

Florida Power

CORPORATION
Crystal River Unit 3
Docket No. 50-302

August 22, 1996
3F0896-15

Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, DC 20555-0001

Subject: NRC Violation 50-302/96-03-13
Failure to Fulfill Escort Responsibilities

References: 1. NRC to FPC letter, 3N0596-12, dated May 24, 1996
2. FPC to NRC letter, 3F0696-05, dated June 20, 1996
3. NRC to FPC letter, 3N0796-20, dated July 26, 1996

Dear Sir:

In Reference 1, the NRC Staff alleged a violation of the Crystal River 3 (CR-3) Security Plan wherein an escort for visiting personnel left some of those personnel to accompany one visitor outside without transferring escort responsibilities for the remaining visitors to another badged individual. The accompanying report stated that upon her return, the escort stated that she did not know what to do when one person requested to leave the area.

In Reference 2, Florida Power Corporation (FPC) accepted the violation and stated that the incident was an isolated event and that the only programmatic corrective action to be implemented was the addition of a note to security procedure SS-207, "Plant Entry and Exit Requirements" regarding the emergency transfer of escort duties.

In Reference 3, the NRC Staff requested additional information regarding the results of our evaluation of the knowledge level and adequacy of training for escorts. It also requested clarification regarding the use of the note which was added to SS-207. This submittal provides FPC's response to that request.

Following the April, 1996 violation, a Management Review Panel (MRP) was convened in accordance with Attachment 2 to NOD-45, "Management Self Assessments and Performance Monitoring", to review the root cause of the event and assess the corrective actions to prevent recurrence. The MRP determined that, notwithstanding the escort's statement immediately following the event that she did not know what to do, she actually did know what to do but failed to take the

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necessary action to reassign escort duties. The panel determined that several factors contributed to the violation which merit corrective action.

The primary contributing factor was determined to be inadequate supervisory oversight by temporary supervision during the refueling outage. Prior to the next refueling outage, FPC will identify the need and available resources for visitor escorts to allow for appropriate selection, in-processing, and training of temporary workers. After receiving badge and job specific training, special function tasks will be performed at least once by the temporary workers under the observation of experienced personnel. FPC will also enhance communications between work groups needing escorts and the supervisors responsible for providing them to identify work scope and the number of escorts needed for the work activities. This should assure an adequate reserve of escorts is available. Multiple escorts will be considered for work activities that include more than one worker when the workers may not remain together.

On August 14, 1996, another escort failed to maintain proper controls over a visitor. A badged vending machine representative was in the process of removing a vending machine from the Technical Support Center (TSC) and was escorting two visitors to assist him. As the machine was being maneuvered through a door, it closed momentarily separating one of the two visitors from the escort. The escort realized the error and reopened the door to regain visual contact. At that time, the NRC Resident was exiting the TSC where his office resides and observed the loss of visual contact. As a result of this and the previous incident, immediate restrictive controls on escorting visitors was established and immediate communication of the incident was made to employees. The restrictions were to establish a requirement for all non-permanent FPC or contractor escorts to escort one visitor only and for all escorts to provide positive affirmation of comprehension of the escort rules. Additionally, visitors escorted by non-permanent FPC or contractor personnel must hold a second detailed discussion with security shift supervision prior to gaining authorization to enter into the protected area. These controls addressed the obvious commonalities between the two incidents; temporary or contractor escort, multiple visitors to one escort, and that both occurred in the TSC. These restrictions also permitted time for a more comprehensive root cause evaluation and corrective action plan.

The root cause evaluation was performed the following day and determined the cause was failure to pre-plan the work and consider the special escort/visitor requirements when doing routine work. Additionally, a contributing factor was the many doors and passages in the TSC provide many opportunities for escorts and visitors to become separated. As with the prior violation, multiple visitors to an escort in the TSC may not be appropriate for all tasks. Further, visitors may have inadequate knowledge of basic escort responsibilities. The evaluation both validated the immediate restrictions and discovered additional issues requiring attention. These additional issues generated a number of additional actions: better human factor (the communication of the escort rules issued and carried by each escort in the protected area, ensure the visitors have a working knowledge of the basic escort requirements, ensure the Computer Based Training modules and tests are comprehensive enough to assure the information is received and understood by badged individuals, and as described above, assure supervisory review of the work scope and associated escort needs.

The immediate restrictions will not be lifted until the process of escort authorization is human factored such that security personnel have positive

assurance the rules are not only heard, but understood by both the escorts and visitors. These actions, in addition to the previous ones described, will provide a heightened awareness of visitor and escort responsibilities. It will also provide a more focused evaluation of escort assignment needs during future refueling outages where the need for escorts greatly increases.

With regard to the note which was added to SS-207, the note reads:

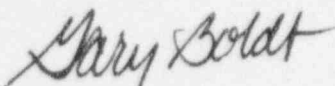
"NOTE: All CR-3 badged employees are trained in, and are authorized to conduct escort duties. With this in mind, all badged personnel need to realize that the ability for emergency transference of escort responsibilities among badged employees already exists. In the event that there is a need to quickly relinquish escort duties and transfer a visitor(s) from their designated escort(s) to one or more other qualified escort(s), the following process is to be followed:

1. The designated escort shall verbally request another CR-3 badged individual to assume escort responsibilities for the visitor(s) they are escorting.
2. The other badged employee will acknowledge the need for the emergency transfer.
3. Security will be contacted as soon as practical concerning the escort transfer."

The note provides a simple method to reassign escort responsibilities in situations similar to those under which the violation occurred.

We believe these actions address all of the factors which together caused the temporary loss of control of visitors to CR-3.

Sincerely,



G. L. Boldt
Vice President
Nuclear Production

GLB:GHr

xc: Regional Administrator, Region II
Senior Resident Inspector
NRC Project Manager