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W3F1-97-0183
A4.05
PR

July 16, 1997

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

Subject: Waterford 3 SES
Docket No. 50-382
License No. NPF-38
Reporting of Security Incident Report

Gentlemen:

Attached is Security Incident Report (SIR) Number 97-S02-00 for Waterford Steam Electric Station Unit 3. This report documents an occurrence on June 16, 1997, where Waterford 3 security personnel determined that two individuals inappropriately entered a vital area due to a faulty security keycard reader.

This condition is being reported pursuant to Appendix G to 10CFR73 (c).

Very truly yours,

T R Leonard

T.R. Leonard
General Manager
Plant Operations

TRL/GCS/tjs
Attachment

IE74

cc: E.W. Merschoff (NRC Region IV)
C.P. Patel (NRC-NRR),
A.L. Garibaldi
J.T. Wheelock - INPO Records Center
J. Smith
N.S. Reynolds
NRC Resident Inspectors Office
Administrator - LRPD

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)
WATERFORD STEAM ELECTRIC STATION UNIT 3	05000 382	1 OF 6

TITLE (4)
UNDETECTED ENTRY INTO PLANT VITAL AREA

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
									N/A	05000
06	16	97	97	-- S02 --	00	07	16	97	FACILITY NAME: N/A	DOCKET NUMBER: 05000

OPERATING MODE (9)	5
POWER LEVEL (10)	000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	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)
E.G. BECKENDORF	(504) 739-6340

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 DATE (15)	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)

On June 16, 1997, Waterford 3 security personnel determined that two individuals inappropriately entered a vital area. The individuals did not have unescorted access to the vital area. There was no malevolent intent involved with the entries. The cause of the event was a faulty security keycard reader that gave individuals access to the vital area. The security keycard reader was repaired and the vital area entered was searched to ensure that no unauthorized personnel were in the area.

Following an investigation into this event, it was determined that there were no unauthorized entries into the vital area. The event did not compromise the health and safety of the public or plant personnel. This Security Incident Report is being submitted per Appendix G to 10CFR73 (c).

REQUIRED NUMBER OF DIGITS/CHARACTERS FOR EACH BLOCK

BLOCK NUMBER	NUMBER OF DIGITS/CHARACTERS	TITLE
1	UP TO 46	FACILITY NAME
2	8 TOTAL 3 IN ADDITION TO 05000	DOCKET NUMBER
3	VARIES	PAGE NUMBER
4	UP TO 76	TITLE
5	6 TOTAL 2 PER BLOCK	EVENT DATE
6	7 TOTAL 2 FOR YEAR 3 FOR SEQUENTIAL NUMBER 2 FOR REVISION NUMBER	LER NUMBER
7	6 TOTAL 2 PER BLOCK	REPORT DATE
8	UP TO 18 -- FACILITY NAME 8 TOTAL -- DOCKET NUMBER 3 IN ADDITION TO 05000	OTHER FACILITIES INVOLVED
9	1	OPERATING MODE
10	3	POWER LEVEL
11	1 CHECK BOX THAT APPLIES	REQUIREMENTS OF 10 CFR
12	UP TO 50 FOR NAME 14 FOR TELEPHONE	LICENSEE CONTACT
13	CAUSE VARIES 2 FOR SYSTEM 4 FOR COMPONENT 4 FOR MANUFACTURER NPRDS VARIES	EACH COMPONENT FAILURE
14	1 CHECK BOX THAT APPLIES	SUPPLEMENTAL REPORT EXPECTED
15	6 TOTAL 2 PER BLOCK	EXPECTED SUBMISSION DATE

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

REPORTABLE OCCURRENCE

Due to a faulty security keycard reader, two individuals inappropriately entered a vital area. The individuals did not have unescorted access to the vital area. In addition, due to the faulty security keycard reader, there was a potential for other individuals to enter into this area who were not authorized access. This event is being reported pursuant to Appendix G to 10CFR 73 (c) as a discovered vulnerability in a safeguards system that could allow undetected access to the vital area. On June 16, 1997, a one hour report of this event was issued per the same requirement.

INITIAL CONDITIONS

During this occurrence, Waterford 3 was in Mode 5 (Cold Shutdown). Unknown to plant personnel, the keycard reader at door 34A was inoperable at the time of this event.

EVENT DESCRIPTION

On June 16, 1997, Waterford 3 security personnel determined that two individuals inappropriately entered a vital area. The individuals did not have unescorted access to the vital area. There was no malevolent intent involved with the entries.

During this event Waterford 3 was in refuel outage 8. In support of the outage, new containment boundary perimeters were established. Special entry/exit keycard readers were installed to facilitate the processing of plant personnel into the containment area through Door 34A (west side access point). Door 34A was kept open and positive entry/exit control was maintained by a posted armed security officer. Door 35 (located inside the containment boundary area) was not used for entry/exit, since its neighboring storm door (Door 36) is kept open and placed in access mode.

On June 15, 1997, at approximately 1256 hours, the armed security officer posted at Door 34A reported to Central Alarm Station (CAS) that the entry keycard reader was malfunctioning and inoperable. The Officer compensated for the malfunction by

manually logging authorized entries. In addition, a condition identification, a document used to correct the deficiency, was generated. The keycard reader was repaired by the I&C department and placed back in service. Per site security procedure PS-012-109, "Security Equipment Inspection and Testing," an operability test was again performed which confirmed that the proper entry proceed lights were being displayed.

On June 16, 1997 at approximately 0623 hours, the security officer posted at Door 34A reported to CAS that the entry keycard reader was again malfunctioning. Since the previous condition identification was not completely administratively closed, repairs were completed under the same condition identification by the I&C Department, and the keycard reader was returned to an operable condition. An operability test was performed which confirmed that the proper entry proceed lights were being displayed.

At approximately 1007 hours an alarm was generated by an employee attempting to exit the containment boundary area through Door 161 located on the - 4 level of the Reactor Auxiliary Building (RAB). During the course of the initial investigation, at approximately 1051 hours, another alarm was generated by an employee attempting to exit the containment boundary area through Door 21 located on the +21 level of the RAB. A computerized card history was generated on the employees' keycard usage, revealing that neither employee had logged into the containment entry keycard reader at Door 34A. However, the report did display that the employees had logged into a keycard reader located at Door 35. Since the containment boundary perimeters were configured for the refueling outage and Door 35 was not being used, the report should not have indicated entry into door 35. A test of the keycard reader at Door 34A was performed by having the posted security officer insert his keycard through the keycard reader and verifying the log-in with CAS. The computerized card history report generated by CAS displayed the officer's keycard as being logged into the Unit/Area/Sector assigned to the keycard reader at Door 35, rather than the Unit/Area/Sector assigned to the keycard reader at Door 34A. A card history report generated on the entry/exit keycard readers for Door 34A, covering the time periods between June 15, 1997 at 1400 hours and June 16, 1997 at 1100 hours, determined no unauthorized entries into the containment area were made. However, the reports did

reveal that employees who were using the keycard reader at Door 34A were being registered as logging into the keycard reader at Door 35. The reports also indicated a number of employees had exited Door 34A, but none had been logged in as having entered Door 34A.

The report revealed that the Unit/Area/Sector address number associated with Door 34A entry was not recognizing the containment entry authorized access level, but was recognizing an access level of a lower value (non-containment boundary access level number). Because of this problem, the security officer posted at Door 34A was instructed to manually log all plant employees seeking access into the containment boundary area, after ensuring positive identification and authorized access level. A request was made to the I&C Department to repair the entry keycard reader at Door 34A. After the repairs were made, the posted officer tested the keycard reader and verified with CAS that the correct Unit/Area/Sector address was being displayed for Door 34A. At the completion of the tests and verification that the keycard reader was working properly, the manual log method was discontinued and use of the keycard reader at Door 34A was resumed.

A review of the Area Access Change Request Authorization forms disclosed, that both employees who had entered containment without the proper access level on June 16, 1997, had been granted containment access. However, access had expired on June 14, 1997. Per the requirements of Security Procedure PS-011-107, "Badge/Key Card Assignment and Control," the individual's containment access was terminated in the security computer 15 minutes after it had expired.

CAUSAL FACTORS

A Root Cause Analysis (RCA) team was formed to investigate this event. The team determined the root cause to be an inadequate test acceptance criteria. If the acceptance criteria had included a requirement to ensure the security keycard reader had been assigned the proper address, then the problem with the keycard reader would have been discovered prior to placing it in service. Site Procedure UNT-005-002,

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

"Condition Identification," does not require equipment identified for repair under the minor maintenance category to have detailed work instructions or procedures in place for repairs. Keycard readers are identified under the minor maintenance category, therefore the I&C Department was not required to maintain procedures outlining testing criteria to be performed on the keycard readers after repairs (other than a manufacturer's technical specification manual). The I&C Department depends on the field acceptance test (performed by the security department) for validation of the repaired equipment. Security's procedure PS-012-109, "Security Equipment Inspection and Testing," did not identify criteria for ensuring address assignment on repaired keycard readers are correct prior to accepting keycard readers back into service.

CORRECTIVE MEASURES

In addition to the corrective measures discussed above, all remaining keycard readers throughout the plant were tested to ensure the correct Unit/Area/Sector had been properly assigned. Furthermore, a complete containment walk down search was performed to ensure that there were no personnel in the area without the approved authorized access levels. The search revealed no one was present who was not authorized.

The keycards of the two employees were inactivated, the employees were escorted out of the Protected Area and statements were taken.

Central Alarm Station /Secondary Alarm Station (CAS/SAS) personnel were instructed, via the "Security Information (SI) File," that testing criteria for accepting any keycard reader as operable shall include verification that the keycard reader has the correct address assignment.

A Security Operations Bulletin will be issued outlining the testing criteria to be performed on keycard readers after maintenance.

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

Security Procedure PS-012-109, "Security Equipment Inspection and Testing," will be revised to incorporate the additional steps verifying the assignment of proper addresses. In addition, other testing criteria within that procedure will be evaluated for adequacy. If inadequacies are identified, they will be remedied by incorporating the criteria in the revision also.

The I&C Department will implement a process whereby prior to placing a keycard reader into service they will ensure that the keycard reader address assignment switch is not malfunctioning.

Additionally, security will monitor in service equipment testing for one year within the scope of the self assessment program.

SAFETY SIGNIFICANCE

The two employees who gained undetected access had previously been granted unescorted containment access, but our administrative controls voided this access on a pre-determined date. Their entry in the area was not malevolent, but was done as part of an assigned task.

Subsequent to the discovery of this event, security tested the remaining keycard readers and determined that they were fully functional. In addition, a complete containment walk down search was performed to ensure that no unauthorized personnel were in the area. The search revealed no unauthorized activities.

This event did not compromise the health and safety of the public and the safe operation of the plant.

SIMILAR EVENTS

No similar events reported as SIRs were identified.