U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket Nos:	50-277, 50-278, 50-352, 50-353
License Nos:	DPR-44, DPR-56, NPF-39, NPF-85
Report Nos:	50-277/96-11, 50-278/96-11, 50-352-96-08, 50-353-96-08
Licensee:	PECO Nuclear
Facilities:	Peach Bottom Atomic Power Station Limerick Generating Station PECO Nuclear Chesterbrook Engineering Information Center
Dates:	October 3-November 27, 1996
Inspectors:	Gregory C. Smith, Sr. Security Specialist Nancy T. McNamara, Emergency Preparedness Specialist
Approved by:	Richard R. Keimig, Chief, Emergency Preparedness and Safeguards Branch Division of Reactor Safety

EXECUTIVE SUMMARY

Peach Bottom Atomic Power Station
Limerick Generating Station
NRC Inspection Report No. 50-277/96-11, 50-278/96-11,
50-352-96-08 and 50-353/96-08

On June 26, 1997, the licensee identified that documents containing Safeguards Information (SGI) were found to be uncontrolled in the Chesterbrook Engineering Information Center and initiated an investigation into the event on June 27, 1996. The scope of the investigation was expanded to include the adequacy of control of SGI at all PECO facilities including the Limerick and Peach Bottom sites, as additional problems with the control of SGI were identified. The investigation also included control of SGI that had originated at PECO but was in the possession of vendors and contractors. The licensee concluded its investigation on September 9, 1996. The investigation found that approximately 150 documents, primarily consisting of aperture cards, containing SGI had been stored in an uncontrolled manner at five locations for periods up to about eight years due to organizational changes, unclear roles and a lack of assigned responsibility for the program. However, it was determined by the licensee that the uncontrolled SGI did not constitute the potential to significantly assist an individual in an act of radiological sabotage.

During the inspection, the NRC monitored the licensee's review and investigation progress through frequent telephone contacts and meetings. On August 5, 1996, during a meeting at the Chesterbrook Information Center, the NRC reviewed the investigation findings to that point and its short-term corrective actions. On October 3, 1996, the NRC initiated an inspection to review the adequacy of the investigation, the findings and corrective actions planned and already implemented. The inspectors determined that: (1) the licensee's investigation was thorough and comprehensive in scope; (2) that as uncontrolled SGI was identified, the licensee took positive actions to control the information; (3) the completed corrective actions were adequate and fully implemented; and (4) long term corrective actions for later implementation were appropriate. The inspectors' review of the SGI documents that were uncontrolled confirmed that the information contained therein would not have significantly assisted an individual in an act of radiological sabotage. However, the number of uncontrolled documents, the various locations and the duration that those documents remained uncontrolled and accessible to unauthorized persons constitute a programmatic breakdown in the protection of SGI in accordance with the requirements of 10 CFR 73.21. This was identified as an apparent violation.

Report Details

P8 Miscellaneous Security and Safeguards Issues

P8.1 General

On July 2, 1996, the licensee notified the NRC that on June 26, 1996, safeguard information (SGI) was found to be uncontrolled and accessible to unauthorized personnel at the Chesterbrook Engineering Information Center. The licensee initiated an investigation into the event on June 27, 1996. As additional problems with the control of SGI were identified during the investigation, the scope of the investigation was expanded to include the adequacy of control of SGI at all PECO facilities and vendors who performed security-related work.

The NRC monitored the progress and developments of the investigation through frequent telephone contacts and meetings with various licensee representatives. On August 5, 1996, an inspector reviewed the licensee's investigation findings up to that point and short-term corrective actions at a meeting at the Chesterbrook Information Center. The licensee concluded its investigation on September 9, 1996, and, on October 3, 1996, the NRC initiated an inspection to review the adequacy and findings of the investigation and to review completed corrective actions and those actions still planned for implementation. The NRC inspection was completed on November 27, 1996.

a. Inspection Scope (81810)

The inspectors reviewed documentation of the licensee's investigation, procedures, and copies of potentially compromised SGI, and interviewed personnel to assess the adequacy and completeness of the licensee's investigation and evaluate the effectiveness of corrective actions in the matter of control SGI at the licensee's facilities and at its vendors.

b. Observations and Findings

The results of the licensee's investigation were documented in Issue Evaluation Report I0005855, dated October 17, 1996. The inspectors' review of the licensee's evaluation report disclosed that the investigation team comprised personnel with quality assurance, engineering, root cause analyses, and security expertise. The inspectors determined that the investigation was very comprehensive, thorough and self-critical. The licensee was particularly proactive in reviewing the initial findings and expanded the scope of the review to include the adequacy of control of all SGI at PECO facilities and vendors when indications of additional potential problems were identified and that the licensee took positive actions to control any SGI that was identified as being uncontrolled. The scope of the licensee's investigation included interviews with contractors, visits to vendor offices, and the review of corporate and site (Peach Bottom and Limerick) files, films, drawings, training and safeguards procedures. The licensee identified 150 findings and initiated 122 action items that were entered into the licensee's tracking

system. At the end of this inspection, 75 of the 122 action items, had been closed. All the action items were given the highest priority level (Category I) that required evaluation and approval by senior management and review boards.

The findings of the licensee's investigation included the following:

- Approximately 150 documents (primarily aperture cards of equipment drawings, but also including film cartridges and hard copies of drawing change information) containing SGI had been stored uncontrolled and accessible to unauthorized personnel at 5 different locations for periods of up to approximately 8 years.

- Uncontrolled aperture cards marked SGI were identified as being stored at the PECO Chesterbrook office.

- Uncontrolled aperture cards marked SGI were identified as being stored at the Plymouth Service Building.

- The uncontrolled aperture cards that were stored at the Plymouth Service Building had been moved to that location in June 1996, from the PECO main office in Philadelphia where they had also been stored in an uncontrolled manner.

- Film cartridges that contained SGI, but were not marked as such, were being stored at the Chesterbrook and Limerick facilities in an uncontrolled manner.

- Uncontrolled drawing change paper, microfilm and modification information containing SGI were identified at the Peach Bottom facility.

- Six vendors were identified that processed SGI. Of the six that processed SGI, two vendors were found to still have SGI in their possession. The responsibilities for handling and storing SGI were reviewed with these vendors by the licensee.

- The breakdown in the process to control SGI properly began approximately 8 years ago and went undetected by the licensee as a result of organizational changes, unclear rolls and a lack of assigned responsibility for the program.

It appeared to the inspectors that when nuclear management was moved from the licensee's corporate headquarters in Philadelphia, PA to the PECO Nuclear headquarters (Chesterbrook), Wayne, PA, control of SGI was relegated to the Peach Bottom and Limerick Nuclear Station security managers for site-specific control. The SGI under the control of the corporate security function was overlooked as no one was assigned responsibility for it.

Some of the licensee's planned corrective actions were: (1) training for handling SGI will be provided on a annual basis; (2) the process for handling and distributing SGI will be standardized between Limerick, Peach Bottom and PECO corporate offices; (3) a review of all common security procedures by an independent contractor will be conducted for compliance to regulations, and (4) future vendor contracts will include a statement describing the vendor's responsibilities for handling controlling and storing SGI. Additionally, until all corrective actions have been implemented, all SGI processing will be done by only one individual and any information that potentially contains SGI will be reviewed and distributed with supervisory sign-off and approval.

The evaluation report also addressed corrective actions that included the revision of Procedure SEC.C-4, Rev. 2, "Control of Safeguards Information". The inspectors reviewed a copy and determined that the procedure was very detailed regarding the responsibilities and handling of SGI and addressed findings from the investigation report. The procedure also described a new position titled Safeguards Administrator. This position has been filled with a knowledgeable individual who will be dedicated to the safeguards information program and will be responsible for providing safeguards training, conducting periodic audits of storage locations, performing self-assessments and recommending any necessary programmatic changes. The inspectors considered this to be a good initiative to strengthen the oversight for the SGI program.

The inspectors interviewed the security system engineers from Limerick and Peach Bottom who had reviewed the potentially compromised SGI and made the determinations that the uncontrolled SGI would not significantly contribute to an act of radiological sabotage. The engineers stated that they used the criteria described in 10 CFR 73.21 and guidance from NUREG-0794 - Protection of Unclassified Safeguards Information, dated August 1981 for making these determinations. The inspectors reviewed 120 of the SGI aperture cards to independently evaluate whether the information would significantly contribute to an act of radiological sabotage.

c. Conclusion

The inspectors determined that the licensee identified the failure to control SGI, took prompt and comprehensive actions to investigate the problems, and developed and implemented an effective corrective action plan. The inspectors concurred with the licensee in the determination that the uncontrolled SGI would not have significantly contributed to an act of radiological sabotage. However, the number of uncontrolled documents at the various locations and the duration that those documents remained uncontrolled and accessible to unauthorized persons constitute a programmatic breakdown in the protection of SGI and is contrary to the NRC requirements contained in 10 CFR 73.21. This is an apparent violation.

PARTIAL LIST OF PERSONS CONTACTED

PECo Nuclear

D. Meyers, Director Site Support , Peach Bottom Atomic Power Station (PBAPS)
R. Kinard, Manager, Security and EP, PBAPS
A. S. MacAinsh, Manager Support Services
P. Supplee, Supervisor Protection Services
H. Owrutsky, System Engineer, PBAPS
J. Spenelli, System Engineer, Limerick Generating Station (LGS)
M. Karney, Manager, Security and EP, LGS

NRC

N. Perry, Sr. Resident Inspector, LGS