NIAGARA MOHAWK
GENERATION
BUSINESS GROUP

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RICHARD B. ABBOTT
Vice President and
General Manager – Nuclear

September 27, 1996
NMP1L 1131

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

RE: Nine Mile Point Unit 1
Docket No. 50-220
DPR-63

Subject: ***Reply to Notice of Violation, Revised***
NRC Inspection Report No. 50-220/96-06

Gentlemen:

Niagara Mohawk Power Corporation's (NMPC) revised reply to the Notice of Violation is enclosed as Attachment A to this letter. As in the original response, Niagara Mohawk admits to the violation as stated.

After further review of our past performance in conjunction with the root cause analysis, NMPC concluded that the original response did not adequately describe our assessment of this issue. While much of the discussion in the original reply remains germane and valid, Niagara Mohawk is submitting a revised reply in its entirety to facilitate your review and evaluation of our conclusions and corrective actions.

Very truly yours,

RB Abbott

R. B. Abbott
Vice President and General Manager - Nuclear

RBA/AFZ/kap
Enclosure

xc: Regional Administrator, Region I
Mr. B. S. Norris, Senior Resident Inspector
Mr. D. S. Hood, Senior Project Manager, NRR
Records Management

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ATTACHMENT A

Niagara Mohawk Power Corporation
Nine Mile Point Unit 1
Docket No. 50-220
DPR-63

REPLY TO NOTICE OF VIOLATION AS CONTAINED IN INSPECTION REPORT 50-220/96-06

STATEMENT OF VIOLATION

During an NRC inspection conducted from March 30 through June 1, 1996, a violation of NRC requirements was identified. In accordance with the NRC "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600, (60 FR 34381; June 30, 1995), the violation is listed below:

> Title 10, Code of Federal Regulations, Part 20, Section 20.1101, requires, in part, that licensees implement a radiation protection (RP) program commensurate with the scope and extent of licensed activities.
>
> Procedure GAP-RPP-02, "Radiation Work Permit," Revision 04, Paragraph 3.7.4, requires that workers shall access the radiologically controlled area (RCA) using either a general, standing, or specific radiation work permit (RWP). Paragraph 2.5 states that radiation workers are responsible for compliance with the requirements of the RWP Program.

Contrary to the above, the licensee failed to properly implement its radiation protection program procedures, as evidenced by the following examples:

> On January 4, 1996, an operator breached the residual heat removal system, a contaminated system, without first notifying the RP department, as required by the RWP.
>
> On January 8, 1996, a contractor entered the RCA without wearing a thermoluminescent dosimeter as required by RWP.
>
> On January 22, 1996, a technician entered the RCA without wearing electronic dosimetry, as required by RWP.
>
> On March 2, 1996, a worker entered the RCA, including a locked high radiation area within the RCA, without wearing electronic dosimetry, as required by RWP.

On April 26, 1996, an individual entered the RCA, failed to sign in on an RWP, and thus failed to wear electronic dosimetry, as would have been required by the RWP.

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

I. The Reason for the Violation

Niagara Mohawk admits to the violation as stated.

The cause of the violation is a previously inappropriate reporting threshold of radworker non-conformance issues into the Deviation Event Report (DER) corrective action program. Thus, station management did not recognize the frequency of these incidents and therefore did not take timely, effective corrective actions to address this performance issue.

A review of radworker performance from May through November 1995 was conducted in December 1995, which identified infrequent, but continued incidents of Radiation Work Permit (RWP) non-conformances. In evaluating this issue, station management identified a failure to use the DER process for reporting and documenting these radiologically low impact non-conformance events. As a result, a new threshold for documenting these events utilizing the DER process was established. Implementation of this new threshold led to an increase in documented events from December 1995 through April 1996, including those cited in the Notice of Violation. Timely corrective actions implemented in response to that trend resulted in an improvement in performance. Many of these corrective actions were implemented prior to issuance of the Notice of Violation.

The specific events cited in the Notice of Violation involved access control problems resulting in no additional exposures, and improperly monitored system breaches resulting in no spread of contamination. Although the radiological impact of these individual events is very low, Niagara Mohawk recognizes that previous corrective actions were not sufficiently comprehensive regarding emphasis on the importance of self-checking and cross-checking by station workers to ensure conformance with Radiation Protection policies and practices.

As noted in Inspection Report 50-220/96-06, these deficiencies were self-identified and the "effectiveness of the corrective action to prevent recurrence will take time to be assessed." Niagara Mohawk believes that the self-identification of these deficiencies is the result of management's emphasis on self-assessment to promote continual improvement. Because of the nature of these types of human errors, Niagara Mohawk concurs that the effectiveness of the corrective actions can only be assessed over a period of time. As discussed below, Niagara Mohawk will be monitoring this trend and taking appropriate actions based on the results of this monitoring.

II. Corrective Actions Taken and Results Achieved

DERs had been previously issued at the time of the occurrence for each of the specific instances noted as examples in the Notice of Violation. The following corrective actions were taken as a result of these cases:

- Physical enhancements were made in the Access Control Areas to the RCA.
- Standdowns were conducted to emphasize Access Control requirements.
- Management oversight and attention was increased in the area of radiation worker conformance with radiological controls.
- The individuals involved in the specific occurrences were counseled by Radiation Protection personnel.
- Electronic Dosimeter Readers (DR-200s) have been equipped with an audible alarm which activates if the electronic dosimeter is not removed from the reader in a timely manner after RCA entry is granted.

These corrective actions have resulted in an improving trend for NMPC site radiation worker performance. This trend is determined by comparing the instances of inappropriate radiological work practices to the total number of hours logged on to RWPs used on the site.

III. Actions Taken To Prevent Recurrence

1. Radiation Protection policies and practices will continue to be emphasized with radiation workers. For the next 18 months, senior management expectations in this area will be reinforced at least quarterly through communications disseminated to site radiation workers.

2. Further human factor enhancements will be evaluated, and if appropriate, implemented for access control evolutions to facilitate self-checking and cross-checking actions. Completion Date: December 31, 1996.

3. During peak RCA activities, such as refueling outages, the station will dedicate specific personnel to enhance the oversight of access control and RCA entry. The effectiveness and the potential for further implementation of this action will be evaluated following the next Unit 2 refueling outage. Completion Date: November 30, 1996.

4. Senior Management has reviewed self assessment practices with all branches to ensure thresholds used for reporting deviations are at an appropriate level.

The actions that Niagara Mohawk has taken have reduced the number of personnel errors related to the radiation protection program over the short term. Niagara Mohawk's efforts to

strengthen the radiation protection program will continue to focus on an effective self-assessment process. The future collection and evaluation of data will be used to assess the long-term effectiveness of these actions and programmatic changes, and will enable Niagara Mohawk to proactively develop further program enhancements if needed.

Niagara Mohawk believes that the self-identification of personnel errors has, in itself, resulted in a reduction of personnel performance issues in this area. Niagara Mohawk will continue to promote the self-identification of concerns and issues by the work force and believes that this atmosphere in conjunction with the periodic re-emphasis of the program's importance and the enhanced human factor controls will reduce the frequency of these deficiencies.

IV. Date When Full Compliance Will Be Achieved

Niagara Mohawk has re-established full compliance upon completion of the corrective actions for each individual event described in the Notice of Violation.

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