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**SUBJECT: Responds to NRC 881209 ltr re violation noted in Insp Rept
50-528/88-31.**

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Arizona Nuclear Power Project

P.O. BOX 52034 • PHOENIX, ARIZONA 85072-2034

102-01086-DBK/TDS

January 9, 1989

DONALD B. KARNER
EXECUTIVE VICE PRESIDENT

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

Reference: Letter from R. J. Pate, Nuclear Material Safety and Safeguards
Branch, U. S. Nuclear Regulatory Commission to Arizona Nuclear
Power Project, Attn. D. B. Karner, Executive Vice President, dated
December 9, 1988

Dear Sir:

Subject: Palo Verde Nuclear Generating Station
Units 1, 2, and 3
Docket No. STN 50-528 (License No. NPF-41)
STN 50-529 (License No. NPF-51)
STN 50-530 (License No. NPF-74)
Reply to a Notice of Violation 528/88-31
File: 89-070-026

This letter is provided in response to the routine security inspection
conducted by Messrs. L. R. Norderhaug and D. W. Schaefer from September 26
through October 25, 1988. Based upon the results of this inspection a
violation of NRC requirements was identified. The violation is discussed in
Appendix A of the referenced letter.

The violation and ANPP's response are provided in the attachment to this
letter. If you should have any questions regarding this response, contact Mr.
Timothy Shriver of my staff at (602) 393-2521.

DBK/TDS/kj

Attachments

cc: J. G. Haynes
J. B. Martin
T. J. Polich
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APPENDIX A

NOTICE OF VIOLATION

Arizona Nuclear Power Project
P.O. Box 52034
Phoenix, Arizona 85072-2034

Docket No. 50-528
License No. NPF-41

During a routine physical security inspection conducted from September 26 to October 25, 1988, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1988), the violation is listed below:

10 CFR 73.21(d)(2) provides in part:

"Knowledge of lock combinations protecting Safeguards Information shall be limited to a minimum number of personnel for operating purposes who have a "need to know" and are otherwise authorized access to Safeguards Information in accordance with the provisions of this section."

Contrary to the above requirement, on September 28, 1988, the combination of a locked safe containing Safeguards Information and located in Trailer No. 13 was set to the standard factory-set combination, 50-25-50, which is non-restrictive and common knowledge to any individual who has been involved in the purchase of a new safe.

This is a Severity Level IV Violation (Supplement III).

REPLY TO NOTICE OF VIOLATION 528/88-31

I. REASON FOR VIOLATION

On September 28, 1988, ANPP was notified by an NRC Region V Safeguards Section representative that a safe (Serial # 1244476) had a "factory issue" combination set in the locking device. As a result, ANPP Security Department initiated an investigation to determine the "root cause" of the event. The results of the investigation (reference ANPP letter identification number 090-02023-NO/GW) and an independent evaluation conducted by the Compliance Department are discussed in the following paragraphs.

A review of the available records indicates that the safe's combination could not be verified as being changed. Therefore, it is concluded that the safe had been in use for the storage of safeguards materials its issue with an improper combination set in the locking device since its issue. The existing process permits an individual to order a safe and take receipt of it without approval of the Security Department. This practice is considered acceptable because the safes are used for purposes other than the storage of safeguard material. There were no procedural controls in place at the time of the event that would have required that the combination be reset from the "factory issue" combination. Therefore, the "root cause" of the event has been determined to be inadequate procedural controls.



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During the course of the investigation other factors were identified that, although they are not considered contributory causes, could have ensured the deficiency was corrected prior to the event's identification in September, 1988.

In March, 1988, one of the two individuals using the safe voluntarily terminated his employment with ANPP.

Procedure PS03.06 revision 0, "Control of Safeguards Information"* paragraph 3.8.3. states:

"Each department/contractor company head shall ensure the combination to their SI container's lock is changed whenever an individual who has knowledge of the SI containers combination no longer requires such access."

Contrary to this requirement the safe's combination was not changed.

In August, 1988, during an audit conducted by the Security Department to verify the corrective actions taken in response to a Quality Assurance concern, it was identified that the safe had the "factory issue" combination set in the locking device. Although the responsible Security Management was notified, the appropriate action was not taken.

*Note: This procedure was revised on 8/1/88, however the controls quoted were in effect as written at the time of the event.



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As previously discussed, neither of the events contributed to the initial deficiency. However, if the combination had been reset upon the employee's termination or if the appropriate corrective action had been implemented in August, 1988, when the deficiency was initially identified by ANPP Security personnel, the identification of the event by NRC personnel in September, 1988, could have been avoided. An assessment of these issues identified two separate "root causes". The first issue was clearly a procedural violation. Discussions with the responsible supervisor identified that he was not aware of the requirement to change the safe's combination upon the termination of an employee who had access to the safe. The "root cause" was determined to be the responsible supervisor's lack of knowledge of the procedural requirements. The second issue is complicated by apparent confusion concerning who was notified of the deficiency and who was responsible for ensuring the appropriate corrective actions were implemented. However, the Security Department's lack of an effective problem identification program which would ensure formal notification of identified deficiencies and ensure the subsequent tracking of required corrective actions is considered the "root cause".

II. CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

As an immediate corrective action, compensatory measures were instituted (i.e., the safe was posted with a Security Officer). On September 29, 1988 the safe's combination was changed. Additionally, an inventory of



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the safe's contents was conducted on September 29, 1988. The inventory verified that no safeguards material was missing. Based upon the location of the safe and no physical evidence to the contrary, ANPP concluded that the safeguards material was not compromised during the period the locking device was set at the "factory issue" combination.

III. CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS

The corrective actions taken to prevent recurrence were expanded to address not only the identified violation but to address the additional discrepancies identified during the investigation:

- a) In order to ensure that safeguards containers have the combinations changed from the factory issue combination, the applicable procedure will be revised to provide specific instructions requiring the combination to be changed prior to the safe's initial issuance. The revision is scheduled to be submitted by March 1, 1989.
- b) In order to ensure that a safe's combination is changed when a person having access to the safe no longer requires that access the following actions have been taken;
 - 1. Procedure 20GB-OSK05, "Control of Safeguards Information", has been revised to provide specific



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responsibilities for ensuring the combinations are changed.

2. A memo will be issued by the Security Manager to all individuals who control safeguards containers reiterating the established requirements. The memo will be issued by February 1, 1989.

- c) In order to ensure that identified deficiencies are promptly addressed, an evaluation of the current problem reporting process within the Security Department will be evaluated. The program will be enhanced as necessary based upon the results of the evaluation. The evaluation is scheduled to be completed by March 1, 1989. Corrective actions resulting from the evaluation will be scheduled as appropriate.

IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on September 29, 1988 when the safe's combination was reset. Expected completion dates for the corrective actions are provided in Section III.

