Commonwealth Edison Company
Dresden Generating Station
6500 North Dresden Road
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ComEd

March 6, 1997

JSPLTR #97-0047

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Enclosed is Licensee Event Report 97-S01, Docket 50-237, which is being submitted in accordance with 10 CFR 73.71(b), specifically, Appendix G.I.c, which requires reporting of any failure, degradation, or the discovered vulnerability in a safeguard system that could allow unauthorized access...to a vital area, for which compensatory measures have not been employed.

This correspondence contains no open or incomplete commitments.

If you have any questions, please contact Pete Holland, Dresden Regulatory Assurance Supervisor at (815) 942-2920 extension, 2714.

Sincerely,

J. Stephen Perry
Site Vice President
Dresden Station

Enclosure

cc: A. Bill Beach, Regional Administrator, Region III
NRC Resident Inspector's Office

IE74

NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Dresden Nuclear Power Station, Unit 2	05000237	1 of 4

TITLE (4)
Vital Area Security Padlock Found Open Due To Deliberate Tampering That Could Have Allowed Unauthorized Access to a Vital Area

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
01	25	97	97	-- S01 --	00	03	06	97	Dresden Unit 3	05000249
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	1
POWER LEVEL (10)	100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

20.2201(b)	20.2203(a)(3)(i)	50.73(a)(2)(iii)	X 73.71(b)
20.2203(a)(1)	20.2203(a)(3)(ii)	50.73(a)(2)(iv)	73.71(c)
20.2203(a)(2)(i)	20.2203(a)(4)	50.73(a)(2)(v)	OTHER
20.2203(a)(2)(ii)	50.36(c)(1)	50.73(a)(2)(vii)	(Specify in Abstract below and in Text, NRC Form 366A)
20.2203(a)(2)(iii)	50.36(c)(2)	50.73(a)(2)(viii)(A)	
20.2203(a)(2)(iv)	50.73(a)(2)(i)	50.73(a)(2)(viii)(B)	
20.2203(a)(2)(v)	50.73(a)(2)(ii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Leo O'Donnell, Security Quality Coordinator Ext. 2737	(815) 942-2920

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

This report is submitted as required by 10 CFR 73.71 to report a tampering incident that could have resulted in unauthorized access to a vital area.

On Saturday January 25,1997 at approximately 00:30 a Security officer reported to his supervisor that he had discovered a Security padlock that was unsecured. This padlock secures a ventilation hatch cover which is also sealed shut. Since no evidence of mechanical failure existed, an investigation was immediately started to determine how the padlock became unsecured. An examination of the hatch cover seal confirmed that the hatch had not been opened. The location was immediately secured and appropriate security measures implemented, a new lock was secured on the hatch, and a search of the vital area was conducted. The search concluded that no unauthorized personnel or material entered the area. Interviews conducted with the personnel who had access to the area where the padlock was located provided no additional information.

On Monday February 10,1997, the investigation revealed that the Security officer who reported the incident intentionally unlocked the Security padlock and then reported to his supervisor that he had discovered the unsecured lock while performing his scheduled Security rounds. The Security officer's unescorted access was immediately retracted and the individual was escorted out of the Protected Area.

PLANT AND SYSTEM IDENTIFICATION

General Electric - boiling water reactor - 2527 MWt rated core thermal power.

Energy Industry Identification System (EIIS) codes are identified in the text as [XX] and are obtained from IEEE Standard 805-1984, IEEE Recommendation Practice for System Identification in Nuclear Power Plants and Related Facilities.

EVENT IDENTIFICATION:

Vital Area Security Padlock Found Open Due To Deliberate Tampering That Could Have Allowed Unauthorized Access to a Vital Area

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 2(3) Event Date: 01/25/97 Event Time: 0030 hrs

Reactor Mode: 1(1) Mode Name: Run(Run) Power Level: 070(073)

Reactor Coolant System Pressure: 1000 psig (1000 psig)

B. DESCRIPTION OF EVENT:

This report is submitted to report a tampering incident that could have resulted in unauthorized access to a vital area in accordance with 10 CFR 73.71(b), specifically, Appendix G.I.c, which requires reporting of any failure, degradation, or the discovered vulnerability in a safeguard system that could allow unauthorized access...to a vital area, for which compensatory measures have not been employed.

On Saturday January 25,1997, at approximately 00:30, a Security officer reported the discovery of an unlocked Security padlock to his supervisor. The officer reported finding this during normal Security rounds. The officer also stated that he had checked this lock at approximately 18:15 on Friday, 01/24/97 and the lock was secure at that time. This padlock is used to secure a sealed ventilation system hatch cover that leads from one vital area to another separate vital area (Control Room). As per Security requirements, a search of the entire vital area was conducted to assure that no undetected or unauthorized personnel or materials entered the area. The search revealed no unauthorized personnel or material. Examination of the vent hatch cover seal confirmed that the hatch had not been opened. Photographs were taken to document the position of the padlock, as it was reported. The padlock was removed for investigation purposes and replaced with a new padlock. The incident was reviewed by the Shift Manager, Station Security Administrator and Security supervision. A PIF was generated and the incident was initially documented as a twenty four hour loggable event. Since no evidence of mechanical failure of the lock existed, a prompt investigation and a Security investigation were initiated. Computer generated card histories were used to identify all personnel who may have had authorized access to the area. Commonwealth Edison Corporate Security investigators were also notified. At approximately 06:30 on 01/25/97, it was determined that Corporate Security would assist with the investigation.

Security and the ComEd operations organizations are the only personnel who have access to the type of key needed to open the padlock. An interview with the Shift Manager determined the following. The Security keys issued to the ComEd operations organization are stored in locked key cabinets in the Work Execution Center. Inspection of the Work Execution Center verified that the key cabinets were locked. A review of the issuance log confirmed that all Security keys issued to the operations organization were accounted for and no Security keys had been issued to any personnel within the previous two weeks. For this reason, the investigation concluded that none of the ComEd operations personnel had opportunity to unlock the padlock.

On Monday, 01/27/97 and Tuesday, 01/28/97, investigators from ComEd Corporate Security conducted initial interviews with personnel identified on the card histories. Evidence was collected and the scene was again photographed. The padlock was delivered to a forensic laboratory for testing.

On Friday, February 07,1997, Commonwealth Edison Corporate Security was contacted by the forensic laboratory and informed that the padlock had not malfunctioned. After receiving this information, Corporate Security investigators returned to the Dresden Station on Monday February 10,1997, to conduct follow up interviews with certain Security personnel. One of the personnel interviewed was the Security officer who reported the padlock as being unsecured. Under direct questioning from the investigators, the Security officer admitted to unlocking the padlock and then reporting this condition to his Supervisor. The Security officer also provided a written statement that documented his actions. Upon receiving this information, the Security officer was escorted out of the Protected Area and his unescorted access was immediately revoked. Per Security procedures, the cores and Security keys associated with all Security related Protected and Vital area locks were changed to a new series. The individual was placed on the denied access list and the remaining Commonwealth Edison Nuclear generating stations were notified. A one hour ENS phone call was placed to the Nuclear Regulatory Commission to report the confirmed event.

No system, structure, or component was inoperable at the start of the event which contributed to the event. In addition, no manual or automatic engineered safety feature (ESF) actuation occurred as a result of this event.

C. CAUSE OF EVENT:

The cause of this event was determined to be personnel error (NRC Cause Code A). During initial and annual training, Security personnel are instructed on the importance of assuring that station equipment is not tampered with. They are also instructed on their responsibility to report any observed suspicious activities or possible acts of tampering. Security personnel are also informed of the potential legal actions that can occur from tampering with station equipment. This Security officer was aware of these responsibilities, yet chose to intentionally unlock the Security padlock.

D. SAFETY ANALYSIS:

During the process of the investigation, Security personnel immediately compensated for the reported deficiency until a new padlock was placed on the hatch. Verification that the hatch seal was still in place and the hatch had not been opened provided evidence that no personnel or foreign material entered the ventilation system. The Security search of the vital area found no indication of unauthorized personnel or material. Therefore, the safety significance of this event is minimal.

E. CORRECTIVE ACTIONS:

1. Upon report of the unsecured padlock, compensatory measures were immediately implemented. The reported padlock was removed and replaced with a new padlock. (Complete)

2. A search of the entire vital area was conducted to verify that no unauthorized personnel or material entered the vital area. The hatch cover seal was examined to assure that the hatch had not been opened. (Complete)

3. Upon confirmation/admission from the Security officer that he had intentionally unlocked the padlock, his unescorted access was immediately revoked. The individual was also escorted out of the Protected Area and placed on the denied access list. The cores and Security keys associated with all Security related Protected and Vital area locks were changed to a new series. (Complete)

4. The Security Officer was subsequently terminated from the contractor security company. (Complete)

5. A review of the Security Officer's work history and previous job assignments was conducted. This review provided no indication or evidence that the individual had previously violated any Security procedures or requirements. (Complete)

6. A Security information notice was issued to Security Department personnel to reconfirm the importance of assuring that personnel do not tamper with station equipment. The possible ramifications of tampering with this equipment were also stressed. (Complete)

F. PREVIOUS OCCURRENCES:

None

G. COMPONENT FAILURE DATA:

Not Applicable