Wisconsin Electric
POWER COMPANY

Point Beach Nuclear Plant
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PBL 95-0213

September 5, 1995

Document Control Desk
U.S. NUCLEAR REGULATORY COMMISSION
Mail Station P1-137
Washington, DC 20555

Gentlemen:

DOCKETS 50-266 AND 50-301
RESPONSE TO AN APPARENT VIOLATION
INSPECTION REPORTS 50-266/95-010 (DRS); 50-301/95010 (DRS)
POINT BEACH NUCLEAR PLANT UNITS 1 AND 2

On August 3, 1995, the Nuclear Regulatory Commission forwarded to Wisconsin Electric Power Company, licensee for the Point Beach Nuclear Plant, the results of a reactive inspection conducted by Mr. T. J. Madeda on July 13-26, 1995. This inspection report included an apparent violation involving the failure by a contract security officer to adequately protect significant safeguards information (SGI) while it was unattended in the licensee's owner controlled area for approximately five hours on July 5, 1995.

We have reviewed this apparent violation and, pursuant to the provisions of 10 CFR 2.201, have prepared a written response of explanation concerning the apparent violation.

Sincerely,

Bob Link
Vice President
Nuclear Power

FAF/cah

Enclosure

cc: NRC Resident Inspector
NRC Administrator,
Region III

IE01
1/1

Subscribed and sworn to before
me on this 5th day of September,
1995.

Ann M. Fitzgerald (SEAL)
Notary Public, State of Wisconsin
Ann M. Fitzgerald
My Commission Expires 1-11-98.

RESPONSE TO APPARENT VIOLATION

WISCONSIN ELECTRIC POWER COMPANY
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2
DOCKETS 50-266 AND 50-301
LICENSES DPR-24 AND DPR-27

On August 3, 1995, the Nuclear Regulatory Commission forwarded to Wisconsin Electric Power Company, licensee for the Point Beach Nuclear Plant, the results of a reactive inspection conducted by Mr. T. J. Madeda on July 13-26, 1995. This inspection report included an apparent violation involving the failure by a contract security officer to adequately protect significant safeguards information (SGI) while it was unattended in the licensee's owner controlled area for approximately five hours on July 5, 1995. In accordance with the instructions provided in the inspection report, our reply to the apparent violation includes: (1) the reason for the apparent violation; (2) corrective steps that have been taken and results achieved; (3) corrective steps that will be taken to avoid further violations; and (4) date when full compliance will be achieved.

APPARENT VIOLATION

On July 5, 1995, shortly before noon, the contract security training officer took three training manuals containing SGI outside the protected area (PA) to conduct training of security officer recruits at the plant site boundary control center. Training was conducted using the manuals between 1200 and 1530 hours. To facilitate transport of the manuals, the security officer placed them in a standard paper box (11-1/2"W x 9-1/2"H x 17-1/2"L), ensuring the cover (lid) was on the box. The box was stowed in the rear cargo compartment of his vehicle after the training session was complete. The box was not marked or labeled as to its contents. The training officer returned to the PA at approximately 1530 to conduct four backshift security drills which were being reviewed during a quality assurance audit.

At approximately 2020 hours, when the drills were completed, the training officer left the PA via the north gatehouse. The training officer noted that he did not remember returning three training manuals containing SGI to the central alarm station (CAS) for storage. A visual inspection determined there was no apparent physical disturbance of the box or its contents which would be indicative of tampering.

RESPONSE TO APPARENT VIOLATION

As documented in your inspection report, we identified the event and reported it to the NRC Operations Center as required by 10 CFR 73.71. We implemented corrective actions, concluded that some of the SGI was significant in importance and determined that none of the information was compromised.

In addition, Wisconsin Electric submitted a 30-day security event report 266/95-S02-00 to the NRC on August 3, 1995 as required by 10 CFR 73.71(b). This report was submitted via our transmittal letter VPNPD 95-065. In that report we provided details of the event, our immediate corrective actions, and long-term corrective actions.

1. Reason for Apparent Violation

   The root cause of this event was personnel error. The security officer failed to adhere to Procedure NP 1.7.7, "Safeguards Information," which requires that SGI be protected while in the custody of an authorized individual. It also requires that when not in use or unattended, SGI be stored in an approved security storage container or controlled access area. The procedure and programmatic controls in place are adequate.

The individual involved in this event was very knowledgeable of program and procedural requirements and recognized the procedural noncompliance when he returned to his vehicle.

Contributing factors to this event were inadequate planning and scheduling of resources, activities and facilities in that:

a. Training of security officer recruits was being conducted outside of the PA because suitable classroom facilities could not be arranged within the PA. This training required the use of SGI.

b. The security training officer was responsible for performing multiple tasks without adequate resources to support the assigned tasks. In addition to conducting recruit training, the security training officer was also supporting a major quality assurance audit, and coordinating and executing performance of backshift security drills. These drills were being observed during a QA audit. It is normal operating practice that several additional security supervisors are available to assist with these drills. Inadequate planning and scheduling of these drills during a holiday week resulted in insufficient resources to support the activities. This placed a significant extra work burden on the security training officer.

2. Corrective Actions Taken and Results Achieved:

a. The SGI was returned to the central alarm station (CAS), a controlled access area, for safekeeping at 2025 hours on July 5, 1995.

b. A detailed inventory of the SGI commenced at 2120 hours and was completed at 2206 hours. The inventory confirmed that an actual compromise of SGI had not occurred. All pages were accounted for in each of the three documents.

c. The individual involved in the incident was counseled. However, Wisconsin Electric considers the actions taken and integrity of this individual to be exemplary. The individual was well aware of the potential regulatory and disciplinary consequences of reporting this event, yet he elected to fully admit his error.

d. All personnel with the need to handle SGI were briefed on this event on July 25, 1995, and were reminded of the importance of protecting SGI while it is in their possession and the consequences of a violation of these requirements.

e. A note was sent on July 25, 1995, to all Nuclear Power Business Unit personnel who have a need to use SGI. The note emphasizes individual responsibilities and requirements for protection and storage of SGI.

3. Corrective Actions to be Taken to Avoid Further Violations

Contract security management oversight for planning and scheduling activities will be increased. The number, schedule and complexity of the tasks concurrently assigned to the security training officer were excessive in view of the resources available to support the tasks.

Wisconsin Electric will devote specific attention toward ensuring that the activities scheduled during a holiday period are commensurate with the resources available to accomplish the work.

Conducting training outside of the PA which requires the use of significant SGI will be avoided. If it becomes necessary to conduct such training, every effort will be made to:

a. Minimize the volume of SGI to be removed from the PA to allow the individual to maintain physical possession of the SGI at all times.

b. Conduct the training at a location where a security storage container is available.

c. Ensure that if a container is used to transport SGI, it is conspicuously labeled in accordance with SGI program requirements.

At this time, the only significant SGI stored outside of the Point Beach Nuclear Plant protected area is in the custody of our security training contractor, Fox Valley Technical Institute (FVTI). FVTI has needed SGI documents necessary for security officer training program development, implementation and instruction. There have been no known or reported violations of our SGI program associated with FVTI possession or use of these materials. Nevertheless, we have requested that significant SGI in the possession of FVTI be returned to Point Beach Nuclear Plant. We anticipate return of these documents by September 8, 1995.

4. Date that Full Compliance will be Achieved:

We have been in full compliance with all regulatory requirements since July 5, 1995.

ADDITIONAL INFORMATION

As noted in the inspection report, we previously identified several other examples over the past two years where we did not adequately control or protect SGI. As a result, in January 1995, we conducted a generic evaluation of these events. We identified several improvements that would result in better control of SGI. We began implementing these measures in early February of this year. Examples of these improvements include:

- We reduced the number of containers from 14 to 5 with a near-term goal of 4.

- Every SGI container is now required to have an inventory of contents to improve tracking and control.

- Every SGI custodian received one-on-one training with the Point Beach Security Supervisor on their responsibilities as an SGI custodian. The Security Supervisor used a formal checklist of responsibilities to ensure appropriate topics were covered.

- We implemented a similar checklist for indoctrinating new users of SGI to ensure they are familiar with their responsibilities in controlling SGI. This checklist is also being used to ensure current SGI users know their responsibilities.

Consistent with the NRC's observation in the inspection report, we have seen improvement in our control and protection of SGI based on a reduction in SGI events. We believe that the additional corrective actions listed above will further improve our control and protection of SGI.