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May 26, 1994

Director, Office of Enforcement
U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Subject: River Bend Station - Unit 1
Docket 50-458
Reply to a Notice of Violation and Proposed Imposition of Civil Penalty 50-458/92-15 & 93-24 and NRC Investigation Case Nos. 4-92-009, 4-92-034, and 4-93-038R

File No.: G9.5, G15.4.1

RBG-40590

Gentlemen:

Pursuant to 10CFR2.201, please find attached Entergy Operations, Inc's. (EOI) response to the notices of violation described in NRC Inspection Report (IR) 92-15 & 93-24 dated April 21, 1994 and payment of $112,500 for the proposed civil penalty.

River Bend Station (RBS) management concurs with the NRC characterization and understands their significance. As presented at the January 6, 1994 enforcement conference, corrective action for the issues has been completed. Significant management and organizational changes have been implemented to integrate EOI management, along with the EOI safety culture and philosophy, into the RBS management structure. These changes included replacement of the Director of Nuclear Station Security and a change in reporting requirements in that the Director reports directly to the Plant Manager. This change provides additional management focus on the security program and organization.

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for $112,500.00.

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Other EOI initiatives include communication of EOI management expectations to site personnel to establish a heightened awareness for strict regulatory compliance, procedural adherence, and effective corrective actions. This includes training to increase the awareness for strict control of safeguards information (SI) and revision of security's compensatory measure procedure to incorporate a conservative approach to regulatory compliance. The corrective action program has also undergone significant changes to incorporate these expectations and focus on accurate root cause determinations and timely implementation of effective corrective actions.

In conjunction with these changes, implementation of the Near Term Performance Improvement Plan (NTPIP) began in October, 1993 and provided an immediate focus on RBS performance issues. This plan will be completed by the end of Refueling Outage 5 and establishes the foundation for transition to the more comprehensive Long Term Performance Improvement Plan (LTPIP). The LTPIP is a three year plan established to solve the root cause of the RBS performance issues. RBS committed to implement the LTPIP in March 1994 and has noted improvements in RBS performance, including the security program.

The March 8, 1994 Systematic Assessment of Licensee Performance (SALP) Report noted "that improvement initiatives and management changes have been effective in addressing some significant weaknesses identified early in the SALP period in the areas of radiological controls, fire protection, and security." In addition, recent security inspection (IR 94-05 dated February 4, 1994) noted significant improvements in management oversight of security operations, the protection of SI, and the RBS contingency procedure.

The underlying root causes and specific corrective actions concerning these events will be discussed in the subsequent attachments.

EOI believes the actions taken in the Security and SI protection program have corrected the problems identified in the notice of violation. EOI management is committed to improving the overall performance at RBS. EOI has successfully improved performance at its other plants and is confident similar results will occur at RBS.

Should you have any questions, please contact Mr. James Fisicaro at (504) 336-6225.

Sincerely,

John R McGaha

enclosures

cc: U.S. NRC Regional Administrator, Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, TX 76011

NRC Resident Inspector
P.O. Box 1051
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Mr. Edward T. Baker
M/S OWFN 13-H-15
U.S. Nuclear Regulatory Commission
11555 Rockville Pike
Rockville, MD 20852

BEFORE THE
UNITED STATES NUCLEAR REGULATORY COMMISSION

LICENSE NO. NPF-47

DOCKET NO. 50-458

IN THE MATTER OF
GULF STATES UTILITIES COMPANY
CAJUN ELECTRIC POWER COMPANY AND
ENTERGY OPERATIONS, INC.

AFFIRMATION

I, John R. McGaha, being duly sworn, state that I am Vice President - Operations of Entergy Operations, Inc., at River Bend Station; that on behalf of Entergy Operations Inc., I am authorized to sign and file with the Nuclear Regulatory Commission, Notice of Violation (NOV) 50-458/92-15 and 93-24 for River Bend Station; that I signed this NOV as Vice President - Operations at River Bend Station of Entergy Operations, Inc.; and that the statements made and the matters set forth therein are true and correct to the best of my knowledge, information, and belief.

John R. McGaha

STATE OF LOUISIANA
WEST FELICIANA PARISH

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for the Parish and State above named, this 26th day of May, 1994.

(SEAL)

Claudia F. Hurst
Notary Public

ATTACHMENT 1

REPLY TO NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTIES/NRC IR NOS. 50-458/92-15 & 93-24

REFERENCE

Notice of Violation - Letter from L.J. Callan to J.R. McGaha dated April 21, 1994

I. VIOLATIONS ASSESSED A CIVIL PENALTY

VIOLATION

A. 10 CFR 73.21(d) requires, in part, that while unattended, Safeguards Information be stored in a locked security storage container.

10 CFR 73.71(b)(1) requires, in part, that the licensee notify the NRC Operations Center within one hour of discovery of the safeguards events described in paragraph I, Appendix G, 10 CFR Part 73. Appendix G, item I.(c) requires that the licensee notify the NRC within one hour of discovery of any failure, degradation, or discovered vulnerability in a safeguards system that could allow unauthorized or undetected access to a protected area or vital area for which compensatory measures have not been employed.

1. Contrary to the above, on March 23-24, 1993, Safeguards Information was unattended and was not locked in a security storage container. Specifically, a safe containing documants with significant Safeguards Information was found unlocked in a building outside the River Bend Station (RBS) Protected Area. The Safeguards Information had been unattended for approximately six hours. Furthermore, the licensee failed to notify the NRC of this event within one hour as required.

2. Contrary to the above, on September 25, 1992 four draft Safeguards Information documents were discovered in a storage room outside the Protected Area and were not stored in a locked security storage container. These documents had been unsecured for approximately 7 months.

REASON FOR THE VIOLATION

For the March 23-24, 1993 event (violation 1 above), the (then) Director Nuclear Station Security (DNSS) failed to follow the procedure that required locking a safeguards information (SI) container, for which he was responsible, when he left

work to go home about ten minutes after midnight on the morning of March 24, 1993. The DNSS had been using documents from the container and was aware of procedural requirements to have the container locked when unattended.

The open SI container was discovered about 0645 that same morning by a security contract employee coming in to work who remained with the container until his supervisor arrived at 0700. The event should have been reported within one hour. However, the event was not reported until 1103 March 24, 1993 because a page by page count was completed for every document in the container and the completion of an investigation by Corporate Security.

For the September 25, 1992 event (violation 2 above), human error by clerical personnel caused the SI documents to be mishandled. The documents were being stored along with non-SI documents in an approved container in the manager of administration's (MOA) office. His office was located in the training center when a decision was made to move the MOA office to the main administration building (MA-1). In preparation for the move, the SI container was emptied and the contents were packaged in cardboard storage boxes. The secretary, who packed the boxes, did not realize that five of the documents (four contingency procedures and one inspection report response) she packed were SI. She did not unpack the boxes until about 7 months later, at which time, she discovered the SI and notified security of the incident.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

For the September 25, 1992 event (violation 2 above), the following corrective actions were completed:

1. An EOI peer review of the SI program was performed and concluded the program lacked the appropriate resources and was not being effectively managed under ownership of the Security organization. As a result, the ownership of the program was transferred from Security to the Records Management Group (formerly Administrative Services). This transfer was completed in June, 1993.

2. In conjunction with the transfer of ownership to Records Management, an individual with no direct responsibility for the contents of the container conducted an inventory on the SI central files and each satellite container. While performing this activity, security personnel initiated a program to reduce the volume of SI materials by at least 50%, including a reduction of satellite storage files outside the protected area. Satellite stations have been reduced from approximately 17 to the present 5. In addition, four of the five remaining satellites are located in the protected area.

3. A courier requirement which prohibits sending SI through on-site inter-office mail was initiated. Currently SI is personally transferred in the custody of an authorized individual.

4. SI access requirements were modified to include additional training performed by the safeguards custodian for all SI qualified personnel. This activity was incorporated into procedure PSP-4-105, "Administration (Safeguards Information Control"), in conjunction with the transfer of ownership of the program. The procedure revision required the inventory of satellite stations be performed by an individual who is not directly responsible for the contents of the container.

5. An instructional program on SI awareness was established and implemented for persons prior to being placed on the SI access list. To remain on the list, an annual written certification is necessary from each individual stating that they continue to have a need to possess SI and understand the manner in which SI is controlled.

6. The procedure change included a requirement for an individual creating a document which may contain SI to have it reviewed by security management personnel knowledgeable in SI requirements, and have the document classified accordingly by the director - nuclear station security/designee. Until this review is conducted, the document shall be properly controlled by the originator.

For the March 23-24, 1993 event (violation 1 above), a physical inventory was initiated and an investigation ordered to determine the extent of compromise. The investigation and inventory of documents were completed at 1130 March 24, 1993. There were no signs of forced entry or disruption, no documents were determined missing, and there were no indications that the documents were compromised. Personnel training was improved to place more emphasis on SI awareness. A baseline audit to define the contents of the central files was completed in July 1993 and for all satellite stations in November of 1993.

In September, 1993, management changes were implemented to improve the Security organization at RBS. An EOI manager was placed in the DNSS position. He has an excellent record and was instrumental in putting together an effective Security organization at another facility with a strong safety and regulatory culture. He has implemented these same leadership attributes within the RBS Security organization. In addition, to focus more management attention on the Security organization, in October, 1993, Security began reporting directly to the plant manager rather than to the manager of site support.

As a result of the September, 1992 and March, 1993 events, control of the SI program was transferred to Records Management. Initiatives were implemented to

enhance the SI control program including new SI forms for documenting safeguards awareness training, determination statements, file actions and a new automated tracking system was developed. The automated control system includes an inventory list by container, page count, SI number, and document history.

The issuance of a revised procedure in December of 1993 also upgraded the SI control program. The procedure was upgraded from a plant security procedure to a station support procedure at that time.

In order to prevent any further SI events, in late December 1993, personnel from the EOI Corporate Security organization were asked to perform an assessment of the RBS security and SI protection organizations. They made recommendations to RBS management on ways that EOI's practices at other units could be adopted to improve the performance at RBS. This assessment focused on training, regulatory compliance, process implementation and program effectiveness and was completed on December 30, 1993. The results of the assessment were very positive and cited strong leadership in the security and SI protection programs and the reduction of SI satellite stations as major factors in recent program improvements.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Chapter 24, Section 5 of the LTPIP implemented initiatives to enhance the awareness and sense of ownership of safeguards controls. These initiatives include communication of the significance of SI control through pamphlets and posters, in addition to management observation. Surveys will also be performed periodically to confirm the effectiveness of these initiatives. Further, Chapter 24, Section 6, of the LTPIP provides initiatives to continue to reduce the inventory of SI. The reduction of inventory will result in more effective control of SI documentation.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The immediate corrective actions, as described in the previous paragraphs, are complete and the SI protection program is in full compliance with 10CFR 73.21(d). Long term initiatives have been implemented to address the concerns identified above and will be completed in accordance with the schedules outlined in the LTPIP.

ATTACHMENT 2

REPLY TO NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTIES/NRC IR NOS. 50-458/92-15 & 93-24

REFERENCE

Notice of Violation - Letter from L.J. Callan to J.R. McGaha dated April 21, 1994

VIOLATION

B. Condition 2.D of the River Bend Station Operating License requires that the licensee maintain in effect and fully implement all provisions of the Commission-approved Physical Security Plan (PSP).

Paragraph 5.3 of the PSP, "Building Walls and Doors Used as Barriers," states, in part, that personnel and equipment doors in buildings housing vital islands are designed and constructed to ensure a level of integrity equivalent to adjacent walls. Paragraph 5.3 also states, in part, that door construction and locking mechanisms are such that the use of several breaching tools or high explosives would be required to obtain a successful breach.

10 CFR 73.71(c)(1) requires, in part, that the licensee log and record safeguards events described in paragraphs II (a) and (b) of Appendix G, Part 73, within 24 hours of discovery by a licensee employee or member of the licensee's contract security organization. Appendix G, paragraph II (b) lists, in part, any act with the potential for reducing the effectiveness of the safeguards system below that committed to in a licensed physical security or contingency plan, or the actual condition of such reduction in effectiveness as matters that must be logged and recorded.

Contrary to the above, from December 6, 1991 until December 10, 1991, a personnel door to a vital island was degraded by the installation of a thumblatch that permitted individuals to traverse from a protected area to a vital area of the plant without the use of breaching tools for high explosives. Furthermore, the licensee discovered that the vital area barrier was degraded on December 10, 1991 by installation of the thumblatch, but did not record the event in the safeguards event log until December 13, 1991, a period in excess of 24 hours.

REASON FOR THE VIOLATION

The G-Tunnel was originally designed to connect River Bend s Unit 1 and Unit 2. With the cancellation of Unit 2, the Unit 2 end of the tunnel was sealed. During the preparations for Refueling Outage 4, metal hatches were installed over the end

of the tunnel that were bolted, padlocked and alarmed through the central alarm station. The closed Unit 2 end of G-Tunnel forms the protected area (PA) boundary and door TU066-G1, located several yards away towards the standby cooling tower end of the tunnel, forms the vital island boundary. Door TU066-G1 is considered the second barrier prior to entering the vital island (VI) and is the door where the thumblatch was located.

During preparation for Refueling Outage 4, contract personnel were working on the PA portion of the tunnel between the two barriers. Members of the crew raised a safety issue with their supervisor concerning the possibility of being trapped in the dead-end tunnel if a personnel safety event (e.g., fire or other industrial accident) occurred simultaneously with a computer/key card reader failure (VI doors fail locked on loss of power). On December 6, 1991, the thumblatch was ordered installed by the (then) Director Nuclear Station Security (DNSS) to address the personnel safety considerations.

Placing a thumblatch on the PA side of the barrier without taking compensatory measures was a violation of NRC requirements and the RBS Physical Security Plan, and was the direct result of an error in judgment on the part of the (then) DNSS. The thumblatch remained on the door until on December 10, 1991 when it was removed.

There was no documentation generated to implement the installation of the thumblatch. This delayed the on-shift officers from learning about the installation. The thumblatch was first noted by the on-shift officers on December 10, 1991 and once it was verified to be a VI door, the event was logged/documented the same day at 1430 in Security Incident Report SIR 91-1217.

The RBS Physical Security Plan and/or implementing procedures were disregarded due to errors in judgment by the (then) DNSS. He apparently did not act with any malevolent intent or for personal gain in any of the events; however, he did not act conservatively to assure compliance with regulatory requirements.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

Door TU066-G1 was restored to an adequate VI barrier when the thumblatch was removed on December 10, 1991. Work performed on VI doors now requires that a security maintenance work order be completed and approved prior to the work being performed. Instructions to security personnel have emphasized that reportable items must be documented and reported in a timely manner.

The former DNSS was relieved of all security duties with GSU on December 15, 1993 and his resignation was accepted January 3, 1994. The company does not support his actions, as demonstrated by this disciplinary action. EOI management believes this action is commensurate with the seriousness of these NRC violations.

This disciplinary action, as well as the disciplinary action taken against other employees and contractors who violated security or safeguards information protection requirements, demonstrates to other employees and contractors the importance the company places on accountability and strict compliance with procedural and regulatory requirements.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

In accordance with Chapter 13 of the LTPIP, programs have been established to increase employee ownership and accountability for successful human performance and resolution of human performance issues. Section 3 describes initiatives to provide training on methodology and emphasize the use of self-checking verification. This section also includes initiatives to provide additional feedback to employees in the "lessons learned" from significant human performance events at RBS. An LTPIP revision incorporating activities to help reduce cognitive or rule based human performance errors is currently being evaluated.

In accordance with Chapter 18 of the LTPIP, several initiatives have been implemented to improve the adequacy of procedures and emphasize management expectations of strict procedural adherence. Section 1.1 provides initiatives to develop individual department writer's guides (including Security) that meet their specific needs. In addition, Section 1.5 provides training initiatives to emphasize the importance of procedure adherence.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Door TU066-G1 was restored to a VI barrier on December 10, 1991, and is currently in compliance with 10CFR73.71(c)(1). Long term initiatives have been implemented to address the concerns identified above and will be completed in accordance with the schedules outlined in the LTPIP.

ATTACHMENT 3

REPLY TO NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTIES/NRC IR NOS. 50-458/92-15 & 93-24

REFERENCE

Notice of Violation - Letter from L.J. Callan to J.R. McGaha dated April 21, 1994

II. Violations Not Assessed a Civil Penalty

VIOLATION

A. Condition 2.D of the River Bend Station Operating License requires that the licensee maintain in effect and fully implement all provision of the Commission-approved Physical Security Plan (PSP).

Paragraph 6.6.2 of the PSP, "Vital islands," states, in part, that when there is a requirement to leave a door open, a Nuclear Security Officer is posted at the Vital Island portal to provide positive access control.

Safeguards Contingency Plan Event 13, Discovery of a Breached Protected Area or Vital Island Barrier, requires the security force to implement compensatory measures.

1. Contrary to the above, from March 3-10, 1992, the licensee failed to maintain posted compensatory measures consisting of posting additional security personnel for five manhole covers which had been identified on March 2, 1992 as having been inadequately secured.

2. Contrary to the above, on December 10, 1991, a door to a vital island was found unlocked (a thumb latch had been installed on the protected area side of the door), and the licensee did not post a Nuclear Security officer at the vital island portal to provide positive access control for two hours after security management was notified of this condition.

REASON FOR VIOLATION

For the March 3-10 event, on March 2, 1992, degraded barriers (storm drain covers) were discovered by a quality assurance (QA) auditor in the presence of the NRC resident inspector during a walkdown of the temporary protected area extension in preparation for Refueling Outage 4. The drain covers were noted to have been bolted in place with the nuts exposed to the open side (or owner controlled side) of the manhole/drain pipe. When this was pointed out to the

(then) DNSS, he agreed that the bolts and nuts should be welded in place. The DNSS arranged with Maintenance to schedule the covers to be welded. It was pointed out at that time that the degraded barriers were compensated for by a compensatory post already established for a separate deficient PA barrier (fencing fabric support).

During the next 24 hours, the DNSS performed research as to the size, length, route and other characteristics of the drainage system piping. He determined that the length, size, and circuitous routing of the piping was such that one could not reasonably expect a person to gain access to the PA via the storm drain system. The next day, March 3, 1992, when the fencing fabric support was repaired, the DNSS terminated the compensatory post. He advised no one of this action except the on-shift security officers directly responsible for those duties.

On March 8, 1992, the same QA auditor observed that the compensatory post had been terminated and that the drain covers had not been welded. When the QA auditor presented his concerns to security operations, Burns' Security Project Manager restored the compensatory post. Shortly thereafter and following a discussion on the subject with the Burns' Security Project Manager, the DNSS canceled the compensatory post once again. The reason for this violation is a misinterpretation and non-conservative approach to the regulations and guidelines by the DNSS. On March 10, 1992, the storm drains were welded closed.

For the December 10, 1991 event, security records (Security Incident Report SIR 91-1217) indicate that the Security Shift Supervisor (SSS) was advised at 0806 that a thumblatch had been installed on door TU066-G1. At 0830, the SSS attempted to confirm the door's designation since he knew the Physical Security Plan was in revision. At 0912, the SSS inspected the door and the locking mechanism arrangement. At 0955, the door was confirmed to be a designated VI door and at 1000 a security officer was posted at the door. The SSS did not post earlier because he questioned the barrier designation of the door and conducted an investigation prior to posting. The decision to delay posting was also influenced by the fact he knew the DNSS had ordered the thumblatch installed and that he would be overriding a superior's decision not to place a compensatory post at the door.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

On March 10, 1992, the storm drain covers were welded closed, on December 10, 1991, the thumblatch was removed and a lock was placed on door TU066-G1; thereby restoring the storm drain covers and door to adequate barriers.

Security's compensatory measure procedure (PSP-4-307) was changed to incorporate the philosophy that when in doubt, post first and determine operability second.

The former DNSS was relieved of all duties with GSU on December 15 and his resignation was accepted January 3, 1994. The company does not support his actions, as demonstrated by this disciplinary action. EOI management believes this action is commensurate with the seriousness of these NRC violations. This disciplinary action, as well as the disciplinary action taken against other employees and contractors who violated security or safeguards information protection requirements, demonstrates to other employees and contractors the importance the company places on accountability and strict compliance with procedural and regulatory requirements.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

To minimize the potential for recurrence of similar events, RBS management has discussed within the contract security organization the importance of strict compliance with NRC requirements. Further, since September 1993, a more conservative approach has been taken to security compensatory measures. The revised compensatory measure procedure emphasizes management expectations of strict regulatory compliance and states when in doubt on the reliability of a system or component, to post first and determine the operability second. In addition, either the Security Operations Supervisor or the DNSS regularly attend the training sessions and tour security work areas to communicate expectations and obtain feedback to assure that the expectations are understood. A security operations bulletin is now published as a standard means of providing information and directions to the security force. It must be posted in specified security work areas.

In accordance with Chapter 13 of the LTPIP, programs have been established to increase employee ownership and accountability for successful human performance and resolution of human performance issues. In particular, Section 3 describes initiatives to provide training on methodology and emphasize the use of self-checking verification. This section also includes initiatives to provide additional feedback to employees in the "lessons learned" from significant human performance events at RBS. An LTPIP revision incorporating activities to help reduce cognitive or rule based human performance errors is currently being evaluated.

In accordance with Chapter 18 of the LTPIP, several initiatives have been implemented to improve the adequacy of procedures and emphasize management expectations of strict procedural adherence. Section 1.1 provides initiatives to develop individual department writer's guides (including Security) that meet their specific needs. In addition, Section 1.5 provides training initiatives to emphasize the importance of procedure adherence.

DATE WHEN FULL COMPLIANCE WAS ACHIEVED

The immediate corrective actions, as described in the previous paragraphs, are complete. Corrective actions addressing the overall control of VI barriers and the significance of timely posting of a compensatory officer are also complete. Long term initiatives have been implemented to address the concerns identified above and will be completed in accordance with the schedules outlined in the LTPIP.

ATTACHMENT 4

REPLY TO NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTIES/NRC IR NOS. 50-458/92-15 & 93-24

REFERENCE

Notice of Violation - Letter from L.J. Callan to J.R. McGaha dated April 21, 1994

VIOLATION

10CFR 50.9 requires, in part, that information required by statute or by the Commission's regulations, orders, or license conditions to be maintained by the licensee be complete and accurate in all material respects.

Plant Security Procedure PSP-4-105 require that records be kept concerning the destruction of documents containing Safeguards Information.

Contrary to the above, on September 25, 1992 or shortly thereafter, the licensee discovered that records indicating the destruction of certain documents containing Safeguards Information were inaccurate in that the documents were found on that date and had not been destroyed. These records are material because they relate to the protection of Safeguards Information.

REASON FOR THE VIOLATION

As described in Attachment 1, the SI documents that were mishandled were out for review and comment when they were misplaced. The Security Systems Supervisor was the person coordinating the review and revision process on the security procedures. On December 2, 1991, the Manager of Administration (MOA) gave the Director Nuclear Station Security (DNSS) several documents, some of which were SI documents and some were not, to return to the Security Systems Supervisor to resolve and incorporate review comments. It was believed that these procedures were part of that group of documents and were given to the Security Systems Supervisor to have comments incorporated and the marked-up procedures subsequently destroyed.

During the February 1992 time frame, the SI coordinator responsible for controlling and distributing SI information for Security performed a review of her records. She discovered that she had not received security procedure PSP-4-404 back from the MOA. A decision was made at that time to purge the files and initiate a search for all documents that were listed as out-for-review. The secretary to the MOA, when questioned about the documents, stated she thought the documents were returned in December, 1991.

During January, 1992, the Security Systems Supervisor separated from the company and was not available to substantiate his role in any of the transactions. The DNSS, believing that he needed to "close the file" on the matter, attempted to do so by writing a memo to file explaining what he believed happened (i.e., the documents were returned to the Security Systems Supervisor for review and incorporation of comments, and that he subsequently destroyed the documents without initiating a destruction notice). In a memo prepared by the DNSS on February 24, 1992, he stated, "This conclusion had been reached because a thorough search of the safeguards cabinets of those involved has not revealed the documents." The DNSS was in error by documenting what he "thought" had happened. In writing the memo, he failed to follow the procedure which requires that first, an investigation be initiated in matters of missing SI documents. The DNSS was aware of procedural requirements concerning the investigation of missing SI and failed to follow procedures.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

When the records were discovered, a document destruction notice form was completed and the records were destroyed and removed from the SI control log. Additional corrective steps that have been taken are described in Attachment 1, violation 2.

Since September 1993, senior management has held three "All Employees" meetings at RBS. The primary purpose of these meetings was to make clear to all employees the company's performance expectations, with particular emphasis being placed on procedural and regulatory compliance, and the importance of identifying and bringing to management attention problems that arise in the plant. RBS employees have been informed of management's expectations and realize they will be held individually accountable for meeting those expectations. The feedback that has been received from these meetings has been positive.

The former DNSS was relieved of all duties with GSU on December 15 and his resignation was accepted January 3, 1994. The company does not support his actions, as demonstrated by this disciplinary action. EOI management believes this action is commensurate with the seriousness of these NRC violations. This disciplinary action, as well as the disciplinary action taken against other employees and contractors who violated security or safeguards information protection requirements, demonstrates to other employees and contractors the importance the company places on accountability and strict compliance with procedural and regulatory requirements.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Chapter 24, Section 5 of the Long Term Performance Improvement Plan (LTPIP) implements initiatives to enhance awareness and develop a sense of ownership of

safeguards controls. These initiatives include communication of the significance of SI control through pamphlets and posters in addition to management observation. Surveys will also be performed periodically to confirm the effectiveness of these initiatives.

In addition, LTPIP Chapter 24, Section 6, efforts are continuing to reduce the inventory of safeguards information. The reduction of inventory will result in more effective control of SI documentation.

DATE WHEN FULL COMPLIANCE WAS ACHIEVED

The immediate corrective actions, as described in the previous paragraphs, are complete and the SI program is in compliance with 10CFR50.9. Long term initiatives have been implemented to address the concerns identified above and will be completed in accordance with the schedules outlined in the LTPIP.