U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 50-219/85-20

Docket No. 50-219 License No. DPR-16

Licensee: GPU Nuclear Corporation
100 Interpace Parkway
Parsippany, New York 07054

Facility Name: Oyster Creek Nuclear Generating Station

Management Meeting: NRC Region I, King of Prussia, Pennsylvania

Management Meeting Conducted: June 17, 1985

Prepared by: R. Keimig for 2-20-86
Jack M. Dunlap, Physical Security Inspector date

Approved by: R. Keimig 2-20-86
R. R. Keimig, Chief, Safeguards Section, date
Division of Radiation Safety and Safeguards

Meeting Summary: The Management Meeting was convened to discuss an event involving a lost security badge and key card on January 16, 1985, which came to the attention of licensee management about February 15, 1985, and to discuss the corrective actions taken by the licensee to prevent a recurrence. The corrective actions described by the licensee appeared to be adequate.

DETAILS

1. Attendees

GPU Nuclear Corporation

R. P. Fasulo, Director of Administration
J. R. Thorpe, Director of Licensing and Regulatory Affairs
J. Knubel, Security Director
D. J. Long, Security Manager
R. T. Ewart, Security Department

NRC Region I

T. T. Martin, Director, Division of Radiation Safety and Safeguards
J. H. Joyner, Chief, Nuclear Material Safety and Safeguards Branch
R. R. Keimig, Chief, Safeguards Section
E. Conner, Chief, Projects Branch - 1A
J. M. Dunlap, Physical Security Inspector

2. Introduction

Mr. Martin opened the meeting and stated his understanding that on January 16, 1985, a photo identification badge and key card had been lost by a regular plant employee and that the site security management did not become aware of the event until February 15, 1985. Three violations of NRC requirements had been cited as a result of the event, which the Region I staff considered as a moderate loss of security effectiveness and which was not reported to the NRC in accordance with 10 CFR 73.71(c). Mr. Martin requested the licensee representatives to discuss the circumstances surrounding the event, any deficiencies or security program weaknesses identified by the licensee, and the actions that have been taken as a result.

Mr. Fasulo expressed the licensee's concerns regarding the event and emphasized GPU Nuclear's commitment to implement a highly effective security program. He discussed several recent initiatives that had been undertaken to upgrade the program. Mr. Long, Oyster Creek Security Manager, provided a chronology of the circumstances surrounding the event and described the investigation that was initiated and its results, and the actions which have been taken to correct the deficiencies which were identified. Mr. Long explained that the event surfaced as a result of an investigation by the Radiation Control Department (Radcon) into a high radiation reading on an employee's thermoluminescent dosimeter (TLD). The TLD apparently had been attached to the badge and key card when they were lost in a radiation area of the plant. Security management did not learn of the lost items until February 15, 1985 when they were advised by Radcon. The Security Department questioned security personnel who were on duty the day the badge, key card, and TLD were lost inside the protected area, and reviewed the key card punch records for the same date.

Mr. Long said that he believed the craft person who lost the items tailgated out of the plant protected area with another craft person (a friend) at the end of the work shift, but that they denied it when questioned.

Mr. Long enumerated the following deficiencies and program weaknesses as a result of their investigation:

a.

b.

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c.

Mr. Long enumerated the following corrective actions which were taken to preclude recurrence of a similar event:

a.

b.

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c.

d.

e.

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f.

g.

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i.

Mr. Fasulo and Mr. Long expressed the view that they didn't believe this event was formally reportable to NRC because, when the incident came to the security department's attention, corrective action was promptly initiated and because the badge and key card had not been used in an unauthorized manner. NRC representatives acknowledged that the event would not have to be reported if the badge and key card had been properly voided from the system at the time it was lost. However, this did not occur because of inadequacies in the licensee's access control program. Region I contended that failure of the security system to compensate for the loss i.e., by voiding the badge and key card, resulted in a moderate loss of security effectiveness that should have been reported. Further, when NRC-approved security systems fail, event reports are necessary in order for the NRC to evaluate whether timely and adequate corrective measures are taken by the licensee and whether the corrective measures taken are sufficient to preclude a recurrence. This is an important NRC responsibility. Mr. Martin stated that he would review the reportability matter further with his staff and advise the licensee regarding his finding in subsequent correspondence.