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LER Header Listing for LER Number: 27899002

Docket Number	Year	Report #	Rev #	DCS Number	Event Date
278	1999	002	1	9907220217	04/06/99

Nuclear Plant: Peach Bottom Unit #3 **NRC Region:** 1
Facility Operator: PECO Energy Company
Architect Engineer: Bechtel Power Corp.
NSSS Vendor: General Electric
Reactor Type: Boiling Water Reactor
Comm. Operations Date: 12/23/74

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ABSTRACT

On March 31, 1999, during planned maintenance to a multiplexer unit, the safeguard system to an unrelated door was inadvertently disabled, by a security alarm station operator, and not re-enabled upon completion of the work. This allowed the alarming function of the door to be deactivated for approximately 6 days. There were no compensatory security measures implemented for the de-activated alarm during this period. The disabling of this alarm could have precluded security from promptly responding to a forced entry or malfunction of the door. Upon discovery of the condition, during a weekly security door functional test on April 6, 1999, security supervision was notified. Immediate compensatory action was taken which included the re-activation of the alarm and successful completion of the security door routine test. Additionally, an immediate search of the area was performed to determine if tampering, forced entry or other unauthorized entry to the area occurred during this period. No apparent signs of tampering or unauthorized entry was evident. The casual factors of this event include noncompliance with procedures, less than adequate shift turnover, less than adequate self checking, and less than adequate communications within the security department. This condition represents a failure to maintain a functional safeguard system in accordance with the requirements of 10 CFR 73.71 (B) (1).

Unit Conditions at Time of Reportable Event:

Power Level: 100%

Operating Mode: Power Operations - Steady State Operation

Reportability Reason(s) for This LER:

10 CFR 73.71(c) - Physical Security System Threatened. [20]

Primary Cause(s) for This LER:

Communication Problem [32]

Human Error [35]

Emergency Classification(s) for This LER:

A/2

2

There is no Emergency Classification for This LER

Referenced LERs:

There are no Referenced LERs for This LER



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ACCESSION #: 9907220217

NON-PUBLIC?: N

LICENSEE EVENT REPORT (LER)

FACILITY NAME: Peach Bottom Atomic Power Station Unit 3 PAGE: 1 OF 4

DOCKET NUMBER: 05000278

TITLE: This LER reports the failure to maintain alarmed access control to a safeguards system vital area door upon completion of scheduled maintenance.

EVENT DATE: 04/06/99 LER #: 99-002-01 REPORT DATE: 05/06/99

OTHER FACILITIES INVOLVED: DOCKET NO: 05000

OPERATING MODE: 1 POWER LEVEL: 100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR SECTION:

OTHER & 73.71

LICENSEE CONTACT FOR THIS LER:

NAME: Andrew Winter TELEPHONE: (717) 456-3598

COMPONENT FAILURE DESCRIPTION:

CAUSE: SYSTEM: COMPONENT: MANUFACTURER:

REPORTABLE EPIX:

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT:

On March 31, 1999, during planned maintenance to a multiplexer unit, the safeguard system to an unrelated door was inadvertently disabled, by a security alarm station operator, and not re-enabled upon completion of the work. This allowed the alarming function of the door to be deactivated for approximately 6 days. There were no compensatory security measures implemented for the de-activated alarm during this period. The disabling of this alarm could have precluded security from promptly responding to a forced entry or malfunction of the door.

Upon discovery of the condition, during a weekly security door functional test on April 6, 1999, security supervision was notified. Immediate compensatory action was taken which included the re-activation of the alarm and successful completion of the security door routine test. Additionally, an immediate search of the area was performed to determine if tampering, forced entry or other unauthorized entry to the area occurred during this period. No apparent signs of tampering or unauthorized entry was evident.

The casual factors of this event include noncompliance with procedures, less than adequate shift turnover, less than adequate self checking, and less than adequate communications within the security department.

This condition represents a failure to maintain a functional safeguard system in accordance with the requirements of 10 CFR 73.71 (B) (1).

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Requirements of the Report

This report is submitted pursuant to 10 CFR 73.71 (B) (1) for a vital area door (EIIS:DR) being incapable of providing an alarm function. This condition represented a failure to maintain the safeguard system, which could have resulted in unauthorized or undetected access to a vital area for which there were no compensatory measures employed.

Unit Conditions at Time of Events

PBAPS Unit 3 was in Mode 1 (RUN) operating at 100 percent thermal reactor power (EIIS:RCT) during the period of March 31 through April 6, 1999.

There were no other systems, structures, or components inoperable that contributed to the event.

Description of the Event

On April 6, 1999 at approximately 0025 hours, a weekly scheduled security door functional routine test was being performed. It was discovered during this test that a vital area door associated with Unit 3 had an inactive alarm. Immediate compensatory actions were initiated to include reactivating the alarm and notifying security supervision. Upon re-activation, the door successfully passed the required functional routine test. An immediate search of the vital area and the surrounding areas was conducted to determine if there had been any signs of tampering or

unauthorized entry of personnel or material into the vital area. The results of the search indicated there was no evidence of damage, tampering, or unauthorized material in the area. The search also indicated that the associated blue light system, locking mechanism, and card reader for the associated door had been operable for the period in which the vital door alarm was in-active. Additionally, security personnel notified security management about the event.

Shift and Security management began their investigation of the incident during the dayshift of April 6, 1999. It was determined during this review, that the door was de-activated during the scheduled multiplexer maintenance by security alarm operators inputting an erroneous command into the security computer, approximately 6 days earlier. During this period there was no safeguard system alarm capability or compensatory measures in place for the door, however the associated card reader, locking mechanism and blue light were considered operable. A review of the card reader printout for this period indicated no unauthorized individuals attempted to enter the vital area.

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The loss of the vital area door alarming function for approximately 6 days, violates the requirement to maintain safeguard boundaries and controls. This disabling of the safeguard alarm could have precluded security from promptly responding to a forced entry or malfunction of the door. The NRC was notified in accordance with 10CFR 73.71 (B) (1).

Causes of the Event

The primary causes of this event are as follows:

1. Procedure non-compliance by security alarm station operators.
2. Less than adequate security alarm station operator shift turnover.
3. Less than adequate communications within the security department during the maintenance activity, which included the lack of 3 part

communication.

4. Failure of the security alarm station operators to perform self-checks.

Analysis of the Event

There are no safety consequences for this condition because the security card reader, door locking mechanism, and the secondary containment blue light system were determined to be working properly during the period of the de-activated alarm. Additionally, this vital area door is controlled within the protected area and access authorization through the door is controlled by a card reader. Security routinely patrols the affected vital area and associated physical boundaries. There were no apparent signs of tampering or unauthorized entry of personnel.

Secondary containment blue lights and security card readers were activated during this period. A review of the card reader records was performed, which indicated no unauthorized individuals attempted to enter the vital area during the above period.

No other safeguard functions or vital areas were impacted by this event.

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Corrective Actions

Completed corrective actions (for causes identified above) include the following:

1. All security personnel have been briefed on the event and the proper use of procedures.
2. The turnover process for the security alarm station operators has been revised. Additionally, all security personnel have been briefed on the requirements for adequate and complete turnovers.
3. All security personnel have been briefed on the proper communications to be used during evolutions.

4. All security personnel will be required to attend Self-check training.

Additionally, management will reinforce the use of the self-check principles with the security department.

Additional Corrective Actions completed not associated with the Cause of the Event:

o Upon discovery, a search of the vital area and surrounding areas was performed to determine if the vital area door had been tampered or if safeguard materials were damaged or missing.

Previous Similar Events

There were no previous similar events at PBAPS.

*** END OF DOCUMENT ***



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