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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-266/86012(DRSS); 50-301/86011(DRSS)

Docket Nos. 50-266; 50-301 Licenses No. DPR-24; DPR-27 Safeguards Group IV

Licensee: Wisconsin Electric Power Company
231 West Michigan
Milwaukee, WI 53201

Facility Name: Point Beach Nuclear Plant, Units 1 and 2

Inspection Conducted: July 18, 1986 onsite
August 6-7, 1986 at Region III office

Enforcement Conference Conducted: August 13, 1986 at Region III office

Date of Previous Physical Security Inspection: April 2-10, 1986

Type of Inspection: Announced Special Physical Security Inspection

Inspector: J. A. Kniceley for 8/21/86
G. L. Pirtle Date
Physical Security Inspector

Reviewed By: J. R. Creed 8/22/86
J. R. Creed, Chief Date
Safeguards Section

Approved By: W. L. Axelson 8/22/86
W. L. Axelson, Chief Date
Nuclear Materials Safety and
Safeguards Branch

Inspection Summary

Inspection on July 18 through August 7, 1986 (Reports No. 50-266/86012(DRSS); No. 50-301/86011(DRSS))
Areas Inspected: Included a review of the circumstances surrounding the degradations of vital area barriers and security event reporting requirements identified in 10 CFR 73.71(c). The inspection was conducted by one NRC inspector and was initiated during the dayshift.

[redacted]

[redacted]

[redacted]

Results: The licensee was found to be in compliance with NRC requirements except as noted below:

a. Physical Barriers - Vital Areas: On three occasions between January 21, 1985 and July 13, 1986, a vital area barrier was degraded without proper compensatory measures being implemented.

b. Records and Reports: Between January 21 and 27, 1985, two security events involving a loss of physical security effectiveness were not reported to the NRC as required by 10 CFR 73.71(c).

Additionally, a weakness was noted in the alarm station operator initial performance evaluation program.

(Details: UNCLASSIFIED SAFEGUARDS INFORMATION)

[redacted]

[redacted]

[redacted]

DETAILS

[redacted]

1. Key Persons Contacted

a. During Onsite Inspection

*C. Fay, Vice President, Nuclear Power Department, Wisconsin Electric Power Company (WEPC)
*J. Zach, Plant Manager (WEPC)
*J. Knorr, Regulatory Engineer (WEPC)
*D. Ivey, System Security Officer (WEPC)
*R. Krukowski, Security Supervisor (WEPC)
*D. Marcelle, Security Specialist (WEPC)
*R. Hedberg, Owner, Guardian Protective Services (GPS)
*R. Nelson, Manager (GPS)
*B. Kopetsky, Site Commander (GPS)
*E. Krueger, Project Coordinator, Fox Valley Technical Institute (FVTI)
*J. Antoon, Project Coordinator (FVTI)
T. Wasmund, Sergeant (GPS)
J. Smith, Sergeant (GPS)
R. Leemon, Resident Inspector, U.S. NRC Region III

*Denotes personnel briefed on the inspection findings on July 18, 1986.

b. Enforcement Conference Attendees (August 13, 1986)

Licensee Attendees

C. Fay, Vice President, Nuclear Power
T. Zach, Plant Manager, Point Beach Nuclear Plant
D. Ivey, Corporate System Security Officer
R. Krukowski, Security Supervisor (PBNP)

NRC Attendees

J. Keppler, Regional Administrator
J. Hind, Director, Division of Radiation Safety and Safeguards
B. Berson, Region III counsel
B. Stampleton, Enforcement Coordinator
W. Axelson, Chief, Nuclear Materials Safety and Safeguards Branch
D. Kosloff, Acting Chief, Reactor Projects Section 2B
G. Pirtle, Physical Security Inspector
R. Leemon, Resident Inspector, USNRC Region III

[redacted]

[redacted]

2. Entrance and Exit Meeting

At the beginning of the inspection, the Plant Manager was informed of the scope of the inspection and the purpose of the visit. The inspector met with the licensee representatives denoted in Paragraph 1 at the conclusion of the onsite inspection on July 18, 1986. A brief description of the scope of the inspection and the tentative inspection findings were discussed. No written material pertaining to the inspection was left with the licensee or contractor representatives. Listed below is a synopsis of the subjects discussed and the licensee's comments pertaining to the subjects:

a. The circumstances pertaining to the July 13, 1986 security event pertaining to an unalarmed, unlocked, and unguarded vital area door was discussed. The licensee representatives stated that the facts presented by the inspector were correct based upon available information at the time. The immediate corrective actions pertaining to the security event were discussed and considered adequate. The inspector noted that two other events similar to the July 13, 1986 event had occurred in early January 1985 and corrective actions for those security events did not appear adequate to prevent recurrence. (Refer to Paragraphs 4.a and b for related information.)

b. The inspector also advised personnel present that the NRC Region III followup inspection of the July 13, 1986 security event showed that the two similar events which occurred in January 1985 were not reported to NRC, HQ as required by 10 CFR 73.71(c). The licensee representatives stated that the failure to report the events was because of their misunderstanding of the reporting requirements. They noted that their Point Beach Security Procedure pertaining to reporting of security events had recently been revised to correct the error. (Refer to Paragraph 3 for related information.)

c. [redacted]

The licensee representatives were advised that the inspection findings would be reviewed by NRC Region III management and the final inspection report would contain the formal perspective for the inspection results. They were also advised that items a and b noted above may warrant consideration for escalated enforcement actions. The security management representatives were requested to advise NRC Region III of any additional information they became aware of pertaining to the three issues noted above. Subsequent to the onsite inspection, the licensee management was advised that an Enforcement Conference would be held at the NRC Region III office on August 13, 1986 to discuss the inspection findings.

[redacted]

[redacted]

3. Records and Reports (IP 81038): One apparent violation was noted as a result of the inspection.

a. 10 CFR 73.71(c) requires licensees under a specific or general license to notify the NRC Operations Center of a major loss of security effectiveness within one hour of discovery by any member of the security organization or any other employee of the licensee, and within 24 hours after discovery of a moderate loss of physical security effectiveness.

Footnote 2 of the Reporting of Physical Security Events Table in 10 CFR 73.71(c) defines a major loss of physical security effectiveness to include, among other incidents, security features breakdown without compensation allowing unauthorized or undetected access to a vital area. Footnote 5 of the same table defines moderate loss of physical security effectiveness as a breakdown in security features protecting vital areas which leaves these areas under the protection of only one security system.

Contrary to the above, on January 27, 1985, a major loss of physical security effectiveness involving an unlocked, unalarmed, and uncompensated vital area door [redacted] occurred and the licensee failed to report the security event to the NRC Operations Center. Additionally, on January 21, 1985, a moderate loss of physical security effectiveness involving an unalarmed and uncompensated vital area door [redacted] occurred and the licensee failed to report the security event to the NRC Operations Center. In both cases cited above, required licensee internal reports were prepared (206/86012-01; 301/86011-01).

b. Because of the length of time since the security events occurred, specific detailed information about the two security events (January 21 and 27, 1985) could not be remembered by the personnel interviewed by the inspector.

The inspector's review of Security Violation Report No. 85-01 showed that vital area door [redacted] was put into the "access" mode at 1024 hours on January 21, 1985 to allow the [redacted] to pass through the door and secure the door by an [redacted]. The [redacted] then exited the [redacted] through another door. "Accessing" the vital area door [redacted]. However, the [redacted] compensated for the computer controlled [redacted] being inactivated. This resulted in door [redacted] being locked by [redacted] but [redacted] attempts through the door. The [redacted] for the door was not compensated for by the security force. The degraded barrier alarm was not discovered by the security force until 2352 hours on January 21, 1985. Therefore, the degraded barrier alarm condition existed without compensatory measures being implemented for about 13 hours.

[redacted]

[redacted]

The inspector's review of Security Violation Report No. 85-02 showed that vital door [redacted] was erroneously accessed for one hour and 16 minutes during the midnight shift on January 27, 1986. The specific time the door was accessed was not indicated on the security violation report and personnel interviewed could not recall the specific time the security event occurred. However, the security violation report did indicate that vital area door [redacted] was in the "accessed" mode [redacted] for one hour and 16 minutes. Interview results showed that compensatory measures were not implemented for the period of time that the door was in the "access" mode and the lack of compensatory measures was the cause for the security violation report being written.

The licensee expressed significant concern about the alarm station operators' poor duty performance in a memorandum, dated January 29, 1985, from the licensee's Security Specialist to the manager of the contract security organization. Both of the security events cited above were identified as examples of inadequate performance by alarm station operators.

c. Interviews with licensee security managers disclosed that the security events reporting procedure in effect at the time of the January 1985 events erroneously identified security event reporting requirements. At that time, Point Beach Security Procedure (PBSP) 1.10, titled "Reporting of Physical Security Events," defined major loss of physical security effectiveness as, among other examples, [redacted] to include [redacted] Security events required by the PBSP to be reported with 24 hours included "properly compensated access control to vital areas when all security features breakdown [redacted] Uncompensated access control failure was not identified as a reportable event. The procedure also identified the wrong NRC office to be notified of physical security events and the required time of implementation of compensatory measures for reporting purposes was also erroneous. In response to a late event reporting violation cited during an April 2-10, 1986 inspection, the licensee stated in writing that the procedure had been modified to address the inspector's concerns (Refer to Inspection Report No. 50-266/86005 and 50-301/86005 for related information.)

4. Access Control - Personnel (IP 81070): One apparent violation was noted as a result of the inspection.

a. Section 11.1.1.2 of the Point Beach Nuclear Plant Security Plan requires all access portals [redacted]

[redacted]

[redacted]

Section 11.1.2.1 of the Point Beach Nuclear Plant Security Plan requires the detection system to immediately [redacted]

Section 5.3.1.3 of the Point Beach Nuclear Plant Security Plan requires internal [redacted]

Figure 5.1-2 of the Point Beach Nuclear Plant Security Plan identifies [redacted] as vital area doors under various plant operating conditions.

Contrary to the above, on January 27, 1985, vital area door [redacted] was improperly placed in the "access" mode [redacted] for about an hour and 16 minutes without compensatory measures being implemented. Additionally, on July 13, 1986, the same vital area door was accessed for about 29 minutes without compensatory measures being implemented. During the above time periods, access to the vital areas could be gained [redacted] Both security events occurred during a weekend or extended into a backshift period and both reactor units were operational during the time the security events occurred. Additionally, on January 21, 1985, the [redacted] for vital area door [redacted] was inactivated for approximately 13 hours without compensatory measures being implemented (266/86012-02; 301/86011-02).

The inspector's review of the above cited security events showed that alarm station operators error was responsible for the vital area doors being erroneously accessed. Interviews and record reviews showed that in the January 27, 1985 and July 31, 1986 instances, the central alarm station (CAS) operator had intended to access [redacted] but entered an incorrect [redacted] The error consisted of [redacted] as being [redacted] rather than [redacted] which is a vital area door under the plant operating conditions that existed at the time of occurrence (both reactor units operational). As a result of the erroneous [redacted] was inactivated, which resulted in the vital area door lock and [redacted]

During accessing of security related doors, the secondary alarm station (SAS) operator is required to [redacted] In both cases, the SAS operator failed to detect the incorrect command and concurred with [redacted] As of about February 1985, after SAS [redacted]

[redacted]

[redacted]

[redacted] to further confirm that the proper device was accessed. Interviews with the CAS operator on duty on July 13, 1986 confirmed that he failed to [redacted] The inspector could not confirm if the same failure to [redacted] occurred on January 27, 1985.

The licensee's corrective actions, as indicated in Security Violation Report No. 85-02, after the January 27, 1985 [redacted] error consisted of disciplinary action for the alarm station operators involved, and counselling of other alarm station operators to be more aware of the [redacted] There were indications from record reviews that the alarm station operators were also [redacted] This restriction was terminated in early February 1985 by memorandum. Inspector interviews with licensee and contractor security managers could not confirm if the [redacted] was prompted by the January 27, 1985 security event or for another reason. The licensee's corrective actions as a result of the January 27, 1985 security event was not effective in preventing recurrence as evidenced by the identical type of event occurring on July 13, 1986.

Immediate corrective actions, after initial response, for the July 13, 1986 security event included: (1) disciplinary action for the alarm station operators involved; (2) [redacted]
(3) reinstruction on proper procedures for [redacted]
(4) briefing of the security force to increase awareness; and
(5) initiation of an analysis by the licensee's [redacted] to determine if software changes could be made to provide closer [redacted] The licensee's immediate corrective actions addressed the inspector's initial concerns.

b. During the inspector's followup on the January 27, 1985 and July 13, 1986 security events, the inspector noted that another incident occurred on January 21, 1985 whereby a vital area door was left in an accessed mode for about 13 hours without compensatory measures being implemented. This event was less significant because the vital area door involved [redacted] was secured by an [redacted] However, the door did lack the required [redacted] for the entire period it was in the access mode (13 hours) and alarm station operator error was the primary cause for the barrier degradation. (Refer to Paragraphs 3.a and 3.b for related information pertaining to the January 21 and 27, 1985 security events).

[redacted]

[redacted]

5. Training and Qualification Requirements (IP 81501)

The inspector reviewed alarm station operators initial training and qualification to determine if a training deficiency may have contributed to the problems noted during the inspection (barrier degradation, failure to implement compensatory measures, and security event reporting deficiencies). The inspector was unable to determine the adequacy of the initial training and evaluation given to alarm station operators because of a lack of documentation involving training topics and initial evaluation of performance criteria.

Section 10.0 of the licensee's Security Force Training and Qualification Plan requires alarm station operators to demonstrate to the satisfaction of the licensee Security Supervisor that they can meet all site procedure requirements in support of the security and contingency plan. Interviews with the licensee Security Supervisor showed that he observes and evaluates alarm station operators prior to them performing unsupervised duties (other than on-the-job training status). [redacted]

This issue is considered a programmatic weakness in the alarm station operator training program (266/86012-03; 301/86011-03)

6. Enforcement Conference

An enforcement conference was held in the NRC Region III office on August 13, 1986 as a result of the preliminary inspection findings which identified apparent violations of NRC requirements. The attendees for the enforcement conference are noted in Paragraph 1.b of this report. The purpose of the conference was to: (1) discuss the apparent violations, their significance and causes, and the licensee's corrective actions; (2) determine whether there were any aggravating or mitigating circumstances; and (3) obtain other information which would help determine the appropriate enforcement action.

During the enforcement conference, Mr. J. Keppler, Regional Administrator, described the purpose and scope of the meeting as well as the NRC enforcement policy in reference to concerns raised as a result of the July 18 through August 7, 1986 inspection findings.

The licensee's presentation included a description of the security deficiencies noted in Sections 3 and 4 of this report, corrective actions implemented and proposed for future implementation, and their perspective of the significance of the events. Although the licensee representatives agreed the discussed security deficiencies were significant, they noted that no threat or damage to the plant or public occurred and the Commission decision on enforcement action should consider these factors along with the adverse affect a civil penalty could have on morale, plant operations, and relations with the adjacent community.

[redacted]

[redacted]

The NRC staff expressed significant concern about the licensee's security staff failure to recognize the seriousness of the potential violations, the ineffectiveness of initial corrective actions, and subsequent failure to fulfill security event reporting requirements.

[redacted]

FOIA-87-166

Tom —

6/16/87

I have reviewed Jim's package on FOIA-87-16, and found the following:

1) Del the "Safeguards Information" markings on the release set of docs, ~~must~~ be removed or completely blacked out. D/1 + D/2

2) Doc. D-2 needs some ~~additional~~ not info deleted on the digest pages. Have redacted the info.

3) Docs. D-2, E-4, E-5, E-6 + E-11 all contain 2.790 (d)(1) info - Ex. 4.

I've put the package back in the safe.

Cor