



**Southern California Edison Company**

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VICE PRESIDENT

March 5, 1990

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

Gentlemen:

Subject: **Docket Nos. 50-361 and 50-362**  
**Reply to a Notice of Violation**  
**San Onofre Nuclear Generating Station, Units 2 and 3**

In a letter dated February 5, 1990, Mr. A. E. Chaffee (NRC) forwarded NRC Inspection Report No. 89-33 and a Notice of Violation (NOV) concerning personnel overtime. In accordance with 10 CFR 2.201, the enclosure to this letter provides the Southern California Edison reply to this NOV. This reply is consistent with my letter to Mr. Roy Zimmerman (NRC) dated January 18, 1990 which discusses use and control of personnel overtime.

If you have any questions, or if you require additional information, please let me know.

Sincerely,

Enclosure

cc: John B. Martin, NRC Regional Administrator, Region V  
C. W. Caldwell, NRC Senior Resident Inspector, San Onofre

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REPLY TO A NOTICE OF VIOLATION

Appendix A to Mr. Chaffee's letter dated February 5, 1990 states in part:

"A. The Unit 3 Technical Specifications, paragraph 6.2.2, Unit Staff, states in part that:

'f. Adequate shift coverage shall be maintained without routine heavy use of overtime. The objective shall be to have operating personnel work a normal 8-hour day, 40-hour week while the plant is operating.'

Contrary to the above, during September 4 - November 19, 1989, while Unit 3 was operating in Mode 1, the reactor operations and health physics staffs were assigned a work routine of 12 hours per day, five days per week. This comprised an average work week of 55 hours excluding shift turnover and meals.

B. Unit 2 License condition (19)b, Shift Manning, states in part that:

'2. An individual shall not be permitted to work... more than 72 hours in any seven day period... (excluding shift turnover time).'

Contrary to the above, during the period between August 27 and September 10, 1989, one health physics technician worked 76 hours during seven consecutive days without proper authorization from responsible management.

This is a Severity Level IV violation (Supplement 1), applicable to Units 2 and 3."

RESPONSE

1. Reasons for the violation, if admitted

Part A

Because of the dual-unit design of San Onofre Units 2 and 3, it is operated and maintained as a single entity with respect to many organizational and management systems. Among these is the system for the management of overtime. For represented employees, the single entity character of the dual units is also reflected in the negotiated working agreement which describes how overtime will be administered.

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During the September 4 - November 19 period of the violation on Unit 3, Unit 2 was undergoing a refueling outage. As a change from past practice, in managing the overtime required by the Unit 2 outage, among other things SCE sought to respond to employees' concerns about the disruptive effect of unpredictable schedules by adhering to a fixed schedule of planned overtime throughout the outage. Because the overtime required to support the Unit 2 outage was fixed and predictable, employees were assured that they would not be called in during periods of planned time off, and we believed the increased overtime would have a less negative effect.

At the time the fixed overtime schedule was implemented, SCE did not consider that it represented routine heavy use of overtime for Unit 3, contrary to the Technical Specifications, because the schedule was limited to the duration of the refueling outage, and the duration beyond which heavy use of overtime becomes routine is not defined. Our survey of similar, dual-unit plants indicates that the average level of personnel overtime for an operating unit is normally increased throughout the period of a refueling outage on the associated unit, and this was considered normal for San Onofre Units 2 and 3 as well.

In summary, the violation occurred because SCE had concluded that use of fixed overtime schedules would be beneficial to the personnel involved and would not significantly increase the average level of overtime considered acceptable in an operating unit for the duration of a refueling outage on the associated unit.

#### Part B

Review of records indicates that having allowed a health physics technician to work 76 hours on an outage unit, instead of 72 hours, during a 7 day period without proper authorization was an isolated incident resulting from supervisor error.

2. Corrective steps that have been taken and the results achieved

#### Part A

Fixed overtime schedules for the duration of a refueling outage will no longer be implemented for those personnel identified in the Technical Specifications who are assigned to an operating unit. Recognizing the dual-unit design of Units 2 and 3, and the inability to temporarily increase certain critical personnel resources (e.g., licensed

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operators), we may in the future implement fixed overtime schedules for these personnel for much shorter durations (e.g., shutdown and startup).

Part B

Action has been taken with the responsible supervisor to ensure that health physics technician overtime is controlled and authorized in accordance with administrative procedures in the future.

3. Corrective steps that will be taken to avoid further violations

The error in not controlling and authorizing overtime in accordance with administrative procedures will be discussed with all Health Physics supervision by April 16, 1990.

4. Date when full compliance will be achieved

Full compliance was achieved on November 19, 1989 when use of planned overtime was terminated following the restart of Unit 2 from its refueling outage.