WOLF CREEK
NUCLEAR OPERATING CORPORATION

Bart D. Withers
President and
Chief Executive Officer

October 24, 1991

WM 91-0147

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D. C. 20555

Reference: Letter dated September 24, 1991 from A. B. Beach, NRC, to B. D. Withers, WCNOC
Subject: Docket No. 50-482: Response to NRC Inspection Report 482/9120

Gentlemen:

Attached is Wolf Creek Nuclear Operating Corporations's (WCNOC) response to violations 482/9120-01 and 02 which were documented in the Reference. Violation 482/9120-01 involved five examples of failure to protect Safeguards Information and violation 482/9120-02 involved inadequate assessment aids. The response to these violations does not contain any Safeguards Information.

If you have any questions concerning this matter, please contact me or Mr. T. E. Cribbe of my staff.

Very truly yours,

B D Withers

Bart D. Withers
President and
Chief Executive Officer

BDW/jra

Attachment

cc: L. L. Gundrum (NRC), w/a
A. T. Howell (NRC), w/a
R. D. Martin (NRC), w/a
W. D. Reckley (NRC), w/a

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Violation (487/9120-01): Inadequate Protection of Safeguards Information

Finding:

10 CFR 73.21(d)(2) requires, in part, that while unattended, Safeguards Information (SGI) be stored in a locked security storage container.

Contrary to the above, the inspector determined through a review of licensee records that SGI was left unsecured for varying intervals on February 13, March 22, April 10, May 3 and May 28, 1991.

Discussion of Individual Events:

The following discussion provides a summary of each Safeguards Information (SI) event cited in the violation. This discussion is offered to assist in the understanding of the nature and significance of each event.

Event A: On February 12, 1991, while reviewing security procedures in the Central Alarm System, a security officer discovered Security Procedure SEC 50-103 was missing from the procedure book. A subsequent search of the area failed to locate the missing procedure

Event B: On March 22, 1991, the Licensing SI cabinet was left unattended for approximately 5 minutes. During this time the drawers were closed but the cabinet was not locked. Upon discovery of the unlocked cabinet, an audit of the cabinet was performed. The audit revealed that no documents were missing.

Event C: On April 10, 1991, it was discovered that a SI document was not in the SI cabinet as indicated by the electronic Safeguards Suspense Log. The document was determined to have been either lost or shredded between November 8, 1989 and January 31, 1990. A significant review of the event concluded that the document was not missing but that the electronic Safeguards Control log had not been properly updated to reflect the document status after shredding. The approximately 17 month delay in discovering this incident resulted from incomplete audit lists used to review suspense log entries.

Event D: On May 9, 1991, it was discovered that a page of a Security procedure had been improperly copied, reduced and laminated. The laminated page was taken off-site and lost. This page was subsequently recovered.

Event E: On May 28, 1991 two pages of a SI document were discovered lodged in the document feeder of a copier. Copies had been made on May 15, 1991 and had apparently remained in the document feed mechanism of the copier until discovery on May 28, 1991. Although the two pages were marked as SI since they were part of the Security Training and Qualification Plan, subsequent review determined there was no actual SI on the two pages.

Reason for Violation:

The cause of events A and B were various personnel errors resulting from inadequate attention to detail by involved individuals. The cause determination for event C is inconclusive, but a personnel error, also involving a lack of attention to detail, is suspected for this event. The cause of event D appears to be a failure to follow procedural requirements. The cause of event E is an unusual combination of circumstances associated with making copies of the SI documents. Although personnel performance was a contributing factor, a review of the specific circumstances did not conclude a personnel error was committed.

Corrective Steps Which Have Been Taken and Results Achieved:
A Programmatic Deficiency Report was generated for each of the above loss of SI control events and specific corrective actions were taken for each event. The details associated with each event are available at the WCGS site for review. These events were reviewed in an effort to identify a common trend. No common trend was identified.

Subsequent to a previous violation (482/8926-02) and in response to WCNOC Corrective Action Request (CAR) 26, a concerted effort has been made to provide enhanced controls and handling of SI documents. This effort included implementing a central index system for tracking and recording SI transactions, clarification of procedure KGP-1106, "Controlling Safeguards Information" and a reduction in the quantity of SI documents and SI cabinets. WCNOC is continuing to enhance the process of controlling SI documents by reducing the quantity of SI documents and SI cabinets and providing annual training on the procedure for control of SI documents.

Only one additional incident involving control of SI has been identified subsequent to the last event cited (i.e., since 05/28/91).

Corrective Steps Which Will Be Taken to Avoid Further Violation:

The details of this violation and specific events will be included in the annual retraining required by procedure KGP-1106.

Date When Full Compliance Will be Achieved:

Full compliance for this violation has been achieved.

Violation (482/9120-02): Inadequate Assessment Aids

Finding:

License Condition 2.E of the Wolf Creek Generating Station (WCGS) Facility Operating License, dated June 4, 1985, requires that the licensee fully implement and maintain in effect the Commissions approved physical security plan, including amendments and changes made pursuant to the authority of 10 CFR 50.54(p).

Paragraph 3.7.3.a of the licensee's physical security plan requires that a closed circuit television system (CCTV) be provided with fields of view that enable observations of the entire protected area barrier and associated isolations zones. It further requires that observations of unauthorized activities in the isolation zone will enable accurate assessment of the intrusion detections.

Contrary to the above, the inspectors determined during a test of the CCTV system on July 25, 1991, that there were two areas in the detection/isolation zones that could not be assessed and that two cameras were required to assess at too great a distance to provide accurate assessment at the distant end of the isolation zones.

Reason for Violation:

The violation resulted from a marginal design involving camera placement and alignment. This created the potential for a lack of assessability of isolated areas within the two involved zones. Additionally, this resulted in greater than optimum distance for two camera poles and a field of view which included portions of the outer isolation zone.

Corrective Steps Which Have Been Taken and Results Achieved:

Upon identification that the two areas in the detection/isolation zones could not be adequately assessed, security personnel were temporarily posted as a compensatory measure until the subject cameras were realigned. The subject cameras were realigned to provide better assessment capabilities and procedure SEC 50-103, "PAB Intrusion Alarm Annuciation at CAS/SAS" was revised to require the console operator to not reset alarms associated with the subject cameras. The procedure revision permits the console operator to maintain observation of the affected zones until arrival of the responding security officer.

Additionally, WCNOC submitted on October 3, 1991, a revision to the WCGS Physical Security Plan altering the isolation zone coverage. This change to the plan allowed the realignment of cameras to the inner isolation zone which results in better assessment capabilities.

Corrective Steps That Will be Taken to Avoid Further Violations:

A plant modification has been initiated to evaluate additional enhancements to improve the assessment capabilities of the closed circuit television system.

Date When Full Compliance Will be Achieved:

Full compliance has been achieved with the realignment of the subject cameras and the change to procedure SEC 50-103.