September 21, 1995

Mr. E. Thomas Boulette, PhD
Senior Vice President - Nuclear
Boston Edison Company
Pilgrim Nuclear Power Station
600 Rocky Hill Road
Plymouth, Massachusetts 02360-5599

SUBJECT: PILGRIM INSPECTION 95-15

Dear Mr. Boulette:

From July 6, 1995 through August 18, 1995, Messrs. R. Laura and A. Cerne of this office conducted a resident inspector safety inspection at the Pilgrim Nuclear Power Station, Plymouth, Massachusetts. Areas relevant to the health and safety of the public examined during this inspection are described in the enclosed report. Our findings were based upon observations of performance and independent evaluations of safety systems and quality records. The preliminary results were discussed with Mr. T. Sullivan and other members of your staff at the conclusion of the inspection.

We observed several elements of your self assessment process that effectively identified and evaluated several potentially safety significant problems. A routine quality assurance audit identified incorrect wiring in a safety related motor operated valve such that the valve stopped travelling shut on the close position limit switch rather than the intended close position torque switch. When bounding the scope of the problem, engineering discovered a second valve that was also wired incorrectly with the same effect. Based on these findings, your action to form an issue team to thoroughly evaluate the significance, identify the root causes, and address the broader area of safety related equipment wiring configuration control, was appropriate for the concern. We previously expressed concern of a lack of collective analysis of field wiring inconsistencies with the electrical drawing details (i.e., NRC Inspection Report 50-293/93-15).

When evaluating the significance of the above quality assurance finding, operations management identified the missed performance of an automatic depressurization system surveillance test. The surveillance was immediately performed with satisfactory results. Also, a detailed root cause analysis of the unplanned down power event involving the "B" seawater pump identified poor human performance as the root cause. Your corrective actions addressed all aspects of this event including additional maintenance training and providing operators with additional alarm response procedure guidance for increasing OMNI guard temperatures. Lastly, the operations review committee (ORC) and nuclear safety review and audit committee (NSRAC) also contributed to reactor safety by thoroughly analyzing problems such as the SBM switch operability evaluation and problem report backlog, respectively. Although each problem identified by your staff is an example of poor implementation of program controls; collectively, the findings indicate that the self assessment processes (i.e., quality assurance, ORC, NSRAC) were actively involved in

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controls; collectively, the findings indicate that the self assessment processes (i.e., quality assurance, ORC, NSRAC) were actively involved in uncovering these problems.

No reply to this report is necessary, and your cooperation with us is appreciated.

Sincerely,

ORIGINAL SIGNED BY:

James Linville, Chief
Projects Branch No. 3
Division of Reactor Projects

Docket No. 50-293

Enclosure: NRC Inspection Report No. 95-15

cc w/encl:
L. Olivier, Vice President - Nuclear and Station Director
T. Sullivan, Plant Department Manager
R. Fairbank, Manager, Regulatory Affairs and Emergency Planning Department
D. Tarantino, Nuclear Information Manager
D. Ellis, Acting Compliance Supervisor
R. Hallisey, Department of Public Health, Commonwealth of Massachusetts
The Honorable Therese Murray
The Honorable Linda Teagan
B. Abbanat, Department of Public Utilities
Chairman, Plymouth Board of Selectmen
Chairman, Duxbury Board of Selectmen
Chairman, Nuclear Matters Committee
Plymouth Civil Defense Director
Paul W. Gromer, Massachusetts Secretary of Energy Resources
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Regional Administrator, FEMA
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