March 6, 2003

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 PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 50-293/03-003

Dear Mr. Bellamy:

On January 31, 2003, the US Nuclear Regulatory Commission (NRC) completed an inspection at the Pilgrim Nuclear Power Station. The enclosed inspection report documents the inspection results, which were discussed on January 31, 2003, with you and members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations, and with the conditions of your license. The inspection involved examination of selected procedures and representative records, observation of activities, and interviews with personnel.

On the basis of the sample selected for review, the NRC concluded that the implementation of the corrective action program was adequate. In general, problems were properly identified, evaluated, and corrected. However, the team identified some instances in which the evaluations were not thorough or timely. These evaluations, some of which were associated with Category "A" condition reports, were not sufficiently detailed to address all underlying issues.

The team identified one finding of very low safety significance (Green) involving a failure to follow procedure, which resulted in a control rod being left in the wrong position. This finding was determined to involve a violation of NRC requirements. However, because of the very low safety significance and because it was entered into your corrective action program, the NRC is treating this finding as a non-cited violation (NCV) consistent with Section VI.A of the NRC Enforcement Policy. If you contest the NCV in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at Pilgrim.

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Sincerely,

/RA/

David C. Lew, Chief
Performance Evaluation Branch
Division of Reactor Safety

Docket Nos: 50-293
License Nos: DPR-35

Enclosure: Inspection Report 50-293/03-03

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
Plymouth Civil Defense Director
D. O'Connor, Massachusetts Secretary of Energy Resources
J. Miller, Senior Issues Manager
Office of the Commissioner, Massachusetts Department of Environmental Protection
Office of the Attorney General, Commonwealth of Massachusetts
Chairman, Citizens Urging Responsible Energy
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Electric Power Division
Commonwealth of Massachusetts, Secretary of Public Safety
R. Shadis, New England Coalition Staff

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T. Tate, PM, NRR
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REGION I

Docket Nos:	50-293
License Nos:	DPR-35
Report Nos:	50-293/03-03
Licensee:	Entergy Nuclear Operations, Inc.
Facility:	Pilgrim Nuclear Power Station
Location:	600 Rocky Hill Road Plymouth, MA 02360
Dates:	January 13 - 17, 2003 January 27 - 31, 2003
Inspectors:	Barry Norris, Senior Reactor Inspector (Team Leader) Paul Bonnett, Project Engineer Tom Burns, Reactor Inspector Kevin Mangan, Reactor Inspector Brice Bickett, Reactor Inspector (Trainee)
Approved by:	David C. Lew, Chief Performance Evaluation Branch Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000293/02-003; 01/13 - 01/31/2003; Pilgrim Nuclear Power Station; routine biennial baseline inspection of Problem Identification and Resolution.

The inspection was conducted by four regional inspectors. One Green non-cited violation was identified. 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 may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

Based on the sample selected for review, the inspection team concluded that the implementation of the corrective action program at Pilgrim was adequate. In general, personnel identified problems at an appropriate threshold and initiated a Condition Report (CR) to enter them into the corrective action program. Audits and self-assessments identified adverse conditions and negative trends, and the results were entered into the corrective action program.

The licensee's evaluations were generally adequate to reasonably identify the causes of problems and provide for corrective actions. However, the team identified some instances in which the evaluations were not thorough or timely. These evaluations, some of which were associated with Category "A" CRs, were not sufficiently detailed to address all underlying issues. One instance, regarding a failure to follow a procedure that resulted in a control rod being left in the wrong position, was determined to be a finding of very low safety significance (Green). The finding was also determined to be a violation of NRC requirements.

Inspector Identified Findings

Cornerstone: Barrier Integrity

- **Green.** A non-cited violation of 10CFR50, Appendix B, Criterion V, was identified for a failure to follow a surveillance test procedure for control rod timing that resulted in a control rod being left in the wrong position.

  This finding is greater than minor because, if left uncorrected, it could lead to reactivity control issues that can result in core thermal limits being exceeded. This finding affected the Barrier Integrity cornerstone. This finding was of very low significance (Green) because issues affecting the fuel barrier screen to Green in Phase 1 of the Significance Determination Process for Reactor At-Power Situations. (Section 4OA2.b(2))

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, Emergency Preparedness, Occupational Radiation Safety, Public Radiation Safety, Physical Protection

4OA2 Identification and Resolution of Problems (IP 71152)

a. Effectiveness of Problem Identification

(1) Inspection Scope

The team reviewed the procedures describing Entergy's corrective action process and determined that the Pilgrim Nuclear Power Station (PNPS) identified problems primarily through the initiation of condition reports (CRs). The site recently changed to the Entergy computer-based Paperless Condition Reporting System (PCRS). The team noted that PNPS's process required the initiation of maintenance requests (MRs) for CRs associated with equipment deficiencies and engineering requests (ERs) for CRs requiring engineering support. To aid the inspectors in understanding PNPS's threshold for identifying and entering problems into their corrective action process, team members attended the daily CR Screening meeting, where CRs were reviewed for initial significance category and assignment. Team members also attended the daily management meeting, the Condition Report Group (CRG) meeting where managers review each CR, and the MR review meeting.

The team reviewed a sample of CRs to determine whether PNPS was identifying, accurately characterizing, and entering problems into the corrective action process at an appropriate threshold. The CRs selected covered the period from the last NRC problem identification inspection in June 2001 to the present. The team selected the CRs to cover the seven cornerstones of safety identified in the NRC Reactor Oversight Process (ROP). In addition, the team considered risk insights from PNPS's probabilistic risk assessment (PRA) to focus the CR sample on risk significant plant equipment. The Attachment to this Inspection Report lists the CRs selected for review.

The team also interviewed selected plant staff to understand the other processes used to address problems. The team conducted walkdowns of the control room and selected areas of the plant, to independently assess whether problems were identified and were being adequately addressed. The team toured the security alarm stations and interviewed guards, and walked down the protected area perimeter to assess security's identification of problems.

The team selected items from PNPS's maintenance, operations, engineering, health physics, emergency preparedness, and oversight processes to verify that PNPS appropriately considered problems identified in these sources for entry into the corrective action program. Specifically, the team reviewed a sample of MRs, ERs, operator log entries, control room deficiency and work-around lists, operability determinations, engineering system health reports, procurement related deficiencies,

completed surveillances, installed temporary modification packages, quality assessment reports, and departmental self-assessments. The documents were reviewed to ensure that underlying problems associated with each issue were appropriately considered for identification and resolution via the corrective action process. The documents reviewed are listed in the Attachment.

(2) Findings

Based on the sample reviewed, the team concluded that PNPS was adequately identifying problems and entering them into their corrective action process. The CRs reviewed generally described and characterized the problems and, as appropriate, identified prior similar occurrences. In addition, the team concluded that personnel initiated corrective action CRs for problems identified in other PNPS processes that met the CR threshold. The inspectors considered the quality assurance audits and department self-assessments reviewed to be generally effective in identifying adverse conditions and negative trends.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The team reviewed the CRs listed in the Attachment to determine whether PNPS adequately evaluated and prioritized problems. The review included the appropriateness of the assigned significance, the timeliness of resolutions, and the scope and depth of the causal analysis. The CRs reviewed encompassed the full range of PNPS evaluations, including root cause analysis and apparent cause evaluations. The team selected the CRs to cover the seven cornerstones of safety identified in the NRC ROP. The team considered risk insights from PNPS's PRA to help focus the CR sample. Additionally, the team attended the CRG meetings to observe the review process and to understand the basis for assigned significance - Category A (highest) to D (lowest).

The team reviewed the CRs associated with the NRC non-cited violations (NCV), issued since the last PI&R inspection, to determine whether PNPS evaluated and resolved the problems associated with compliance to applicable regulatory requirements. The team reviewed PNPS's evaluation of industry operating experience information for applicability to their facility. The team also reviewed the PNPS assessment of equipment operability, reportability requirements, and the potential extent of the problem. The team further reviewed equipment performance results and assessments recorded in completed surveillance procedures, operator log entries, and system engineer trending data to determine whether PNPS's evaluation of equipment performance was technically adequate to identify degrading or non-conforming equipment.

(2) Findings

The inspectors determined that the CRs reviewed were properly classified as to significance level ("A" through "D"). Significant conditions adverse to quality were

classified as Category “A” and received a formal root cause analysis (RCA), and an extent-of-condition review. The Category “B” CRs usually received an apparent cause evaluation (ACE). The quality of the RCAs and ACEs reviewed was mixed; however, the team noted that the causal determinations performed in the last six months were generally more detailed and thorough, with better correlation between the causes and the corrective actions, and with corrective actions to preclude recurrence. The backlog of issues appeared reasonable and properly evaluated for risk, both individually and collectively. The majority of the CRs were for minor issues and were classified as Category “C or D” - corrected and closed to trending.

Notwithstanding the above, the team identified several occurrences where the PNPS staff did not perform a thorough or timely evaluation of the problems. Some of the evaluations were associated with Category “A” CRs; the Pilgrim station initiates about 25 Category “A” CRs each year. Examples of these weak evaluations, including one which was dispositioned as a Green finding, include:

- In January 2001, during bench testing of safety-related relays for a temporary modification, a PNPS technician noted that the relays did not conform to the required design specification. The extent of condition review identified two other non-conforming relays, that had been purchased at the same time, that were installed in the plant. Specifically, the relays were in the safety-related automatic bus transfer power supply scheme for the valves in the “B” train of the low pressure coolant injection system (LPCI) since April 2000. PNPS initiated CR-2001-09004. The resident inspectors reviewed the event and documented in NRC Inspection Report 50-293/2001-02 a licensee-identified NCV against 10CFR50, Criterion VII, “Control of Purchased Material, Equipment, and Services.”

  During this inspection, the team reviewed the RCA associated with the CR and concluded that the licensee’s evaluation was weak. While the team concluded that the overall corrective actions should be adequate to prevent recurrence, the licensee’s review of the event was not thorough. Specifically, the team noted that PNPS did not determine why the pre-installation bench test did not identify the non-conforming relays in April 2000, while the test was able to identify that the second set of relays were non-conforming in January 2001. Further, the licensee initiated a corrective action task to evaluate the bench test procedures; however, the action was closed with the belief that the procedures were acceptable as-is. During this inspection, PNPS re-issued the original task because the intent of the review was not understood; i.e., to evaluate the existing procedure or develop a new procedure for other relay types used in the plant.

- In July 2002, during an emergency preparedness (EP) drill, an EP manager raised a concern as to whether the main stack high range effluent radiation monitor would remain on scale if significant fuel damage occurred. It was noted in the CR that the monitor was operable, but an engineering request (ER #02113994) was submitted to verify that the range of the monitor was adequate. The CR was closed before the ER was completed. The high range monitor is a requirement of NUREG 0737, “Clarification of TMI Action Plan Requirements,” it is described in the PNPS Updated

Final Safety Analysis Report (UFSAR), and it is listed in the PNPS Technical Specifications (TSs).

During this inspection, the team discovered that the ER had not yet been completed - a period of six months since the initiation of the ER. Subsequently, a draft engineering evaluation was performed by the licensee at the end of the inspection. However, the basis for the evaluation appeared invalid. An NRC effluents specialist in Region I confirmed that the basis for the draft engineering evaluation was improper. However, the NRC specialist was able to describe the flowpath from the main stack to the monitor, and why the dilution of the flowpath would assure that the monitor would be on scale for all postulated accidents. The specialist and team leader discussed this issue with PNPS staff, who acknowledge that their original evaluation was not valid.

Mis-Positioned Control Rod

Introduction: A Green Non-Cited Violation (NCV) was identified for failure to comply with 10CFR50, Appendix B, Criterion V, related to a mis-positioned control rod.

Description: In November 2002, CR-2002-12550 was initiated for a mis-positioned control rod following the performance of a surveillance test for control rod timing and adjustment. The CR was classified as Category A, with a RCA required.

The surveillance test being performed was Procedure 2.2.87.3, "Control Rod Drive Venting, Timing, and Adjustment," a detailed operation involving multiple valve manipulations, numerous control rod timings, and frequent documentation by the operator performing the evolution and a second operator verifying the activity. The shift crew decided to time one control rod while concurrently adjusting another control rod. Specifically, the reactor operator moved control rod 34-47 from position 48 to 44 to measure the insertion time; at the same time, an in-plant operator informed the control room that control rod 06-43 was adjusted and ready to be timed again. Instead of returning control rod 34-47 to its original position, the reactor operator became distracted and selected control rod 06-43 for timing.

The specific steps required for adjustment of the control rods were detailed in Attachment 4A to the procedure. When no further adjustments were required, the attachment required the operator to record the "as-left" position in Attachment 4B and initial the entry; the procedure also required a 2nd operator to verify the position and initial. The mis-positioning was identified after about 5 hours, at which time the rod was returned to the appropriate position.

The team reviewed the licensee's evaluation associated with the level "A" CR and determined that the licensee's evaluation was not thorough and was not sufficiently detailed to address the underlying issues. The evaluation attributed the cause of the event to the crew's deviation from the intended sequence for performing the surveillance test, and further states that the procedure did not specifically preclude the approach. However, PNPS did not look at the past occurrences of mis-positioning for similarities

and overall corrective action effectiveness. The team noted during the inspection that numerous mis-positioning events occurred last year. Many were associated with equipment issues, but several were the result of human errors.

Additionally, the inspectors learned that Attachment 4A was not used for this occurrence of the surveillance, and that the "as-left" section of Attachment 4B had not been completed for multiple control rods. During discussions with operations management, the inspectors were informed that the operators were not required to use Attachment 4A, as it was a "place-keeping" aid. However, PNPS Procedure 1.3.34, "Conduct of Operations," step 6.8[3], stated that surveillance tests and procedures, which required initials for verification of step performance, shall be present and followed verbatim while the task is being performed. The team concluded that these were issues regarding procedural adherence that should have been addressed in the evaluation.

Analysis: The failure to follow the control rod surveillance test was a performance deficiency which involved reactivity control. This finding is greater than minor because, if left uncorrected, it can lead to reactivity control issues that can result in core thermal limits being exceeded. This finding affects the Barrier Integrity cornerstone. Using Phase I of the Significance Determination Process (SDP) for Reactor At-Power Situations, the inspectors determined that this finding is of very low significance (Green) because issues affecting the fuel barrier screen to Green.

Enforcement: 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires that activities affecting quality be prescribed by written procedures of a type appropriate to the circumstances and be accomplished in accordance with the procedures. Contrary to the above, control rod drive venting, timing, and adjustment was not accomplished in accordance with procedures and resulted in a mis-positioned control rod. Because the mis-positioning is of very low safety significance and is in the PNPS corrective action program (CR-2003-00398), this violation is being treated as a Non-Cited Violation (NCV), consistent with Section VI.A of the NRC Enforcement Policy. **NCV 50-293/2003-003-01**, Failure to Follow Procedures, Resulting in a Control Rod Mis-Positioning During Surveillance Testing

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The team reviewed the CRs listed in the Attachment to determine whether the actions addressed the identified causes of the problems. The team reviewed PNPS's timeliness in implementing corrective actions and their effectiveness in preventing recurrence of significant conditions adverse to quality.

(2) Findings

No significant findings were identified in this area. The licensee's actions were generally effective in correcting the identified deficiency and preventing recurrence. However, as

noted in Section 4OA2.b, the team noted a number of control rod mis-positioning events.

d. Assessment of Safety Conscious Work Environment

(1) Inspection Scope

Team members interviewed plant staff, observed various activities throughout the plant, and attended a cross section of meetings to determine if conditions existed that would result in personnel being hesitant to raise safety concerns to their management and/or the NRC.

(2) Findings

No findings of significance were identified.

4OA6 Meetings, Including Exit

The team presented the inspection results to Mr. R. Bellamy, Site Vice-President, and other members of the PNPS staff on January 31, 2003. PNPS management acknowledged the results presented. No proprietary information was retained after the inspection.

On February 6, 2003, the inspection team leader clarified the NRC's position relative to concerns associated with the main stack high range effluent radiation monitor. PNPS participants included B. Ford, Licensing Manager, and D. Landeche, Corrective Action Manager

Attachment: Key Points of Contact
Items Opened, Closed, and Discussed
Documents Reviewed
Abbreviations Used

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel:

A. Battikha	Procurement Engineer
R. Bellamy	Site Vice President
S. Bethay	Engineering Director
A. Bordan	Quality Assurance Receipt Inspector
W. Coady	Radiation Protection Technician
M. Dagnello	Electrical Maintenance Supervisor
P. Dietrich	General Manager Plant Operations
B. Ford	Licensing Manager
W. Grieves	Quality Assurance Manager
J. Haley	Licensing Engineer
J. Hurley	Radiation Protection Supervisor
J. Keyes	Corrective Action Superintendent
D. Landeche	Corrective Action Manager
B. Lyons	Operations Support Superintendent
G. McCarthy	Work Week Manager
B. Riggs	Director Nuclear Safety & Assessment
R. Rose	Security Manager
K. Sejkora	Senior HP/Chem Specialist
B. Sholler	Mechanical Maintenance Supervisor
T. Sowden	Emergency Preparedness Manager
N. Walo	Employee Concerns Program Coordinator

NRC Personnel:

D. Lew	Branch Chief
W. Raymond	Senior Resident Inspector
C. Welsh	Resident Inspector

ITEMS OPENED and CLOSED

Opened & Closed

50-293/003-03-01	NCV	Failure to Follow Procedures, Resulting in a Control Rod Mis-Positioning During Surveillance Testing. (Section 4OA2.b(2)

DOCUMENTS REVIEWED

Procedures:

- - -	Cause Analysis and Trending Handbook
- - -	Entergy Root Cause Analysis Handbook, Revision 5
- - -	Guideline for the Completion of Root Cause Analysis
1.2.4	Operations Performance Assessment Program, Revision 33

1.3.121	Corrective Action Program, Revision 10 (retired - replaced by ENN-LI-102)
1.3.34	Conduct of Operations, Revision 78
1.3.34.6	Conduct of Operations - Control Room Self-Assessment, Revision 3
1.3.34.5	Operability Determination and Evaluations, Revision 3
1.3.36	Measuring and Test Equipment, Revision 18
1.3.4	Procedures, Revision 54
2.2.87.3	Control Rod Drive Venting, Timing, and Adjustment, Revision 9
2.4.11	Control Rod Malfunction, Revision 24
3.M.2-2.1	Routine Security Maintenance Repairs, Revision 7
5.4.6	Primary Containment Venting and Purging Under Emergency Conditions, Revision 29
8.E.43	Jet Pump Instrumentation Calibration, Revision 7
ENN-DC-112	Engineering Request and Project Initiation Process, Revision 0
ENN-DC-113	Grading Engineering Requests, Revision 0
ENN-LI-102	Corrective Action Process, Revision 2
ENN-TQ-201	Systematic Approach to Training Process, Revision 0
EOP-3	Primary Containment Control, Revision 6
EOP-5	Radioactivity Release Control, Revision 3
EP-IP-300	Offsite Radiological Dose Assessment, Revision 4
EP-IP-330	Core Damage, Revision 4
QA-7.13	Receipt Inspection, Revision 3
RP-STD-21	Pre-Job Briefings, Revision 3
SCM-B1-B	Procurement Engineering, Revision 3
SCM-B4-1	Standard Quality, Technical, and Inspection Clauses, Revision 2
SCM-G1-1	Warehouse Receiving, Revision 3

Non-Cited Violations:

01-02-01	Installed Relay Had a Time Delay Function on Only Two of the Four Contacts
01-03-03	Emergency Response Organization Respirator Qualification Lapse
01-03-05	Failure to Establish Line up
01-05-02	Shipping Bolts on the Drywell-to-Torus Vent Line Expansion Bellows Were Installed since Original Construction
01-05-03	A Missing Step in the Restoration Section That Resulted in the Loss of Electrical Bus A5 and a Plant Scram
01-06-01	Ineffective Corrective Action for Reactor Vessel Level Spiking
01-07-01	Reference Leg Backfill System Design Vulnerability
01-08-01	Non-Posted High Radiation Area
01-08-03	Failure to Correct Reactor Vessel Level Spiking

Quality Assurance Audits:

01-06	Corrective Action Program
01-07	DC Power System
02-03	Technical Specification Activities
02-05	Measuring and Test Equipment Program
02-08	Triennial Fire Protection
02-10	Corrective Action Program

Self-Assessments:

LO-2002-00011	EQ Program Assessment
LO-2002-00015	Adverse Trend in Security Closed Circuit Televisions
LO-2002-00019	Fire Protection Program Assessment
LO-2002-00027	Radiation Work Practices
LO-2002-00032	Effectiveness of Minor Modification Assessment
LO-2002-00046	Radiation Work Practices & Contamination Controls - INPO Assist Visit
LO-2002-00058	Assessment of Corrective Action Process
LO-2002-00061	Security - CAS/SAS Operations Assessment
LO-2002-00065	Assessment of Backlog of Open Plant Design Changes
LO-2002-00076	Process Assessment of 50.59 Activity
LO-2002-00079	Station Problem Analysis and Trending Assessment
LO-2002-00093	Special Nuclear Materials Handling Assessment
PM-SA-2002-01	Maintenance Self-Assessment
May 2002	Quarterly Self-Assessment - “Radiological Work Practices”
June 2002	Corrective Action Program
June 2002	Maintenance Technical Training Second Quarter Self-Assessment
September 2002	Maintenance Department Third Quarter Self-Assessment

Condition Reports: (* denotes CRs generated as a result of this inspection)

1998-09525	2001-04409	2001-09809	2002-09354	2002-10451	2002-11404
2000-01491	2001-04579	2001-09838	2002-09376	2002-10534	2002-11407
2001-02063	2001-04591	2001-09873	2002-09461	2002-10535	2002-11433
2001-02129	2001-04592	2001-09927	2002-09467	2002-10538	2002-11464
2001-02440	2001-04848	2002-00006	2002-09548	2002-10539	2002-11475
2001-02517	2001-08001	2002-00015	2002-09564	2002-10539	2002-11477
2001-02550	2001-08047	2002-00027	2002-09574	2002-10540	2002-11481
2001-02632	2001-08070	2002-00046	2002-09575	2002-10541	2002-11503
2001-03000	2001-08070	2002-00058	2002-09582	2002-10582	2002-11534
2001-03030	2001-08083	2002-00061	2002-09611	2002-10585	2002-11542
2001-03288	2001-08092	2002-00082	2002-09705	2002-10586	2002-11582
2001-03297	2001-08111	2002-00093	2002-09717	2002-10624	2002-11609
2001-03314	2001-08151	2002-00282	2002-09731	2002-10638	2002-11678
2001-03328	2001-08152	2002-00345	2002-09820	2002-10641	2002-11720
2001-03366	2001-08157	2002-00346	2002-09881	2002-10650	2002-11731
2001-03429	2001-09004	2002-08070	2002-09886	2002-10666	2002-11786
2001-03695	2001-09007	2002-09034	2002-09909	2002-10761	2002-11805
2001-03725	2001-09048	2002-09061	2002-09948	2002-10783	2002-11878
2001-03748	2001-09112	2002-09076	2002-09961	2002-10816	2002-11884
2001-03773	2001-09241	2002-09089	2002-09989	2002-10839	2002-11992
2001-03867	2001-09385	2002-09150	2002-10010	2002-10844	2002-12011
2001-03867	2001-09485	2002-09161	2002-10108	2002-10889	2002-12017
2001-04119	2001-09486	2002-09165	2002-10190	2002-10900	2002-12034
2001-04169	2001-09671	2002-09227	2002-10200	2002-11051	2002-12046
2001-04171	2001-09690	2002-09275	2002-10201	2002-11086	2002-12108
2001-04343	2001-09774	2002-09298	2002-10214	2002-11140	2002-12109
2001-04350	2001-09775	2002-09304	2002-10349	2002-11203	2002-12141
2001-04391	2001-09779	2002-09320	2002-10409	2002-11346	2002-12179

2002-12210	2002-12476	2002-12641	2002-12818	2003-00162	2003-00232*
2002-12228	2002-12488	2002-12650	2002-12852	2003-00163	2003-00234*
2002-12251	2002-12549	2002-12683	2002-12951	2003-00164	2003-00353*
2002-12361	2002-12550	2002-12719	2002-12955	2003-00203	2003-00398*
2002-12384	2002-12571	2002-12724	2002-12967	2003-00210*	2003-00399*
2002-12424	2002-12573	2002-12795	2003-00161	2003-00213*	2003-00458*
2002-12426	2002-12627				

Maintenance Requests:

MR 01120857	MR 02119516	MR 02118337	MR 02121374
MR 02120992	MR 02121686	MR 02120705	MR 01108033

Engineering Requests:

ER 02113078	ER 02114860	ER 02117615	ER 02119829
ER 02113325	ER 02114884	ER 02117616	ER 02119925
ER 02113437	ER 02116649	ER 02118653	ER 02121198
ER 02113855	ER 02117594	ER 02119058	

Miscellaneous Documents:

ANSI N45.2.13-76 Quality Assurance Requirements for Control of Procurement of Items & Services for Nuclear Power Plants
Gaseous Effluent Monitoring (GEMS) - (a)(1) Action Plan
IE Bulletin No. 80-10 Contamination of Non-radioactive System and Resulting Potential for Unmonitored, Uncontrolled release of Radioactivity to Environment
LER 50-293/2001-03 ESF Actuations Due to Invalid Water Level Indications
LER 50-293/2001-06 Automatic Scram During Surveillance Test and Subsequent Reactor Water Level Anomalies
LER 50-293/2001-07 Automatic Scram During Transient Caused by Failure of Calibrating Unit
LER 50-293/2001-01 Swing Bus B6 Potentially Inoperable Under Certain Conditions
Maintenance Rule SSC Basis Document for MCR Annunciator System, Revision 1
NUREG-0737 Clarification of TMI Action Plan Requirements
P&ID M227 Containment Atmosphere Control System, Sheet 1, Revision 16
P&ID M294 Heating, Ventilation, and Air Conditioning, Standby Gas Treatment System, Control Diagram, Revision 14
PDC/FRN-02-66 Remove Vent Line Connection on T-108 form Common Tie to T-105A/B
Pilgrim Updated Final Safety Analysis Report
Pilgrim Technical Specifications
PNPS Firearms Safety Rules
PNPS Visitor & Escort Security Regulations
Quarterly Integrated Assessment/Trend Reports for 2nd & 3rd Quarters 2002
Radiation Worker Practices Communication Schedule
Radiation Monitoring System - PNPS System Report Card
Radiological Survey Forms, Serial Nos. 2498, 3436
RWP 02-5001 RP Surveys and Routine Surveillances, General RWP
TM 01-08 EDG "A" Install Temporary Jacket Water Pipe Protection, Revision 0

ACRONYMS USED

CFR Code of Federal Regulations
CR Condition Report (i.e., deficiency document)

ER	Engineering Request
IP	NRC Inspection Procedure
LPCI	Low Pressure Coolant Injection
MR	Maintenance Request
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PCRS	Paperless Condition Reporting System
PI&R	Problem Identification and Resolution
PNPS	Pilgrim Nuclear Power Station
PRA	Probabilistic Risk Assessment
RCA	Root Cause Analysis
ROP	Reactor Oversight Process
SDP	Significance Determination Process
TS	Technical Specifications
UFSAR	Updated Final Safety Analysis Report