

LICENSEE EVENT REPORT (LER)

(See reverse for required number of
digits/characters for each block)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-8 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.

FACILITY NAME (1)

DOCKET NUMBER (2)

PAGE (3)

Waterford Steam Electric Station Unit 3

05000 382

1 OF 6

TITLE (4)

Potential for 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
07	04	97	97	503	00	08	04	97	N/A	05000
									FACILITY NAME	DOCKET NUMBER
									N/A	05000
OPERATING MODE (9)		5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
POWER LEVEL (10)		000	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, Security Superintendent

(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)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On July 4, 1997, Security personnel discovered scaffolding that permitted egress from the +40 foot elevation of the turbine building to within the High Pressure Turbine Enclosure on the turbine deck (+67 elevation). Because the enclosure doors were unsecured, the scaffolding permitted undetected access to the turbine deck, a non-vital area, and the Reactor Auxiliary Building (RAB) roof, a vital area. A contract employee with unescorted access to both the turbine deck and the RAB roof used the scaffold to gain access to the turbine deck. The contractor did not enter the RAB roof. The contractor informed Security within minutes of entering the turbine deck; however, Security failed to recognize the potential for undetected access onto the RAB roof for approximately 36 minutes. Once the vulnerability was recognized, Security took immediate compensatory actions and searched the area for unauthorized personnel and evidence of sabotage or tampering. No problems were identified. The apparent cause of this event is inadequate communications regarding proper High Pressure Turbine Enclosure controls when normal steam flow is absent. A Security Directive will be developed to address outage configurations and appropriate compensatory measures. This event did not compromise the health and safety of the public.

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**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

A contract employee gained access to the turbine deck, a non-vital area, and could have entered a vital area (Reactor Auxiliary Building (RAB) roof) without detection. The individual has unescorted access to both the vital and non-vital area. This event is being reported pursuant to 10 CFR Part 73, Appendix G, Paragraph I(c) as a discovered vulnerability in a safeguards system that could allow undetected access to a vital area. Appropriate compensatory measures were not implemented within ten minutes of discovering the event. On July 4, 1997, a one hour report of this event was issued per the same requirement.

INITIAL CONDITIONS

At the time of this event, Waterford 3 was in Mode 5 (Cold Shutdown). Refuel Outage Eight (RF08) activities were in progress. Doors 180 and 181, which provide positive entry/exit control to the turbine deck and the RAB roof, were operable. A scaffold was installed that permitted egress from the +40 foot elevation of the turbine building into the High Pressure Turbine Enclosure on the turbine deck (+67 elevation). The enclosure doors were unsecured. Security had initiated compensatory measures pending startup of the turbine by increasing the frequency of armed security patrols of the turbine deck.

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EVENT DESCRIPTION

During RF08, Doors 180 and 181 were maintained open to facilitate the egress of plant personnel performing turbine/generator maintenance. Positive entry/exit control to the RAB roof was maintained by a posted armed security officer.

On June 12, 1997, subsequent to completion of turbine/generator maintenance, the Security post at the +67 Turbine Generator Building (TGB) was relieved, Doors 180 and 181 were placed in the secure mode, and the High Pressure Turbine Enclosure was secured. Security officers were instructed to perform periodic patrols of the turbine deck. If the enclosure doors were found open, the officers were instructed to report the situation to Security Supervision.

On July 4, 1997, a contract employee gained access to the turbine deck via scaffolding that permitted egress from the +40 foot elevation of the turbine building into the High Pressure Turbine Enclosure on the turbine deck. The scaffolding was being built to allow removal of oil soaked insulation. The employee, needing additional scaffolding materials, entered the High Pressure Turbine Enclosure, exited through an open door, and proceeded to Door 180 to key card out of the turbine deck area. At approximately 1309 hours, upon carding out the employee received four flashing green lights. At that time, a security officer entered the area to perform an assigned 2 hour surveillance tour. The employee questioned the security officer regarding the flashing green light. The officer instructed the contract employee to run his key card through the card reader a second time and exit the area upon receipt of a solid green light. Neither the security officer nor the contract employee recognized that an undetected pathway to a vital area had been created. At 1347 hours, a second Security employee discussed the event with the contract employee and recognized the vulnerability for access to the RAB roof.

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The contract employee had authorized access to both the turbine deck and the RAB roof. There was no malevolent intent involved with the entry. The potential for an undetected pathway via the scaffolding was created, identified, and eliminated on July 4, 1997.

CAUSAL FACTORS

A Root Cause Analysis (RCA) team investigation into this event is not yet complete. However, preliminary investigations indicate the root cause of the event is inadequate communication. For example, Security Supervision ineffectively communicated expectations for controlling access through the floor of the High Pressure Turbine Enclosure when normal steam flow is not present in the secondary piping. With steam flow present, ambient temperatures preclude personnel egress into the High Pressure Turbine Enclosure from the +40 foot elevation. In addition, Doors 180 and 181 would be in the secure mode, and an armed security officer would not be posted.

Though security performed rounds every 2 hours, it is apparent that at least one security officer was confused about the access requirements for this area. This Security Officer erroneously presumed that the enclosure doors were permitted to be open for ventilation or to facilitate work in the area.

The contract employee did not recognize he had gained undetected access to the turbine deck and the consequences of that action. Additionally, the High Pressure Turbine Enclosure doors are not labeled or positively controlled (i.e. locked) to alert employees that the doors must remain closed when Doors 180 and 181 are in the secure mode and the plant is not operating.

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CORRECTIVE MEASURES

The following corrective measures were (will be) implemented:

- Security immediately initiated compensatory measures (Security Officer posting and a walk-down of the area for evidence of sabotage and tampering). Those measures were established at approximately 1347 hours, about 36 minutes after the contract employee initially brought the situation to the attention to Security personnel.
- A permanent sign was affixed to the High Pressure Turbine Enclosure doors to alert employees to keep the doors closed and notify Security if they must be opened.
- The individuals immediately involved with this event were briefed by Security Management on the correct access requirements for this area.
- A Security Directive will be developed to include specific instructions relating to outage or off-normal situations and identification of access requirements.
- This SIR will be revised when the RCA investigation is completed if the investigation identifies additional information that meets the revision criteria of NUREG -1022.

SAFETY SIGNIFICANCE

The safeguards vulnerability was discovered the same day it was created. The employee who gained undetected access through the unprotected pathway had authorized access. The entry in the area was not malevolent, but was implemented in support of efforts to facilitate planned maintenance.

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Subsequent to the discovery of this event, security completed a RAB roof walk-down/ search to ensure that no unauthorized personnel were in the area. The search revealed no unauthorized activities (sabotage or tampering) and no presence of unauthorized personnel. This event did not compromise the health and safety of the public and the safe operation of the plant.

SIMILAR EVENTS

Within the last two years no similar events reported as SIRs were identified.