ORIGINAL

SEP 23 1988

Docket Nos. 50-424, 50-425
License Nos. NPF-68, CPPR-109

Georgia Power Company
ATTN: Mr. W. G. Hairston, III
Senior Vice President -
Nuclear Operations
P. O. Box 4545
Atlanta, GA 30302

Gentlemen:

SUBJECT: ENFORCEMENT CONFERENCE

This refers to our previous Enforcement Action No. 87-100 furnished to you in our letter of September 4, 1987. In that letter you were advised that certain additional potential violations, associated with security incidents which had occurred at Plant Vogtle earlier in 1987, were being reviewed and that you would be advised of that effort in future correspondence.

The NRC's Office of Investigations (OI) has completed its investigation of three security incidents and has concluded that the former Site Security Manager at Plant Vogtle did on two occasions willfully violate the reporting requirements of 10 CFR 73.71. Synopses of the three OI reports are enclosed.

OI Report No. 2-87-008 concludes that a security event which occurred on January 26, 1987, relative to a plant tour by several unauthorized individuals was not documented in the Safeguards Event Log as required by 10 CFR 73.71, nor was the event file located in the container used to secure the files indexed by the Safeguards Event Log. Our inspector, upon inquiry, was furnished the event file by the Site Security Manager who had it located in his office desk.

OI Report No. 2-87-009 concludes that a security event which occurred on April 1, 1987, relative to a contract security officer being found asleep while posted as a compensatory measure at a degraded vital area barrier, was not reported to the NRC within the time frame required by 10 CFR 73.71. The Site Security Manager did not notify the NRC of the event because it was the security contractor, and not the Site Security Manager, who made the determination that the officer was in fact asleep on post.

OI Report No. 2-87-010 is furnished for your information; it does not hold any relevance to the former Plant Vogtle Site Security Manager. This Report addressed possible falsified alarm station records and concluded the records reflected human error and were not deliberately falsified. Therefore, no further enforcement action is planned on this issue.

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In view of the OI findings, you are requested to attend an Enforcement Conference in our office to discuss this matter. We will contact you separately to establish a mutually agreeable date and time for the meeting.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2 Title 10, Code of Federal Regulations, a copy of this letter and its enclosure will be placed in the Public Document Room.

Should you have any questions concerning this letter, we will be pleased to discuss them.

Sincerely,

J. Nelson Grace
Regional Administrator

Enclosure:
Synopses of OI Reports 2-87-008;
2-87-009; 2-87-010

cc w/encls:
R. P. McDonald, Executive Vice President, Nuclear Operations
P. D. Rice, Vice President, Project Director
C. W. Hayes, Vogtle Quality Assurance Manager
G. Bockhold, Jr., General Manager, Nuclear Operations
J. P. Kane, Manager Licensing and Engineering
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B. W. Churchill, Esq., Shaw, Pittman, Potts and Trowbridge
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NRC Resident Inspector
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RII	RII	RII	RII	RII	RII
WTobin	PMcGuire	WCline	JSchhr	MSinkule	VLBrownlee
09/21/88	09/21/88	09/21/88	09/21/88	09/ /88	09/21/88

RII	RII	RII
LReyes	GJenkins	MErnst
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SYNOPSIS

This investigation was requested by the U.S. Nuclear Regulatory Commission (NRC), Region II, Regional Administrator after a March 1987 inspection by Division of Reactor Safety and Safeguards (DRS) officials revealed possible programmatic deficiencies in the security program at Georgia Power Company's (GPC) Alvin W. Vogtle Electric Generating Plant (VEGP), the licensee, Waynesboro, Georgia. Specifically, the inspection revealed, among other disclosures, that VEGP security officials may have deliberately failed to search a Board of Directors, Nuclear Operations Overview Committee (NOOC) group, including their GPC escorts, in violation of the licensee's Physical Security Plan (PSP) before they were accessed into Protected and Vital Areas (PA/VA) of the facility. The requestor cited other potentially willful violations of security requirements and commitments in the request letter which will be addressed and reported in Office of Investigations Report Numbers 2-87-009 and 2-87-010.

The investigation of the January 26, 1897, NOOC visitation event at the VEGP facility focused on three separate but related aspects of this incident. Reportedly, the VEGP General Manager (GM) had arbitrarily waived or exempted the PSP search requirements for the NOOC tour group and their bus even though a member of his staff informed him that searches were required. Further, once licensee management recognized the severity of the incident immediately following the plant tour, their actions reportedly may have violated the safeguards event reportability requirements set forth in 10 CFR 73.71(c).

Finally, the licensee, through possible improper activities by its Site Security Manager, may have violated 10 CFR 73.71(c) safeguards event logging requirements while intentionally attempting to withhold safeguards information from the NRC.

A review of VEGP documentation, including organization charts, security correspondence, and security department records, substantiated that the GPC received from the NRC a low power license to operate the VEGP on January 16, 1987, and that final lockdown (a totally secure environment) and full compliance with the requirements of the PSP was expected concurrent with activation of the facility. These records also reflect that the VEGP General Manager (GM) convened a staff meeting on January 23, 1987, to discuss final arrangements for the NOOC plant tour on January 26, 1987. Various documents associated with the January 26, 1987, incident identify the plant tour participants, agenda, and significant aspects of the event. The VEGP incident report of the NOOC visit (SR117-87) dated January 26, 1987, indicates the GM was advised at the staff meeting on January 23, 1987, by a security department employee that "search requirements were in effect for entry into the PA." According to the incident report the GM replied that he "did not want the visitors searched" and to "expedite their entry into the Protected Area."

The VEGP security department employee who reportedly informed the GM that search requirements were in effect was interviewed on two separate occasions. He acknowledged that although he told the GM that search requirements (personnel and vehicle) were in effect, he admitted that he did not clearly and forcefully communicate to the GM that a PSP violation would occur if searches were waived. He further indicated that, in retrospect, it is possible he caused the GM to believe he had legitimate authority to exempt certain well known individuals

from the PSP access control requirement. A corporate Nuclear Security Coordinator (NSC) who was the acting Site Security Manager (SSM) during the afternoon of the January 26, 198.. NOOC visitation event reported that immediately after the tour it was determined conclusively the General Manager did not have the authority to waive searches, although this issue was first broached while the tour was in progress inside the PA. The NSC reported he immediately contacted the GPC corporate security manager who implemented corrective actions and reportedly began discussions concerning 10 CFR 73.71 reportability aspects of this event.

Other corporate and VEGP personnel provided substantive corroboration concerning the events prior to, during, and following the January 26, 1987, NOOC plant tour. The acting Site Security Administrative Supervisor commented regarding regulatory requirements relating to the various aspects of safeguards events reportability and maintenance of required logs and records. An interview of the Technical Assistant to the General Manager acknowledged that visitor search instructions in the January 23, 1987, meeting were non-specific and allowed the GM to believe he could legitimately waive searches. The Assistant Plant Support Manager concurred that he participated in significant reportability discussions with other managers immediately following the plant tour event and the consensus of participants, based upon their interpretation of regulatory language, was that the event was not reportable to the NRC but would be recorded and filed appropriately at the VEGP for future (NRC) inspection purposes.

The General Manager was interviewed and he steadfastly denied he knowingly violated a PSP or regulatory access control requirement by exempting personnel and vehicle searches during the NOOC plant tour incident. He steadfastly maintained that he believed he had legitimate PSP authority to exempt the search requirements at the time he did so. He advised that immediate remedial actions were implemented when it was determined following the tour that he did not have this authority pursuant to the PSP. He advised that deliberative 10 CFR 73.71 reportability discussions with VEGP and corporate officials ensued immediately which resulted in the decision that the incident was not a reportable safeguards event but one that would be logged and filed pursuant to applicable requirements. The VEGP Plant Manager, the corporate Nuclear Security Manager and the Senior Vice President for Nuclear Operations, within their realm of knowledge of the NOOC visitation event, provided compatible testimony regarding the incident and denied any willful deliberate behavior by the GM or others in permitting the plant tour participants to access the PA without being searched or in resolving the NRC reportability issue in the manner it was initially addressed. The licensee, in a May 19, 1987, letter to the NRC, reversed its initial decision regarding reportability and advised that under a more conservative approach the January 26, 1987, NOOC visitation event was now deemed reportable pursuant to 10 CFR 73.71 criteria.

During the investigation a fact pattern developed which strongly indicates that the actions of the SSM regarding the safeguards event logging and/or incident report filing requirements pertaining to the NOOC visitation matter, were suspicious of willful attempts to conceal safeguards information from the NRC. Safeguards event records, which are the responsibility of the SSM, were devoid of an entry regarding this incident. By chance, during the NRC inspection in March 1987, the inspecting official learned of the event and after being unable to locate the incident report in the VEGP safeguards file obtained it from the SSM who took it from his desk. His reactions to the discovery of the incident

report were reportedly indicative of surprise and disappointment that the NRC had learned of the event. During the interview of the SSM, he acknowledged extensive discrepancies and deficiencies in the VEGP incident report management system. He admitted that the NOOC visitation event was not recorded in the safeguards event logs and the incident report was not filed in the proper location for NRC inspection purposes; but he denied any willful attempts to violate 10 CFR 73.71(c) or PSP requirements or to conceal safeguards information from the NRC.

In conclusion, and based upon investigative disclosures, it does not appear that the GM knowingly violated PSP requirements by directing that NOOC members be exempted from searches. Instead, his actions in this respect were apparently predicated upon misleading instructions from a staff member who did not assertively communicate to him the absolute PSP requirements. Further, testimony revealed that the reportability discussions of the event by licensee management were significant and deliberative and in their judgment the incident did not require a report to the NRC, based upon their interpretation of regulatory language. Finally, it is apparent from investigative disclosures that the conduct and behavior of the SSM regarding his failure to log the NOOC visitation event and properly file the incident report indicate a willful attempt to violate provisions of 10 CFR 73.71(c) and thus conceal safeguards information from the NRC.

SYNOPSIS

This investigation was requested on April 10, 1987, by the U.S. Nuclear Regulatory Commission (NRC), Region II, Regional Administrator after an April 1, 1987, anonymous telephone allegation revealed that a contract Nuclear Security Officer (NSO) was returned to duty after being discovered asleep at a compensatory post inside the vital area at Georgia Power Company's (GPC) Vogtle Electric Generating Plant (VEGP), Waynesboro, Georgia (the licensee). Specifically, the investigation was initiated to determine whether the licensee deliberately and intentionally failed to document and report a safeguards event (NSO asleep on post) to the NRC pursuant to the requirements set forth in 10 CFR 73.71(c). Additionally, other potentially willful licensee violations of VEGP security requirements and commitments noted in the investigation request letter which were identified during two March 1987 NRC inspections have been addressed and reported in the Office of Investigations (OI) report numbers 2-87-008 and 2-87-010.

The focus of this investigation concerned the apparent deliberate failure by the licensee to expeditiously document and report, within the time requirements of 10 CFR 73.71(c), the circumstances of the termination of a contract NSO for sleeping on post. The incident was initially reported telephonically to the NRC Duty Officer by an anonymous alleger who stated that a female contract security officer at the VEGP was returned to duty after being discovered asleep at a vital area post. On April 2, 1987, the NRC Resident Inspector for Operations (RIO) reviewed all safeguards event log entries for the previous day and noted there were none relating to a security officer sleeping on post.

Additionally, the RIO requested from the Site Security Manager (SSM) copies of all safeguards events/incident reports prepared on April 1, 1987, and no documents referring to an NSO asleep on post were provided.

The contract NSO who was allegedly asleep on her post related in essence that two licensee Response Force (RF) members reported her asleep at approximately 1415 hours on April 1, 1987. She categorically denied this accusation and vehemently explained she was squinting her eyes as her post faced directly into the afternoon sun. The two RF members, upon interview, steadfastly maintained that the female security officer was asleep but acknowledged their respective testimonies were inconsistent regarding their observations and the manner in which they approached and confronted the NSO on her post. The Acting Shift Captain (ASC) for the uniformed security officers related he immediately interviewed the three personnel involved in the incident and, with the assistance of the two RF members, re-enacted the entire sequence of events in an attempt to objectively resolve the matter. The ASC related he apprised the Acting SSM (ASSM) of his actions and his subsequent conclusion that he could not establish unequivocally the female NSO was asleep as reported. He said the ASSM, apparently prompted by this conclusion, returned the female NSO to duty and instructed him (the ASC) not to prepare a safeguards event report since it had been determined to be a non-event. The ASC reported that comments regarding the loss of RF integrity and credibility and complaints of favoritism, inconsistent treatment, and discrimination by some officers may have prompted the ASSM to inform the SSM of the incident on April 3, 1987. He said the SSM, who was not present on the day of the incident, re-interviewed the two RF members on April 4, 1987, then revoked the unescorted access of the female NSO,

directed her to return to her employer and ordered him (the ASC) to prepare an event report. The ASC said the ASSM informed him the RF members modified their testimonies regarding the NSO sleeping on post when interviewed by the SSM, however, he speculated that the female officer was suspended and returned to her employer to quell the complaints of favoritism and discrimination and to restore the apparent impugned reputation of the RF members. The ASC testified that a safeguards event report is customary and should have been prepared on April 1, 1987, even though the female NSO was restored to a duty status at the time.

The ASSM related his rationale for initially returning the contract NSO to duty, stating he had done so because the ASC was unable to clearly establish that the officer was sleeping on post. The ASSM admitted he told the ASC not to prepare an incident report, a decision he said he later regretted, notwithstanding the fact that four handwritten statements containing the observations and actions of the event participants had been obtained. The ASSM further acknowledged that the RF integrity issue and complaints of preferential treatment towards the sleeping guard convinced him on April 3, 1987, to advise the SSM of the event. He related that, in his presence, the SSM interviewed the two RF members on April 4, 1987, and because they appeared to be convinced the female NSO was asleep on post, the SSM suspended her and returned her to the contractor for final disposition. The ASSM admitted he discussed the 10 CFR 73.71(c) NRC reporting requirement with the SSM after the female NSO was suspended and noted unequivocally the SSM rationalized that since the contractor, and not the licensee, would eventually make the decision the female NSO was sleeping on post, the licensee was not responsible for reporting the event to the NRC. The ASSM strongly dissented with the rationale of the SSM and acknowledged in retrospect that the "sleeping guard" incident was inappropriately handled by the licensee. He stated that the incident should have been immediately documented in a safeguards event report and reported to the NRC pursuant to 10 CFR 73.71(c).

The contract security manager, who performs only administrative functions for his company and has no nuclear security operations responsibilities, noted that the SSM informed him indirectly on April 4, 1987, that he had revoked the unescorted access of the female NSO for sleeping on post and was returning her to the contractor for disposition. He said the licensee provided him with a complete copy of the incident package a week later and after interviewing the ASC and the two RF members regarding their observations, he terminated the female NSO for sleeping on post. The contract security manager related he informed the SSM of the officer's disposition in a memorandum on April 14, 1987, the same date that she was terminated. The licensee's Nuclear Security Manager (NSM) was unable to provide any additional substantive information regarding the incident but reiterated much of the testimony provided to the OI by the ASC and the ASSM, who is a member of the NSM's corporate staff. The NSM also speculated that the action of the SSM in suspending the female officer was predicated on his attempts to quell complaints of discrimination and restore the credibility, integrity, and reputation of the RF members. The NSM advised that because OI was investigating the incident, the licensee re-evaluated the 10 CFR 73.71(c) reportability requirement and formally reported it as a safeguards event on May 19, 1987.

The SSM advised essentially that he suspended the female NSO based only upon the testimonies of the two RF members when he interviewed them on April 4,

1987. He related these two individuals reported "with great confidence" that the female NSO was asleep on post. He further rationalized that, notwithstanding the reason for which the contractor terminated the female officer, the licensee only revoked her unescorted access and therefore the event was not reportable to the NRC. The SSM opined that initial mistakes in judgment were made by the ASC and the ASSM regarding the evaluation and resolution of the incident but denied he reversed their decision because of alleged discrimination or to restore the integrity of the RF members. He related that although he pondered the 10 CFR 73.71(c) reportability requirements when he suspended the female NSO, he did not then and does not now, consider the "sleeping guard" incident reportable to the NRC regardless of the ultimate determination by corporate licensee officials on May 19, 1987. The SSM, in contradiction of the statement that the RF members "with great confidence" reported to him the female NSO was asleep on post, advised that he was not personally convinced the female NSO was asleep on post as alleged by these two individuals. He related that even though VEGP documentation and correspondence he authored, transmitted, or received regarding the incident is clearly labelled "officer sleeping on post," this printed material does not reflect his personal characterization of the event.

During the investigation numerous records relating to the "sleeping guard" event were obtained and reviewed for information applicable to the incident. First, an internal NRC memorandum regarding the 10 CFR 73.71(c) reportability of the incident states that a security officer posted as compensatory measures who is discovered asleep on post is reportable (to the NRC) within 24 hours. Pertinent licensee correspondence which originated prior to the April 1, 1987, event discusses the consequences and regulatory impact for security officers found asleep on post. Further, the VEGP incident package number 87-309 entitled "Alleged Sleeping On Post" contains specific information regarding the event as noted by the participants. Specifically, the incident package contains two separate handwritten statements from each RF member which reflect their observations regarding the female NSO asleep on post. Additionally, licensee and contractor originated correspondence and documents concerning the April 1, 1987, event contain statements that categorically indicate the female NSO was asleep on post. A letter to the NRC from the licensee dated May 19, 1987, contains the details of the April 1, 1987, incident and advises it is now, "albeit late," being reported to the NRC pursuant to 10 CFR 73.71(c). The licensee provided a copy of the security contractor's file regarding the sleeping guard incident and it was noted that only licensee developed information was contained therein, indicating the contractor relied exclusively upon the data provided by the licensee to terminate the female NSO.

In conclusion, and based upon facts developed during the investigation, it appears that the SSM intentionally failed to advise the NRC of the suspension of the female NSO by the licensee for sleeping on post even after learning that she had been terminated for this offense by the contractor. Further, the investigation revealed that the SSM rationalized the termination of the female NSO as contractor initiated rather than as an action of the licensee and therefore deemed that the event was not reportable to the NRC. The rationale of the SSM appears to be a defensive explanation for his apparent deliberate failure to notify the NRC of the event as required by the regulations, the Physical Security Plan, and VEGP procedures. Finally, it appears that the SSM attempted to conceal this incident from the NRC to avoid informing the agency of another embarrassing VEGP safeguards incident which would further erode

their (NRC) confidence in the licensee's security organization following the deficiencies which had been previously identified during March 1987 inspections.

SYNOPSIS

This investigation was requested by the U.S. Nuclear Regulatory Commission (NRC), Region II, Regional Administrator, after a March 1987 inspection revealed apparent willful and intentional violations of regulatory and Physical Security Plan (PSP) requirements at Georgia Power Company's (GPC) Alvin W. Vogtle Electric Generating Plant (VEGP) (the licensee), Waynesboro, Georgia. Specifically, this investigation was initiated to determine whether VEGP security department employees and officials willfully falsified Central Alarm Station (CAS) and Secondary Alarm Station (SAS) response/annotation records which are maintained pursuant to the PSP and 10 CFR Part 73 requirements.

An initial review and analysis of selected radio and telephone (voice) communication recordings and alarm response/annotation logs was conducted by the reporting investigator and participating inspectors. This activity revealed disparities between these two sources of information, especially during the January, February, and March 1987 time frame. An analysis of the records for one specific event on February 14, 1987, revealed that the licensee's actions as indicated by voice communications are inconsistent with the alarm response/annotation records in that dispatching of guards does not match record entries. Other CAS/SAS records also revealed discrepancies and inconsistencies during the aforementioned period of time.

Two CAS/SAS operators were interviewed and both acknowledged deviations in alarm assessment, response, and annotation activities during the period from January to April 1987. Inexperience in an operational environment, the lack of formal CAS/SAS training, inadequate supervisory guidance, the lack of procedures and constant revisions to existing procedures, an overwhelming number of alarms which inundated CAS/SAS operators and significant computer hardware and software difficulties were cited as reasons that alarms were occasionally annotated in groups rather than individually. Both operator interviewees described the initial phase of CAS/SAS operations as hectic, chaotic, and confused and that operators and supervisors were, at times, uncertain as to the manner in which certain events and situations should be resolved. A CAS/SAS supervisor essentially concurred that the volume of alarms between January and April 1987 taxed the abilities of both the operators and the computer system. The two CAS/SAS operators acknowledged that although some alarms were annotated in groups rather than individually, they did not deviate from procedures for the purpose of deceiving the NRC or to deliberately violate regulatory requirements and PSP commitments. The CAS/SAS supervisor emphatically denied that he was aware of any procedural violations by operators concerning alarm response log annotations and said all records were maintained with the view that they were NRC inspectable items. All three interviewees concurred that since April 1987, CAS/SAS operations have stabilized due to the experience gained by employees since January 1987 and because of operator familiarity with the computer system. Two additional VEGP security officials with some knowledge of the CAS/SAS systems related they were unaware of any improprieties associated with alarm station activities.

Two supervisors involved in response force duties who are familiar with alarm response and annotation activities testified that they have responded to all alarms in a manner they believe is consistent with regulations and procedures. They vouched for the integrity of the response force members involved in

CAS/SAS activities but noted that chaos and confusion existed within the alarm system during the early months of operation. One of these supervisors acknowledged discrepancies between data contained in alarm and event records but added that he believed his actions were always consistent with procedural requirements. Both sources categorically denied they intentionally or willfully performed any CAS/SAS activities to deceive the NRC or to conceal safeguards information from NRC inspection personnel.

Based upon the testimonies of all interviewees it does not appear that licensee employees intentionally and deliberately falsified alarm response and annotation logs for the sake of violating a regulatory requirement. Further, even though some procedural violations were noted, there was no substantive evidence that CAS/SAS personnel attempted to deceive the NRC or to conceal information from NRC inspection personnel. It appears that any improper alarm response, assessment, and annotation activities during the January to April 1987 time frame were mitigated by computer hardware and software difficulties, inadequate operational training, lack of experience by CAS/SAS personnel, apparent frequent procedural revisions and, at times, the receipt of a very large volume of alarms with insufficient human resources for an expeditious response, assessment, and resolution of each.