NOTICE OF VIOLATION

GPU Nuclear Corporation
Three Mile Island Nuclear Station, Unit 1

Docket No. 50-289
License No. DPR-50

During an NRC inspection conducted on September 20-21, 1995, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381; June 30, 1995), that violation is listed below:

The TMI Modified Amended Physical Security Plan (the Plan), Revision 31, dated February 10, 1995, Section 4.8.2, states, in part, that "barriers are installed at the entrance to, or the exit from, openings that exceed 96 square inches, or in culverts, tunnels or sewers that penetrate the protected area barrier. These openings are secured by grates, doors or coverings of sufficient strength to preserve the barrier integrity." The Plan further states, in part, that "if the integrity of the physical barrier is degraded, increased patrols are instituted, or if the Protected Area is breached, an Armed Site Protection Officer is assigned at the degraded barrier until such time as the barrier is restored."

Contrary to the above, from September 12-21, 1995, the GPU Nuclear Corporation failed to provide compensatory measures during maintenance activities, which resulted in the existence of three, and the potential for a fourth, unmonitored and unprotected pathways with cross sectional areas significantly greater than 96 square inches from the owner controlled area into the protected area. The pathways were as follows:

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

Pursuant to the provisions of 10 CFR 2.201, the GPU Nuclear Corporation is hereby required to submit a written statement or explanation to the U. S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region I, and a copy to the NRC Resident Inspector at the facility that is the subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the

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violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued to show cause why the license should not be modified, suspended, or revoked, or why such action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, Pennsylvania
this 16th day of November, 1995

ENCLOSURE 2

ATTENDEES

LICENSEE

J. Knubel, Vice President and Director, TMI
J. Fornicola, Director Licensing and Regulatory Affairs
R. Hulshouser, Manager-Nuclear Security
R. Goodrich, Site Security Manager
J. Wetmore, Manager, TMI Licensing Department
R. Adamiak, Manager, Logistical Support
J. Schork, Technical Analyst Senior, II
T. Gilman, Senior Community Relations Representative
G. Busch, Manager, Oyster Creek Licensing Department

STATE and GENERAL PUBLIC

S. Maingi, Nuclear Engineer, Penna. Department of Environmental Resources
G. King, Captain, Harrisburg Police Department

U.S. NUCLEAR REGULATORY COMMISSION, REGION I

W. Kane, Deputy Regional Administrator,
Office of the Regional Administrator (ORA)
D. Holody, Manager, ORA
K. Smith, Regional Counsel, ORA
J. Wiggins, Director, Division of Reactor Safety (DRS)
R. Keimig, Chief, Emergency Preparedness and Safeguards Branch, DRS
E. King, Physical Security Inspector, DRS
P. Eselgroth, Chief, Projects Branch 7, Division of Reactor Projects (DRP)
M. Evans, Senior Resident Inspector, DRP

U. S. NUCLEAR REGULATORY COMMISSION, HEADQUARTERS

R. Hernan, Project Manager for TMI, Office of Nuclear Reactor Regulation

ENCLOSURE 3

SAFEGUARDS INFORMATION

GPUN Presentation for the NRC Enforcement Conference Regarding Security Barrier Problems at TMI

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Introduction	J. Knubel
Description of Events	R. Adamiak, R. Goodrich
Root Causes and Corrective Actions	J.Schork
Severity of Violation	J. Schork

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ROOT CAUSES OF THE EVENT

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2. **There was inadequate awareness on the part of Job Planners and Job Supervision regarding the need to inform Security prior to performing any task which may degrade a barrier to the protected and vital area.**

3. **The Job Orders did not identify a need to contact Security.**

4. **The Job Supervision did not inform Security that they were going to perform an activity that involved a barrier to the protected area.**

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CORRECTIVE ACTIONS TAKEN

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Completed

1. Site Protection Officers were posted at the vulnerability locations.

2. On September 21, 1995, TMI job planners and lead maintenance foremen were counseled.

3. On September 21, 1995, TMI supervisory control room personnel were directed in writing to ensure Security is notified prior to the conduct of a task that could degrade a protected or a vital area barrier.

4. TMI Security and Plant Operations performed a review of potential pathways into either the protected area or vital areas and identified the pathways that must be reviewed by Security prior to any activity that could alter the pathway.

5. Supervisory Security personnel attended the daily afternoon planning meeting for TMI-1 for the remainder of the 11R outage.

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In Process

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2. **The list of pathways described in corrective action 4 will be incorporated into a modification of the GMS-2 job planning computer software.**

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4. **Security and supervisory control room personnel will review this event and the resultant corrective action as part of their requalification training.**

5. **Supervisory Security personnel will routinely attend the daily planning meetings in the future whenever the plant is in a refueling outage.**

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Severity of the Violation

The event violated the TMI Modified Amended Physical Security Plan and NRC regulations.

The failure to maintain all security barriers is a serious matter.

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The Case for a Level IV Violation

1. The pathways into the protected area that were not properly controlled were neither easily or likely to be exploited because:

   a. Although not required by Part 73, GPU Nuclear controls access to the owner controlled area.

   b. Employees were in the area at all times.

   c. Neither the presence of the openings not the pathways into the protected area were easily identifiable.

2. All of the protected area barrier problems were licensee identified.

3. Prompt corrective action was taken in response to each problem as it was identified.

4. All of the problems were promptly reported in accordance with 10 CFR 73.71.

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5. The problems found on September 20 were identified as a direct result of followup from the September 15 problem and were promptly reported. Licensees should receive credit for a comprehensive followup investigation of a problem, even when the investigation reveals that the problem was larger than originally realized. In fact, that is one of the prime objectives of a followup investigation. We agree that the followup investigation should have been accomplished more quickly.

6. The problems which were identified were derived from a set of common root causes combined with the drained down state of the Circulating Water System, and do not collectively represent a significant lack of attention or carelessness toward licensed responsibilities.

7. No similar problems have occurred within the last two (2) years.

8. Comprehensive and effective long-term corrective action is being taken in response to the problems and weaknesses identified.

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NUREG 1600, Supplement 3, 4.D Severity Level IV - Violations involving for example:

3.D.1	A failure or inability to control access such that an unauthorized individual (i.e. authorized to protected area but not to vital area) could easily gain undetected access into a vital area from inside the protected area or into a controlled access area;	Access to a vital area was not involved.
3.D.2	A failure to respond to a suspected event in either a timely manner or with an adequate response force;	No response force was involved.
3.D.3	A failure to implement 10 CFR Parts 25 and 95 with respect to the information addressed under Section 142 of the Act, and the NRC approved security plan relevant to those parts;	10 CFR 25 and 95 were properly implemented
3.D.4	A failur to make, maintain or provide log entries in accordance with 10 CFR 73.71 (c) and (d), where the omitted information (i) is not otherwise available in easily retrievable records, and (ii) significantly contributes to the ability of either the NRC or the licensee to identify a programmatic breakdown.	Log entries were not involved
3.D.5	A failure to conduct a proper search at the access control point;	There was no failure to make a proper search.
3.D.6	A failure to properly secure or protect classified or safeguards information inside the protected area which could assist an individual in an act of radiological sabotage or theft of strategic SNM where the information was not removed from the protected area;	Access to safeguards information was not involved
3.D.7	**A failure to control access such that an opportunity exists that could allow unauthorized and undetected access into the protected area but which was neither easily or likely to be exploitable;**	**Applicable**
3.D.8	A failure to conduct an adequate search at the exit from a material access area;	Search of persons exiting a material access area was not involved
3.D.9	A theft or loss of SNM of low strategic significance that was not detected within the time period specified in the security plan, other relevant document, or regulation;	There was no loss/theft of SNM
3.D.10	Other violations that have more than minor safeguards significance;	Not applicable

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NUREG 1600, Supplement 3.C, Severity Level 3 - Violations involving for example:

3.C.1	A failure or inability to control access through established systems or procedures, such that an unauthorized individual (i.e. not authorized unescorted access to protected area) could easily gain undetected access into a vital area from outside the protected area;	Entry was not available into a vital area.
3.C.2	A failure to conduct any search at the access control point or conducting an inadequate search that resulted in the introduction to the protected area of firearms, explosives, or incendiary devices and reasonable facsimles thereof that could significantly assist radiological sabotage or theft of strategic SNM;	The events did not involve an inadequate search of a failure to perform a search.
3.C.3	A failure, degradation, or other deficiency of the protected area intrusion detection or alarm assessment systems such that an unauthorized individual who represents a threat could predictably circumvent the system or defeat a specific zone with a high degree of confidence without insider knowledge, or other significant degradation of overall system capability;	The intrusion detection system was not involved in the event.
3.C.4	A significant failure of the safeguards systems designed or used to prevent or detect the theft, loss, or diversion of strategic SNM;	The event did not involve a safeguards system for strategic SNM.
3.C.5	A failure to protect or control classified or safeguards information considered to be significant while the information is outside the protected area and accessible to those not authorized access to the protected area;	Safeguards information was not comprimised.
3.C.6	A significant failure to respond to an event either in sufficient time to provide protection to vital equipment or strategic SNM, or with an adequate response force;	The event did not involve vital equipment or SNM.
3.C.7	A failure to perform an appropriate evaluation or background investigation so that information relevant to the access determination was not obtained or considered and as a result a person who would likely not have been granted access by the licensee, if the required investigation or evaluation had been performed, was granted access;	The event did not involve a background investigation.
3.C.8	A breakdown in the security program involving a number of violations that are related (or, if isolated, that are recurring violations) that collectively reflect a potentially significant lack of attention or carelessness toward licensed responsibilities	Each degradation was promptly responded to and the NRC was notified.

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NUREG 1600, Section 6.B.2, Civil Penalty Assessment

	Decisional Point	GPUN Response
VI.B.2(a)	Whether the licensee has had any previous escalated enforcement action (regardless of the activity area) within the past 2 years or pas 2 inspections, whichever is longer	TMI has had no escalated enforcement actions in the past 2 years (the longest period)
VI.B.2(b)	Whether the licensee should be given credit for actions related to identification	All of the problems were licensee identified.
VI.B.3(c)	Whether the licensee's corrective actions are prompt and comprehensive	Prompt corrective action was taken in response to each problem as they were identified. Prompt and effective immediate and long term corrective actions, as defined in NUREG 1600, were taken in response to the event.
VI.B.4(c)	Whether, in view of all the circumstances, the matter in question requires the exercise of discretion	Enforcement discretion is warranted because of the above factors and taking into account the past record of GPU Nuclear in regards to the performance of the Security program at TMI.

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