UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

August 31, 1999

Richard Ferreira, Assistant General Manager
Energy Supply and Chief Engineer
Sacramento Municipal Utility District
6201 'S' Street
Sacramento, California 95852

SUBJECT: NRC INSPECTION REPORT 50-312/99-03

Dear Mr. Ferreira:

On August 6, 1999, the NRC completed an inspection at your shutdown Rancho Seco nuclear reactor facility. On August 30, 1999, a followup telephonic exit was held with your staff. The enclosed report presents the scope and results of this inspection.

Areas reviewed as part of this inspection included decommissioning and dismantlement activities, verification of compliance with selected technical specifications, review of completed safety evaluations, evaluation of maintenance and surveillance activities, verification of fuel handler training and verification of agreements with local hospitals.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room (PDR).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/s/

Dwight D. Chamberlain, Director
Division of Nuclear Materials Safety

Docket No.: 50-312
License No.: DPR-54

Enclosure:
NRC Inspection Report
50-312/99-03

A111

EXHIBIT 35
PAGE 1 OF 21 PAGE(S)

4-1999-011

U. C. Davis Medical Center. The memorandum of understanding with the Galt Fire District established provisions for transporting injured, contaminated persons to U. C. Davis Medical Center. Emergency plan implementing procedure EPIP-5330, "Transportation of Contaminated and Injured Personnel," Revision 5, provided specific directions for the radiation protection technician to follow upon arriving at the hospital. If a radiation protection technician was not available at the Rancho Seco site when the ambulance arrived, EPIP-5330 required that the duty radiological assessment coordinator be contacted at home and directed to dispatch a radiation protection technician directly to the hospital emergency room.

2.3 Conclusion

The certified fuel handler training program was being implemented consistent with the requirements of the technical specifications and defueled safety analysis report. Contracts with the local hospital and ambulance services were reviewed and found to be current. Recent changes to the reactor facility emergency plan and procedures to incorporate the emergency planning considerations for the ISFSI were reviewed. Changes made to the reactor facility emergency plan were determined to be appropriate for the current condition of the facility and the potential for an emergency condition.

3 Safety Reviews, Design Changes, and Modifications (37801)

3.1 Inspection Scope

Technical Specification D6.5 and 10 CFR 50.59 required the licensee to maintain a functional safety review program that controlled facility design changes, temporary modifications, procedure changes, tests and experiments. This inspection reviewed selected safety evaluations that had been completed since the last inspection.

3.2 Observations and Findings

Technical Specification D6.5.1, established the requirements for the plant review committee. Technical Specification D6.5.1.6, established the scope of activities to be reviewed by the committee. The plant review committee was required to meet at least monthly in accordance with Technical Specification D6.5.1.4. Meeting minutes for the plant review committee were reviewed for the period between March 1999 and July 1999. Meetings had been held more frequently than monthly and included a review of procedure changes, facility design changes, corrective actions and completed 10 CFR 50.59 safety evaluations. A review of the meeting minutes found the plant review committee to be functioning in compliance with the technical specifications.

Safety reviews conducted under the provisions of 10 CFR 50.59 provided the licensee with a process to make changes to the facility during decommissioning, as long as the changes were consistent with the existing technical specifications and did not involve an unreviewed safety question. Implementation of the safety review process used by the licensee was reviewed, including a review of the following four selected design change packages (DCP):

- DCP-R99-0002, "Remove Bruce Diesel Walls and Obstructions"
- DCP-R99-0005, "Replacement of SFP Level Monitoring Instrumentation"
- DCP-R99-0009, "Isolate Reactor Building Hydrogen Monitoring System"
- STP-1348A, "SFP Chiller Verification Test"

The design change packages were found to adequately document the required safety evaluations. Additionally, the inspector reviewed the licensee's list of qualified 10 CFR 50.59 safety evaluation reviewers. The latest list was dated January 20, 1999, and stated that the safety evaluation refresher training was conducted in accordance with Technical Specification D6.5.3(d). Thirty-two individuals were qualified to conduct 10 CFR 50.59 safety evaluations.

The licensee had established Procedure RSAP-0305, "Field Problem Report," Revision 6 as a procedural process for identifying and documenting problems found in the field during implementation of design change packages. This procedure was used by the licensee to implement the requirements of 10 CFR 50 Appendix B.VI concerning the control of documents when problems were encountered for work performed under a design change package. As specified in Appendix B.VI, measures shall be established to control the issuance of documents, such as instructions, procedures and drawings, including changes thereto, which prescribed all activities affecting quality. The licensee, in their quality assurance plan, Attachment II-1, "Application of Rancho Seco Quality Program Criteria," Revision 9 identified the quality assurance requirements for document control as being applicable to security.

Procedure RSAP-0305, Step 6.2.1 required that upon identification of the need for a field problem report, the originator shall complete the first section of the field problem report form and forward the form to the originator's supervisor for review. Step 4.2 defined a field problem report as a document that provided a means of describing and resolving design and construction problems encountered during design change package implementation or testing.

Procedure RSAP-1308, "Potential Deviation from Quality," Revision 12 established requirements for initiating a potential deviation from quality (PDQ) form. Step 2.1 of RSAP-1308 specified that a PDQ form was to be initiated for deviations from licensing document requirements, state and federal regulations, codes, standards, specifications, quality assurance requirements or administrative controls, including RSAP and sub-tier procedures. The licensee had issued PDQ-0038 on May 14, 1999 concerning the failure to document on a field problem report that a security radio had been installed in a manner different than specified in the design change package. Specifically, the location of the radio in the console was different than the design drawings because the radio would not fit into the space initially selected. This problem had originally been identified in March, 1997 by an employee and reported to management, however the employee had failed to initiate a field problem report form as required by procedure RSAP-0305. No action concerning the updating of the as-built drawing for the security console had been initiated to reflect the new location of the radio. The issuance of the PDQ form on May 14, 1999 was over two years later. Despite this lengthy period of time between identification of the problem and the issuance of a PDQ form, no criteria was found in the procedures concerning timeliness requirements for documenting problems. The