

May 15, 2003
NG-03-0373

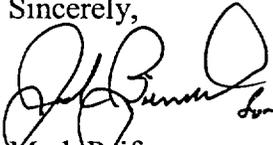
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Station 0-P1-17
Washington, D.C. 20555-0001

Subject: Duane Arnold Energy Center
Docket No: 50-331
Op. License No: DPR-49
Licensee Event Report #2003-S01-00
File: A-120

Dear Sirs:

Please find attached the subject Security Licensee Event Report (LER) submitted in accordance with 10CFR73.71, Appendix G. There are no new commitments contained within this report. Neither this letter nor the enclosed LER contain safeguards information. Should you have any questions regarding this report, please contact this office.

Sincerely,



Mark Peifer,
Site Vice President

5/15/03

cc: Mr. James Dyer
Regional Administrator, Region III
U.S. Nuclear Regulatory Commission
801 Warrenville Road
Lisle, IL 60532

NRC Resident Inspector – DAEC
NRC Director, Spent Fuel Project Office
IRMS

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1) Duane Arnold Energy Center	DOCKET NUMBER (2) 05000331	PAGE (3) 1 of 3
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TITLE (4)
Unattended Safeguards Information Outside of the Protected Area Caused by Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
04	17	2003	2003	S01	00	05	15	2003	FACILITY NAME	DOCKET NUMBER
OPERATING MODE (9)		4	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 31.103 (Check all that apply) (11)							
POWER LEVEL (10)		0	20.2201(b)			20.2203(a)(3)(ii)			50.73(a)(2)(ii)(B)	50.73(a)(2)(ix)(A)
			20.2201(d)			20.2203(a)(4)			50.73(a)(2)(iii)	50.73(a)(2)(x)
			20.2203(a)(1)			50.36(c)(1)(i)(A)			50.73(a)(2)(iv)(A)	X 73.71(a)(4)
			20.2203(a)(2)(i)			50.36(c)(1)(ii)(A)			50.73(a)(2)(v)(A)	73.71(a)(5)
			20.2203(a)(2)(ii)			50.36(c)(2)			50.73(a)(2)(v)(B)	X OTHER
			20.2203(a)(2)(iii)			50.46(a)(3)(ii)			50.73(a)(2)(v)(C)	Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iv)			50.73(a)(2)(i)(A)			50.73(a)(2)(v)(D)	
			20.2203(a)(2)(v)			50.73(a)(2)(i)(B)			50.73(a)(2)(vii)	
			20.2203(a)(2)(vi)			50.73(a)(2)(i)(C)			50.73(a)(2)(viii)(A)	73.71 Appendix G I(c)
			20.2203(a)(3)(i)			50.73(a)(2)(ii)(A)			50.73(a)(2)(viii)(B)	

LICENSEE CONTACT FOR THIS LER (12)

NAME John Schwertfeger, Security Consultant	TELEPHONE NUMBER (Include Area Code) 319-851-7504
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On the morning of April 17, 2003, a Security Plan Change Request letter, which contained safeguards information (SGI), was left unattended on the Site Vice President's Executive Assistant's desk. The Site Vice President's office is located in the Plant Support Center, which is within the Owner Controlled Area (OCA) but is outside of the Protected Area (PA). However, as a result of upgraded security measures at the time, only pre-authorized visitors or employees with badges were granted access to the OCA. There was no evidence of disclosure or duplication of the SGI to personnel not authorized to have access to SGI. The cause of the event was personnel error. Corrective actions included coaching the individual and stricter controls and minimizing the number of pages of Security Plan changes in review and approval routing.

This report is being submitted pursuant to 10CFR73.71 Appendix G, I (c) which requires, "Any failure, degradation, or the discovered vulnerability in a safeguard system that could allow unauthorized or undetected access to a protected area, material access area, controlled access area, vital area, or transport for which compensatory measures have not been employed."

Neither this abstract nor the narrative portion of this report contains safeguards information.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Duane Arnold Energy Center	05000331	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 of 3
		2003	-- S01	-- 00	

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

I. Event Narrative:

On the morning of April 17, 2003, at approximately 0948, a Security Plan Change Request (SPCR) letter, which contained safeguards information (SGI), was left unattended for approximately 12 minutes on the Site Vice President's Executive Assistant's desk. The Site Vice President's office is located in the Plant Support Center, which is within the Owner Controlled Area (OCA), but is outside of the Protected Area (PA). Control of the SGI was re-gained at 1000. The cause of the event is personnel error. The Executive Assistant was familiar with the requirements for controlling SGI and had received refresher training in August 2002. There was no evidence of disclosure or duplication of the SGI to unauthorized personnel.

The following detailed information is provided in accordance with the format and guidelines provided in NRC Regulatory Guide (RG) 5.62:

- A. Date and time of event: April 17, 2003 at approximately 0948.
- B. Location: Duane Arnold Energy Center (DAEC) Plant Support Center (PSC), which is within the OCA, but outside of the PA.
- C. Plant condition: The plant was shutdown for a refuel outage. Homeland Security Threat Level was Yellow.
- D. Safety systems affected: None.
- E. Type of security force on site: Proprietary.
- F. Number and type of personnel involved: Three DAEC employees consisting of the Site Vice President (VP), his Executive Assistant, and a Senior Licensing Analyst. All three are authorized to have access to SGI.
- G. Method of discovery: While meeting for final approval and signature for the SPCR, the Site VP and Senior Licensing Analyst found the SPCR package unattended on the Executive Assistant's desk. The package had been delivered to the Executive Assistant earlier (Approximately 0925) for the VP's review prior to a scheduled 1000 meeting.
- H. Procedural errors involved: The DAEC Procedure for controlling SGI, Administrative Control Procedure (ACP) 106.6, "Control of Safeguards Information," was not in error. The requirements contained in it were not followed. Specifically, Section 3.4.1 "Protection During Use," item (1) states, "While in use, SGI shall be under the control of an authorized individual. The individual to whom SGI is issued shall keep it under control and protect it to prevent unauthorized disclosure. SGI is considered to be "under control" when it is maintained in a manner that prevents UNAUTHORIZED DISCLOSURE and LOSS." Also, Section 3.4.2, "Protection During Storage," item (1) states, "When unattended, SGI shall be stored in an approved, locked Security Storage Container."

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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		2003	-- S01	-- 00	3 of 3

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

I. Event Narrative (continued):

- I. Immediate actions taken: Control of the SGI was re-gained at approximately 1000 as soon as it was discovered. The SPCR package was page checked satisfactorily. Both available copier locations in the PSC were checked. In both cases, there was no evidence that copies of the SGI were made. Security force personnel were contacted and an immediate investigation performed.
- J. Corrective actions taken or planned: The Executive Assistant was coached and reminded of the responsibilities for controlling SGI. The administrative control procedure (ACP) for processing SPCRs, ACP 106.9, is being revised to require hand delivery of the SPCR package to each reviewer and to limit review and approval distribution to only revised pages versus the entire plan. (CA 27596).
- K. Local, State or Federal law enforcement agencies contacted: None.
- L. Indication of previous similar events: A search of the DAEC corrective action database revealed the following previous issues with control of SGI.

In December 2002, the security staff discovered that SGI had been entered on a network computer (CAP 25048). In July 2002, it was identified (by the site) that from May 2001 to October 2001 an index of security event log information (which contained SGI) was being stored on a floppy disk that was used on a network computer versus a required stand-alone computer (AR 31774). In March 1999, Nuclear Oversight identified that undeveloped film containing SGI was left unattended in the microfilming camera. It was also noted that when film was transmitted to the corporate office for developing, the film was not being stored in an approved security storage container (AR 14885). Corrective actions from these events were focused on the specific issues and are not expected to have prevented this event.

- M. Knowledgeable contact: Mr. John Schwertfeger (319-851-7504).

II. Assessment of Significance:

The SPCR package containing the SGI was left unattended for approximately 12 minutes. The package contained all pages, appeared the same as when it was delivered (the binder clip on the package was still in the same location), and there was no evidence that any copies were made. The package did contain the entire composite physical security plan (10CFR73.21(b)(1)(i)), however, significant SGI like contingency response locations and strategies were not included. Also, as a result of upgraded security measures in place at the time of the event, only pre-authorized visitors or employees with badges were granted access to the OCA. Therefore, it is concluded that the unattended SGI was not sufficient nor descriptive enough to significantly assist an intruder in an act of sabotage or theft had the information been actually obtained.

This event is being submitted pursuant to 10CFR73.71Appendix G, I (c).
Event notification (EN): 39766.