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SUBJECT: Responds to NRC 941103 ltr re violation noted in Insp Rept 50-410/94-18 on 940821-1001.Corrective actions:Nuclear Interfacing Procedure NIP-SEC-01, "Protected/Vital Area Access" will be revised by 950101.

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NIAGARA MOHAWK

NIAGARA MOHAWK POWER CORPORATION/NINE MILE POINT, P.O. BOX 63, LYCOMING, NY 13093/TELEPHONE (315) 349-2882

Ralph Sylvia
Executive Vice President
Nuclear

December 2, 1994
NMP2L 1512

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

RE: Nine Mile Point Unit 2
Docket No. 50-410
NPF-69

Subject: ***RESPONSE TO NOTICE OF VIOLATION***
NRC Inspection Report No. 50-220/94-16 and 50-410/94-18

Gentlemen:

Attached is Niagara Mohawk Power Corporation's response to the Notice of Violation contained in the subject Inspection Report dated November 3, 1994. If you have any questions concerning this matter, please contact me.

Very truly yours,

B. Ralph Sylvia
Executive Vice President - Nuclear

BRS/RLM/lmc
Attachment

xc: Mr. T. T. Martin, Regional Administrator, Region I
Mr. B. S. Norris, Senior Resident Inspector
Mr. L. B. Marsh, Director, Project Directorate I-1, NRR
Mr. D. S. Brinkman, Senior Project Manager, NRR
Records Management

120065

ATTACHMENT

NIAGARA MOHAWK POWER CORPORATION
NINE MILE POINT UNIT 2
DOCKET NO. 50-410
NPF-69

"RESPONSE TO NOTICE OF VIOLATION," AS CONTAINED IN
INSPECTION REPORT 50-220/94-16 AND 50-410/94-18

VIOLATION 50-410/94-18-02

During an NRC inspection conducted from August 21 to October 1, 1994, a violation of NRC requirements was identified. In accordance with 10 CFR Part 2, Appendix C, "General Statement of Policy and Procedure for NRC Enforcement Actions," the violation is listed below:

> 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires that measures be established to assure that conditions adverse to quality are promptly identified and corrected, and that the cause of the condition is determined and corrective action taken to preclude repetition.
>
> The Nine Mile Point Nuclear Power Station Physical Security Plan, Issue 4, Revision 0, requires, in part, that individuals not granted unescorted access will be continuously accompanied by a person who has unescorted access authorization while within the protected area.
>
> Contrary to the above, on August 26, 1994, an individual not granted unescorted access was found in the protected area without an escort. This condition existed for approximately 10 minutes. This is the third instance since August 1993 where an individual not granted unescorted access was not continuously accompanied by a person who had unescorted access authorization. Consequently, the corrective actions for the previous events failed to preclude repetition.

This is a Severity Level IV violation (Supplement III).

I. THE REASON FOR THE VIOLATION

Niagara Mohawk admits to the violation as stated in Inspection Report 94-16/94-18.

A root cause analysis was performed in accordance with Nuclear Interface Procedure NIP-ECA-01, "Deviation/Event Report." The analysis included the event that occurred on

August 26, 1994, as well as two previous events that occurred in August 1993 and September 1993. The immediate causes for each of the three events were determined to be different. The most recent event in August of 1994 was caused by inadequate work practices when the contractor foreman broke visual contact with the visitor he was escorting. The foreman should have stopped the work and had the visitor follow to maintain visual contact. The August 1993 event, described in Deviation/Event Report DER 2-93-1777, involved a contractor being escorted by an NMPC System Engineer. The System Engineer transferred responsibility for the visitor to an Operator without ensuring the Operator understood this responsibility. Hence, poor verbal communication was the immediate cause. The September 1993 event, described in DER C-93-2106, involved yet a third contractor being escorted by another contractor. Two cognitive personnel errors caused the visitor to walk away from the escort when the escort was conversing with another individual. In all three cases, the cause and corrective actions focused on the specific circumstances and individuals involved. Without the benefit of multiple events to evaluate, the corrective actions did not address the root cause and subsequently, did not prevent recurrence.

The analysis of all three events has identified several common causes that did not appear as the root causes of any of the three events. In all three instances, the visitors involved were granted visitor access for extended periods. Only the event in DER 2-93-1777 involved an urgent or emergency situation. Further, in all three cases, the visitors were performing physical work at the station as opposed to touring the site or attending meetings. Involved personnel (e.g., project managers) should have given more consideration to ensuring adequate quantities of escorts were available to support the activity, or required the contractors to go through the process for obtaining unescorted access authorization thereby eliminating the need for escorts. The analysis identified the root cause of all three events as inadequate work organization and planning. Specifically, in all three cases personnel who were accountable for planning visitor access failed to consider the additional burden that escort responsibilities imposed on the ability of the escort to perform routine job functions.

There were two contributing causes identified during the review of these events. The first was inadequate Work Practices - self-checking was not applied to ensure the intended action of the escort was correct causing the visitor to be left unattended. The second was Managerial Methods - the procedure governing the visitor escort policy, NIP-SEC-01, does not clearly define the parameters for which visitor badges are intended.

The fact that two of the three events involved contractors escorting contractors was also noted. This fact could not, however, be verified as a common cause to the three events. The General Employee Training (GET) program was examined and found to be more than adequate and the contractor escorts were determined to be aware of their escort responsibilities. Eventhough not a cause, the preventive actions listed in section III would eliminate contractor escorts as a cause.

II. CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

A Deviation/Event Report was immediately initiated for the August 26, 1994 event to identify and document the corrective actions for that event. These actions included:

1. All work on the project was stopped and the unescorted access of the contractor escort was terminated.

2. New restrictions were placed on the use of visitors' access for the Maintenance Building project. Specifically, the use of visitors' access was only allowed if the normal NMPC badging process could not be completed because of unforseen circumstances.

3. All NMPC escorts for the project were briefed on their responsibilities and management's expectations.

III. ACTIONS TAKEN TO PREVENT RECURRENCE

1. To improve work organization and planning as it applies to use of visitors and to better define policy with regard to responsibilities for ensuring visitors are properly escorted, Nuclear Interfacing Procedure, NIP-SEC-01, "Protected/Vital Area Access," and related Security Branch procedures will be revised by January 1, 1995. The revisions will involve the following:

   - Responsible personnel will be required to evaluate and address any special circumstances associated with bringing a visitor into the Protected Area. Of paramount importance will be the determination of whether personnel assigned escort duties can adequately perform those tasks when they are also expected to carry out routine job functions. This evaluation will determine the appropriate ratio of visitors to escorts depending upon the visitor's intended tasks while in the Protected Area.

   - Use of a visitor's badge will be limited to no more than three consecutive days, unless the responsible manager has obtained permission from the Manager Nuclear Security to exceed that limit.

2. To foster self-checking and reinforce the accountability of visitor escorts, the following corrective actions will be implemented by January 1, 1995:

   - Before being allowed to bring a visitor into the Protected Area, escorts will be required to review and sign a set of escort instructions.

   - Escort instructions will be affixed to each visitor's badge. When accountability for a visitor is transferred from one escort to another, the new escort will review and sign the instructions accepting responsibility.

3. To heighten personnel awareness of expectations related to performance of visitor escorts, a summary of the events leading to the Notice of Violation, the corrective actions embodied in this response and reinforcement of NMPC management's expectations will be added to the General Employee Training (GET) Requalification Program by January 1, 1995. In addition, Revision of the Security module for the GET Full Qualification Program to stress the importance of escort responsibilities will be completed by January 1, 1995.

IV. DATE WHEN FULL COMPLIANCE WAS ACHIEVED

Full compliance with the Site Security Plan was achieved on August 26, 1994 when the unescorted visitor was returned to an escort and the unescorted access of the responsible contractor foreman was terminated.