review of operability evaluation (OE) 98-052, "Excessive Head Loss in Reactor Building Closed Cooling Water Pump Startup Strainers." These included attention-to-detail problems pertaining to the procedures governing operability and engineering evaluations. Also, the preliminary engineering work supporting PDC 99-09, "Decrease of the EDG Building Low Temperature Design Limit," was not comprehensive. Structural considerations were not being reviewed regarding the 20 °F EDG room design temperature decrease and the resultant impact on the piping stress analysis, the EDG silencer supports, and the compressed air receivers.
7/9/99	Positive	IR 99-03	N	ENG	4B	The licensee has a process in place to control the OE backlog and appears to be on track in reducing the number of open OEs, expecting to have 5-10 open OEs at the end of RFO 12.
7/9/99	Positive	IR 99-03 LER 98-21 NCV 99-03-03	N	ENG	5A	The failure to have sufficient diesel fuel oil supply on-site
5/17/99	Positive	IR 99-02	N	ENG	4A	The plant design changes (PDC) reviewed clearly identified those controlled documents and training activities that were required to be updated prior to turnover of the component/system to operation. The PDCs were properly implemented in accordance with NRC and licensee requirements.
4/20/99	Positive	IR 99-01	N	ENG	4B 4C	The engineering backlog was tracked by engineering management with established goals in place. The overall backlog has started to trend down slightly during the last quarter. Engineering self assessments determined that additional resources was needed in the form of 4 to 6 additional full time engineers.
4/20/99	Negative	IR 99-01	N	ENG	4B	A relatively large number (i.e., 76) of operability evaluations remain open. Also, the licensee has not yet established the process for written justification of operability evaluations which will not be resolved during the first opportunity in RFO12.
4/20/99	Negative	IR 99-01 NCV 99-01-02 LER 98-24	L	ENG	4A	A design control error effecting the control room air filtration system is considered a non-cited violation.
2/19/99	Negative	IR 98-11	N	ENG	4B	A mechanical failure of a ventilation damper actuating assembly during a special test resulted in insufficient EDG radiator air cooling and increasing EDG operating temperatures. Shortly thereafter, the EDG tripped automatically on high jacket water temperature. Manual actions by the operator and engineering test director to trip the EDG prior to automatic trip were hindered due to weaknesses in test control and in the test procedure.

PILGRIM PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
2/19/99	Negative	IR 98-11 IFI 98-11-04	N	ENG	4B 3A	Initial engineering corrective measures to address AO-220-45, which failed a 10 second stroke-close test, were minimal. Approximately two weeks later, the valve was again declared inoperable when the stroke time was just under the 10 second limit. A review of the stroke close time data since 1992 revealed a repetitive pattern of increasing stroke times every two years. Also, the stroke-close time data in 1995 showed an adverse trend which was not rigorously evaluated.
2/19/99	Positive	IR 98-11	N	ENG	3A	A quality assurance audit of the CRHEAF system identified important findings regarding the maintenance history of the relative humidity switches. An effective synergy was noted between QA, engineering, I&C and operations when evaluating and correcting the system operability aspects of the audit findings. The audit report was detailed and contained supporting and compliance details but contained sparse assessment information.
12/22/98 537	Positive NCV	IR 98-10 LER 98-03 NCV 98-10-07	L	ENG	5A 5B	As part of the USI A-46 program the licensee identified that the reactor building closed cooling water and turbine building closed cooling water support plates did not conform to design drawings.
12/22/98 536	Misc	IR 98-10 LER 97-27 LER 98-02 LER 98-04	L	ENG	5B 5C	Emergency diesel generator air temperature went below its design temperature on three occasions.
12/22/98 535	Positive NCV	IR 98-10 LER 98-07 NCV 98-10-05	L	ENG	5A 5C 4A	Single failure vulnerability of the residual heat removal system when in suppression pool cooling.
12/22/98 534	Positive NCV	IR 98-10 LER 97-13 NCV 98-10-06	N	ENG	5A 5C	The inspector concluded that the licensee's extensive engineering review for resolving a previous load shed issue resulted in the identification of the load-shed-circuit cable separation problem. This problem was properly evaluated, reported to the NRC with corrective actions taken and planned.
12/22/98	Positive	IR 98-10	N	ENG	5C	The licensee's corrective actions taken and planned for degraded and non-conforming equipment conditions (residual heat removal single failure vulnerability, heat exchanger supports) was determined to be good.

PILGRIM PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
11/24/98	Negative	IR 98-203 IFI 98-203-17	N	ENG	4A	Several ASME VIII heat exchangers did not have overpressure protection devices installed on the equipment or on the adjacent piping. The original Bechtel Specification had required that the seller furnish shell and channel relief valves on these heat exchangers. The licensee stated that when the RBCCW and SSW systems are in their normal lineups there is no potential for overpressure to occur. However, during maintenance the heat exchanger may be isolated, resulting in the potential for thermal pressurization. The licensee concluded that this potential could be eliminated with procedural controls.
11/24/98	Negative	IR 98-203 IFI 98-203-16	N	ENG	4B 5B	The design and protection of the RBCCW system inside containment was not well documented. The licensee did not evaluate the potential effects of losing RBCCW inventory before the failure could be isolated by the operators.
11/24/98	Misc	IR 98-203 IFI 98-203-15	N	ENG	4A	The team questioned the basis of the ISI classification boundaries located at the normally open RBCCW non-essential loop isolation valves (MO4085A/B, MO4009A/B) and at the primary containment penetrations (30-CK-432 to X-23, X-24 to MO4002). It is necessary that a final determination be made as to the appropriate classification of the RBCCW non-essential piping and components. Engineering Evaluation (EE) 98-0081 prepared during the inspection, determined that the non-classified portion of the system should either be included in the ISI program, or be included in a similar inspection program.
11/24/98	Misc	IR 98-203 IFI 98-203-18	N	ENG	4A	Elements of design control require that measures be established for the selection and review for suitability of application of materials, parts, and equipment that are essential to the safety-related functions of the structures, systems and components. The licensee's commercial grade item process did not require an evaluation of the radiological effects on non-electrical items outside the scope of the radiological EQ program.
11/24/98	Misc	IR 98-203 URI 98-203-14	N	ENG	4A	Adequacy of design controls associated with emergency core cooling systems room potential flooding to assure that multiple ECCS equipment rooms are not adversely impacted by a single flooding event.
11/24/98	Negative	IR 98-203 URI 98-203-13	N	ENG	4A	The licensee has no formal procedure for tracking and controlling DC loads other than the revision of appropriate D calculations or by calculation comment sheets. Calculation comments associated with vendor calculations were not controlled as well.

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Date	Type	Source	ID	SFA	Code	Item Description
11/24/98	Negative	IR 98-203 IFI 98-203-12	N	ENG	4A	The team reviewed calculation PS47G regarding voltage available at DC components (end devices). In most cases, the licensee calculated the available voltage at the distribution panel level and not down to the DC end devices. The licensee did not determine, by analysis, what the minimum battery terminal voltage would be during a given station battery's discharge cycle. The service test acceptance criteria had no basis except that the licensee believed it to be conservative.
11/24/98	Negative	IR 98-203 IFI 98-203-11	N	ENG	4A	There is no calculation that determines available fault currents for the new batteries installed by PDC 93-28 in 1993 and 1994. The licensee has since learned that possibly five buses (D4, D5, D10, D16, and D17, in the DC distribution systems of the three station batteries, have to be replaced with ones with higher fault ratings since the fuses in question will not properly limit DC fault currents.
11/24/98	Negative	IR 98-203 IFI 98-203-10	N	ENG	4A	Several discrepancies were identified during review of the loading calculation for the 125V "A" battery. The licensee determined the station batteries had sufficient margin in accordance with IEEE 485 even after accounting for the outstanding load discrepancies.
11/24/98	Negative	IR 98-203 IFI 98-203-09	N	ENG	4B	The licensee's safety evaluation for the modification for the degraded bus protection for the 480V swing bus did not discuss the effect on the TS. The licensee's 10 CFR 50.59 safety evaluation Procedure P83E5 "Safety Review," Revision 12, did not require any review for TS impact. It was not clear that the licensee's review of this modification completely satisfied the TS impact review requirements specified in 10 CFR 50.59.
11/24/98	Negative	IR 98-203 IFI 98-203-06	N	ENG	4A	The licensee had used the 345 kV switchyard, back feeding through the main transformer, as the preferred off-site source during shutdown conditions. The 345 kV back feed feature is an alternate qualified offsite power source. The team learned that no written basis existed to confirm backfeed adequacy as to required voltage, loading, or short circuit protection requirements.
11/24/98	Misc	IR 98-203 IFI 98-203-05	N	ENG	4A	Review of recent EDG surveillance test reports for the "B" EDG showed that electrical loads, including ECCS loads, were sequenced onto the EDG within the required times and that the drop and recovery in output voltage and frequency were acceptable. The licensee's existing tests were not verifying the EDG's capability to carry worst-case loading conditions. Non worst case testing nor steady state calculations completely demonstrate EDG capability under transient loading conditions.

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Date	Type	Source	ID	SFA	Code	Item Description
11/24/98	Negative	IR 98-203 IFI 98-203-02	N	ENG	4B	The licensee's safety evaluation regarded the LPCI injection time delay did not identify any needed changes to UFSAR Section 6.5. The team was also concerned that the level of detail provided in the UFSAR for description of the LOCA analysis inputs and results (i.e., only a reference to the GE report) was not appropriate. Also, an important design input to the licensing basis LOCA analysis (swing bus transfer time), and the resulting impact on the PCT, were developed in SE No. 2989 but were not documented in an engineering calculation; therefore, although the SE was reviewed, independent verification was not documented.
11/24/98	Positive	IR 98-203	N	ENG	5A	Other issues regarding Design Control, Calculation Control, and UFSAR inconsistencies are included within the report. During the course of the inspection the licensee documented many of the issues in their corrective action program. The number and nature of the items documented on problem report (PRs) demonstrated good sensitivity for problem identification.
11/24/98	Misc	IR 98-203	N	ENG	4C	Regarding battery testing, it is the NRC's understanding that PNPS plans to review the current TS requirements and modify them if necessary, after verifying the new testing method is technically acceptable to the battery vendor.
11/24/98	Misc	IR 98-203 IFI 98-203-07	N	ENG	4A	Electrical system concerns associated with electrical penetration single device protection, station battery TS testing, and control of electrical loads through the use of calculation comment sheets were identified. During the exit meeting, PNPS staff described their plans to test the electrical penetration single protective device on an approximate 4 year schedule. This increased testing should provide additional assurance as to the reliability of the single protective device.
11/24/98	Negative	IR 98-203 IFI 98-203-04	N	ENG	4A 4C	The potential for RHR shutdown cooling line thermal over pressurization and for water hammer and two-phase flow conditions in RBCCW are being addressed through the NRC's review of Generic Letter 96-06, Assurance of Equipment Operability and Containment Integrity During Design-Basis Accident Conditions.
11/24/98	Negative	IR 98-203	N	ENG	4A	Several ASME VIII heat exchangers did not have overpressure protective devices installed as specified in the original specifications and for compliance with ASME Code, Section VIII requirements.
11/24/98	Misc	IR 98-203	N	ENG	4A	Equipment drains supporting the ECCS rooms may subject the ECCS equipment to common mode flooding concerns. PNPS staff is currently evaluating the basis and design of this equipment to ensure adequate protection from flooding.

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Date	Type	Source	ID	SFA	Code	Item Description
11/24/98	Negative	IR 98-203 IFI 98-203-01	N	ENG	4C 4A	RHR pump surveillance test acceptance criteria and RHR system LOCA hydraulic analysis do not appear to adequately account for instrument uncertainties. PNPS is planning to address instrument uncertainty on a graded and programmatic basis. However, PNPS staff does not believe that there is a design or licensing requirement to specifically account for instrument uncertainty in testing or analyzing variables used in the LOCA analysis. Additionally, LOCA analysis inputs and results currently contained in the UFSAR do not reflect the impact of delaying LPCI injection flows due to the increase in the swing bus transfer time.
11/24/98	Negative	IR 98-203 URI 98-203-03	N	ENG	4B 4A 1B	Emergency operating procedure (EOP) mitigation strategy for a design basis loss of coolant accident (LOCA) directs the operators to flood the containment, although this action is not necessary for short or long term core cooling. The radiological consequences, equipment demands, and environmental qualification associated with containment flooding are more severe than that assumed in the UFSAR and used to form the basis for equipment design. PNPS's plant specific 10CFR50.59 evaluations for EOP implementation did not identify the consequences of containment flooding as a potential unreviewed safety question (USQ). This potential generic issue is currently being reviewed by the NRC and additional followup actions may result.
11/24/98	Positive	IR 98-203	N	ENG	4A 5C	The PNPS efforts, to assemble, verify, and correct design basis documentation have generally resulted in new calculations of good quality and a consolidated design basis document (DID) that was useful for the team's review. These same documents, when completed for other systems, should provide useful design information for future activities. In the electrical area, many of the calculations that support the design basis of the system have not been completed and are still being revised.
11/24/98	Positive	IR 98-203	N	ENG	2A 4A	Overall, the team found that the RHR system was capable of performing its design and licensing basis functions under all design basis conditions, including loss of off-site power and single active failure. The support systems, such as reactor building closed cooling water and electrical distribution, provided adequate margin to ensure short-term and long-term RHR system emergency core cooling performance objectives.
11/20/98	Positive	IR 98-08	N	ENG	4C	An effective system has been implemented for processing degraded and non-conforming conditions from identification through correction. Review of open operability evaluations confirmed that individual conditions in the aggregate did not seriously degrade safety systems.
11/20/98	Positive	IR 98-08	N	ENG	4B	A local leak rate test (LLRT) of a primary containment penetration was well controlled by the system engineer with effective support from the I&C, operations and health physics groups.

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Date	Type	Source	ID	SFA	Code	Item Description
11/20/98	Positive	IR 98-08 LER 97-30 NCV 98-08-02	L	ENG	5A 5B	Effective engineering problem identification was indicated by subtle discrepancies involving the UFSAR drywell free volume and seismic classification of vacuum relief valves. These issues were properly evaluated and reported to the NRC.
11/20/98	Negative	IR 98-08 LER 98-09 NCV 98-08-01	L	ENG	4A	Incorrect seismic values were used for the main steam safety relief valve line vacuum breakers when they were originally purchased.
7/9/99	Positive	IR 99-03	N	PS	3A 1A	Radiological controls were effectively implemented for RFO12 as evidenced by close health physics oversight of work and improvements in radiological controls implemented for drywell work including assignment of a drywell radiological controls coordinator, installation of permanent shielding, and use of video monitoring.
7/9/99	Positive	IR 99-03	N	PS	5A 5C	An opportunity for improving radiological controls for access to upper drywell elevations during movement of irradiated core components was identified and licensee staff responded quickly to improve program controls.
7/9/99	Positive	IR 99-03	N	PS	5A 5B 5C	The problem reporting system was effectively used to identify, evaluate, and resolve radiological control deficiencies.
7/9/99	Positive	IR 99-03	N	PS	3A	The licensee was conducting security and safeguards activities in a manner that protected health and safety in the area of access authorization and fitness for duty.
7/9/99	Positive	IR 99-03	N	PS	2B	The review of the licensee's audit program for security and safeguards activities indicated that audits were comprehensive in scope and depth, that the audit findings were reported to the appropriate level of management, and that the program was being properly administered. In addition, a review of documentation applicable to the self-assessment program indicated that the program was being effectively implemented to identify and resolve potential weaknesses.
5/17/99	Positive	IR 99-02	N	PS	1A	Through observation of ongoing activities, the inspector concluded that the licensee's radiological controls for routine activities were properly being implemented.
5/17/99	Positive	IR 99-02	N	PS	1A	Security measures for personnel access and security measures for temporary structures were properly being implemented.

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Date	Type	Source	ID	SFA	Code	Item Description
4/20/99	Positive	IR 99-01	N	PS	1C	A limited radiological site characterization performed in February 1999 showed that significant amounts of radioactive contamination were not present in onsite surface soils and appropriate records of spills and other unusual occurrences involving the spread of contamination were maintained in accordance with 10 CFR 50.75 (g).
4/20/99	Positive	IR 99-01	N	PS	3A	Radiological planning for refuel outage (RFO) 12 was properly focused on minimizing radiation exposure associated with drywell work where as much as 220 person-rem or 71% of RFO12 dose is expected to be received. The use of expanded dose goals to increase personnel awareness and encourage dose minimization, installation of additional permanent shielding, and assignment of a drywell manager to improve work coordination and reduce time in the drywell through efficiency improvements were positive initiatives.
4/20/99	Positive	IR 99-01	N	PS	1C	Security and safeguards activities were performed in a manner that protected public health and safety in the areas of alarm stations, communications, and protected area access control of personnel, packages and vehicles. This portion of the program, as implemented, met the licensee's commitments and NRC requirements.
4/20/99	Positive	IR 99-01	N	PS	2A	Security facilities and equipment in the areas of protected area assessment aids, protected area detection aids, and personnel search equipment were well maintained and reliable, and met the licensee's commitments and NRC requirements.
4/20/99	Positive	IR 99-01	N	PS	1C	Security and safeguards procedures and documentation were properly implemented. Event logs were being properly maintained and effectively used to analyze, track, and resolve safeguards events
4/20/99	Positive	IR 99-01	N	PS	3B	The security force members (SFMs) adequately demonstrated that they had the requisite knowledge necessary to implement the duties and responsibilities associated with their position.
4/20/99	Positive	IR 99-01	N	PS	3B	Training was conducted in accordance with the T&Q plan, and based upon interviews and inspector observations was considered effective.
4/20/99	Positive	IR 99-01	N	PS	3A	The level of management support was adequate to ensure effective implementation of the security program, and was evidenced by adequate staffing levels and the allocations of resources to support programmatic needs.

PILGRIM PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
2/19/99	Positive	IR 98-11	N	PS	3A	Radioactive material/waste management and transportation programs were effectively implemented as evidenced by use of up-to-date regulations and facility licenses, appropriately trained personnel, proper procedural guidance and adequate maintenance of procedures, appropriate use of scaling factors to estimate isotopic content of radioactive material/waste packages, and proper shipping records.
2/19/99	Positive	IR 98-11	N	PS	2A	Housekeeping practices were effective as evidenced by clear aisles and walkways, neatly stored tools and equipment, and generally good conditions of painted floors and wall surfaces.
2/19/99	Positive	IR 98-11	N	PS	2A	Access controls and radiological posting practices were effective as evidenced by clear radiological postings, well defined contaminated area boundaries, and use of radiation work permits, physical barriers and/or locked doors for all high radiation area boundaries. One exception was water leakage in a radwaste corridor from the retube building drain line which was not well contained.
2/19/99	Positive	IR 98-11	N	PS	2B	A significant self-assessment and program improvement effort was made in the area of radioactive waste management and transportation of radioactive materials including a broad and probing audit, multiple performance based surveillances, and self-assessments that included bench marking with other nuclear power plants and a detailed review of solid low level waste generation, minimization, processing, and disposal practices.
12/22/98	Negative	IR 98-10	N	PS	5A	Two radiation dose rate signs in the "B" residual heat removal (RHR) quadrant were not updated after chemical decontamination of the RHR system.
12/22/98	Positive	IR 98-10	N	PS	1C	The implementation of the fire protection program was found to be acceptable, as evidenced by: the installed detection and suppression systems are in good repair, the smoke detectors and sprinkler heads were not obstructed, control of combustible material was generally good, the new "B" switchgear room raceway fire barrier enclosures met the requirements for 3-hour rated barriers for safe shutdown systems, the design of the main transformer fire detection, fire suppression, and oil drainage systems documented in the field revision notices (FRN), and the fire brigade was well trained, knowledgeable, and enthusiastic.
12/22/98	Positive	IR 98-10	N	PS	5A 5C	Based upon generally good licensee performance during drills, the absence of repeat audit findings, and no adverse trends in the EP program, the licensee's problem identification and corrective action processes were determined to be effective. The EP program audits were thorough and the reports were useful for licensee management to assess the effectiveness of the EP program.

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Date	Type	Source	ID	SFA	Code	Item Description
12/22/98	Positive	IR 98-10	N	PS	3B	Overall ERO member training was assessed as good because Plan requirements were being met and no adverse drill performances were observed. The licensee maintains the ERO at least three deep in key positions.
12/22/98	Positive	IR 98-10	N	PS	3C	A review of the licensee's procedure change review process, and a sampling of recent procedure changes, indicated that a good procedure control program was being implemented.
12/22/98	Positive	IR 98-10	N	PS	1C 2B	Emergency equipment surveillances and communication tests were performed as required and the facilities were determined to be in a good state of operational readiness.
12/22/98	Positive	IR 98-10	N	PS	5A	Based on the issues documented in the fire protection program self-assessment report, the fire protection program audits, and the associated PRs, the inspector determined that the self-assessment and audits had been successful in identifying program strengths and areas for improvement. The Fire Protection Improvement Program is an excellent initiative, and appears to have the proper focus to resolve fire protection program deficiencies.
11/20/98	Negative	IR 98-08 NCV 98-08-03	L	PS	1A 2A	There was an isolated event with low risk significance due to the low radiation levels present in areas adjacent to the onsite storage container.
11/20/98	Positive	IR 98-08	N	PS	1A	Effective self-assessment oversight of the radiological controls program was evidenced by the identification of an inadequate radiological survey and prompt actions taken to investigate, evaluate, and implement corrective actions.
11/20/98	Positive	IR 98-08	N	PS	1C	Overall response by the emergency response organization to the September 15, 1998, drill was good. No major concerns were noted.
11/20/98	Positive	IR 98-08	N	PS	1A 2A	Radiological boundaries were well defined and posted, and housekeeping in the reactor building was generally well maintained. The material condition of the trash compactor facility had improved in that the facility had been cleaned, painted, and color coded to implement human factors to aid waste handling.
11/20/98	Positive	IR 98-08	N	PS	1A	The chemical decontamination of RHR systems substantially reduced radiation dose rates in the RHR quadrants. This reduction in dose rates eliminated high radiation areas in both RHR quadrants and is expected to result in significant long term radiation exposure savings.
11/20/98	Positive	IR 98-08	N	PS	1A 3B	The chemical decontamination of the RHR system included thorough and detailed planning and preparation as evidenced by a generally thorough safety evaluation, clear and detailed procedural guidance, an equipment setup that guarded against leaks and minimized radiation exposures, and effective health physics access controls.

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region 1
PILGRIM

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
07/25/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: Sec: Ter:	Operator Performance for starting of a reactor recirculation pump at low power was very good. The pre-evolution briefing and operator performance for starting of a reactor recirculation pump, all low power was very good. All personnel involved were trained on the evolution using simulator prior to the starting of the recirculation pump.
Dockets Discussed: 05000293 PILGRIM 1						
07/25/1999	1999004-01	Pri: OPS Sec:	NRC	NCV	Pri: Sec: Ter:	Operator Procedure Use Error The failure of the reactor operators to verify plant conditions while placing the residual head removal system in the low pressure coolant injection mode of operation resulted in a reduction of ten inches reactor vessel level. This level 4 procedure violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as PR 99-9380. (NCV 50-29399-04-01). Interim corrective actions to improve configuration control problems were effective in preventing further problems during the reactor startup.
Dockets Discussed: 05000293 PILGRIM 1						
07/25/1999	1999004-02	Pri: ENG Sec:	NRC	NCV	Pri: Sec: Ter:	Safety evaluation did not evaluate the degradation of the fire suppression system The inspector identified an EDG TMOO and related safety evaluation did not evaluate the degradation of the fire suppression system. This occurred due to inadequate communications within the engineering department as well as an improper field walk down. The failure to evaluate the impact of the TMOO on the fire sensor is considered a violation of NRC design requirements. This level 4 violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as PR 99-9405. (NCV 50-29399-04-02)
Dockets Discussed: 05000293 PILGRIM 1						

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

by Primary Functional Area / Issue Date

Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	Non-Cited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

ENCLOSURE 2:

PILGRIM INSPECTION PLAN THROUGH MARCH 2000

Inspection / Activity Plan
10/01/1999 - 03/31/2000

Units	Inspection Activity	Title	Number of NRC Inspectors / Individuals	Planned Dates Start	Planned Dates End	Inspection Type
1	IP 71001	Licensed Operator Requalification Program Evaluation	2	10/04/1999	10/08/1999	Core
1	IP 84750	Radioactive Waste Treatment, And Effluent And Environmental Monitoring	1	11/15/1999	11/19/1999	Core
1	IP 40500	Effectiveness Of Licensee Process To Identify, Resolve, And Prevent Problems	1	12/01/1999	12/31/1999	Regional Initiative
1	IP 82301	Evaluation Of Exercises For Power Reactors	4	12/06/1999	12/10/1999	Core
1	IP 83750	Occupational Radiation Exposure	1	12/13/1999	12/17/1999	Core
1	IP 37001	10 CFR 50.59 Safety Evaluation Program	1	01/10/2000	01/21/2000	Core
1	IP 37550	Engineering	1	01/10/2000	01/21/2000	Core
1	IP 83728	Maintaining Occupational Exposures Alara	1	01/18/2000	01/21/2000	Regional Initiative
1	IP 37550	Engineering	1	02/28/2000	03/03/2000	Regional Initiative