# CATEGORY 1

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ACCESSION NBR:9603060095 DOC.DATE: 96/02/27 NOTARIZED: NO DOCKET # FACIL:50-275 Diablo Canyon Nuclear Power Plant, Unit 1, Pacific Ga 05000275 AUTH.NAME AUTHOR AFFILIATION

BEHNKE, D.H. Pacific Gas & Electric Co. FUJIMOTO, W.H. Pacific Gas & Electric Co. RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 95-019-00:on 950920, overtime restriction not met due to inadequate overtime control program. Overtime restrictions

revised.W/960227 ltr.

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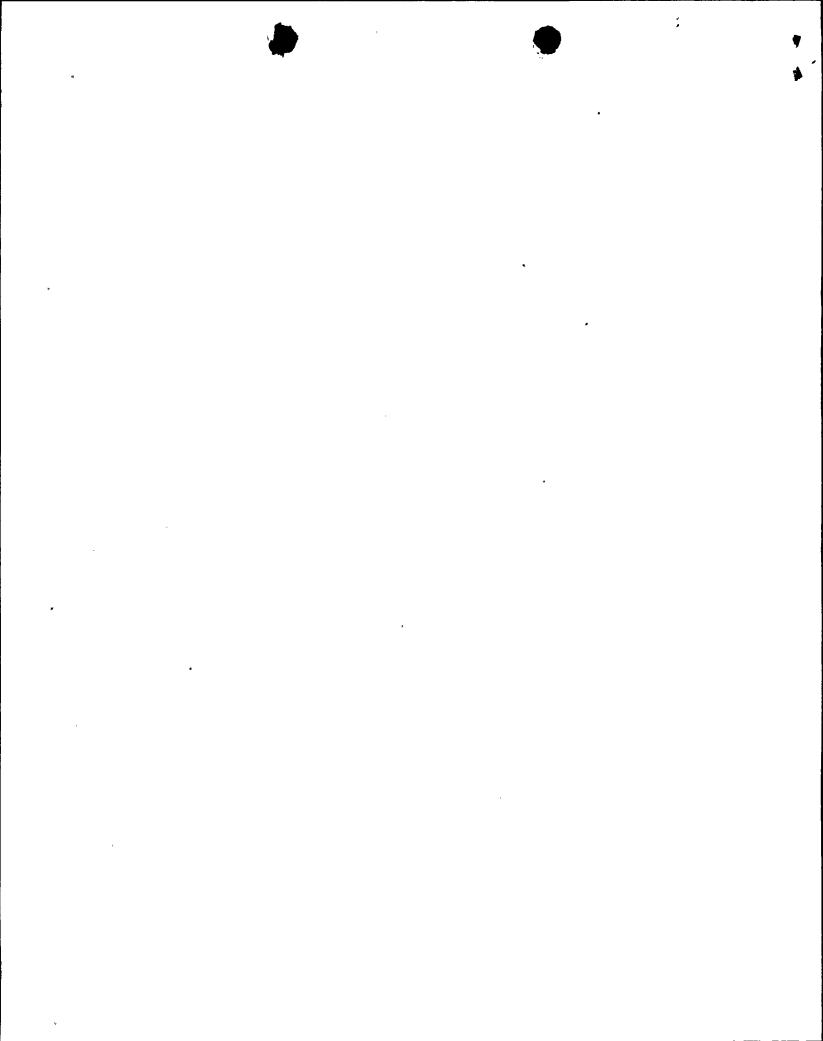
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Diablo Canyon Power Plant P.O. Box 56 Avila Beach, CA 93424 805/545-6000 Warren H. Fujimoto Vice President-Diablo Canyon Operations and Plant Manager

February 27, 1996



PG&E Letter DCL-96-062

U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D.C. 20555

Docket No. 50-275, OL-DPR-80
Diablo Canyon Unit 1
Licensee Event Report 1-95-019-00
Technical Specification 6.2.2f., Overtime Restrictions Not Met Due to Inadequate
Overtime Control Program

Dear Commissioners and Staff:

Pursuant to 10 CFR 50.73(a)(2)(i)(B), PG&E is submitting the enclosed Licensee Event Report regarding Technical Specification 6.2.2f., overtime restrictions not being met due to inadequate overtime control program.

The event did not adversely affect the health and safety of the public.

Sincerely,

Warren H. Fujimoto

cc: Steven D. Bloom

L.J. Callan

Kenneth E. Perkins Michael T. Tschiltz Diablo Distribution

INPO

**Enclosure** 

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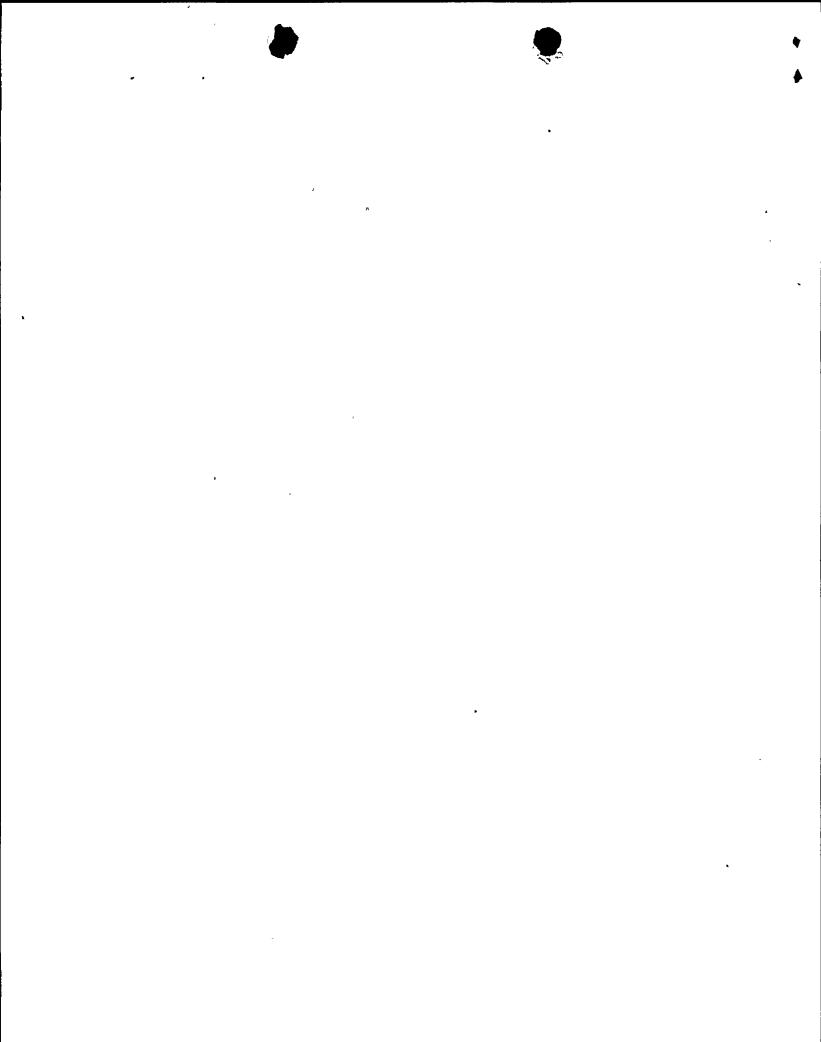
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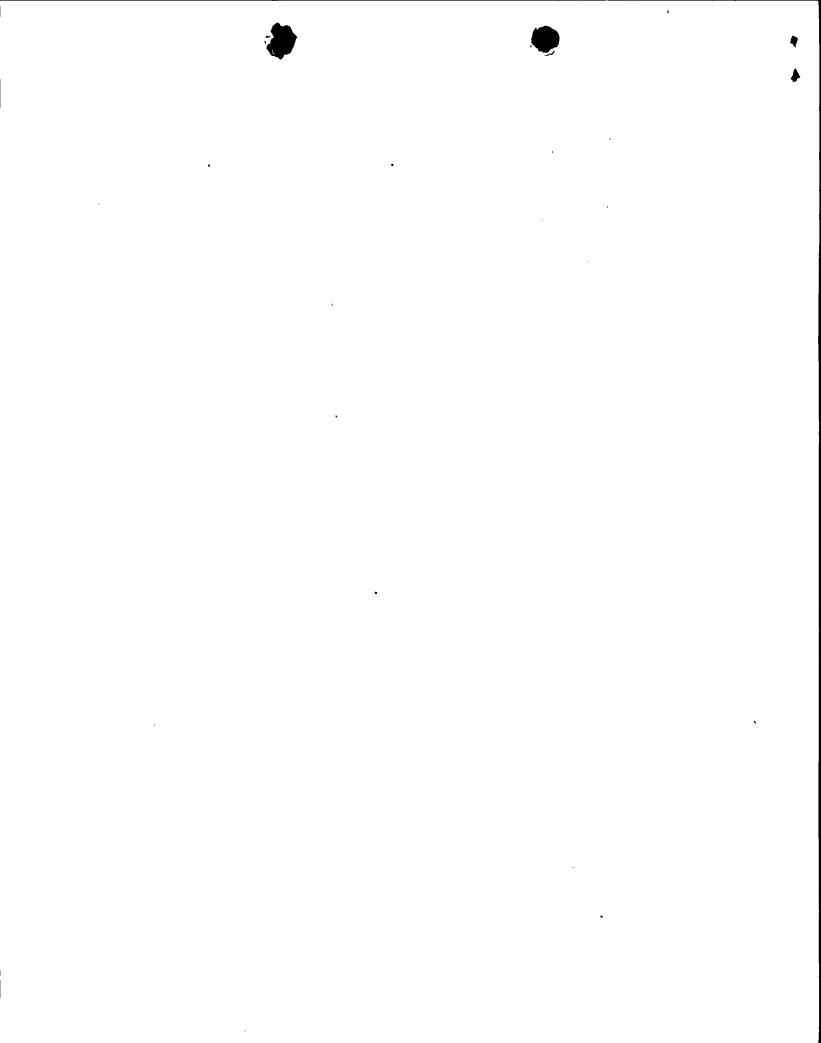


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Between September 30, 1995, and November 26, 1995, with Unit 1 in varjous modes during its seventh refueling outage (1R7), Technical Specification (TS) 6.2.2f. regarding overtime restrictions was not met. On January 29, 1996 during a review of the contributing causes for the transformer fire event (Reference LER 1-95-014-00, submitted on November 20, 1995), PG&E determined that TS 6.2.2f. was not met during 1R7.

The root cause of this event was determined to be a programmatic deficiency in that the approval level for overtime deviations was inappropriately delegated to too low of a management level. Insufficient management oversight was determined to be a contributing cause to this event.

Inter-Departmental Administration Procedure OM14.ID1, "Overtime Restrictions," will be revised prior to the next refueling outage to incorporate the lessons learned from the current event. All personnel at Diablo Canyon Power Plant will be limited to no more than a six day work week, unless approval is obtained from the Vice President - Diablo Canyon Operation and Plant Manager or the Vice President - Nuclear Technical Services in accordance with established procedures. The upcoming Unit 2 refueling outage is being planned and staffed in support of the six day work week requirement.



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### I. Plant Conditions

Unit 1 was in various modes during this event.

### II. <u>Description of Problem</u>

### A. Summary:

Between September 30, 1995, and November 26, 1995, with Unit 1 in various modes during its seventh refueling outage (1R7), Technical Specification (TS) 6.2.2f. regarding overtime restrictions was not met. On January 29, 1996, during a review of the contributing causes for the transformer fire event (Reference LER 1-95-014-00, submitted on November 20, 1995), PG&E determined that TS 6.2.2f. was not met during 1R7.

### B. Background:

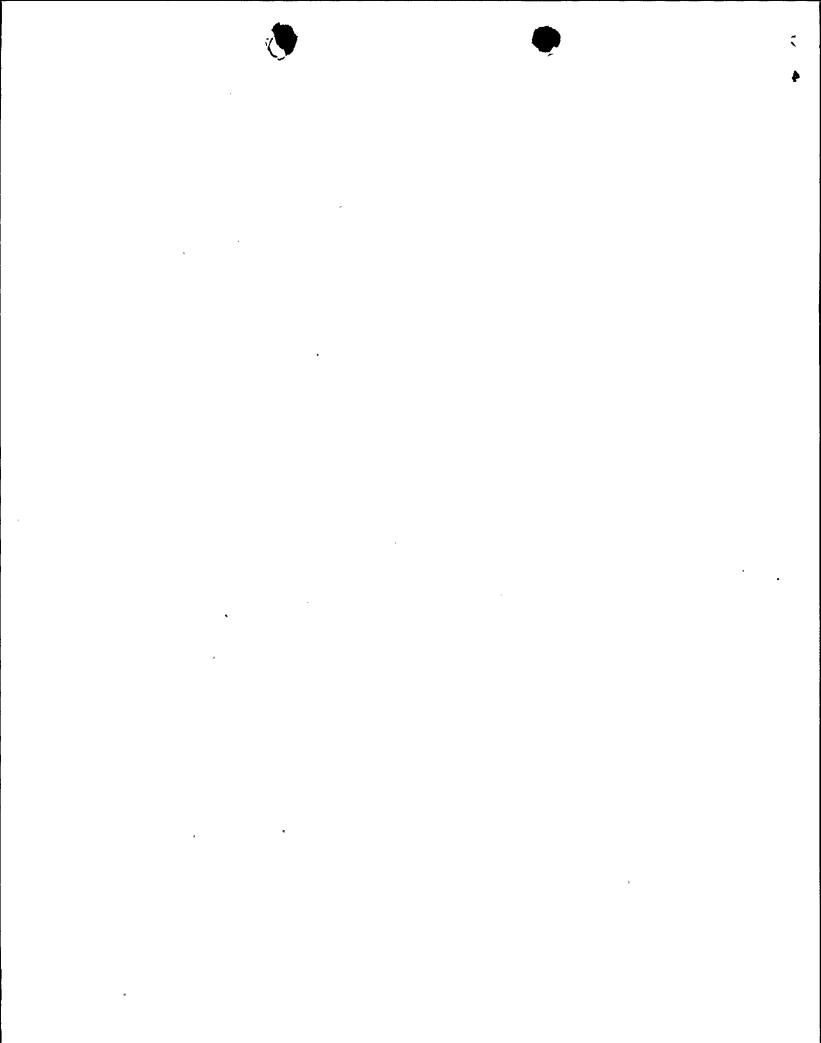
TS 6.2.2f. requires that, during refueling the following guidelines shall be followed: An individual shall not be permitted to work more than 16-hours in any 24-hour period, nor more than 24-hours in any 48-hour period, nor more than 72-hours in any 7 day period, all excluding shift turnover time. Any deviation from the above guidelines shall be authorized by the Vice President - Diablo Canyon Operation and Plant Manager or the Vice President - Nuclear Technical Services or their designee in accordance with established procedures.

Inter-Departmental Administration Procedure OM14.ID1, "Overtime Restrictions," requires that the basis for granting the deviation be documented and that individual overtime shall be reviewed monthly by the Vice President - Diablo Canyon Operation and Plant Manager or his designee to assure that excessive hours have not been assigned. Routine deviation from the above guidelines is not authorized.

#### C. Event Description:

Between September 30, 1995, and November 26, 1995, 1R7 was completed.

On January 29, 1996, during a review of contributing causes for the transformer fire event, PG&E determined that TS 6.2.2f. was not met during 1R7.



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Inoperable Structures, Components, or Systems that Contributed to the Event: D.

None.

E. Dates and Approximate Times for Major Occurrences:

Between September 30, 1995, and Event Date: 1R7.

November 26, 1995:

January 29, 1996:

Discovery Date: PG&E determined that

TS 6.2.2f. regarding overtime restrictions

was not met during 1R7.

Other Systems or Secondary Functions Affected: F.

None.

Method of Discovery:

On January 29, 1996, during a review of concerns raised by the investigation of the transformer fire event, PG&E determined that TS 6.2.2f. was not met during 1R7.

H. **Operator Actions:** 

None required.

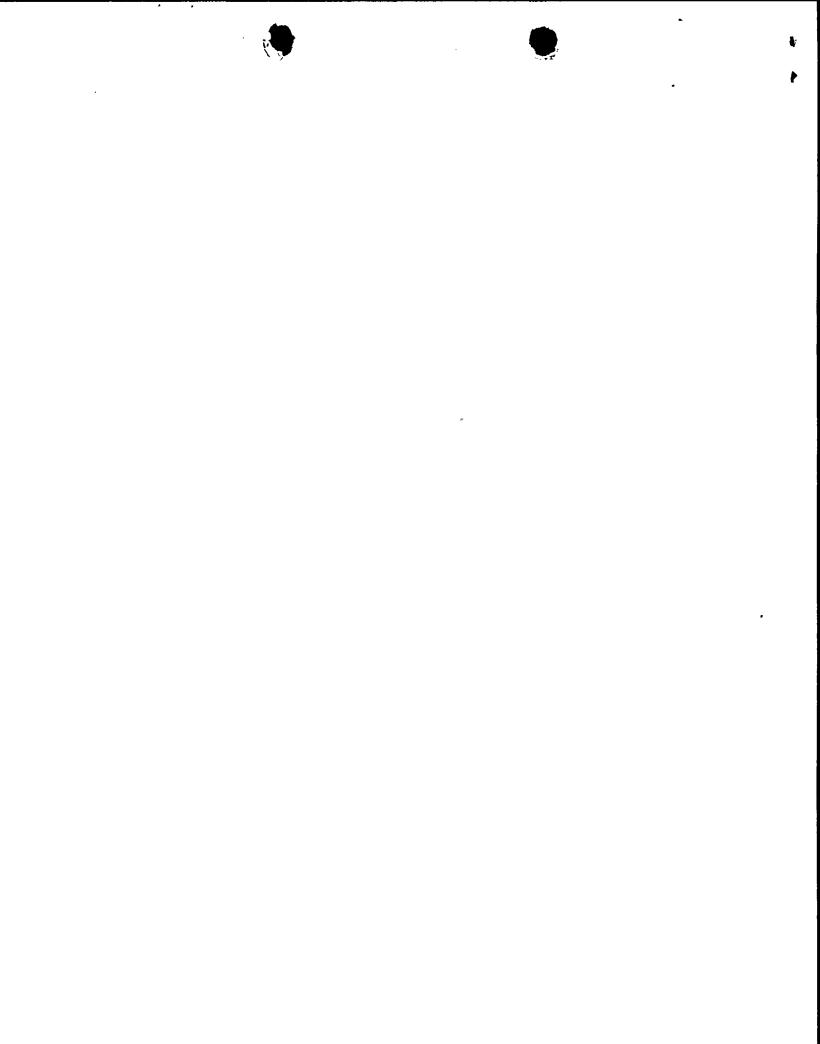
١. Safety System Responses:

None required.

#### III. Cause of the Problem

Immediate Cause:

Although the procedure implementing TS 6.2.2f. regarding overtime restrictions was met, the TS requirements were not met.



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#### B. Root Cause:

The root cause of this event was determined to be a programmatic deficiency in that the approval level for overtime deviations was inappropriately delegated to too low of a management level.

### C. Contributory Cause:

Lack of adequate management involvement in the implementation of the overtime control program.

### IV. Analysis of the Event

PG&E has not identified any 1R7 events that were directly attributable to not conforming to the requirements of TS 6.2.2f.

Thus, the health and safety of the public were not adversely affected by this event.

### V. Corrective Actions

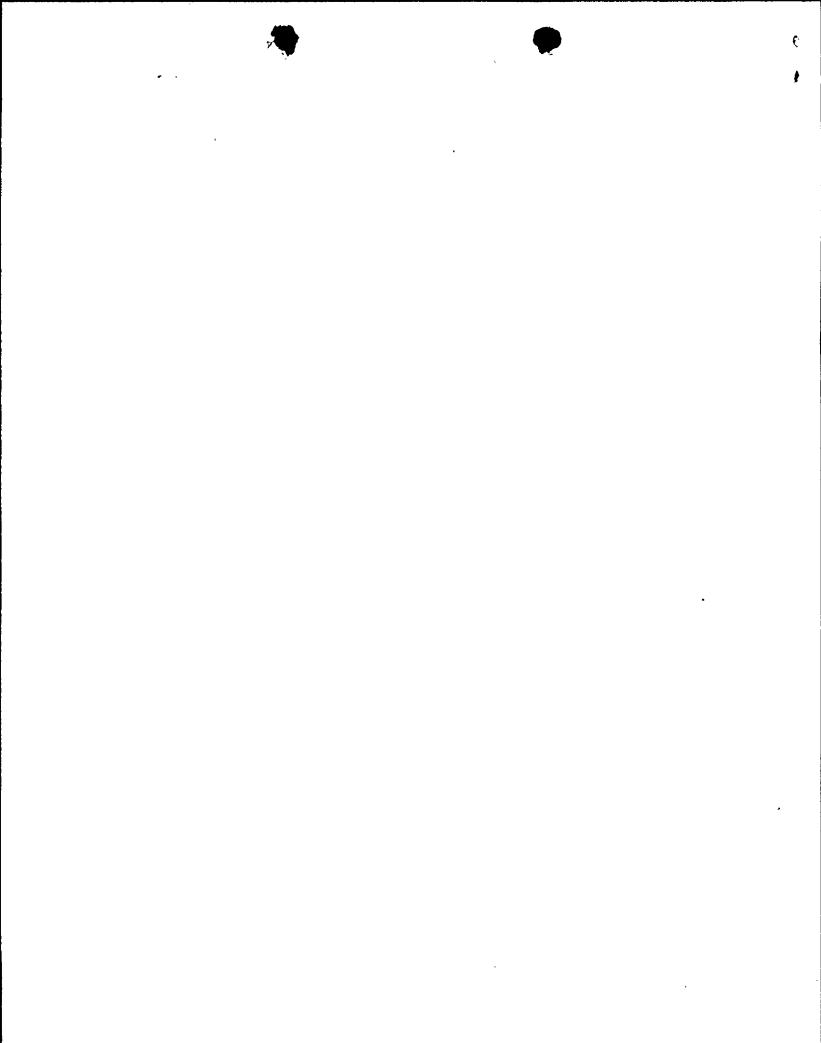
#### A. Immediate Corrective Actions:

A Technical Review Group was formed to investigate the consequences of this event and determine applicable corrective actions.

#### B. Corrective Actions to Prevent Recurrence:

IDAP OM14.ID1 will be revised prior to the next refueling outage to incorporate the lessons learned from this event.

All personnel at Diablo Canyon Power Plant will be limited to no more than a six day work week, unless approval is obtained from the Vice President - Diablo Canyon Operation and Plant Manager or the Vice President - Nuclear Technical Services in accordance with established procedures. The upcoming Unit 2 refueling outage is being planned and staffed in support of the six day work week requirement.



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### VI. <u>Additional Information</u>

A. Failed Components:

None.

B. Previous LERs on Similar Problems:

LER 1-92-021-001, "TS 6.2.2f. Overtime Restriction Violations Due to Inadequate Overtime Control Program," reported a similar event that occurred during the Unit 1 fifth refueling outage. A memorandum, Conformance with OM14.ID1, "Overtime Restrictions," was issued to managerial personnel. The memorandum requested that all managerial personnel review the requirements of IDAP OM14.ID1. In addition, IDAP OM14.ID1 was revised to improve the clarity of the overtime restriction requirements. However, in preparation for the Unit 1 seventh refueling outage, IDAP OM14.ID1 was revised and the management level for approval of overtime deviations was lowered to improve the efficiency of obtaining and documenting overtime deviations. Therefore, the corrective actions for LER 1-92-021-001 were ineffective at preventing the current event because IDAP OM14.ID1 was revised.

