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SUBJECT: Provides response to NRC violations noted in Insp Repts  
 50-220/92-05 & 50-410/92-05. Corrective actions:  
 accountability meeting held w/personnel directly involved to  
 provide insight into reasons for event.

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B. Ralph Sylvia  
Executive Vice President  
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March 12, 1992  
NMP1L 0649

United States Nuclear Regulatory Commission  
Document Control Desk  
Washington, DC 20555

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

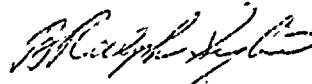
Nine Mile Point Unit 2  
Docket No. 50-410  
NPF-69

Gentlemen:

SUBJECT: RESPONSE TO NOTICES OF VIOLATION - NRC COMBINED INSPECTION  
REPORT NOS. 50-220/92-05 AND 50-410/92-05

Attached is Niagara Mohawk Power Corporation's response to the Notices of Violation contained in the subject Inspection Report dated February 11, 1992, (Attachments 1 and 2). We share your concerns addressed in the Inspection Report, and feel that our corrective actions have appropriately addressed the root cause and recurrence of these violations. If you have any questions concerning this matter, please contact me.

Very truly yours,



B. Ralph Sylvia  
Executive Vice President - Nuclear

BRS/RM/NS/lmc  
ATTACHMENTS

xc: Mr. T. T. Martin, Regional Administrator, Region I  
Mr. W. L. Schmidt, Senior Resident Inspector  
Mr. R. A. Capra, Director, NRR  
Mr. D. S. Brinkman, Senior Project Manager, NRR  
Mr. J. E. Menning, Project Manager, NRR  
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# ATTACHMENT 1

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## 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 50-220/92-05

#### VIOLATION 50-220/92-05

10 CFR 50.36 (a) states in part that each license authorizing operation of a production or utilization facility will include Technical Specifications. Plant Technical Specification 6.12 states in part that for High Radiation Areas, the area be conspicuously posted and entrance be controlled by requiring issuance of a Radiation Work Permit. Any individual or group of individuals permitted to enter the area shall be provided with or accompanied by: a radiation monitoring device which continuously indicates radiation dose rates, or; a radiation monitoring device which continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received, or; an individual qualified in radiation protection, with a radiation dose rate monitoring device.

Contrary to the above, on December 16, 1991, three members of the licensee's Operations Department entered the South Condenser Moisture Separator Room on the 277' elevation of the Turbine Building, a posted High Radiation Area, without being on a Radiation Work Permit, and without a dose rate meter, an alarming dosimeter, or accompanied by a Radiation Protection technician with a meter.

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

#### 1. THE REASONS FOR THE VIOLATION

Niagara Mohawk admits to the violation as stated. Operations personnel are covered by an extended Radiation Work Permit (RWP) if they meet the qualifying conditions for such permit. However, one of the prerequisites to the application of an extended RWP, obtaining a radiation monitoring device, was not met. The Station Shift Supervisor (SSS) failed to obtain a radiation monitoring device or Radiation Protection (RP) support prior to entrance into a High Radiation Area. The root cause for this event is personnel error due to Operations personnel not following station procedures, which are based upon the above cited Technical Specification. Specifically, Generation Administrative Procedure GAP-RPP-08, "Control of Transient, High, and Locked High Radiation Areas," Section 3.2, was not followed. Operations personnel did not have monitoring capability such as a radiation monitoring device, an alarming dosimeter, or a person qualified in RP procedures possessing a radiation dose rate monitoring device before entering the locked High Radiation Area.

Also, better availability of portable radiation monitoring equipment assigned to Operations in the control room through appropriate controls would have allowed the proper entry into the locked High Radiation Area. The SSS attempted unsuccessfully to get a portable radiation monitoring device before entering the High Radiation Area.



# ATTACHMENT 1

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## NIAGARA MOHAWK POWER CORPORATION

NINE MILE POINT UNIT 1

DOCKET NO. 50-220

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### RESPONSE TO NOTICE OF VIOLATION AS CONTAINED IN INSPECTION REPORT 50-220/92-05

#### 2. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

Radiological Occurrence Reports (ROR) for entering the locked High Radiation Area without a radiation monitoring device (ROR #1-91-00-57) and breaking in the "break-to-enter" key box (ROR #1-91-00-56) were generated on December 16, 1991. Immediate corrective actions taken for ROR #1-91-00-57 were for Radiation Protection to survey the South Condenser Moisture Separator Room area, document dosimetry readings from Operations personnel, and verify that doses received were within Regulatory limits, Niagara Mohawk guidelines, and posted values at the gates. Each person who entered the area recorded an exposure of 10 mrem on an extended RWP log. The follow-up radiation survey identified a general area radiation exposure rate, in the travel path Operations took, of less than or equal to 450 mr/hr. Immediate corrective actions taken for ROR #1-91-00-56 were to contact Security I&C to replace the key box glass and have Radiation Protection audit and account for the keys in the "break-to-enter" key box. An accountability meeting was held with personnel directly involved to provide insight into the reasons for this event.

The SSS was coached by Operations management regarding compliance with applicable procedures and impact on Technical Specifications. Also, to provide immediate access to a radiation monitoring device for Operations in the control room, a radiation monitoring device station has been provided in that location. The Assistant SSS has single point accountability for return and issue of radiation monitoring devices as part of shift turnover. Additionally, a radiation monitoring device has been located atop the emergency key box in the SSS office for the exclusive use of the SSS or designee during emergency entry into High Radiation Areas. These actions have alleviated the radiation monitoring device availability problem that contributed to the violation.

#### 3. CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

A Lessons Learned Transmittal has been generated for the Unit 1 event and has been distributed to Nuclear Division senior management personnel, Unit 1 and 2 Operations and Unit 1 and 2 Radiation Protection. This will allow Operations and other branch departments to understand the significance of this violation.

Operations will also present shift training to Operations crews to emphasize this event and the Lessons Learned, including the overriding requirement to comply with Technical Specification requirements and station procedures. The shift training will also include instructions that if radiation monitoring devices become unavailable, Radiation Protection will be notified and no entry made into a High Radiation Area until applicable procedures and requirements have been fulfilled. Radiation Protection personnel will be involved with this shift training.





# ATTACHMENT 1

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NIAGARA MOHAWK POWER CORPORATION

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RESPONSE TO NOTICE OF VIOLATION AS CONTAINED IN  
INSPECTION REPORT 50-220/92-05

## CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS (cont.)

The Radiological Occurrence Report process will be replaced by the Deviation/Event Report (DER) process to allow for a higher level and more immediate management review. The DER procedure is being revised to provide a process which will allow dissemination of events, such as the Unit 2 High Radiation Area entry, between both units in a more timely manner. This procedure revision will be completed by March 31, 1992, with training to be completed by April 30, 1992.

### 4. DATE WHEN FULL COMPLIANCE WAS ACHIEVED

Full compliance was achieved on December 16, 1991, when doses received by Operations were determined and found to be within regulatory limits after surveys were performed by Radiation Protection.



# ATTACHMENT 2

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## 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 50-410/92-05

#### VIOLATION 50-410/92-05

10 CFR 50.36 (a) states in part that each license authorizing operation of a production or utilization facility will include Technical Specifications. Plant Technical Specification 6.12 states in part that for High Radiation Areas, the area be conspicuously posted and entrance be controlled by requiring issuance of a Radiation Work Permit. Any individual or group of individuals permitted to enter the area shall be provided with or accompanied by: a radiation monitoring device which continuously indicates radiation dose rates, or; a radiation monitoring device which continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received, or; an individual qualified in radiation protection, with a radiation dose rate monitoring device.

Contrary to the above, on October 23, 1991, five members of the licensee's Operations Department entered the Northeast and Northwest Condenser Area on the 277' elevation of the Turbine Building, a posted High Radiation Area, without being on a Radiation Work Permit, and without a dose rate meter, an alarming dosimeter, or accompanied by a radiation protection technician with a meter.

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

#### 1. THE REASONS FOR THE VIOLATION

Five Operations personnel entered the Northeast and Northwest Condenser area on the 277' elevation of the Turbine Building on October 23, 1991, in response to a loss of condenser vacuum condition. This area is a locked High Radiation Area and entry is controlled by procedure S-RAP-RPP-0801, "High Radiation Area Monitoring and Control" (formerly S-RPIP-3.8). The Operations personnel who entered the area are qualified as self monitors, and as such were authorized to enter under an Extended Radiation Work Permit (RWP) as provided for in Administrative Procedure AP-3.3.2, "Radiation Work Permit." One member of the team entering this area was carrying a radiation monitoring device as required by Technical Specifications and Radiation Protection procedures.

The condenser bay entry was monitored via a remote camera monitor by a Radiation Protection Supervisor in the area. The operator carrying the radiation monitoring device became involved in responding to the loss of vacuum and failed to devote the proper attention to performing radiation surveys. The Radiation Protection Supervisor determined that an adequate radiation survey was not performed by the operator carrying the radiation monitoring device, nor did he inform the other operators of radiation levels. The reason for the inadequate survey has been determined to be a personnel error due to a failure to follow procedures. Upon exiting the High Radiation Area, personnel completed the required log entries for the Extended RWP.



# ATTACHMENT 2

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## 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 50-410/92-05

#### 2. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

The immediate corrective actions were to have Radiation Protection personnel verify radiation levels in the area and verify that doses received were within Regulatory limits, Niagara Mohawk guidelines and values posted at the gates. All personnel entering the area recorded an exposure of less than or equal to 5 mrem on an extended RWP log. The Plant Manager, Operations Manager, and Radiation Protection Manager, were all notified of the event. A Radiological Occurrence Report (ROR) was written to track and document the event and any corrective actions generated.

An accountability meeting was held with all personnel directly involved, to provide insight into the reasons for the event. Participants discussed the procedural requirements for and the importance of personnel radiation monitoring in High Radiation Areas. In addition, they discussed the need for Operations and Radiation Protection to work as a team to promote safer plant operations.

Further, the control of keys that allow entry into locked High Radiation Areas (XH Keys) has been shifted from the Station Shift Supervisor (SSS) to the Radiation Protection office. This will facilitate Operations personnel coordination with Radiation Protection technicians during response to plant transients. An emergency XH Key has been staged in the SSS office along with an emergency use only radiation monitoring device. These may be used if a condition were to develop where immediate access to a High Radiation Area is required.

#### 3. CORRECTIVE STEPS TO BE TAKEN TO AVOID FURTHER VIOLATIONS

The Operations Manager will discuss with Operations personnel the Radiation Protection requirements for operators to enter a High Radiation Area, stressing that during an emergency, the preferred response is to involve Radiation Protection personnel if available. He will also stress that when utilizing the self-monitoring technique, personnel will determine radiation levels in all accessed areas, and ensure all other personnel in the area are made aware of these radiation levels.

Operations Training will be integrating Radiation Protection interfaces into appropriate training and evaluated simulator scenarios. This will promote teamwork that allows operators to focus on responding to plant transients and Radiation Protection technicians to supply the appropriate radiological monitoring. This interface, once internalized, will be a practiced emergency response and an evaluated portion of the simulator scenario.



ATTACHMENT 2

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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 50-410/92-05.

4. DATE WHEN FULL COMPLIANCE WAS ACHIEVED

Full compliance was achieved on October 23, 1991, when doses received by Operations were determined to be within Regulatory limits after surveys performed by Radiation Protection.

