North Atlantic

North Atlantic Energy Service Corporation
P.O. Box 300
Seabrook, NH 03874
(603) 474-9521

The Northeast Utilities System

March 14, 1997

Docket No. 50-443
NYN-97031

United States Nuclear Regulatory Commission
Attn.: Document Control Desk
Washington, D.C. 20555-0001

Seabrook Station
Security Event Report (LER) 97-S01-00
Loss of Duty Firefighter Shift Keys

Enclosed, please find Security Event Report (LER) 97-S01-00 for Seabrook Station which occurred on February 12, 1997. This event is being reported pursuant to 10 CFR 73.71.

Should you require further information regarding this matter, please contact Mr. Terry L. Harpster, Director of Licensing, at (603) 773-7765.

Very truly yours,

NORTH ATLANTIC ENERGY SERVICE CORP.

Ted C. Feigenbaum
Executive Vice President and
Chief Nuclear Officer

cc: H. J. Miller, Regional Administrator
A. W. De Agazio, NRC Project Manager, Seabrook Station
J. B. Macdonald, Senior Resident Inspector, Seabrook Station

INPO
Records Center
700 Galleria Parkway
Atlanta, GA 30339

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NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
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TITLE (4)

LOSS OF DUTY FIREFIGHTER SHIFT KEYS

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
02	12	97	97	S01	00	03	14	97	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
POWER LEVEL (10)	100	20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	[X] 73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Allen L. Legendre, Jr., Nuclear Licensing Supervisor	(603) 773-7773

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION	MONTH	DAY	YEAR
[ ] YES (If yes, complete EXPECTED SUBMISSION DATE).	[X] NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

At approximately 0615 on 2/12/97, the off-going (mids) duty Firefighter identified that the firefighters shift key ring was missing. The shift key ring contains a security master key. A search of the immediate office area was performed with no success. The mids duty Firefighter called Security to inquire if anyone had found "any" keys, but never identified to Security that the missing keys in question were the firefighters shift key ring that contained a security master key. The inquiry that the mids Firefighter made to Security about missing keys was misinterpreted by the days Fire Brigade Leader that Security had been notified about the lost firefighters key ring. At 0750, during the briefing for a Containment entry, the day shift Firefighter discussed the missing keys with the Security Officer present. The Security Officer stated that he was not aware of any missing keys. The day Firefighter notified the day Fire Brigade Leader that it appeared that Security had not been properly informed of the missing firefighter key ring. Security was notified by the Fire Brigade Leader and Security notified the Operations Manager that a one hour report notification to the NRC was required. The NRC was notified at 0840 per the requirements of 10CFR 73.71. While the immediate report was made within the one hour of notification of Security personnel, North Atlantic management expectations were not met regarding the communications preceding the notification. The locks were changed by 1705. There were no unaccountable vital door alarms. Subsequent searches have not located the lost keys.

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TEXT *(If more space is required, use additional copies of NRC Form 366A)* (17)

I. Description of Event

At approximately 0615 on 2/12/97, the off-going (mids) duty Firefighter identified that the firefighters shift key ring was missing. The shift key ring contains a security master key. A search of the immediate office area was performed by the mids and the on coming (days) duty Firefighters and Fire Brigade Leaders with no success. The mids duty Firefighter called Security to inquire if anyone had found "any" keys, but never identified to Security that the missing keys in question were the firefighters shift key ring that contained a security master key. The inquiry that the mids Firefighter made to Security about missing keys was misinterpreted by the days Fire Brigade Leader that Security had been notified about the lost firefighters key ring. At approximately 0700, during the Operations Shift briefing, the day Fire Brigade Leader informed the Operations shift personnel that the firefighters shift key ring was missing and please keep an eye out for them during their rounds. At 0750, during the briefing for a Containment entry, the day shift Firefighter discussed the missing keys with the Security Officer present. The Security Officer stated that he was not aware of any missing keys. The day Firefighter notified the day Fire Brigade Leader that it appeared that Security had not been properly informed of the missing firefighter key ring. Security was notified by the Fire Brigade Leader and Security notified the Operations Manager that a one hour report notification to the NRC was required. The NRC was notified at 0840 per the requirements of 10CFR 73.71. North Atlantic procedures require immediate security related NRC notification to be made to appropriate Security Department personnel. While the immediate report was made within the one hour of notification of Security personnel, North Atlantic management expectations were not met regarding the communications preceding the notification.

The locks were changed by 1705. Subsequent searches have not located the lost keys.

II. Cause of Event

Lost Keys

The cause of the lost Firefighter shift key ring is unknown. The Firefighter has no knowledge of when or how the keys were lost.

Untimely Notification

Notifications associated with this event were untimely as a result of miscommunications. The mids Firefighter originally called Security at 0620 to inquire about lost keys, never mentioning that the lost keys in question were actually the Firefighters shift key ring and that it contained a security master key. It was this original contact with Security by the mids Firefighter that lead the days Firefighter, Fire Brigade Leader and the oncoming Operations Shift to think that Security had been properly notified and that Security was handling the event. It was not until 0750 that the day Firefighter asked a Security Officer, during the briefing for a Containment Entry, if the Firefighters shift keys had been found. The Security Officer was not aware of the missing keys. The day Firefighter then contacted the Fire Brigade Leader, who in turn contacted the Security Shift Supervisor.

Related Contributing Issues

A clear understanding of the Security and Operations Key Control Programs was not present. The Security and Operations Key Control Programs do not clearly identify their "expectations" when addressing control of security keys. This lead to a misunderstanding by the Operations and Fire Protection personnel about the urgency of losing the Firefighter shift key ring since it contained a security master key.

III. Analysis of Event

The safety consequences and implications of this event are very low. Upon notification of the lost Firefighter shift key ring, Security initiated a change-out of the lock cylinders on all vital area doors. The change-out was completed at 1705 on 2/12/97. In addition, Security performed a review of the security door alarm list to ensure that no unaccountable door alarms were received during the time period from discovery of the lost Firefighter shift key ring to completion of the lock cylinder change-out. There were no unaccountable vital door alarms.

IV. Corrective Action

Completed corrective actions include:

(1) With the aid of a security door printout, a complete search of the route taken by the mids Firefighter was performed by Security and Fire Protection personnel.

(2) The day Operations personnel were informed of the missing Firefighter shift key ring and asked to search for the missing keys during their normal rounds.

(3) Operations and Security personnel have been informed of the differences between the Security "control" expectations and the current Operations/Fire Protection "control" processes. Operations/Fire Protection personnel have been informed of the need for better key control practices.

(4) The Fire Brigade Leader and the (new) Firefighter key rings were inventoried to document the keys on the key ring and to eliminate any unnecessary keys.

(5) The miscommunications issues were highlighted in an Operating Experience Summary that was presented at the morning Station Directors meeting.

Additional Corrective Actions:

(1) This event will be included in the Operations and Fire Protection Adverse Condition Report discussions as part of continuing training.

(2) North Atlantic will determine acceptable methods for the control of security keys that are part of the shift key ring.

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TEXT *(If more space is required, use additional copies of NRC Form 366A)* (17)

(3) Provide initial training of Operations/Fire Protection personnel on Security programmatic requirements and establish periodic refresher training.

(4) Establish a monitoring/self assessment program to ensure compliance to the Security Key Control Program.

It is anticipated that the additional corrective actions will be completed by September 30, 1997.

V. Additional Information

None

Similar Events

None

Manufacturer Data

None