NRC FORM 366 (6-1998) U.S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER)

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

APPROVED BY OMB NO. 3150-0104
EXPIRES 06/30/2001

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the 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. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

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TITLE (4)

Potential Compromise of Safeguards Material Because of Unlocked Safeguards Cabinet

| EVENT DATE (5) | | | LER NUMBER (6) | | | REPORT DATE (7) | | | OTHER FACILITIES INVOLVED (8) | |
|---|---|---|---|---|---|---|---|---|---|---|
| MONTH | DAY | YEAR | YEAR | SEQUENTIAL NUMBER | REV NUMBER | MONTH | DAY | YEAR | FACILITY NAME | DOCKET NUMBER |
| 10 | 11 | 98 | 98 | 005 | 00 | 11 | 06 | 98 | FACILITY NAME | DOCKET NUMBER |

OPERATING MODE (9): MODE 1

POWER LEVEL (10): 100 percent

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 20.402(b) | | 20.405(c) | | 50.73(a)(2)(iv) | | 73.71(b) |
| | 20.405(a)(1)(i) | | 50.36(c)(1) | | 50.73(a)(2)(v) | | 73.71(c) |
| | 20.405(a)(1)(ii) | | 50.36(c)(2) | | 50.73(a)(2)(vii) | X | OTHER |
| | 20.405(a)(1)(iii) | | 50.73(a)(2)(i) | | 50.73(a)(2)(viii)(A) | | 73.71, App. G, I (c) |
| | 20.405(a)(1)(iv) | | 50.73(a)(2)(ii) | | 50.73(a)(2)(viii)(B) | | |
| | 20.405(a)(1)(v) | | 50.73(a)(2)(iii) | | 50.73(a)(2)(x) | | |

LICENSEE CONTACT FOR THIS LER (12)

NAME
Michael J. Angus
Manager, Licensing and Corrective Action

TELEPHONE NUMBER (Include Area Code)
316-364-4077

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

| CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO EPIX | CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO EPIX |
|---|---|---|---|---|---|---|---|---|---|
| X | | | | YES | | | | | |
| | | | | | | | | | |

| SUPPLEMENTAL REPORT EXPECTED (14) | | | EXPECTED SUBMISSION DATE (15) | MONTH | DAY | YEAR |
|---|---|---|---|---|---|---|
| YES | X | NO | | | | |

ABSTRACT (16):

On October 11, 1998, at approximately 1:27 P.M. (CST) a Wolf Creek Nuclear Operating Corporation (WCNOC) Security Officer, conducting a building walkdown, entered the WCNOC Document Services Safeguards Room to verify that all Safeguards Cabinets were locked. The lock on all four cabinets appeared to be locked. To verify that the padlocks were secure, the Security Officer pulled on the padlocks. This resulted in the padlock on Safeguards Cabinet 075 opening. The Security Shift Lieutenant was immediately notified and subsequently Security management was notified. Because of the potential compromise of safeguards information, a one-hour notification was made to the NRC on October 11, 1998, at 6:27 PM. Investigation of this event confirmed that there was no compromise of Safeguards Information. The cause of this event was lack of guidance for proper locking of padlocks. Corrective actions include an instructions memo, and the incorporation of these instructions into annual training. This event had no impact on plant equipment, plant operation, or the health and safety of the public.

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PDR ADOCK 05000482
S PDR

**Plant Conditions Prior to the Event:**

MODE = 1
Reactor Coolant Pressure: = or < 2235 psig
Reactor Power: 100 percent

**Basis for Reportability:**

10 CFR 73.71, Appendix G, I (c) requires a thirty-day report on NRC Form 366 as a follow-up to the one hour-notification required by 10 CFR 73.71 (b) (1).

**Description of Event:**

On October 11, 1998, at approximately 1:27 P.M. (CST) a Wolf Creek Nuclear Operating Corporation (WCNOC) Security Officer, conducting a building walkdown, entered the WCNOC Document Services Safeguards Room to verify that all of the Safeguards Cabinets (CINs) in the room were locked. The locks on all four of the Safeguards Cabinets appeared to be locked. However, to verify that the padlocks were secure, the Security Officer pulled on each padlock. This resulted in the padlock on CIN 075 opening. The Security Shift Lieutenant was immediately notified and subsequently Security management was notified. Because of the potential compromise of safeguards information, a one-hour notification was made to the NRC.

CIN 075 is located within the Protected Area Boundary at the Wolf Creek Generating Station (WCGS) in the Document Services area of the Clyde Cessna Administration Facility.

The Security Officer remained at the location of the Safeguards Cabinet CIN 075 until Document Services Safeguards Custodians arrived from off-site to perform an audit of the cabinet. An inspection of the cabinet and lock showed them to be in good condition. There were no signs of the lock or cabinet being compromised. The Safeguards Cabinet was secured after the audit was complete. The audit of the contents of CIN 075 accounted for all safeguards documents on the inventory list.

The lock used on CIN 075 was tested by the WCNOC Locksmith with the following results:

- The lock was placed in the open position and then closed into the locked position. Three individuals, including the Locksmith, could not open the lock after multiple pulls.
- With the lock in the closed/locked position, the combination was dialed. In almost all cases, the lock was difficult to open. In most instances, four or more pulls on the shackle were required to open the lock.
- With the lock in the open position, the lock was closed slowly to determine locking capability. The lock was tested approximately eight times. Each time the shackle closed with no resistance and locked into position. When pulled multiple times, the lock did not open.
- The lock was disassembled by the Security Locksmith. After inspection of the lock, the Locksmith could not identify any problems with the lock. The Security Locksmith checked

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the padlock after it was taken apart and found no broken or worn parts that would indicate a problem. The combination must be dialed correctly before the shackle can be pulled opened. It is the opinion of Security Locksmith that the padlock in question was working correctly.

Review of procedure AP 27-004, "Controlling Safeguards Information," identified that there is no information contained in the procedure on the proper method to lock a cabinet or how to ensure the cabinet is locked. In addition, the Lesson Plan for Safeguard Custodian and Safeguard Authorities does not include instructions for proper lock verification.

**Root Cause:**

The root cause of this event is the omission of necessary guidance in training lesson plans. Training and performance standards are not included in the lesson plan.

The root cause investigation identified that the verification process to ensure the cabinet was locked was not adequate. The custodian dialed the combination and the lock would not open. The custodian believed that an incorrect combination had been used and left the area. If the custodian would have spun the lock dial and pulled on the lock for proper verification, the lock would have been secured.

Based on interviews with Safeguards Custodians, this dual verification is not a standard practice for lock verification. Generally, Safeguards Custodians open the cabinet, obtain the needed information, and close the lock. This process is generally effective in securing the lock. If the dial is not spun on the lock every time the combination is dialed, the lock is not secure and could open when pulled upon. Safeguards Custodians had not been trained on the importance of this two step process to ensure the lock is secure. The Safeguards Custodian training does not provide guidance that this two step verification of the lock is necessary to secure the lock.

A contributing cause is inadequate interface among organizations. When trouble with padlocks was known, no immediate actions were taken to replace the locks.

An additional contributing cause to this event is the lock was catching, i. e., not unlocking, after the Safeguards Custodian dialed the combination and pulled on the lock. The design of the lock requires the combination to be dialed perfectly for the lock to open. If one number is off by just a fraction, the lock will not open.

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**Corrective Actions:**

Immediate Corrective Actions:

- The Security Shift Lieutenant was immediately notified and a one-hour report was made to the NRC. The Shift Lieutenant notified the Shift Supervisor, Superintendent Security, and the Security Shift Lieutenant Operations.
- A Security Officer was posted in the area until the Safeguards Cabinet Custodian arrived to inventory the cabinet.
- The Safeguards Custodians of the cabinet were called to report to work to perform an inventory of the Safeguards Cabinet. A complete audit of Safeguards Cabinet CIN 075 was performed. No documents were found to be missing.
- The Security Shift Lieutenant verified that the lock was operable and locked the cabinet.
- The Security Shift Lieutenant and Shift Supervisor made the required one hour report to the NRC.
- Performance Improvement Request (PIR) 98-3030 was initiated to determine root cause of, and corrective actions for this event.

Corrective Action to Prevent Recurrence:

- On October 12, 1998, all locks on the four Safeguards Cabinets in the Document Services Safeguards Room were replaced.
- The Safeguards Custodian and the Locksmith were counseled on the importance of taking immediate actions when problems are encountered with Safeguards Locks.
- As an interim measure, letter DS 98-0009 was issued on October 27, 1998, to Safeguards Custodians providing instructions on the proper method of ensuring Safeguards Cabinets are locked. This letter also addressed proper padlock operation.
- A copy of PIR 98-3030 was distributed to Safeguards Custodians and Safeguards Authorities on October 30, 1998.
- Lesson Plan GT1240701, "Safeguards Information Training," Safeguards Custodians and Safeguards Authorities annual training, will be revised to include proper locking information by January 15, 1999.

**Safety Significance:**

This event had no impact on plant equipment, plant operation, or the health and safety of the public.

Investigation of this event determined that WCNOC did not have a loss of Safeguards Information as a result of this event. Tests performed by WCNOC personnel indicate that the only way for the lock to have been in the as-found condition is for the lock combination to have been dialed. It was further determined that the combination had been dialed by the Safeguards Custodian and left in the unlocked position because when the discovering Security Officer pulled on the lock it opened.

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The potential for compromise of Safeguards Information did exist; however, there is no evidence that a compromise occurred. The basis for this statement is: It is necessary that the lock be separated from the cabinet for removal, or copying of Safeguards Information. To place the lock in the as-found condition, it is necessary to place the lock on the cabinet and close it. Closing the lock secures the lock.

**Other Previous Occurrences:**

Performance Improvement Requests (PIRs) and Licensee Event Reports (LERs) - A review of past PIRs and LERs from 1989 to present were reviewed with the following results:

LER 89-S02-00 - This LER addressed sixteen safeguards problems identified between 1985 and 1989. Of the sixteen events, six dealt with safeguards cabinets being left open. It was identified that the events occurred as a result of a human performance problem, although no single root cause could be identified. Two causal factors applicable to a majority of the events were identified. The first causal factor was a poor understanding of Safeguards Information handling requirements, significance of errors, and resulting consequences. The other major causal factor was identified as a lack of self-verification or inattention to detail. The volume of Safeguards Information handled on a daily basis by personnel was identified as being a prominent contributing factor.

LER 92-S01-00 - Safeguards Cabinet left open. The root cause of this event was a personnel error attributed to lack of attention to detail by not verifying that the safeguards cabinet was locked upon completion of work. The responsible safeguards custodian has been counseled on the importance to verify that the safeguards cabinet is locked when not in use. Also, Document Control personnel developed and implemented a checklist which requires physical verification that the safeguards cabinet is locked at the end of each workday. This checklist requires the time and date of verification and the initials

LER 97-002 - Safeguards Cabinet left unlocked - Document Services was unable to identify who left the cabinet unlocked or when it was left unlocked. Document Services believes this to be an isolated personnel error. Current administrative controls are acceptable. The document services custodian did not ensure the safeguards cabinet was properly locked. Responsible custodians were counseled and the Manager of Document Services reaffirmed expectations to Document Services SI Custodians via letter DS 97-0003.

These LERs were all identified as personnel error due to the lack of attention to detail. In the listed cases the cabinets were physically left opened. In this case the custodian tried to open the lock and could not get it open. Because the padlock did not open when the custodian pulled on it, the custodian felt that the cabinet was locked prior to leaving. In conclusion this event is unrelated to the previous events.

The Operating Experience (ITIP) database was reviewed from 1991 to present. No related information was identified.

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Three other Nuclear plants were contacted, Callaway, Cooper and Comanche Peak to identify their past history and any corrective actions. Based on these interviews there are no improvements or recommendation that Wolf Creek does not already have in place.