U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-341/89012(DRSS)

Docket No. 50-341 License No. NPF-43

Licensee: Detroit Edison Company
2200 Second Avenue
Detroit, MI 48226

Facility Name: Enrico Fermi Atomic Power Plant, Unit 2

Inspection At: Plant Site and NRC Region III Office

Inspection Conducted: Between February 25 and June 23, 1989

Inspector: G. L. Pirtle 7/12/89
G. L. Pirtle Date
Physical Security Inspector

Approved By: J. R. Creed 7/12/89
J. R. Creed, Chief Date
Safeguards Section

Inspection Summary

Inspection between February 25 and June 23, 1989 (Report No. 50-341/89012(DRSS))
Areas Inspected: Included review of three allegations pertaining to security operations at the Enrico Fermi Atomic Power Plant.
Results: The licensee was found to be in compliance with NRC requirements within the areas inspected, except for issues described as "licensee identified" items in Section 3 of the report details.

DETAILS

1. Persons Contacted

In addition to the key members of the licensee staff listed below, the inspector interviewed other licensee employees and members of the security organization. The asterisk (*) denotes those present during the telephone exit meeting conducted on June 23, 1989.

R. Kelm, Director, Nuclear Security, Detroit Edison Company (DECo)
*L. Goans, Supervisor, Security Plans and Programs (DECo)
L. Edwards, Supervisor, Security Compliance (DECo)
J. Korte, General Supervisor Security Operations (DECo)
*P. Anthony, Licensing Staff (DECo)
*T. Riley, Licensing Staff (DECo)

The names of personnel identified in the allegations are not included in the Report Details to protect the personal privacy of the individuals involved.

2. Exit Meeting (30703)

A telephone exit meeting was conducted on June 23, 1989 with the personnel denoted in Section 1 above. The scope of the allegations and NRC conclusions, as described in Section 3 of the Report Details, were discussed with the personnel present. The licensee representatives acknowledged the inspector's comments and presented no dissenting positions in reference to the allegation conclusions.

3. Allegation Review

The following information provided in the form of allegations was reviewed by the inspector as specifically noted below:

a. (Closed) Background (Allegation No. RIII-89-A-0018): On February 1, 1989, NRC Region III received an allegation pertaining to security activities at the Enrico Fermi Atomic Power Plant. The initial allegation contained three parts (described below) and was sent to the licensee by NRC letter dated March 22, 1989, after preliminary analysis and review by the NRC Region III staff. The licensee's inquiry results and conclusions pertaining to the allegation were provided to NRC Region III by letter, dated April 21, 1989.

During an onsite inspection conducted between April 16-21, 1989, two additional parts of the allegation were provided to the inspector (described below). These parts of the allegation were addressed by the inspector during the onsite visit and at the NRC Region III office subsequent to the inspection.

(1) Allegation: On January 10, 1989, a Security Shift Lieutenant allegedly left his security badge unattended while in a security office area. The unattended badge was subsequently discovered by a plant operator (who was in the area to check some security equipment) and brought to the attention of the security personnel. Security procedures supposedly require that the individual involved remain under escort until a computer transaction check has been made to ensure no unauthorized keycard use. In this case, the individual allegedly was not escorted prior to or during the computer check. Additionally, no documentation was prepared pertaining to the specifics of the incident (i.e., no security logbook entry was made).

NRC Review Actions: The licensee's investigation results concluded that on January 10, 1989, a security supervisor did fail to maintain control of his keycard for approximately a 16 minute period while within the security building. The supervisor was left in his office without an escort for about 30 seconds after the uncontrolled keycard was discovered because another supervisor left the office to run a keycard usage report to confirm that the keycard was not used during the period it was not controlled.

The licensee's investigation report also confirmed that the supervisor received retraining as required by the licensee's practices on January 11, 1989, and the supervisor was counseled by the General Supervisor, Security Operations.

The inspector also confirmed that the incident was logged as a security event (Page 2 of Safeguards Events Log, dated April 28, 1989), and a Nuclear Security Incident Report (No. 89-004) was prepared.

Conclusion: The incident occurred generally as described in the allegation and the supervisor was left in his office without an escort for about 30 seconds. However, when advised of the incident, security management took the appropriate actions in reference to counseling and retraining of the supervisor, and documenting the incident in a Security Incident Report and Safeguards Event Log. Therefore, the allegation that the event occurred was substantiated. The allegation that appropriate documentation of the incident was not prepared was not substantiated. No enforcement action appears warranted since the incident meets the criteria of 10 CFR Part 2, Appendix C, Section G, as a "licensee identified" item.

(2) Allegation: On January 13, 1989, a vendor delivering milk within the protected area exited the area without dropping off his visitor's badge. Upon discovering that he still had his badge, he returned to the Primary Access Portal (PAP) and left his badge with security personnel. The incident apparently happened because a Security Supervisor did not properly perform his duties. Allegedly, a door in the PAP was opened to allow the dolly being used for the delivery to leave the area. The delivery man was then supposed to return

to the protected area and exit normally through the turnstiles, leaving his badge at the PAP. He was not directed by the escort to do this and, therefore, he left the PAP while still in possession of the badge. Upon return of the badge, the required computer check was slow in being made thereby violating the time constraint identified in the security plan. Additionally, proper documentation/reporting of the event was allegedly not made.

NRC Review Actions: Review of the licensee's investigation results (dated April 21, 1989) showed that on January 6, 1989, a vendor delivering milk exited the protected area with his assigned visitor badge and was outside of the protected area with the keycard for about ten seconds.

The person responsible for escorting the vendor was a security officer, not a supervisor as stated in the allegation. During licensee interviews with the supervisor and the security officer, both personnel agreed that the security officer volunteered to perform escort duties for the vendor; however, the security officer responsible for recording the vendor's escort's name on the appropriate log was not specifically advised of that fact. Both the supervisor and security officer thought the access control officer heard their conversation and knew who the escort officer would be. The licensee's investigation results also concluded that a timely keycard transaction report could not be completed at the time the incident occurred because of computer problems that could not later be duplicated when they tried to resolve the issue.

The person responsible for escorting the vendor and responsible for advising the vendor to return his visitor badge was retrained on the security module in orientation training and counseled by her supervisor.

The inspector confirmed that the incident was initially reported to NRC HQ by telephone at 7:15 a.m. on January 6, 1989, (Event No. 14422). At about 10:45 a.m. on January 6, 1989, the telephone notification was withdrawn and the incident was correctly determined to be a loggable security event. The incident was logged as a security event (Page 1 of Safeguards Events Log dated April 28, 1989) and a Nuclear Security Incident Report (No. 89-003) was prepared.

Conclusions: The incident occurred generally as described in the allegation. However, the escort responsible for the vendor was a security officer rather than a supervisor. When advised of the incident, security management took the appropriate actions in reference to counseling and retraining the personnel involved, and documenting the incident in a Security Incident Report and Safeguards Event Log. Therefore, the allegation that the event

occurred was substantiated. The allegations that a supervisor was the escort and that appropriate documentation of the incident was not prepared was not substantiated. Because of the minor significance of the incident (visitor's badge outside of the protected area for about 10 seconds) and the licensee's actions, no enforcement action appears warranted.

(3) Allegation: Improper access control to a security door allegedly occurred when a security officer on patrol requested (by radio) access through a vital area door. The Central Alarm Station (CAS) operator mistakenly thought the request was for another door and after verification by another alarm station operator, released the latch on the door. The security officer who made the request responded that his door would still not open. When another verification was made, it was determined that the wrong door had been unlocked. Fortuitously, another security officer was at the unlocked door, thereby providing adequate compensatory measures. The incident was allegedly classified as a non-loggable event. Such type of incidents allegedly occur frequently, and disciplinary actions are not taken and logging of the incidents is questionable in the alleger's judgment.

NRC Review Actions: Review of the licensee's investigation report (dated April 21, 1989) showed that the above described incident occurred on January 19, 1989. The Secondary Alarm Station (SAS) operator rather than the Central Alarm Station (CAS) operator made the initial error and the CAS operator concurred in the error. The error resulted in the vital area door being unlocked for about 20 seconds and a security officer was present at the unlocked door at the time the error occurred. The door involved was tested and status of alarm capability was verified. An independent verification was conducted to confirm that no unauthorized entry occurred while the door was unlocked. Disciplinary action was initiated for the two security officers involved. The licensee correctly determined that the incident was not a loggable event since a security officer fortuitously was at the door at the time it was mistakenly unlocked.

At the request of NRC Region III, the licensee reviewed compliance with security procedures pertaining to compensatory measures for vital area doors for the period between December 15, 1988 to March 15, 1989. Their review of the appropriate documentation (Point Record Book and randomly selected alarm summaries) concluded that compensatory measures for vital area doors had been implemented when required. Additionally, the licensee's investigation report noted that nine surveillances of the Point Record Book had been completed between January 1988 and January 1989 to confirm that compensatory measures were in effect when vital area doors were not adequately protected.

Conclusions: The incident occurred generally as described in the allegation, except that the SAS operator made the initial error. The incident did not require reporting to the NRC in accordance with 10 CFR 73.71. No evidence was noted of similar incidents occurring on a frequent basis or frequent failure to meet security reporting requirements. The NRC does not determine the adequacy or appropriateness of licensee personnel disciplinary actions since such issues are appropriately addressed by labor and management representatives.

(4) Allegation: In November 1988, a Security Shift Supervisor allegedly left a vital area key ring unattended in a desk when cleaning personnel were present. A security officer returned the key ring to the supervisor, and the officer was confronted by the supervisor a few days later in reference to the incident.

NRC Review Actions: During an onsite inspection conducted between April 16-21, 1989, the inspector reviewed an event investigation report (file 88-0640, dated November 11, 1988) pertaining to a security supervisor leaving a key ring unattended on the supervisor's desk within the security building. The incident occurred in early November 1988 (exact date not noted). The key ring did not contain vital or protected area keys and, therefore, did not require protection under NRC regulations. As such, the incident also did not require reporting to the NRC in accordance with 10 CFR 73.71.

The event investigation report also addressed the issue that the person finding the unattended key ring and returning it to the supervisor and another security officer felt threatened based upon the supervisor's comments or behavior. On November 16, 1988, a meeting was held with all persons involved in the incident and with the General Supervisor, Security Operations being present. The event investigation report noted that at the time of concluding the meeting each person felt that their concerns were addressed and resolved to their satisfaction.

Conclusion: The supervisor's key ring did not contain vital or protected area keys and, therefore, the incident did not require notification to the NRC or warrant NRC enforcement action.

(5) Allegation: In February 1989, a security supervisor failed to implement the required compensatory measures when some special search equipment was out-of-service.

NRC Review Actions: During an onsite inspection between April 16-21, 1989, the inspector conducted interviews and reviewed licensee interview notes (dated April 18, 1989) pertaining to an incident which occurred on February 6, 1989, involving improper compensatory measures for special search equipment which was out-of-service. The security plan allows pat-down searches to be used for site entry, instead of

equipment searches being used, only under specified conditions (the specific conditions are considered safeguards information and exempt from public disclosure). On February 6, 1989, a security supervisor, after reviewing the security plan, mistakenly determined that hands on pat-down searches could be used because of some search equipment being out-of-service. However, the situation required that other serviceable search equipment be used rather than pat-down searching being implemented. Security management was advised of the incident on February 7, 1989. The supervisor was counseled on the specific security plan requirements for the situation that occurred, and the incident was logged for reporting to the NRC as required by 10 CFR 73.71 (page 5 of Safeguards Events Log dated April 28, 1989).

Conclusion: On February 6, 1989, improper compensatory measures were implemented for some out-of-service search equipment. The cause of the incident was supervisory error. The event was logged for NRC review and the supervisor involved was counseled. The pat-down searches did not significantly reduce the level of contraband control before entry into the protected area. No enforcement action appears warranted since the incident meets the criteria of 10 CFR Part 2, Appendix C, Section G, as a "licensee identified" item.

b. (Closed) Background (Allegation No. RIII-89-A-0040): On April 10, 1989, NRC Region III received an allegation that a change in security policy violated the licensee's As Low As Reasonably Achievable (ALARA) policy as it pertains to radiation exposure. Another allegation about the same concern was received on May 1, 1989. This issue was reviewed by the inspector during an onsite inspection between April 16-21, 1989, and at the NRC Region III office subsequent to the onsite inspection.

Allegation: A change in a security policy which reduced the number of patrols within the radiological controlled area (RCA) at the plant could cause increased radiation exposure, unnecessary exposure to radon, noise, and other health risks. Additionally, security officers were required to remain within the RCA during their entire period of patrol responsibilities.

NRC Review Actions: Interviews with security management personnel disclosed that the number of patrols within the RCA had been changed (specific number of patrols and patrol areas are considered Safeguards Information and exempt from public disclosure in accordance with 10 CFR 73.21). The number of patrol personnel was reduced by half, therefore, requiring personnel to be in the RCA about twice as long. However, the frequency that personnel would perform the patrol function was also reduced by half. Therefore, as a general policy, the exposure time for each officer was basically the same.

Exceptions may occur because of required compensatory measures within the RCA that may have to be implemented. A rest area that does not require radiological controls (clean area) has been established for security officers to rest at when their patrol and other duties in the RCA are completed.

The interviews also disclosed that the patrol routes are surveyed monthly by plant radiation protection personnel and reviewed by security management. Quarterly reports of the survey results are provided to the Director, Nuclear Security, who also is a member of the site ALARA committee.

Discussions with the Director, Nuclear Security, disclosed that total radiation exposure to the security force is monitored by the security staff on a monthly basis. Other ALARA issues, such as use of temporary barriers instead of posting personnel in RCAs during outages were being evaluated. Interview results also disclosed that between November 1988 and May 1989, total recorded radiation exposure to security force members was limited to one person's exposure of 25 mrem.

Radon exposure is not regulated by the NRC. However, radon exposure at a nuclear facility should normally be no greater than a non-nuclear facility of similar size and construction within the same environmental area.

Noise exposure hazards within a workplace are normally addressed by the Occupational Safety and Health Administration (OSHA). However, interview results disclosed that the entire RCA has been designated as a mandatory ear protection area and ear protection equipment is available for personnel upon entering the RCA.

All of the above concerns were made known to senior managers at the plant by an undated letter prepared by a union representative. A copy of the letter was also provided to the onsite NRC Senior Resident Inspector.

Conclusions: The change in the patrol procedures for the RCA does not violate ALARA principles, nor were exposures to radon or industrial health risks increased inasmuch as total security manhours spent in the RCA did not increase. The security staff committed during the exit meeting to periodically remind security personnel to avoid radiological hot spots and areas with increased radiation doses during periods within the RCA. When barrier checks are not required within the RCA, the rest area (clean area) will be available for use by security personnel.

c. (Open) Background (Allegation No. RIII-89-0053): On April 14, 1989, NRC Region III received two allegations that involved fitness-for-duty concerns. One allegation pertained to a security force supervisor and the other allegation pertained to a security officer. The first issue was reviewed by the inspector during an onsite inspection between April 16-20, 1989, and at the NRC Region III office subsequent to the onsite inspection.

(1) Allegation: In late 1987 or early 1988, a security supervisor was reported because he allegedly smelled of alcohol on his person when he reported for work. The supervisor responsible to address and resolve the issue allegedly failed to obtain written statements or take appropriate actions in reference to the incident.

NRC Review Actions: The inspector conducted interviews with security management personnel and reviewed the licensee's investigation interview results for the person allegedly reporting to work under the influence of alcohol and for the supervisor who was advised of the fitness-for-duty issue (Case File 87-0560, December 2, 1987). The licensee's investigation was initiated because of an allegation they had received that the supervisor failed to take appropriate action when advised of a fitness-for-duty issue.

The licensee's interview results and document review showed that the supervisor confronted the individual allegedly unfit for duty on November 23 or 24, 1987. During the licensee's investigation, the transcript showed that the supervisor stated that she confronted the person as soon as she was advised, told the person of the allegation, did not smell the odor of alcohol on the person, asked the person if he had been drinking (which he denied), and observed him during their conversation. The supervisor further stated that she felt it was her decision at that time to determine if the person was fit for duty, and she determined that he was fit for duty. Based on that decision, she also determined that no report or further notifications were required since he was fit for duty in her judgement.

The person allegedly under the influence of alcohol was also interviewed by the licensee, and he denied drinking before coming to work or being under the influence of alcohol. The transcript of his interview also supported the supervisor's statement that she confronted the person and made inquiries about his drinking and fitness for duty.

Nuclear Operating Directive (NOD)-16 "Substance Abuse and Use of Medication" (dated April 2, 1984) effective at the time of the incident required actions and notifications by a supervisor only if a person was determined to be "unfit" for duty. No actions were required if a person was determined to be fit for duty. The current procedure, Fermi Interfacing Procedure AD4-01, "Continual Behavior Observation" (dated January 16, 1989) now requires the Director, Nuclear Security, to be advised of observations of an individual under the influence of drugs or alcohol or "upon receiving a documented report" of an individual under the influence of drugs or alcohol, regardless of a fitness-for-duty subjective judgement made by a supervisor. Such reports or observations of behavior currently require resolution by testing for substance abuse.

Conclusions: The fitness-for-duty issue was resolved in accordance with the procedure in existence at the time the incident occurred (November 1987). The licensee's investigation into the allegation was adequate. This part of the allegation is closed.

(2) In reference to the fitness-for-duty issue allegation pertaining to the security officer involved in a weapon safety issue which occurred on February 7, 1989, a violation was cited for the incident in Inspection Report No. 50-341/89020, dated May 15, 1989 Other allegations pertaining to the event have been received by NRC Region III, and they will be evaluated, resolved, and addressed in a separate inspection report. At that time, the second part of this allegation will be closed.