

NIAGARA MOHAWK

GENERATION
BUSINESS GROUP

NINE MILE POINT NUCLEAR STATION/LAKE ROAD, P.O. BOX 63, LYCOMING, NEW YORK 13093/TELEPHONE (315) 349-1812
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RICHARD B. ABBOTT
Vice President and
General Manager - Nuclear

March 24, 1997
NMP1L 1197

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: Notice of Violation dated February 21, 1997
NRC Inspection Report 50-220/96-14 and 50-410/96-14*

Gentlemen:

Niagara Mohawk Power Corporation's (NMPC) reply to the Notice of Violation is enclosed as Attachment A to this letter. We have admitted to the cited violation.

Very truly yours,

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

RBA/GJG/kap
Attachment

xc: ~~Mr. H. J. Miller, NRC Regional Administrator~~
Mr. S. S. Bajwa, Acting Director, Project Directorate I-1, NRR
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**

**"RESPONSE TO NOTICE OF VIOLATION," AS CONTAINED IN
INSPECTION REPORT 50-220/96-14 AND 50-410/96-14**

A. VIOLATION 50-220/96-14-03

The Unit 1 Technical Specifications, Section 6.11, requires written procedures to be approved, maintained, and adhered to for all operations involving personnel radiation exposure.

Nine Mile Point Procedure GAP-RPP-08, "Control of High, Locked High, and Very High Radiation Areas," Revision 03, Section 3.6.1 requires personnel maintain positive access control for High, Locked High, and Very High Radiation Areas. The procedure required that barriers remain closed and locked after each entry, and that barriers be checked closed by shaking.

Contrary to the above, on September 17 and November 29, 1996, the east gate to the Unit 1 turbine deck, a posted High Radiation Area, was found unlocked and unattended.

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

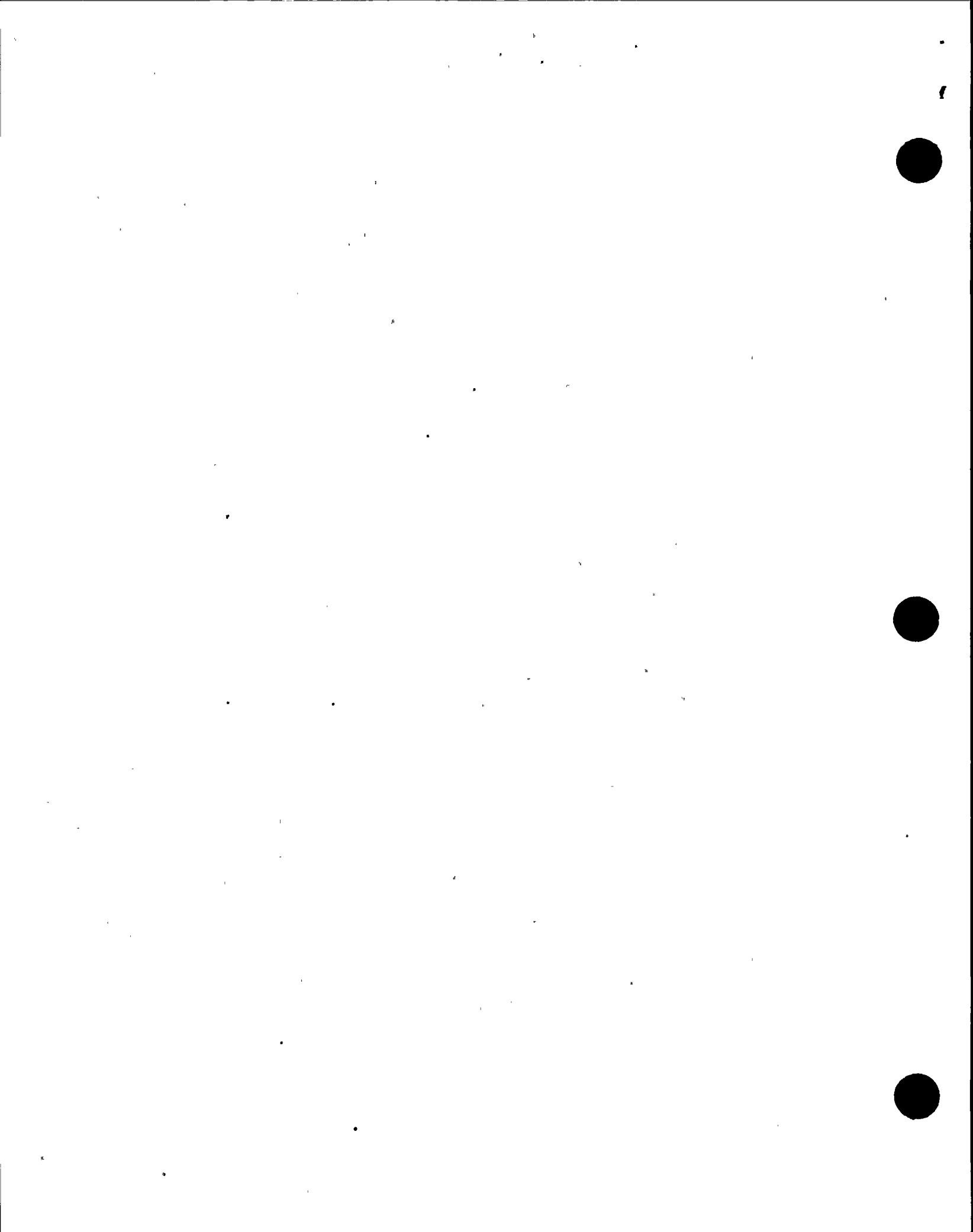
I. THE REASON FOR THE VIOLATION

The cause of the events described in the violation is personnel error in that operators failed to follow site procedures that direct holders of High, Locked High, and Very High Radiation Area keys to ensure that lockable barriers remain closed and locked via shaking, after exiting. In addition, the Corrective Actions taken as a result of the September 17, 1996 event were not effective in preventing the November 29, 1996 event.

II. CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

The following corrective actions were taken after the September 17, 1996 event:

- a. The individual who left the gate open was counseled on the proper physical checks required when transiting High, Locked High, and Very High Radiation Area boundaries.



- b. The Manager Operations reinforced expectations regarding verification of radiation gate closure with each shift of operations personnel.

The following corrective actions were taken after the November 29, 1996 event:

- a. It could not be determined who the individual was that left the gate unlocked; however, since operators were the only personnel who had access to the turbine deck during routine rounds, it is assumed that an operator left the gate open. The Manager Operations reinforced expectations with each Station Shift Supervisor as to his responsibility to assure that his crews know the requirements, and hold crew members accountable to meet these requirements. The Manager Operations also directed the Station Shift Supervisors to reinforce their expectations with regard to compliance with these radiation protection procedures with their crews. Subsequently, Station Shift Supervisors counseled shift personnel as to the proper physical checks required when transiting High, Locked High, and Very High Radiation Area boundaries. The Manager Operations then followed up with selected operators to validate that the expectations were clearly communicated and understood.
- b. The routine weekly gate check was performed immediately to verify that the affected gate and others were properly closed.
- c. Relevant radiation records were reviewed. No unusual personnel exposures were attributed to the turbine deck area as a result of these incidents.

III. ACTIONS THAT WILL BE TAKEN TO PREVENT RECURRENCE

The following preventative actions have been taken:

- a. The Plant Manager has reinforced with Branch Managers and Supervisors his expectations of station personnel to verify closure of radiation area gates and vital area doors and Branch Manager and supervisory responsibility to assure that personnel know the requirements and are held accountable.
- b. The Manager Operations continues to reinforce procedure compliance in general with each Station Shift Supervisor as part of his routine management oversight.
- c. A written statement was placed in the Control Room key control log to reinforce with the keyholders their responsibility to verify gate latching by shaking. This reminder already existed in the Radiation Protection department key log.
- d. The Radiation Protection department will continue to use program self-assessments of radiation worker practices to verify procedure conformance, including high radiation area controls. In February 1997, such a self-assessment of high radiation area radiation worker controls was performed. During the assessment, an operator was observed not adequately checking a high radiation area gate, although the gate was in fact locked.



Disciplinary action has been taken with the individual and the Station Shift Supervisor has been counseled. Corrective action from this resulted in reaffirming expectations with the remaining crews. NMPC is committed to continuing self-assessment in this area.

- e. Based upon the September 17, 1996 event, the November 29, 1996 event and the results of our self-assessment, NMPC will take progressive disciplinary action as appropriate in response to further incidences of this nature.
- f. In February 1997, NMPC published "RP Surveyor" (a publication to inform site personnel of radiation protection issues) which contained an article on radiation worker requirements for key holders of High, Locked High, and Very High Radiation Areas.
- g. Although not a contributor to these events, there were hardware deficiencies identified with the gate which have been corrected.

IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance with station procedures was achieved on November 29, 1996, when the gate was secured and checked.



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