LICENSEE EVENT REPORT (LER)			Form Rev. 2.0
Facility Name (1)	Docket Number (2)		Page (3)
Quad Cities Unit One	0 5 0 0 0 2 5 4		1 of 0 4

Title (4) Safeguards Cabinet found unsecured due to failure of an individual to implement a barrier directed by a policy.

Event Date (5)			LER Number (6)			Report Date (7)			Other Facilities Involved (8)	
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)
10	04	1999	1999	S01	00	11	03	1999		05000265

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)							
POWER LEVEL (10)	100		20.402(b)		20.405(c)		50.73(a)(2)(iv)	X	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)		Other (Specify in Abstract below and in Text
			20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
			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	TELEPHONE NUMBER
	AREA CODE
Charles Peterson, Regulatory Affairs Manager, ext. 3609	309 654-2241

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

SUPPLEMENTAL REPORT EXPECTED (14)		Expected Submission Date (15)	Month	Day	Year
	YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO	00	00	0000

ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) (16)

ABSTRACT:

On October 4, 1999, at 0700 hours, a contract security Administration Supervisor opened the Safeguards Information (SGI) cabinet in his office. At 0714 hours, the Administration Supervisor left the office for a meeting, leaving the SGI cabinet open and SGI out. At 0920 hours, another Security supervisor discovered the SGI safe unlocked and open. This Supervisor took immediate control of the cabinet. Shortly after discovery it was determined that unauthorized personnel may have obtained access to the information.

The root cause of this event is the failure of the Administration Supervisor to implement a barrier directed by policy.

Corrective actions include:

All SGI material controlled by the Security contractor was moved inside the Protected Area.
Additional training on SGI control will be included in Security annual training.
QCAP 0800-02, "Control of Safeguards Information," will be revised to incorporate existing guidance.

A search of the Security Event Reports (SERs) produced several Safeguards Information events caused by personnel. The apparent cause of these previous events was a lack of adequate training and knowledge in the handling of SGI.

Although no Safety Analysis was performed, as this event is being reported under 10 CFR 73.71, an evaluation of the impact of this event concluded that no SGI information was missing.

A One-hour Emergency Notification System (ENS) call was made to the United States Nuclear Regulatory Commission (U.S. NRC) at 1027 hours.

PLANT AND SYSTEM IDENTIFICATION:
General Electric - Boiling Water Reactor - 2511 MWt rated core thermal power.

EVENT IDENTIFICATION: Safeguards Cabinet found unsecured due to failure of an individual to implement a barrier directed by a policy.

A. CONDITIONS PRIOR TO EVENT:

Unit:	1	Event Date:	10041999	Event Time:	0920
Reactor Mode:	1	Mode Name:	RUN	Power Level:	100%

This report was initiated by Security Event Report 254/99-S01

Power Operation (1) - Mode switch in the RUN position with average reactor coolant temperature at any temperature.

B. DESCRIPTION OF EVENT:

On October 4, 1999, the Safeguards Information (SGI) cabinet in the Training/Administrators office, outside of the Protected Area, was found unlocked and open.

The SGI cabinet was opened at 0700 hours to review a monthly inventory log template at the request of a Training Lieutenant. This inventory information is filed on a computer disc that is properly marked as SGI. The Administration Supervisor removed the disc from the cabinet, placed it in the stand-alone computer designated for SGI use and reviewed the file containing the inventory. While the inventory was on the screen, the Administration Supervisor called the Training Lieutenant and discussed changes to the inventory log thought to be required. After a short discussion, the Administration Supervisor decided not to make any changes at this time because more information was needed. The Administration Supervisor shut down the computer program and performed the checks required to ensure SGI did not transfer on to the computer internal hard drive. He had just completed talking to the Training Lieutenant when the Security Force Manager (SFM) stopped by his office door and informed the Administration Supervisor that it was time to go to a meeting with the Station Security Administrator (SSA). At this time the Administration Supervisor left the SGI cabinet open and the disc in the stand-alone computer.

The Training Lieutenant, who had previously been talking with the Administration Supervisor entered the Administration Supervisor's office at 0920 hours and discovered the SGI safe unlocked and open. The Training Lieutenant took immediate control of the cabinet and called the Assistant Station Security Administrator (ASSA). The Administration Supervisor returned to the office after being notified of the discovery that the cabinet was left open, and checked the contents of the cabinet. A One-Hour Emergency Notification System (ENS) phone call was made to the United States Nuclear Regulatory Commission (U.S. NRC) at 1027 hours.

Upon the Administration Supervisor returning to his office, he found no items out of place and there was nothing missing from the cabinet. An investigation showed that during the time frame of 0714 hours to 0920 hours there were eleven (11) individuals in the Building. All eleven (11) individuals were contacted and there was no observation of any individual in the Administration Supervisor office.

C. CAUSE OF THE EVENT:

The root cause of this event is the failure of the Administration Supervisor to implement a barrier.

During the interview with the Administration Supervisor, he admitted to committing the error by not properly following the established guidance for Security personnel when handling SGI.

The administrative barrier failed because although the memo was correct it was not used. The individual chose not to follow the memo due to his overconfidence in his knowledge when dealing with SGI.

The guidance states in part, "***The individual will unlock the safe, take the Safeguards Information out of the safe ... will then place the "Safeguards Out" sign on the inside of the entrance door to the office...***"

He failed to follow the memo issued to prevent this incident from occurring. Had the SGI "stop sign" been placed on the frame of the doorway as stated in the 1996 memo, this event could have been prevented.

D. SAFETY ANALYSIS:

Although no Safety Analysis was performed, as this event is being reported under 10 CFR 73.71, an evaluation of the impact of this event concluded that no SGI information was missing.

E. CORRECTIVE ACTIONS:

Corrective Actions Completed:

The Administration Supervisor was counseled concerning his actions that caused this event. The Administration Supervisor also wrote a "Lesson Learned" for the Security force.

A review of all SGI material in the security offices outside the Protected Area was completed. As a result of this review, SGI controlled by the security contractor was moved inside the Protected Area. Any Security SGI outside of the Protected Area will be properly stored in the Assistant Station Security Administrator's office only.

Memorandum QC9610-04 has been revised. This revised memo, now labeled QC9910-02, states in part "***...first place the "STOP Safeguards Out" sign on the inside of the entrance doorframe to the office/area...***"

Corrective Actions to be Completed:

Additional training on SGI control is to be included in Security annual training.

QCAP 0800-02, "Control of Safeguards Information," will be revised to incorporate existing guidance.

F. PREVIOUS OCCURRENCES:

A review of Security Event Reports (SERs) for the previous two years of SGI events shows two SGI events at Quad Cities Station during 1997; one SGI event at the Corporate office during 1998 and three other SGI events at Quad Cities Station during 1999.

One event in 1997 involved Security and the discovery of a packet marked as SGI when in fact the packet did not contain SGI.

The other events involved improper control of SGI and were determined to be individual knowledge and training issues.

A review of Problem Identification Forms (PIFs) for the previous two years concurs with the SER data.

G. COMPONENT FAILURE DATA:

None.