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AUTH.NAME AUTHOR AFFILIATION
GREBEL,T.L. Pacific Gas & Electric Co.
BRAND,D.A. Pacific Gas & Electric Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-017-00:on 891212,personnel performing safety related activities exceeded TS overtime restrictions.

W/8 ltr.

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TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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A014

Pacific Gas and Electric Company

77 Beale Street
San Francisco, CA 94106
415/973-2870

D. A. Brand
Senior Vice President and General Manager
Engineering and Construction Services
Business Unit

January 11, 1990

PG&E Letter No. DCL-90-011

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

Re: Docket No. 50-275, OL-DPR-80
Docket No. 50-323, OL-DPR-82
Diablo Canyon Units 1 and 2
Licensee Event Report 1-89-017-00
Personnel Performing Safety-Related Activities Exceeded Technical Specification Overtime Restrictions Without Proper Authorization

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(i)(B), PG&E is submitting the enclosed Licensee Event Report (LER) concerning plant personnel working overtime in excess of the Technical Specification overtime restrictions.

This event has in no way affected the public's health and safety.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

D. A. Brand

cc: A. P. Hodgdon
J. B. Martin
M. M. Mendonca
P. P. Narbut
H. Rood
CPUC
Diablo Distribution
INPO

Enclosure

DCO-89-MM-N101

3010S/0076K/JHA/2246

IE22
1/1

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
DIABLO CANYON UNIT 1	0 5 0 0 0 2 7 5	1 OF 0 6

TITLE (4): PERSONNEL PERFORMING SAFETY RELATED ACTIVITIES EXCEEDED TS OVERTIME RESTRICTIONS WITHOUT PROPER AUTHORIZATION

EVENT DATA (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER (S)
12	12	89	89	0 1 7	0 0	0 1	11	90	DIABLO CANYON UNIT 2	0 5 0 0 0 3 2 3
										0 5 0 0 0 1 1 1

OPERATING MODE (9)	6	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR : (11)
POWER LEVEL (10)	0 0 0	X 10 CFR 50.73(a)(2)(i)(B)
		OTHER (Specify in Abstract below and in text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER AREA CODE	TELEPHONE NUMBER
TERENCE L. GREBEL, REGULATORY COMPLIANCE SUPERVISOR	805	595-4720

COMPLETE ONE LINE FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (16)

On October 25, 1989, a mechanical maintenance journeyman was identified as working in excess of Technical Specification (TS) 6.2.2 overtime restrictions on a Unit 1 safety-related valve without proper authorization.

A subsequent investigation concluded that plant personnel had exceeded the TS 6.2.2 overtime restrictions without proper authorization on numerous occasions.

The root cause of this event was personnel error and a programmatic breakdown due to a lack of specific guidance in administrative procedures on the applicability and implementation of the TS overtime restrictions of plant personnel.

Corrective actions include revising the applicable administrative procedure to clearly inform all plant personnel of the scope of the procedural requirements.

I. Plant Conditions

Unit 1 was in Mode 6 (Refueling) and Unit 2 was in Mode 1 (Power Operation) at various power levels during this event.

II. Description of Event

A. Event:

On October 25, 1989, an NRC Resident Inspector discovered that a mechanical maintenance journeyman working on a Unit 1 safety-related valve was on a work schedule of 12 hours a day for 7 days. The inspector discussed this with both the foreman on the job and the assistant outage manager and discovered that other craft personnel were also on the same schedule. Technical Specification (TS) 6.2.2, "Plant Staff," paragraph f. provides overtime restrictions for plant staff who perform safety-related functions. To exceed these restrictions an individual must have the authorization of the Plant Manager or his designee including a basis for granting the deviation. However, the required authorization was not obtained.

As immediate action, the maintenance manager issued a memo to all of his maintenance General Foremen and supervisors establishing a work policy more restrictive than that stated in the TS. Although the observations of the NRC inspector were brought to the attention of plant management on October 25, 1989, individuals in the electrical maintenance shop exceeded the 72 hour maximum as late as November 3, 1989. Due to the staggered shift coverage during the Unit 1 refueling outage, some delay was experienced in the collection of employee time records and promulgating the manager's memo to all maintenance personnel. This time delay resulted in four additional electrical workers exceeding the overtime restriction without prior approval. A small fraction of their excess overtime involved work on safety related equipment.

A subsequent investigation was conducted by plant management to determine the extent of the problem. A period of time from October 6, 1989, to November 17, 1989, was selected as a representative period of time to examine overtime records. The time cards of approximately 900 personnel representing operations, maintenance, engineering, and management were collected and reviewed to identify individual violations of the TS overtime restriction.

The investigation identified 139 people who apparently had worked hours in excess of the overtime restrictions of the TS. Their individual records were examined further to determine if they had performed safety-related activities during the hours worked. The examination

showed that of the 139 people identified above, the majority were acting in a supervisory capacity, or performing nonsafety-related work.

Those personnel who had performed safety-related activities and exceeded the overtime restriction of the TS included auxiliary operators, licensed senior control operators, test engineers, foremen, machinists, electrictions, quality control engineers, and supervisors. The types of safety-related work performed by these individuals consisted of maintenance, supervision of surveillance tests, Outage Control Center Staffing, and the performance of post-modification testing. These types of activities involved step-by-step procedure adherence, independent verification, quality verification, and overall supervision by on shift operations personnel. Satisfactory completion of post-modification and surveillance tests and performance of a successful post-outage startup following these activities indicates that violations of the overtime requirement would not have significant impact on plant safety.

B. Inoperable structures, components, or systems that contributed to the event:

None.

C. Dates and approximate times for major occurrences:

1.	October 25, 1989	Event date. A maintenance journeyman was interviewed by the NRC inspector. The NRC inspector notified management of his concern about overtime.
2.	October 31, 1989	Maintenance manager issued a memo to his maintenance General Foremen and supervisors outlining more restrictive overtime requirements.
3.	December 12, 1989	Discovery Date. A Technical Review Group (TRG) determined that a programmatic breakdown in administrative control of employee overtime existed.

D. Other systems or secondary functions affected:

None.

E. Method of Discovery:

The problem was initially discovered by an NRC inspector during a routine inspection. The TRG determined that this represented a reportable event because of the programmatic breakdown in the control of overtime.

F. Operator actions:

None.

G. Safety System Responses:

None.

III. Cause of Event

A. Immediate cause:

Programmatic breakdown in the implementation of the TS overtime restrictions. Administrative Procedure NPAP A-8, "Overtime and Emergency Relief Restrictions," Revision 8, provides instructions relating to the TS overtime requirement without providing specific guidance on applicability or implementation of the TS.

B. Root Cause:

1. The program for assuring compliance with TS 6.2.2 was inadequate. AP A-8 did not include specific guidance with regard to personnel applicability, responsibilities and monitoring employee overtime. In addition, AP A-8 did not include the guidance provide in Generic Letter 83-14 regarding the definition of key maintenance personnel. This resulted in managers not being aware that the TS restriction on overtime applied to their department personnel.

2. For some maintenance personnel who exceeded their allowed overtime, the responsible forman assigning the work was aware of the TS requirement, but neglected to implement the requirement to his personnel due to management oversight.

IV. Analysis of Event

Those personnel who had performed safety-related activities and exceeded the overtime restriction of the TS included auxiliary operators, licensed senior control operators, test engineers, foremen, machinists, electricians, quality control engineers, and supervisors. The time records of 55 personnel who were

identified as having exceeded the overtime requirement were reviewed in detail by plant management to determine what safety-related work may have been performed during that time period. The types of safety-related work performed by these individuals consisted of maintenance, supervision of surveillance tests, Outage Control Center Staffing, and the performance of post-modification testing. These types of activities involved step-by-step procedure adherence, independent verification, quality verification, and overall supervision by on shift operations personnel. The performance of independent verifications, (e.g., post-maintenance tests and surveillance tests) following these activities served to mitigate the possibility that violations of the overtime requirement would have had a significant impact on plant safety.

Based upon the investigation results of employee time records, it can be assumed that additional violations of the TS overtime restriction were made in previous plant outages. Surveillance testing, post-maintenance and post-modification testing, periodic and preventive maintenance, quality control and quality assurance inspections provide reasonable assurance that previous violations of the TS overtime restrictions have not had a adverse impact on plant operation or the public health and safety.

V. Corrective Actions

A. Immediate Corrective Actions

The maintenance manager issued a memo on October 31, 1989, to maintenance General Foremen and supervisors establishing a work policy more restrictive than the TS. Specifically, permission was required to work more than 12 hours in a 24 hour period and more than six consecutive days. As explained in the description section of this LER, this memo was not immediately effective in precluding recurrence of this event until it had received full distribution and implementation.

B. Corrective Actions to Prevent Recurrence:

1. A memo was distributed from the Plant Manager on January 2, 1990 informing plant personnel of the TS restriction on overtime.

2. NPAP A-8, "Overtime and Emergency Relief Restrictions," will be revised to clarify which personnel are affected by the TS restriction on overtime, and to provide clear direction to supervisors and plant personnel regarding compliance with the overtime restriction. The procedure will specify that individuals are responsible for being cognizant of their hours worked and of the procedural and TS restrictions on overtime. Supervisors and foremen will be responsible to track hours worked and to ensure that the requirements of this procedure are met for the employees assigned to them.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
DIABLO CANYON UNIT 1	0 5 0 0 0 2 7 5	8 9	0 1 7	0 0	0 6 OF 0 6

TEXT (If more space is required, use additional NRC Form 366A's) (17)

VI. Additional Information

A. Failed components:

None.

B. Previous LERs on similar events:

None.