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RI-87-A-137 1/12/88

Memo To: A. Shropshire, Office Allegation Coordinator

From: E. McCabe, Chief RPS-1B

Subj: PROPOSED ACTION ON ALLEGATION RI-87-0137

Because the office closing on 1/12/88 postponed the planned Allegation Panel meeting on this allegation, I reviewed the allegation with the resident inspector again, and then with the Security Section Chief, and then with the Region I OI Director. The following discusses follow-up/closure aspects and recommendations.

1) CHECK NOT MADE BUT ENTERED AS MADE ON ROUNDS SHEET

Inspector follow-up found that the rounds sheet had been whited-out at the date/time identified by the alleger. The entry recorded over the whited-out entry reflected the condition described by the alleger as existing. This matter was discussed with the security section chief. We concluded that, while using white-out is not the preferred method of changing an incorrect entry, it is not specifically prohibited. The existing entry is correct and was made the same day the alleger identified the incorrect entry, and failure to make this check has not been identified as a significant security problem.

This alleger stated, if effect, that the sergeant who made the wrong entry did so knowingly and later stated that this was due to a misunderstanding, and that the security captain the alleger contacted knew that the sergeant didn't misunderstand. These are alleger opinions about two other persons' thoughts. Failure to check a key ring with no attendant loss of security has minor security significance, as does improving the means of correcting record entries.

Discussion with OI (C. White) on 1/12/88 identified that this is not an appropriate matter for OI follow-up. Because of the low security significance, and because trying to establish what was in the minds of the security sergeant and captain is not considered likely to be a productive endeavor, addressal of correcting wrong entries and completion of specified rounds during routine security inspection is recommended as the follow-up. Closure of the allegation based on incorporation of these considerations in security inspection planning, and so informing the alleger, is recommended.

2) PERSON WITH WRONG BADGE AND KEY CARD.

This matter involves an unidentified person alleged to have the wrong badge and key card for about 8 hours sometime during a two-month time frame. It is recommended that further specifics be solicited from the alleger by the projects section chief. Unless a significant security issue is specified, the recommended additional follow-up is routine

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resident and specialist attention to badge issue practices. If a significant and verifiable security aspect is identified, it will be provided to the Allegation Panel for further evaluation and dispositioning. Otherwise, closure is recommended based on incorporating specific plans to assure addressal of this matter during routine inspection, and so informing the alleger.

3) SECURITY FORCE MEMBER COMES TO WORK INTOXICATED ON BACK SHIFT

On this matter, the alleger specified the name of the individual and another person who has knowledge of the matter. The site security force is a contractor force. It is recommended that this matter be referred by letter to the licensee for follow-up and response to the NRC (names and associated details to be provided separately by the senior resident inspector). Also, pending licensee response, resident inspector back shift checks will specifically include assessment of security personnel fitness for duty. Upon receipt and evaluation of the licensee's response, significant licensee and/or resident inspector findings will be referred to the Allegation Panel for consideration. If no significant fitness for duty inadequacies are identified, closure and communication of the substance of our findings to the alleger are recommended.

4) SAFEGUARDS MATERIAL MAY HAVE BEEN TAKEN OFFSITE.

The alleger stated that, during training, several individuals were given Safeguards material and told they could take it home. The alleger reportedly did not do so but thought the others might have. Discussion of this concern with the security section chief identified that, in many cases, material is marked as Safeguards when it is not, and that the Safeguards identification in such cases may just be marked through. It is recommended that this matter be referred to the licensee for evaluation and response with Item 3 above.

4) THINGS GO WRONG IN CAS AND ARE COVERED UP.

On this, we have only a generality. The security section chief stated that the CAS (Central Alarm Station) received particular attention in security inspections, including the pre-licensing evaluation for Millstone-3, and that very good performance was found. Solicitation of specifics by the projects section chief is recommended. If a significant matter is identified, referral to the Allegation Panel will be made. Failing identification of specifics, closure is recommended based upon planned routine specialist inspection and identification of the planned resolution to the alleger.

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copy: R. Keimig/W. Raymond/C. White (OI)