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T.R. "Ted" Leonard
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Waterford 3

W3F1-97-0133
A4.05
PR

June 4, 1997

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

Subject: Waterford 3 SES
Docket No. 50-382
License No. NPF-38
Reporting of Licensee Event Report

Gentlemen:

Attached is Licensee Event Report (LER) Number 97-012-01 for Waterford Steam Electric Station Unit 3. This LER, which documents the discovery of plant personnel working in excess of hours allowed by Technical Specification (TS) requirements, was initially submitted to you by letter W3F1-97-0091, dated May 5, 1997. Attached is revision 1 which includes a change to the corrective actions delineated in revision 0. This LER is submitted in accordance with 50.73(a)(2)(i)(B) as a condition prohibited by TS.

Very truly yours,

for TRL

T.R. Leonard
General Manager
Plant Operations

TRL/GCS/tjs
Attachment

060033

cc: E.W. Merschoff (NRC Region IV), C.P. Patel (NRC-NRR),
A.L. Garibaldi, J.T. Wheelock - INPO Records Center,
J. Smith, N.S. Reynolds, NRC Resident Inspectors Office,
Administrator - LRPD

NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
WATERFORD STEAM ELECTRIC STATION UNIT 3	05000 382	1 OF 5

TITLE (4)

PROGRAMMATIC BREAKDOWN OF OVERTIME PROGRAM

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
04	04	97	97	012	01	06	04	97	N/A	05000
									FACILITY NAME: N/A	DOCKET NUMBER: 05000

OPERATING MODE (9)	1
POWER LEVEL (10)	100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.2201(b)		20.2203(a)(2)(v)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)
	20.2203(a)(1)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
	20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
	20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
	20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
DENNIS MATHENY, OPERATIONS MANAGER	(504) 464-3178

COMPLETE ONE LINE FOR EACH COMPONENT 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 (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On April 4, 1997, a determination was made that a programmatic breakdown in the administration of the Technical Specification limits for allowed overtime had occurred. On several occasions, during the month of February, 1997, maintenance and operations personnel exceeded the allowed overtime limit specified in Technical Specification 6.2.2.e without obtaining the required approvals. The cause of this occurrence has been attributed to a lack of management oversight in administering and implementing the plant's working hour policy. To address this issue, the requirements of the Technical Specification and the working hour policy have been reemphasized to management and supervisory personnel. In addition, the working hour procedure, UNT-005-005, will be revised to clarify requirements.

Although personnel worked in excess of the allowed overtime hours, the amount of hours worked had no impact on their ability to do quality work and therefore had no impact on the health and safety of the public or plant personnel.

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
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TEXT *(If more space is required, use additional copies of NRC Form 366A)* (17)

REPORTABLE OCCURRENCE

Technical Specification 6.2.2.e states that administrative procedures shall be developed to limit working hours of individuals of the nuclear power plant operating staff who are responsible for manipulating plant controls or for adjusting on-line systems and equipment affecting plant safety which would have an immediate impact on public health and safety. Revision 1, Second Draft of NUREG 1022 states that a substantial breakdown in the required program (program to administratively control overtime worked) or a general failure to have the required program would be considered reportable.

On April 4, 1997 Waterford discovered a substantial breakdown in the administration of its program to control overtime hours worked. This breakdown resulted in plant personnel exceeding the maximum overtime hours allowed by Technical Specification 6.2.2.e without obtaining the required approvals. Accordingly, this occurrence is being reported per 10CRF50.73(a)(2)(i)(B) as a condition prohibited by the Technical Specifications.

INITIAL CONDITIONS

During the month of February, 1997, when the violation of Technical Specification 6.2.2.e occurred, Waterford 3 was operating in Mode 1 at approximately 100%. No structures, systems or components were inoperable that contributed to this event.

EVENT DESCRIPTION

In late March, 1997, an NRC inspector discovered that a Shift Technical Advisor had exceeded the maximum allowed working hours as specified in plant procedure UNT-005-005, "Working Hour Policy For Nuclear Safety-Related Work," and Technical Specification 6.2.2.e without obtaining proper authorizations for the deviations.

The procedure states, in part:

- An individual shall not work more than 16 hours straight.
- An individual shall not 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.
- Any deviation from the working hour guidelines set forth in the procedure shall be approved by the General Manager Plant Operations, the Operations & Maintenance Manager, the Technical Services Manager, or the Operations Superintendent.

Additional reviews by the NRC inspector and subsequent reviews by plant personnel identified several additional occurrences where personnel exceeded the maximum allowed working hours. A summary of the working hour deviations is provided below:

- 30 examples of individuals working more than 24 hours in a 48 hour period.
- 6 examples of individuals working more than 72 hours in a 7 day period.
- 3 examples of individuals working more than 16 hours in a 24 hour period.
- 12 examples of the wrong individual approving a deviation to the working hour policy.
- 15 examples of individuals approving a deviation of the working hour policy after the hours had been worked.

CAUSAL FACTORS

A Root Cause Analysis (RCA) team was formed to investigate this event. The RCA team determined that the root cause is a lack of management oversight in administering and implementing the plant's working hour policy. Management did not adequately address previous isolated violations of the working hour policy. Site Procedure UNT-005-005, "Working Hour Policy For Nuclear Safety-Related Work," and Technical Specification 6.2.2.e were not complied with.

A contributing cause of this occurrence was that procedure UNT-005-005 was somewhat vague in its explanation as to which plant personnel are affected by the

working hour policy. The procedure states that the working hour policy applies to Waterford 3 plant staff who manipulate safety-related plant controls or adjust on-line safety-related systems and equipment.

Conversation with some maintenance personnel indicate they did not believe the working hour policy applied to them. They assumed the working hour restriction applied only to operators whom they thought were solely responsible for manipulating safety related plant controls, systems and equipment.

CORRECTIVE MEASURES

The Operations' Manager issued a letter to operations, maintenance and plant support supervisory personnel reemphasizing the working hour policy as outlined in procedure UNT-005-005.

The General Manager Plant Operations issued an action to department managers to brief their personnel on UNT-005-005 and to document the completion of this action.

Department Heads will brief personnel on the results of a Root Cause Analysis on this event and the resultant corrective actions.

The Vice President, Operations will discuss this issue and reinforce expectations regarding implementation of the working hour policies with Senior Management.

Procedure UNT-005-005 will be revised to include the following:

1. An enhancement to Attachment 6.1, "Authorization of Working Hour Policy Deviations," to indicate, in addition to the reasons for the deviation, the number of hours required to be worked.
2. A clarification on the requirement for approval of working hour deviations prior to the commencement of the work activity.
3. A clarification on the 2 hour exception for the "late watch relief".

4. A clarification on who the working hour policy applies to.

Quality Assurance will evaluate organizational compliance with the working hour policy during audits required by the Quality Assurance Program Manual.

SAFETY SIGNIFICANCE

The working hour policy violations are not considered safety significant. In each instance, authorization to deviate from the working hour policy should have been granted in advance, in accordance with the UNT-005-005 guidelines.

In assessing the safety significance of this issue, several factors were considered:

- In no instance were the deviations considered detrimental to the safety of the plant , employees, or public.
- The hours worked in excess of the guidelines constitute only a very small fraction of the total hours worked at the station or by the individual departments.

The majority of the hours worked and the working hour deviations at the station were in compliance with the guidelines specified in UNT-005-005. Accordingly, the programmatic aspect of this event is not considered safety significant. In consequence, the event did not compromise the health and safety of the public.

SIMILAR EVENTS

No previous similar events were identified.