NIAGARA MOHAWK

NIAGARA MOHAWK POWER CORPORATION 300 ERIE BOULEVARD WEST SYRACUSE N.Y. 13202/TELEPHONE (315) 474-1511

January 30, 1987

Mr. Richard W. Starostecki, Director
Division of Project and Resident Program
United States Nuclear Regulatory Commission, Region I
631 Park Avenue
King Of Prussia, PA 19406

Re: Nine Mile Point Unit #2
Docket No. 50-410
NPF-54

Dear Mr. Starostecki:

In accordance with 10 CFR 73.71 (c), enclosed for your information is a copy of a Report of Physical Security Event reported to the NRC Region I office by telephone on January 26, 1987.

This information concerns subject matter which is exempt from disclosure under 2.790 (d) of the NRC's Rules of Practice, Part 2, Title 10, Code of Federal Regulations. Accordingly, we request that the attachment not be placed in the Public Document Room and that they be disclosed only in accordance with the provisions of 10 CFR 9.12.

Very truly yours,

NIAGARA MOHAWK POWER CORPORATION

Joseph P. Beratta

Joseph P. Beratta
Supervisor, Nuclear Security

JPB/kal

Enclosure

H/3

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PDR FOIA
PERSON90-269 PDR

REPORT OF PHYSICAL SECURITY EVENT

REGION I, USNRC, OFFICE OF INSPECTION AND ENFORCEMENT
631 PARK AVENUE, KING OF PRUSSIA, PA. 19406
PHONE (215) 337-5000

Date of Occurrence: 01/25/87; 01/26/87*

Time of Occurrence: 0738 hrs; 1419 hrs*

*Date and time Security Management became aware that the appropriate procedures had not been complied with.

Facility and Location: Nine Mile Point Nuclear Station Unit 2, Lycoming, NY 13093 | Docket No.: 50-410 | License No. NPF-54

Licensee's Occurence Report No. 87-01

Brief Title (Subject): Lost Vital Area Key

DESCRIPTION OF EVENT: On Sunday, January 25, 1987, at approximately 0738 hours, the Security Department was notified via telephone that an operator had lost a Vital Area Key. A search was immediately initiated with negative results. As a direct result of the lost key, a new core change must be initiated in accordance with our Security Administrative Procedure. However, on January 26, 1987, at 1419 hours, it was confirmed that the appropriate Security Pr[illegible]dure had not been fully complied with.

RESPONSE BY LICENSEE: Immediately upon being made aware of the lost key, the Captain, Nuclear Security made the proper notifications as initially indicated in the Captain's Log and complied with Security Administrative Procedure S-SAP-1.1 which requires a new vital area core change be initiated [redacted] However, it was determined at 1419 on the 26th of January 1987, that the initial core change did not commence until 0900 on the 26th of January 1987 and completed at 1130, which as a result exceeded the [redacted] and required us to report the incident by way of ENS. The results of further investigations into the incident and actions taken to correct the root causes are contained on attached pages.

CONSEQUENCES AT FACILITY: Minimal; any use of the lost Vital Area Key would have resulted in [redacted] The key was found at 2030 hours on 28 Jan 87 by Security Personnel indicating that it was not found and used by unauthorized personnel.

Licensee Employee Reporting: Daniel D. O'Hara, Asst. Nuclear Security Specialist (315) 349-1319

NRC Staff Employee Receiving Phone Call: Mr. William Jones, H.O.O.

Date Of Phone Call: 01/26/87

Security Event Report 87-01
Nine Mile Point Unit #2
50-410/NPF-54

At 1100 hours, January 26, 1987, Security management became aware that a security procedure may not have been properly implemented. An investigation was immediately initiated to ascertain the circumstances involved and to identify the causes.

The focus of the investigation was to:

1) Learn the reason why the loss of the vital area key went undetected during the daily audit conducted on [ ] shift.

2) Determine why the appropriate Security Procedure was not properly followed.

The vital area key was first reported lost at 0738 hours on January 25, 1987, when the individual to whom it was issued reported for work. The day shift supervisors were apprised of the incident, filed a Security Incident Report, and initiated the appropriate Security Procedure.

At approximately 0930 hours on January 25, 1987, the Supervisor of Operations, was notified by the on-duty Captain, that an operator had lost her vital area key. A search of the area was conducted with negative results. The Captain advised that he had left a message on the telephone answering machine of the individual responsible for lock core changes and that the appropriate procedure was being complied with.

At [ ] the shift supervisor reporting for the [ ] shift learned of the missing key from the on-duty Captain. At the same time, the guard who had been involved in the audit conducted during the [ ] learned of the incident. The guard then informed her immediate supervisor that she had been aware of the key missing when she made the count on the preceding shift. The Captain contacted the Supervisor of Operations and advised that a core change had been done on the previous shift which kept us in compliance with S-SAP-1.1 and the Plan. Additionally, he advised the Supervisor that the key had been lost prior to 0730 hours. The Captain was then advised to take statements from the parties involved with the improper key count on the previous [ ]

Statements taken from the Guard and supervisor indicated that the Guard had mentioned the missing key to the supervisor while he was involved in other duties and asked what course of action should be taken. The response by the supervisor was apparently misinterpreted and, as a result, the key count showed no discrepancy. Thus, the fact that a vital area key was missing was not discovered until 0738 hours on January 25, 1987.

On January 26, 1987 at 0700 hours, the Supervisor of Operations spoke with the individuals concerned and considered the matter closed. However, at 11:30 hours he was notified that the core change had just been completed. As a result, of further conversation, it was recognized that no cores had been changed until 0900 hours on the 26th of January 1987.

Attempts were made to contact the Captain responsible for initiating the core change, however, he was unavailable until 1400 hours.

At 1419 hours on January 26, 1987, it was confirmed that the appropriate Security Procedure had not been fully complied with, as had been implied in a Security Log entry. According to the log entry, a message had been left on the telephone answering machine of the individual responsible for lock core changes. That individual never received the message. When relieved, the on-duty Captain, who had left the message on the answering machine, brought the log entry to the attention of his relief. The relieving Captain interpreted the log entry as indicating that a core change had been initiated per the referenced security procedure.

The following problems have been identified:

1) It is apparent that the Guard who conducted the vital area key audit and was aware that one was missing, failed to ensure that her comment to the supervisor was fully understood. The importance of vital area key accountability is well known by all security personnel and is addressed in training. Since the supervisor took no immediate action, it should have been apparent to the Guard that the supervisor was not really aware that a vital area key had not been accounted for during the audit.

   The importance of vital area key accountability as well as proper audit techniques will be strongly emphasized with the parties concerned. This matter, in itself, will be further reviewed with procedural changes if applicable.

2) The supervisor to whom the Guard initially reported the missing key was remiss in not following up the Guards comment. In an effort to preclude similar problems, the procedures being changed require a duplicate count of vital area keys. All levels of security supervision will be instructed on the implementation of changes.

3) The Captain, who initially received the report of the missing key, initiated the appropriate security procedure. However, neither he, nor the Captain who relieved him followed up to ensure that the individuals responsible for core changes had, in fact, received the message and was directing his personnel to perform the task.

   This deficiency will be addressed with the procedural change requiring the on-duty supervisor to expediate the core change on his shift and follow up with documentation that has been complied with.

On January 28, 1987, the subject key was located within the protected area and returned to the Security Department.