NIAGARA MOHAWK

NIAGARA MOHAWK POWER CORPORATION/300 ERIE BOULEVARD WEST, SYRACUSE, N.Y. 13202/TELEPHONE (315) 474-1511

November 10, 1986

Mr. Richard W. Starostecki, Director
Division of Project and Resident Programs
United States Nuclear Regulatory Commission, Region I
631 Park Avenue
King of Prussia, PA 19406

Re: Nine Mile Point Unit #2
Docket No. 50-410
NPF-54

Dear Mr. Starostecki:

In accordance with 10 CFR 73.71 (c), enclosed for your information is a copy of a Report of Physical Security Event reported to the NRC Region I office by telephone on November 6, 1986.

This information concerns subject matter which is exempt from disclosure under 2.790 (d) of the NRC's Rules of Practice, Part 2, title 10, Code of Federal Regulations. Accordingly, we request that the attachment not be placed in the Public Document Room and that they be disclosed only in accordance with the provisions of 10 CFR 9.12.

Very truly yours,

NIAGARA MOHAWK POWER CORPORATION

Joseph P. Beratta

Joseph P. Beratta
Supervisor, Nuclear Security

Enclosure

H/92

REPORT OF PHYSICAL SECURITY EVENT

REGION 1, USNRC, OFFICE OF INSPECTION AND ENFORCEMENT
631 PARK AVENUE, KING OF PRUSSIA, PA 19406
PHONE (215) 337-5000

Date of Occurrence: 11/3/86; 11/6/86*
Time of Occurrence: 2010 hrs; 0445 hrs.*
* Time and Date Breach was recognized

Facility and Location: Nine Mile Point Nuclear Station Unit #2, Lycoming, NY 13093 Docket: 50-410 License: NPF-54

Licensee's Occurrence Report No. 86-01

Brief Title (subject): Breach of Vital Area Barrier

Description of Event: On Monday, November 3, 1986, at approximately 2010 hours, an access plug, measuring 6'X12'X2', was removed from the ceiling of the [redacted] which is located within the [redacted] This was removed for an authorized reason in accordance with existing Breach Permit procedures. Such procedures do not currently include consideration, or notification, of security. On Wednesday, November 5, 1986, at approximately 0506 hours, two members of the security organization entered the area and noticed the penetration. They, however, failed to notify their supervisors, or to mention the breach to anyone because they assumed that it had already been reported by previous patrols and that management had already evaluated it and taken required measures. Security supervision first heard of the penetration on November 6, 1986, at approximately 0445 hours, when it was mentioned by the two guards in an informal discussion regarding procedures.

Response by Licensee: Immediately upon being made aware of the penetration, the Lieutenant, Nuclear Security initiated a response by the Sergeant, Nuclear Security to confirm that the breach still existed and to establish a guard post at the breach until the plug was replaced. The Sergeant, who was on a patrol of the exterior protected area at the time of notification, arrived at the Service Water Pump Room at 0500 hours and remained in the area until a guard post was established at 0511 hours. The results of further investigation into the incident and actions taken to correct the root causes are contained on attached pages.

Consequences at Facility: Minimal; the penetration was made on the roof of the Vital Area which was located approximately 19 feet above the floor of the [redacted] which itself was located within the protected area. Access to the roof is normally gained through the vital area doors to the vital area. Station is presently conducting initial fuel load.

Licensee Employee Reporting: Dennis K. MacVittie, Nuclear Security Specialist (315) 349-1030
NRC Staff Employee Receiving Phone Call: John MacKinon, H.O.O.

Time of Phone Call: 1900 hours, November 6, 1986

On November 6, 1986, at 1150 hours, Security Management was made aware of the subject incident. An investigation was immediately initiated to verify the facts and to identify the problems and root causes.

Initially, the scope of the investigation was limited to determining: when the breach had occurred; how the breach had occurred without security notification; and why the penetration was not noticed by security personnel conducting interior watchtours.

The fact that a breach had occurred and gone unrecognized by security personnel for about 57 hours was reported to the NRC resident inspectors at approximately 1600 hours on November 6, 1986. At that time it was thought that the two guards had made their observation on November 6th, and that they had immediately notified their supervision. A review of computer records, however, indicated that the security personnel involved actually entered the area the previous day. This fact was verified with the individuals by telephone. The correct sequence of events, as described on the first page of this report, were reported to Region I by ENS telephone at 1900 hours.

During the period 2344 hours, November 6, 1986 through 1400 hours, November 7, 1986, the two security personnel who first observed the breach and their supervisors were interviewed and statements were taken. The movements of the involved individuals were confirmed via a review of computer records, and time estimates were better defined.

At 1420 hours, November 7, 1986, the NRC resident inspectors were updated, and incorrect information from the previous day was corrected.

The following problems have been identified:

1) The procedure for obtaining a Breach Permit does not include an evaluation of the effects of the breach on security commitments, nor does it address notifying security.

This deficiency was recognized approximately two months ago and a revision to the procedure was requested by the security department. The revision had been prepared and is undergoing technical review by other disciplines.

2) The subject Breach was never discussed at the Plan of the Day meeting.

3) Security Supervision had been directed to make guards aware of the deficiencies in the existing breach permit procedure, and to stress that they had to carefully verify the integrity of vital area barriers during their routine interior patrols. This was not done.

4) The penetration was not detected by security personnel during their performance of watchtours through the area.

5) When the penetration was detected, it was not recognized as a breach and procedures were not followed to properly compensate.

6) Security Supervision, when made aware of the breach, failed to follow up and obtain all of the facts.

7) The root cause of this problem is poor communication between site departments and within the Security department.

Security Management is working closely with other departments such as Fire and Operations in order to develop the necessary coordination between disciplines. Subsequent breach permits have been discussed at the Plan of the Day meeting and security has been informally notified by the Fire Department when such permits are issued. The formal change to the Breach Permit procedure is progressing at a faster rate.

Security Personnel are cycled into training every five weeks. One to two hours are being set aside each week for informal discussions between the guards and security management. This will be used to discuss philosophy, problems, procedures, etc. in an effort to increase the effectiveness of intradepartmental communications.

Security supervision will receive more extensive training in supervisory skills, communication,, and security philosophy. In addition, regular informal discussions will be held between supervision and management in an effort to increase the effectiveness of such communication.