

U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No: 50-312/89-13

Docket No. 50-312

License No. DPR-54

Licensee: Rancho Seco Nuclear Generating Station
Sacramento Municipal Utility District
14440 Twin Cities Road
Herald, California 95638-9799

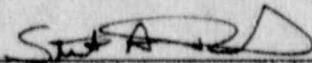
Facility Name: Rancho Seco Unit 1

Inspection at: Herald, California (Rancho Seco Site)

Inspection conducted: July 22, 1989 through September 8, 1989.

Inspectors: A. J. D'Angelo, Senior Resident Inspector
C. J. Myers, Resident Inspector
P. M. Qualls, Resident Inspector

Approved By:


S. A. Richards, Chief
Reactor Projects Section II

10-17-89
Date Signed

Summary:

Inspection between July 22 and September 8, 1989 (Report 50-312/89-13)

Areas Inspected: This routine inspection by the Resident Inspectors involved the areas of operational safety verification, health physics and security observations, ESF system walkdown, maintenance, surveillance and testing, and followup items. During this inspection, Inspection Procedures 71707, 71710, 61726, 62703, 92701 and 30703 were used.

Results:

General Conclusions:

No significant strengths were observed during this inspection. NRC concerns expressed to licensee management included 1) the reduced plant staffing and compliance with NRC commitments during the shutdown effort and 2) the apparent reluctance of plant personnel to generate Potential Deviations from Quality (PDQs).

Summary of Violations or Deviations:

One violation was noted in paragraph 5 of this report concerning failure to promptly write a PDQ.

8911080039 891018
PDR ADDCK 05000312
Q PDC

DETAILS

1. Persons Contacted

- *D. Keuter, Assistant General Manager (AGM), Nuclear
- *J. Shetler, Deputy AGM
- B. Gibson, Manager, Nuclear Support Services
- *P. Bender, Manager, Quality and Safety
- P. Lydon, Manager, Nuclear Plant
- D. Brock, Manager, Nuclear Maintenance
- *S. Crunk, Manager, Nuclear Licensing
- R. Baim, Manager, Nuclear Cost Control and Plant Services
- M. Bua, Manager, Nuclear Radiation Protection
- J. Clark, Manager, Nuclear Chemistry
- W. Peabody, Manager, Technical Services
- L. Houghtby, Manager, Nuclear Security
- J. Delezenski, Supervisor, Regulatory Coordination, Licensing
- Q. Coleman, Quality Assurance

Other licensee employees contacted included technicians, operators, mechanics, security, and office personnel.

*Attended the Exit Meeting on September 8, 1989.

2. Operational Status of Rancho Seco

The plant started this inspection period in cold shutdown, performing activities leading to eventual defueling of the reactor vessel due to the June 6, 1989 vote. At the conclusion of the inspection period, these activities were continuing.

3. Operational Safety Verification (71707)

The inspectors reviewed control room operations which included access control, staffing, observation of system alignments, procedural adherence, and log keeping. Discussions with the shift supervisors and operators indicated an understanding by these personnel of the reasons for annunciator indications, abnormal plant conditions and maintenance work in progress. The inspectors also verified, by observation of valve and switch position indications, that emergency systems were properly aligned as required by technical specifications for plant conditions.

The resident inspectors closely monitored plant staffing during this inspection period, checking on staffing levels weekly. Throughout this period the plant overall staff consisted of about 1000 people, including security personnel. Operations had about 85 people and experienced no large personnel losses.

Tours of the auxiliary, reactor, and turbine buildings, including exterior areas, were made to assess equipment conditions and plant conditions. Also, the tours were made to assess the effectiveness of radiological controls and adherence to regulatory requirements. The

inspectors also observed plant housekeeping and cleanliness, looked for potential fire and safety hazards, and observed security and safeguards practices. Several minor housekeeping deficiencies were noted inside of containment during tours. Plant management was informed and corrective actions initiated.

During work activities, it appeared that the health physics managers were conducting plant tours and monitoring work in progress. They appeared aware of significant work which occurred during this period.

The inspector's Radiation Work Permit (RWP) review revealed that the RWPs did include: job description, radiation levels, contamination, airborne radioactivity (if expected), respiratory equipment, protective clothing, dosimetry, special equipment, RWP expiration, health physics (HP) coverage, and signatures. The RWP radiation and contamination surveys were kept current. Employees understood the RWP requirements.

The inspectors observed that personnel in the controlled areas were wearing the proper dosimetry and personnel exiting the controlled areas were using the monitors properly. Labeling of containers appeared appropriate.

The inspectors walked down portions of the protected and vital area boundaries to ensure that they were intact and that security personnel were properly posted where known deficiencies existed. The inspectors also observed protected area access control, personnel screening, badge issuing and maintenance on access control equipment. Access control was observed. Personnel entering with packages were properly searched and access control was in accordance with licensee procedures. The inspectors observed no obstructions in the isolation zone which could conceal a person or interfere with the detection/assessment system. Protected area illumination appeared adequate.

The inspector verified that the plant licensed operators had received their biannual physical examination as required. The inspector checked a sample of 24 of 33 licensee records and verified that licensed personnel currently performing licensed activities had received the required examination. No discrepancies were noted.

No violations or deviations were identified.

4. ESF System Walkdown (71710)

During the inspection period the inspectors walked down the "B" Train Decay Heat Removal System, the Vital Electrical Switchgear and the "B" Train Emergency Diesel Generators.

The inspectors concluded that:

- All observed hangers and supports were properly made up and aligned.
- Housekeeping was adequate except as noted in paragraph 3.
- No excessive packing leakage was observed on valves.

- ° Major system components were properly labeled, lubricated and cooled. No excessive leakage was apparent.
- ° Instrumentation appeared to be properly installed.
- ° No out of calibration gauges were identified.
- ° Flow path components appeared to be in the correct position.
- ° Required support systems were available.
- ° Proper breaker and switch positions were verified.

No violations or deviations were identified.

5. Monthly Surveillance Observation (61726)

Technical Specification (TS) required surveillance tests were observed and reviewed to ascertain that they were conducted in accordance with Technical Specification requirements.

The following surveillance activities were observed.

- ° SP.56B "B" Bruce GM Monthly Operability Surveillance

The following items were considered during this review: testing was in accordance with adequate procedures; test instrumentation was calibrated; limiting conditions for operation were met; removal and restoration of the affected components were accomplished; test results conformed with TS and procedure requirements and were reviewed by personnel other than the individual directing the test; the reactor operator, technician or engineer performing the test recorded the data and the data was in agreement with observations made by the inspector; and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

While performing SP.56B, the "B" Bruce GM Monthly Operability test, on August 17, 1989, the diesel (EDG) tripped while unloading the generator at about 2000kw load. The diesel control panel indicated an apparent local overspeed trip but the operator did not know what caused this indication. The EDG trip occurred at 2240 on August 17, 1989. At about 0715 on August 18, 1989, the inspector questioned the plant operators as to whether a Potential Deviation from Quality (PDQ) had been written. By writing a PDQ the licensee ensures that unexplained test failures get an adequate and formal investigation. Plant Procedure, RSAP-1308, Potential Deviation from Quality, requires that a PDQ be written within 4 hours after a problem meeting specified criteria, e.g., malfunction of plant equipment, is identified. No PDQ had been written at that time. The operators indicated that one should be written but took no action at that time to do so. A PDQ was written later after management had discussed the issue. The problem was later identified and corrected as a faulty electrical overspeed switch. The failure to write a PDQ within 4 hours as required by RSAP-1308 is an apparent violation (50-312/89-13-01). This violation is a repeat violation of item 88-33-02. Although a

similar violation was identified in late 1988, the inspector did not consider this violation to constitute a breakdown of the PDQ system or the establishment of a significant trend, however the inspector cautioned the licensee that future similar violations could be viewed more seriously. Another issue the inspectors discussed with licensee management is the apparent reluctance of plant personnel to write a PDQ without a clear management consensus to do so.

One violation was identified.

6. Monthly Maintenance Observation (62703)

Maintenance Activities

Maintenance activities for the systems and components listed below were observed and reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, industry codes or standards, and the Technical Specifications.

- ° Troubleshooting of the "B" Bruce GM Diesel Generator.

The following items were considered during this review: The limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing or calibration was performed prior to returning components or systems to service; activities were accomplished by qualified personnel; and fire prevention controls were implemented.

No violations or deviations were identified.

7. NRC Open Items (92701)

a. IE Bulletins

IB-88-11 (Closed), "Pressurizer Surge Line Thermal Stratification"

By letter dated March 6, 1989, the licensee responded to the bulletin requirements to conduct an inspection of pressurizer surge line piping. No discrepancies were identified by this inspection. For the generic analysis required by the bulletin, the licensee stated in the letter that a B&W Owners Group (BWOG) analyses is in progress and will be reported to the NRC by October 31, 1989. This item is closed.

b. Enforcement Items

89-04-02 (Closed), "Replacement Part Review"

In response to this violation, the licensee changed the applicable procedures, NEAP-4202 and NEAP-4205 to highlight the procurement requirements for processing replacement parts. This item is closed.

88-31-01 (Closed), "Calibration Frequency for Steam Generator Pressure Transmitters"

This issue concerned steam generator pressure transmitters which had an 18 month programmatic calibration frequency while a licensee evaluation had documented the need for a 12 month calibration. The licensee calibrated the instruments and changed both the surveillance procedures and schedule to require 12 month calibrations. This item is closed.

c. Followup Items

88-14-02 (Closed), "No Contingency Plan for Coping With Strikes"

Although the licensee still has no contingency plan for strikes, due to staffing requirements for current cold shutdown, plant conditions and imminent defueling of the plant and the licensee's closure plan, this item is closed.

88-22-01 (Closed), "Verification of Compliance to RG 1.97 Standby Power Instrumentation"

The inspector reviewed licensee actions to document the instruments used to monitor the status of standby power. This instrumentation is documented also in a letter to the NRC dated September 30, 1989. This item is closed.

88-27-02 (Closed), "CST Level Indication Discrepancies"

By letter dated September 30, 1988, the licensee committed to correct the condensate storage tank (CST) level indication unit discrepancies by the end of the Cycle 8 refueling. This item is closed.

d. Licensee Event Reports (92700)

88-06-L0 (Closed), "Spurious CR/TSC HVAC Actuation"

This actuation was caused by high control room temperature. There was no NRC requirement to have a high temperature actuation. The licensee changed the high temperature actuation to an alarm function only. This item is closed.

8. Exit Meeting (30703)

The inspector met with licensee representatives (noted in paragraph 1) at various times during the report period and formally on September 8, 1989. The scope and findings of the inspection activities described in this report were summarized at the meeting. Licensee representatives acknowledged the inspector's findings at that time.