

NORTHEAST UTILITIES

THE CONNECTICUT LIGHT AND POWER COMPANY
WESTERN MASSACHUSETTS ELECTRIC COMPANY
HOLYOKE WATER POWER COMPANY
NORTHEAST UTILITIES SERVICE COMPANY
NORTHEAST NUCLEAR ENERGY COMPANY

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July 1, 1991

Docket No. 50-336

A09569

Mr. Charles W. Hehl, Director
Division of Reactor Projects
U. S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, Pennsylvania 19406

Dear Mr. Hehl:

Millstone Nuclear Power Station, Unit No. 2
RI-91-A-0063

We have completed our review of identified issues concerning activities at Millstone Unit No. 2 (RI-91-A-0063). As requested in your transmittal letter, our response does not contain any personal privacy, proprietary, or safeguards information. The material contained in this response may be released to the public and placed in the NRC Public Document Room at your discretion. The NRC letter and our response have received controlled and limited distribution on a "need to know" basis during the preparation of this response. Based upon our request on June 25, 1991 with Region I personnel, a four-day extension to this letter was granted to allow for routine and proper administrative processing.

Issue:

On April 1, 1991, an Instrument and Controls technician and a contractor employee were performing troubleshooting activities on radiation monitor RM-8132 in the Auxiliary Building. The two workers entered the Auxiliary Building together but only the technician had authorized access to that area. There should have been a local alarm to alert the individuals involved that access was not authorized for the contractor. Security responded to the unauthorized access when the individuals were exiting the area approximately 15 minutes after entering. The issue was logged in the Security logs.

Please discuss the validity of the above assertions. If the assertions are true, please explain why Security did not respond when the individuals entered the Auxiliary Building and provide us the details of any investigation that was conducted to ensure that plant security was maintained. Please provide the corrective actions planned or taken to correct any identified deficiencies.

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Mr. Charles W. Hehl, Director
S. Nuclear Regulatory Commission
569/Page 2
y 1, 1991

Response:

On April 1, 1991 a security officer responded to an "Intrusion Unauthorized Key - Door Open" event that occurred on Door 244S, entering the Millstone Unit No. 2 Auxiliary Building, at 08:10:06 hours. The unauthorized entry was made by a contractor technician working with a Millstone Unit No. 2 Instrument & Control (I&C) technician. The contractor had been badged on January 16, 1991 in support of the Millstone Unit No. 3 outage, and was cleared for unescorted access to all vital areas on Unit 3. The contractor had recently been assigned to work on Millstone Unit No. 2.

The contractor keyed into the Millstone Unit No. 2 Auxiliary Building following the I&C technician, who was authorized for the area and had accessed the door properly. The contractor keyed into the area while the security door was open. No alarm was received at the security door and the pair continued to their assigned work location. A security officer was dispatched to respond to the ensuing security alarm and entered the Millstone Unit No. 2 Auxiliary Building through the same door at 08:11:44 hours. The Security Officer had been advised of the name of the individual he was looking for as well as the name of the I&C technician who was with him when he entered the area. The Security Officer proceeded to search for the individuals.

The Security Officer initiated the search on the 14'6" elevation of the Auxiliary Building and then proceeded to the upper levels of this building. The radiation monitor that the individuals were working on is located in the East Penetration Room on the 38'6" elevation.

At 08:32:14 hours an "Intrusion Unauthorized Exit" event was received on Door 244N. This event was caused by the same contractor who entered the Auxiliary Building at 08:10:06 hours. The Security Officer, who was still searching for the individuals, was advised that the individuals were attempting to leave the area and made contact with the individuals in the area of Door 244 at 08:32:22 hours.

Subsequent investigation into this event identified that the LED in the card reader on the south side of the door had failed. As a result there was no local indication to the contractor that he was not authorized for the area. A few select doors in Millstone Unit No. 2, Door 244 being one of them, had previously been equipped with audible alarms that annunciate in conjunction with the red (denied) LED. The red LED and the audible alarm are in series and are dependent on each other for operation. The failure of either component will render the circuit inoperable. Our experience with this design has been excellent and there have been very few LED failures over the past six years. No further corrective actions are planned.

Once the LED failure was identified, a work order was generated and repairs were completed the same day. The weekly surveillance for Door 244 had been performed on the previous day and was signed off as satisfactory at 0027 hours. Hence, we conclude that this was a recent failure of the LED. If the door had been closed when the contractor used his key in the reader, he would not have been able to gain access to the area. The response by the security officer, and by the (CAS) Dispatcher was both timely and appropriate.

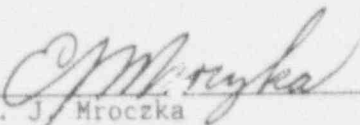
Mr. Charles W. Hehl, Director
U. S. Nuclear Regulatory Commission
A09569/Page 3
July 1, 1991

The failure of the LED and audible alarm on Door 244 contributed to this event. It is the responsibility of each individual granted unescorted access to ensure they are authorized for a particular area prior to entering. The supervisor and contractor were counseled in the need to ensure that access authorization has been granted to an individual for a specific area prior to assigning work to that individual in that area. It should be noted that the contractor involved reported to work at Millstone Unit No. 2 the same day that this event occurred (April 1, 1991). Subsequent to this event, the contractor was authorized for all vital areas on Millstone Unit No. 2. This authorization was effective within several hours of the event.

After our review and evaluation, we find that this event did not present any indication of a compromise of nuclear safety. We appreciate the opportunity to respond and explain the basis for our actions. Please contact my staff if there are any further questions on any of these matters.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY



E. J. Mroczka
Senior Vice President

cc: W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2,
and 3
E. C. Wenzinger, Chief, Projects Branch No. 4, Division of Reactor
Projects