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SACRAMENTO MUNICIPAL UTILITY DISTRICT □ 6201 S Street, P.O. Box 15830, Sacramento CA 95852-1830, (916) 452-3211
AN ELECTRIC SYSTEM SERVING THE HEART OF CALIFORNIA

AGM/NUC 89-226

November 17, 1989

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Docket No. 50-312
Rancho Seco Nuclear Generating Station
License No. DPR-54
RESPONSE TO NOTICE OF VIOLATION 89-13

Attention: George Knighton

On October 18, 1989 the Sacramento Municipal Utility District received a Notice of Violation concerning activities at the Rancho Seco Nuclear Generating Station. In accordance with 10 CFR 2.201, the District provides the enclosed response to this violation.

This letter acknowledges the violations cited and describes the District's intended corrective actions. Members of your staff with questions requiring additional information or clarification may contact Mr. Bob Jones at (916) 452-3211, extension 4675.

Sincerely,

Dan R. Keuter
Assistant General Manager
Nuclear

Enclosure

cc w/encl: J. B. Martin, NRC, Walnut Creek
A. D'Angelo, NRC, Rancho Seco
INPO

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DISTRICT RESPONSE TO NOTICE OF VIOLATION 89-13

NRC STATEMENT OF VIOLATION

A. Technical Specification 6.8.1 states, in part:

"Written procedures shall be established, implemented and maintained covering. . . the applicable procedures recommended in Appendix "A" of Safety Guide 33, November 1972."

Safety Guide 33, November 1972, Appendix A states, in part, that Administrative Procedures shall be developed to assure procedure adherence and temporary change methods when procedures cannot be followed.

Procedure, RSAP-1308, "Potential Deviation from Quality," Section 5.3.4, states:

"The originator shall deliver the Potential Deviation from Quality (PDQ) report to the Operations Technical Advisor (OTA) within four (4) hours from the time of identification."

Contrary to the above, on August 17, 1989, a PDQ reporting that the "B" Bruce GM Emergency Diesel Generator failed a surveillance test due to an "unexpected malfunction of plant equipment" was not written and delivered to the OTA within 4 hours of identification.

This is a repeat Severity Level IV violation (Supplement I).

DISTRICT RESPONSE

1. **Admission or denial of alleged violation:**

The District acknowledges that the above occurred.

2. **Reason for the violation:**

On August 17, 1989, Operations declared the 'B' Emergency Diesel Generator (EDG) inoperable while they conducted Surveillance Procedure SP.56B "'B' Bruce GM Monthly Operability Surveillance." At approximately 2240 hours, while conducting the test, the 'B' EDG tripped due to an apparent overspeed condition. The operating crew conducting the test intended to initiate a PDQ; however, the PDQ was not processed.

With regards to the requirement to submit the PDQ to the Shift Supervisor within 4 hours of identifying the problem, the following consideration should be made. The intent of getting a PDQ to the Shift Supervisor within 4 hours is so that he can review the PDQ to determine the impact of the situation on the operability of equipment and determine whether the situation is reportable pursuant to 10 CFR 20, 10 CFR 50.9(b), 10 CFR 50.72, 10 CFR 50.73, 10 CFR 73.71, 10 CFR 100, or 10 CFR 140. In this case, the onshift operating crew was conducting the surveillance test and, therefore, had immediate knowledge of the impact of the 'B' EDG trip on the plant as well as the potential for meeting any reporting criteria.

DISTRICT RESPONSE (continued)

3. **Corrective actions taken and results achieved:**

- At approximately 0700 hours on August 18, 1989, the cognizant systems engineer initiated a PDQ (PDQ 89-631) to document the 'B' EDG tripping on overspeed. As part of the disposition to the PDQ, the systems engineer initiated a work request to perform a visual inspection of the overspeed trip mechanism.

  The inspection indicated that the overspeed switch actuator arm roller was worn and that the pivot point of the switch assembly had appreciable play. The interim corrective action was to adjust the overspeed assembly such that it will remain functional until the overspeed switch assembly is replaced.

- The District reviewed a similar violation identified in NRC Inspection Report 88-33. In that situation, the cognizant individuals recognized the need to initiate a PDQ but were unaware of the requirement to submit the PDQ to the Shift Supervisor within 4 hours. In this case, the cognizant individuals did not process the PDQ properly in order to meet the 4 hour time requirement. It does not appear that these two violations have a common cause or are indicative of a trend.

4. **Corrective actions to avoid further violations:**

- The Shift Supervisors have reviewed this Notice of Violation (NOV) with their crews. This discussion emphasized the requirement and the importance of delivering PDQs to the Shift Supervisor within 4 hours after identifying a problem.

- The AGM, Nuclear issued a site-wide memo emphasizing the importance of initiating a PDQ to document potential problems.

5. **Date when full compliance will be achieved:**

The NOV was discussed with all operating crews by November 10, 1989.