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U. S. NUCLEAR REGULATORY COMMISSION
REGION 1

Report No. 50-293/84-17

Docket No. 50-293

License No. DPR-35 Priority -- Category C

Licensee: Boston Edison Company
800 Boylston Street
Boston, Massachusetts 02199

Facility Name: Pilgrim Nuclear Power Station

Inspection Conducted: June 5, 1984 - July 16, 1984

Inspectors: Robert M. Gallo FOR
J. Johnson, Sr. Resident Inspector
M. McBride, Resident Inspector
D. Lipinski, Resident Inspector (Millstone)

8/1/84
date

Approved By: Robert M. Gallo
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Section No. 2A, Projects Branch No. 2

8/1/84
date

Inspection Summary:

Inspection on June 5, 1984 - July 16, 1984 (Report No. 50-293/84-17)

Areas Inspected: Routine unannounced safety inspection of plant operations including followup of previous findings, an operational safety verification, followup on plant events and LERs, a review of surveillance and maintenance activities, evaluation of equipment failures, recirculation piping replacement actions, and a meeting with local officials. The inspection involved 222 inspector-hours by three resident inspectors.

Result: No violations were identified. A concern regarding the licensee's adherence to 10 CFR 20.203 requirements for radioactive material container labeling is discussed in Paragraph 3.6.3.

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DETAILS

1. Persons Contacted

Within this report period, interviews and discussions were conducted with members of the licensee (and contractor) staff and management to obtain the necessary information pertinent to the subjects being inspected.

2. Followup on Previous Inspection Findings

- a. (Closed) Licensee Identified Item (50-293/81-L0-58). Carbon Dioxide system failed a discharge test in 1981. LER No. 81-58 stated that an engineering analysis would be performed in order to determine the best resolution. An updated LER No. 81-58-01X-1, dated June 8, 1983, was submitted describing the results of the engineering evaluation and a decision to install a Halon 1301 flooding system. The licensee has partially implemented Plant Design Change Request 83-15. Several tests have been performed with the latest being a manual actuation test on May 2, 1984. The licensee is tracking completion of this installation during the current outage. This LER is closed.
- b. (Open) Violation (50-293/81-22-01). Primary Containment Isolation Valve instrumentation power supplies. NRC Report No. 82-30 documents corrective actions regarding trouble shooting. However, the licensee has yet to complete the long term corrective actions described in the March 19, 1982 (BEC Co. letter No. 82-87) response to the Notice of Violation and Proposed Imposition of Civil Penalties, namely, revise system operating procedures which deal with electrical distribution panels to include the effects of de-energizing power sources and to identify T.S. requirements. The inspector determined that procedure No. 2.2.12, 120 VAC Safeguard Power Supply Y3-Y4, had been revised to include the effects of loss of power. However, operating procedures for the other distribution panels (Y1, Y2 and D4, D5, and D6) had not been revised. At the exit, the Station Manager provided the inspector with a plan and schedule to complete this action. A purchase order has been issued for six Bechtel Power Corp. engineers to walkdown the panels. This effort is scheduled from September 10 - November 26, 1984. Drawing revisions are scheduled by February, 1985 and procedure (2.2.11 through 2.2.16) revisions by April 1, 1985. This item remains open pending a review of implementing this action.
- c. (Closed) Unresolved Item (50-293/82-10-08). Submit deviations from NUREG 0737 regarding containment high range radiation monitor. NRC Report No. 82-13 reported additional problems with equipment installed by the licensee for which some differences with specifications in NUREG 0737 were noted and for which deviations were not submitted to NRC:NRR as required. These items were reviewed by the NRC in Inspection Report No. 84-11 which documents the licensee's actions to report these deviations to the NRC. This item is closed.

- d. (Closed) Violation (50-293/83-07-02) Failure to follow Procedure (TP 82-43) by not testing the redundant Standby Gas Treatment System (SGTS) train prior to inspection and cleaning of the other train. The licensee's response, dated May 31, 1983, describes corrective actions. In addition to immediate system testing, personnel involved were counseled on the importance of procedural adherence. Long term corrective actions were completed on April 6, 1983 when procedure TP 82-43 was revised to require 1) Watch Engineer review of the sequence and scope of inspection and 2) verification of pre-inspection redundant train testing. This item is closed.
- e. (Closed) Violation (50-293/83-13-01). Failure to follow procedure for shelf life of chloride mixed indicator solution. NRC Report No. 83-13 describes immediate corrective actions consisting of the preparation of a new mixed indicator solution on May 11, 1983. In addition, the licensee's response dated July 14, 1983, states that chemistry technicians were counseled on the requirements of procedure 7.10.4, Shelf Life of Chemicals. The inspector reviewed records indicating that all six chemistry technicians were counseled on the requirements of Procedure 7.10.4. This item is closed.
- f. (Closed) Violation (50-293/83-19-01) Failure to vent the Core Spray System from the high point. NRC Report No. 83-19 describes immediate corrective actions to verify that the discharge piping was filled solid. The inspector verified that the licensee issued a memorandum on October 4, 1983 (CR 83-163) to operating personnel specifying that all "keep-fill" checks are to be done at the system high point vents. During the operating period prior to the current outage a recurrence was not observed. This item is closed.
- g. (Closed) Unresolved Item (50-293/84-04-02). Review acceptability of warehouse access control. The licensee has proposed two methods of controlling access to the warehouse from the outside ISI and NDE office corridor fire exit: 1) provide a door position alarm annunciated in a manned location, and 2) control access to the outside door via a lock with keys controlled by the QA department. This method is acceptable and this item is resolved.

3. Operational Safety Verification

a. Scope and Acceptance Criteria

The inspector observed control room operations, reviewed selected logs and records, and held discussions with control room operators. The inspector reviewed the operability of safety related and radiation monitoring systems. Tours of the reactor building, turbine building, station yard, switchgear rooms, SAS, cable spreading room, auxiliary bay, radwaste building, and control room, were conducted. Tours of the drywell were also included in this review. Observations included a review of equipment condition, security, housekeeping,

radiological controls, and equipment control (tagging); in addition, records of radioactive liquid and gaseous releases from the station were reviewed.

These reviews were performed in order to verify conformance with the facility technical specifications and the licensee's procedures.

b. Findings

- (1) During a radioactive liquid discharge of the D Treated Water Tank (TWT) on June 8, 1984, the inspector observed that the warning sign was posted above the dilution pump controls as required, that the radiation monitor was operable (with the alarm and trip setpoints properly established), and that the operator was knowledgeable of the evolution. During a review of the discharge permit (84-294) the inspector noted a series of 3 discharges (84-294, 84-294A, and 84-294B) between 2:50 am on June 7, 1984 and 12:40 pm on June 9, 1984.

The licensee was limited to a very slow discharge flow rate because of the low dilution flow (service water pumps only because circulating water pumps were tagged out). If during a long discharge (of the 18,000 gallon TWT at 5 gpm) another tank needed pumping then the TWT discharge would be temporarily suspended and later reinitiated. The inspector verified for each partial discharge that the licensee approved a separate discharge permit, performed a valve lineup check, and established the discharge flow rates. However, the tank was sampled only once before the first discharge. The inspector reviewed the licensee's methods to demonstrate the adequacy of this. The tank level did not change between discharges, the governing procedure (2.2.72) requires closing the inlet to the tank in question, and the radiation monitor isolation will shut off the discharge if a more radioactive discharge were to take place. The inspector had no further questions.

The inspector determined that the liquid radioactive waste discharge was in accordance with the T.S. and 10 CFR 20. No violations were identified.

- (2) During a tour of the drywell on June 20, 1984, the inspector noted that a large amount of metal shavings from machining operations were inside the piping on penetration X-12. Following discussions with BECo. QC personnel, the inspector noted that General Electric Co. QC personnel had been monitoring this evolution and had issued Nonconformance Report No. Recirc. 112 to effect and track corrective actions. The inspector had no further questions at this time. An examination is planned after thorough cleaning of the penetration.

- (3) On July 2, the inspector noted several unmarked wooden boxes inside a radiologically posted storage area located just outside the reactor building truck lock. Three of the boxes had maximum contact radiation levels of 30, 80, and 900 mR/hr, respectively, on accessible outer surfaces.

Two of the boxes (30 and 80 mR/hr contact levels) were unmarked. The box with 900 mR/hr contact level was also unmarked, except for "45 mR/hr" indicated on one corner. The licensee indicated that these boxes contain equipment from the recirculation system decontamination project which took place earlier this year.

The storage area was roped off and posted as a radiation area, a radioactive materials storage area, and radiation work permit (RWP) required for entry on July 2. The licensee's health physics management stated that to the best of their knowledge, all personnel who entered the area were escorted by health physics personnel.

Radiation Work Permit 84-1520, issued May 30, 1984, is currently used to control work in the storage area and requires constant health physics coverage for activities in the area. The previous RWP, 84-818, required only intermittent (daily) health physics coverage for storage area activities from February 21 to May 16, 1984. A dose estimate form attached to RWP 84-919 indicates constant coverage was considered for loading waste into truck trailers in the waste storage area in February.

The licensee indicated that the boxes were initially loaded with radioactive material and placed in the storage area during February or March, 1984.

Licensee personnel subsequently inspected and corrected container postings around the site. Radioactive material labels and hot spot stickers with contact dose rate information were placed on the three boxes in the storage area. The box with 900 mR/hr contact level was also posted as a high radiation area and a radiation work permit area.

In addition, on July 6, 1984, a temporary change was made in Procedure No. 6.1-024, "Radiological Posting of Areas of the Station", to make the procedure's labeling requirement consistent with 10 CFR 20.203(f). The procedure had previously not required containers of licensed material to be labeled if the containers were located in posted radioactive material storage areas. All health physics technicians were required to sign forms indicating that they had read and understood the procedure changes.

To identify future posting problems at the site the health physics technicians will tour the site once per shift. Health

physics foremen and management will also conduct routine site tours to check postings. These actions will be reviewed during future routine inspections of the facility.

- (4) During a tour on July 11, 1984, the inspector noted several areas where tagging practices needed corrective actions. Tagging on outside hydrogen reagent and calibration gas makeup lines was wet and deteriorating. Tags on the B hypo pump flow meter were wet and deteriorating and the tagged jockey fire pump heat tracing plug was unplugged from the power supply (although not needed, it had a tag requiring it to be plugged in). These problems were brought to the attention of the shift Watch Engineer who initiated immediate action to correct these discrepancies. Tagging controls will continue to be reviewed during future inspections of the facility. No violations were identified.

4. Followup on Events and Licensee Event Reports (LERs)

A. Events

- (1) At 7:05 pm on June 11, 1984, the station experienced a loss of off site power line No. 342 (one of two 345 KV lines) with no reclosure. Following realignment of the switchyard, line No. 342 was reclosed in to the station at 7:20 pm. The cause of the loss was a lightning storm in the local area providing an upset condition offsite.

The inspector verified that the temporary loss did not affect plant safety. The reactor is in cold shutdown and defueled. Power supplies available were one emergency diesel generator, one 345 KV line and the 23 KV line. No unacceptable conditions were identified.

- (2) On June 26, 1984 at 4:45 a.m., a control room operator noticed smoke coming from a GE HFA relay. The relay, model 12 HFA 51A49F, had a nylon core and is normally maintained energized with a.c. power. The relay is part of the Primary Containment Isolation logic system (16A-K5C) and initiates transversing incore probe (TIP) withdrawal and low pressure coolant injection (LPCI) valve lineup. The licensee replaced the damaged relay with a Century Series relay.

This is the third HFA relay to fail in this manner in 1984. The licensee is planning to replace many of the HFA relays with Century type relays prior to startup from the outage, consistent with guidance in I.E. Bulletin 84-02, "Failures of General Electric Type HFA Relays in Use in Class 1E Safety Systems." The licensee actions will be reviewed during a followup to this bulletin.

No violations were identified.

B. Review of Licensee Event Reports (LERs)

LERs submitted to the NRC:Region I office were reviewed to verify that the details were clearly reported and that corrective actions were adequate. The inspector also determined whether generic implications were involved and if on site followup was warranted. The following reports were reviewed.

No.	Subject
84-05	Safety Relief Valve (SRV) Problems
84-07	Degraded Fire Barrier Seals
84-08	HFA Relay Problem

- The licensee has performed a metallurgical review of the SRV sticking problems and has initiated several corrective actions: 1) changing the pilot disc material to a lower carbon content stellite, 2) providing modified lapping controls, and 3) recommending to test the valves at a high pressure. These licensee actions have been accepted by the BWROG and will be further reported to the NRC staff for review.
- Degraded fire barriers were reviewed during NRC Report 84-15, and
- The HFA relay failure of May 21, 1984 was described in NRC Report No. 84-12.

No inadequacies were identified.

5. Surveillance Testing

The inspector reviewed the licensee's actions associated with surveillance testing in order to verify that the testing was performed in accordance with approved station procedures and the facility Technical Specifications.

The following tests were observed:

- Routine surveillance of the diesel generators (OPER 27) on July 6, 1984.
 - Hydrostatic testing of the A Core Spray discharge piping on June 13, 1984
- A. The A diesel generator lube oil temperature and the fuel oil temperature were both above the recommended operating temperature on the OPER 27 surveillance sheet on July 6. The licensee had issued

maintenance requests for the lube oil temperature problem on October 24, 1983 and for the fuel oil temperature on June 8, 1984. The licensee stated that fluid temperatures (143 - 148 F for lube oil and 100 F for fuel oil) did not make the A diesel generator inoperable and were not considered serious problems.

No violations were identified.

- B. The inspector observed the licensee's actions to perform a hydrostatic test of the A Core Spray discharge piping on June 13, 1984. The inspector made the following observations: 1) the hydrostatic pump and test gages were continuously manned, 2) the two test gages were in calibration and indicated 565 and 566 psig (middle of the gage range and in accordance with the specified test pressure of 556 to 576 psig), 3) the test procedure was being followed including holding test pressure for 4 hours on lagged piping (2.1.8.2, Safety Class 2 and 3 Hydrostatic Test Procedure, Revision 7), and 4) the licensee's test director was knowledgeable of the activities in progress. The inspector also noted that the licensee's QC personnel were monitoring these activities, and that the licensee ISI and ANI representatives were performing the piping inspections.

The inspector questioned the licensee concerning the basis for the specified test pressure on Core Spray discharge (550 psig) and RHR suction (250 psig) because they were so much higher than the system design pressures (300 psig and 80 psig respectively). The licensee's test representative stated that the Nuclear Engineering Department (NED) had approved these test pressures, in accordance with ASME Boiler & Pressure Vessel Code Section XI, IWC-5222. This section requires a hydrostatic test at 1.1 times the lowest system relief valve setting. As an example, the relief valve in the Core Spray piping was set at 500 psig.

The inspector noted that Section 6.4.3 of the Updated FSAR specifies the Core Spray discharge relief valve setting as 500 psig. On June 20, 1984, the inspector met with the licensee's NED Group Leader responsible in this area. He stated that a consultant (Cygn) had performed a review of the materials in the Core Spray discharge piping and concluded that the maximum working pressure was 700 psig, and therefore the test was not detrimental. However, there were no available records to describe the basis for the relief valve set points. Pending a review of the basis for the relief valve settings on the RHR suction and Core Spray discharge piping, this item is unresolved (50-293/84-17-01).

6. Maintenance / Modification Activities

A. Scope

The inspector reviewed the licensee's actions associated with maintenance and modification activities in order to verify that they

were conducted in accordance with station procedures and the facility Technical Specifications. The inspector verified for selected items that the activity was properly authorized and that appropriate radiological controls, equipment control tagging, and fire protection were being implemented.

The items/documents reviewed included the following:

- Scram Discharge Volume Modifications
- HFA Relay replacement, and
- M.R. 83-46-345, Calibration and Overhaul of Circuit Breaker 1042 on bus B10)

B. Findings

(1) Scram Discharge Volume Modifications

The inspector observed work in progress in the reactor building on the modification of the Scram Discharge Volumes (SDV) in accordance with Plant Design Change (PDC) 82-10 as required by IEB 80-17 and NRC Order dated June 24, 1984. The review included the modification design, documentation and management controls. Portions of related electrical circuitry in the cable spreading rooms were also observed.

The modifications in progress incorporate the diverse level instrumentation described in the NRC Confirmatory Order dated June 24, 1984. The diverse level sensors include level transmitters operating on a differential pressure principle and heated resistance temperature detectors (RTD) operating on a thermal conductivity principle. The level transmitters will provide: (1) continuous level indication between 4 and 45 gallons; (2) "Scram Discharge Volume Not Drained" alarms at 4.5 gallons, and (3) "Scram Discharge Volume High Level" scram at 39 gallons.

The RTDs will provide (1) "Scram Discharge Volume High Level" rod block at 13 gallons, and (2) "Scram Discharge Volume High Level" scram at 39 gallons.

The modifications in progress incorporate continuous 6 inch extension of each 6 inch scram discharge volume header into separate and independent 12 inch diameter scram discharge volume instrument volumes.

The modification package includes documentation of approvals of the plant manager and group leader as well as documentation of an independent engineering design review.

The inspector reviewed the licensee's safety evaluation and design change review in accordance with 10 CFR 50.59 and found them to be adequate.

The licensee's plans explicitly address changes to the Technical Specifications, Final Safety Analysis Report, station drawings, and surveillance procedures which are affected by the modification.

The workmanship observed by the inspector in the course of monitoring work in progress was consistent with the construction standards specified.

A review of quality assurance inspection documents revealed indications of ongoing critical inspection. For example, independent measurements prior to concrete core boring for cables was documented and led to a design revision to further limit the potential for interference.

Health Physics practices observed while monitoring work in progress were acceptable for existing conditions.

The licensee demonstrated a noteworthy attention to his ALARA program in designing this modification. The scram discharge volumes and instrument volume had become sources of high radiation exposures to the extent that the exposures inhibited the conduct of short term activities specified in IEB 80-17. The piping configuration selected specifically avoids development of "crud traps" and includes flushing connections to permit removal of radioactive material build-up. Additionally, a removable, segmented shield envelope is provided to each instrument volume to limit the contribution to general radiation exposure from any "crud" build-up that does develop.

No unacceptable practices or conditions were observed.

- (2) On June 22, 1984, cuts on the insulation of internal cabling were noted in new analog trip panels being installed in the cable spreading room for the modification described above. The panels route water level signals from the scram discharge volumes to the reactor protective system.

The insulation cuts were identified near the ends of internal wires in the cables and often penetrated the wire insulation to the conductors. The licensee believes that the cuts were made during the manufacturing process, when the outer cable insulation was stripped from the cable ends. Over two hundred instances of insulation damage were found. The panels were manufactured by Nutherm International of Vernon, IL.

The damaged cables were detected during installation of the panels, after receipt inspection. The licensee stated that the panels were being modified to ensure that adequate separation existed between Q and nonQ components when the defects were noticed. A nonconformance report was issued (Bechtel No. 205) and the defective cables were replaced under supervision of the Nutherm Quality Assurance Program.

On July 12, 1984, the licensee determined that the damaged insulation constituted defects reportable to the NRC under 10 CFR 21. The licensee notified the NRC Region I Administrator of the defects by telephone on July 13 and plans to submit a followup written report. The licensee stated that Nutherm International Corporation notified the NRC on July 11, 1984.

No violations were identified.

- (3) On June 22, 1984, the inspector reviewed M.R. 83-46-345, observed the condition of circuit breaker 1042 in bus B10, and held discussions with the licensee's electrical engineer. The breaker supplies power for a non-safety related load (main turbine turning gear oil pump) however, the licensee had issued a QC nonconformance report No. 2880 because of an arcing problem caused during torquing the connections after overhaul. The inspector determined that the licensee's actions to correct this problem were adequate and being independently tracked by QC. No damage to the safety related bus was identified. The inspector had no further questions.

7. Evaluation of Equipment Failures

A. Scope

A special review was conducted of equipment failures during 1983. The purpose of this review was to ensure that equipment failures are evaluated for frequency and root cause and that adequate maintenance is conducted to limit repetitive failures.

The following records for 1983 were examined during the course of the review:

- Maintenance Requests (MR's), including MR's for the reactor core isolation cooling (RCIC) system, the high pressure coolant injection (HPCI) system, the core spray system, the salt service water system, the diesel generators, and A priority (highest priority) MR's.
- Failure and Malfunction Reports related to ECCS systems.
- Failure and Malfunction Report Trend Analysis Reports for 1983.

- Failure and Malfunction Report Reviews for Significance for 1983.
- Licensee Event Reports related to ECCS systems.
- Quality Assurance Surveillances and Audits of the Failure and Malfunction Report System.

Discussions were held with representatives of the Maintenance, Technical, Shift Technical Advisor, Compliance Management, and Quality Assurance groups.

B. Findings

The following repetitive maintenance activities during 1983 were identified:

- Spurious electrical grounds in the 125V d.c. power system. Multiple MRs were submitted for electrical grounds in the 125V d.c. electrical system during 1983. Four of the MRs were related to grounds in a terminal strip junction box J-51 which is located in the HPCI quadrant. The Maintenance Department stated that the current junction box is affected by steam leaks in the HPCI system and will be replaced during the current outage with a box of better design. Steam leaks in the HPCI quadrant are discussed below.
- Failures in diesel generators' fuel oil pump belt. Five A priority MRs were issued for fuel pump belt problems during 1983. The maintenance department indicated that the initial failures were due to belt wear. Subsequent failures were due to the type and orientation of the coupling which joins the two belt ends. During May, 1983, the licensee switched from a screw type to a staple type coupling and has experienced no subsequent failures. The belt failures were reported in Licensee Event Reports (LER) 83-009 and 83-023.
- Loose motor operator mounting cap screws. On February 22 and on June 10, 1983, loose cap screws were noted on the motor operator of valve 4A in the A loop of the core spray system. The licensee stated that the root cause of the loose screws was vibration in the motor operator. A nearby pipe hanger was tightened after the second occurrence and no further problems were noted. The loose cap screws were reported in LER's 83-010 and 83-035.
- Steam leaks in the HPCI and RCIC systems. Multiple MRs were submitted in 1983 for valve steam leaks in the HPCI and RCIC systems. The licensee is aware of the multiple leaks and stated that many system valves were being overhauled or replaced

during the current outage in a valve betterment program. Some problem valves (e.g. RCIC AO 71 valve) are being eliminated from the systems. Six MRs were submitted for steam leaks on this valve in 1983.

The Chief Maintenance Engineer tracks equipment problems by major component, to identify trends and appropriate corrective actions. High priority maintenance problems are also identified and tracked. This system, although not documented in procedures, is actively used and appears to assist the Engineer in identifying repetitive equipment failures and in determining root causes.

In November, 1983, the Shift Technical Advisors started reviewing each Failure and Malfunction Report for repetitiveness. The results of these reviews are recorded and recommendations for corrective actions documented in memos to the Station Manager. The problems discussed above were not identified in the STA reviews, however, the equipment failures largely predate the STA program.

The Technical Group also periodically reviews Failure and Malfunction Reports for maintenance trends in systems. Reports are issued every six months, identifying trends and recommending corrective actions.

Overall, the licensee's maintenance program appears to adequately seek root causes and take actions to limit repetitive equipment failures. No violations were identified.

During the evaluation of licensee equipment failures, a 1984 Failure and Malfunction Report was reviewed which described dye penetrant indications found on a collet retainer tube of a control rod drive housing during the current outage. The report, 84-011, was evaluated by the licensee's technical staff and by the Operations Review Committee (meeting 84-48). The evaluation indicated that 51 installed drives are made of older material and may be subject to the cracks. The licensee currently plans to inspect and rebuild 27 of these older drives during the outage and leave 24 in place for the next cycle.

The bases for technical specification 3.3.A.2 indicates that when cracking is found, there is a potential for a generic cracking problem affecting a number of drives. The results of the licensee's inspections of the 27 drives will be reviewed during a future inspection. This item is unresolved (50-293/84-17-02).

8. Recirculation Piping Replacement Project Activities

On June 24 and 25, 1984, the licensee noted dye penetrant indications on two reactor vessel nozzle thermal sleeves. The sleeves are inside two 12-inch reactor vessel inlet nozzles for the recirculation system. The

indications were near the welded bases of blocks used to center the sleeves in the nozzles. The licensee's evaluation showed that the indications are acceptable and would not require repair.

On June 29, 1984, the licensee's procedure for conducting half bead weld repairs on recirculation system discharge nozzles was discussed during a conference call between the licensee's project manager and Region I staff. Subsequently, the licensee clarified several items in the procedure.

During June and July, 1984 the licensee found ultrasonic indications near two welds in loop B of the residual heat removal system (RHR) and one weld in loop A of the core spray system outside containment. The welds are located between the first injection valve and the drywell penetration in both systems. The licensee stated that a preliminary evaluation showed that the indications are consistent with intergranular stress corrosion cracking. The licensee plans to conduct additional testing on the weld material to confirm the results.

The RHR and core spray welds with the indications, were subject to inspection under the NRC Confirmatory Order, dated December 10, 1983. However, the licensee requested permission not to inspect the welds in a letter to the NRC, dated December 8, 1983. The licensee now plan to ultrasonically inspect all the welds listed in the December 8, 1983 letter, with the exception of inaccessible welds in penetrations for the RHR, core spray, and reactor water cleanup systems.

No violations were identified.

These items (as well as other recirculation piping activities) were reviewed by an NRC specialist inspector during NRC Inspection No. 50-293/84-19.

9. Meeting with Local Officials

At 7:30 pm on July 10, 1984, the inspectors, along with NRC:Region I management met with the Plymouth, Massachusetts Board of Selectmen in the Plymouth Town Hall. The meeting was held at the request of the Selectmen and was open to the public.

The NRC, Region I, Administrator provided the Selectmen with a brief overview of performance at the Pilgrim station, and the current and planned inspection activities during the recirculation piping replacement outage.

The Acting Chairman of the Selectmen noted that communications between the NRC and the Selectmen have been better in recent years and are very important in helping the Selectmen with their duties.

10. Unresolved Items

Areas for which more information is required to determine acceptability are considered unresolved. Unresolved items are discussed in Paragraphs 2, 5 and 7.

11. Management Meetings

During the inspection, licensee management was periodically notified of the preliminary findings by the resident inspectors. A summary was also provided at the conclusion of the inspection and prior to report issuance. No written material was provided to the licensee during this inspection.