



NOV - 7 1996

L-96-296
10 CFR 73.71

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Re: St. Lucie Units 1 and 2
Docket Nos. 50-335 and 50-389
Reportable Event: 96-502
Date of Event: October 11, 1996
Failure to Terminate Access of Temporary Licensees
Employee due to Lack of Notification of Security

The enclosed Safeguards Event Report is being submitted pursuant to the requirements of 10 CFR 73.71 to provide notification of the subject event.

Very truly yours,

J. A. Stall for JAS
J. A. Stall
Vice President
St. Lucie Plant

JAS/WGW/ejb

Attachment

cc: Stewart D. Ebner, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, St. Lucie Plant

2-11-97
THIS DOCUMENT CONTAINS NO SAFEGUARDS INFORMATION

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EX-21
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LICENSEE EVENT REPORT (LER)

(See reverse for required number of
digits/characters for each block)ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY
INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS
LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FEED
BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE
TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (IT-6 P33),
U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545-0001,
AND TO THE PAPERWORK REDUCTION PROJECT (2150-0104), OFFICE OF
MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

ST LUCIE UNIT 1

DOCKET NUMBER (2)

05000335

PAGE (3)

1 OF 4

TITLE (4)

Failure to Terminate Access of Temporary Licensee Employee Due to Lack of Notification of Security.

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 NAME	DOCKET NUMBER
10	11	96	96	- S02	- 00	11	07	96	ST. LUCIE UNIT 2	05000389
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 1: (Check one or more) (11)							
1			20.2201(b)			20.2203(a)(2)(v)			50.73(a)(2)(i)	
POWER LEVEL (10)			20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)	
100			20.2203(a)(2)(i)			20.2203(a)(3)(ii)			50.73(a)(2)(iii)	
			20.2203(a)(2)(ii)			20.2203(a)(4)			50.73(a)(2)(iv)	
			20.2203(a)(2)(iii)			50.36(c)(1)			50.73(a)(2)(v)	
			20.2203(a)(2)(iv)			50.36(c)(2)			50.73(a)(2)(vi)	
									OTHER	
									Specify in Abstract below or in NRC Form 365A	

LICENSEE CONTACT FOR THIS LER (12)

NAME

W. G. White, Plant Security Supervisor

TELEPHONE NUMBER (Include Area Code)

(561) 468-4176

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

YES

(If yes, complete EXPECTED SUBMISSION DATE).

X

NO

EXPECTED
SUBMISSION
DATE (15)

MONTH

DAY

YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On July 28, 1996 a temporary licensee employee completed his work assignment. On September 19, 1996, while comparing a listing of individuals who have not accessed St. Lucie Plant within the last 30 days to a data base listing of active Florida Power & Light Company employees, three individuals, including the above temporary employee, were found to have been terminated from employment but still retained site access. On discovery, the subject card keys were deleted (unassigned) from the security system. On October 9, 1996, while in-processing one of the three individuals who had their access unassigned on September 19, 1996, for unescorted access as a temporary employee, it was noted that the individual had used his card key on three occasions, August 7, 9, and 15, 1996, for a total of thirteen hours. These uses occurred after he ended his temporary employment on July 28, 1996. Upon discovery, this event was logged in the Safeguards Log on October 11, 1996. St. Lucie Units 1 and 2 were operating in mode 1 at 100% power at the time of discovery. Further review and evaluation resulted in a decision to notify the Nuclear Regulatory Commission Operations Center pursuant to 10 CFR Part 73, which occurred on October 16, 1996 at 1617 hours.

The cause of this event was cognitive personnel error on the part of licensee department supervisors who failed to follow Administrative Procedure 0010509 which requires notification to security upon employee terminations.

Corrective Actions: 1. Security unassigned card keys. 2. All department heads were required to validate the continued plant access for all licensee and contractor employees under their cognizance. 3. Security verified that all Nuclear Division employees released since January 1, 1996, did not have site access or were since re-badged. 4. Security reviewed a non-use list to verify the employment status of personnel with 30 day unused key cards. 5. Plant procedure was revised to reflect new site access requirements. 6. The periodic vital area access review was revised and improved. 7. Plant management will be trained in the process for terminating employees' employment. 8. Guidance will be developed on the process for terminating employment.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
ST. LUCIE UNIT 1	05000335	96	- S02	- 00	2 OF 4

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

DESCRIPTION OF THE EVENT

On July 28, 1996 a temporary licensee employee completed his work assignment at the end of a scheduled refueling outage. On September 19, 1996, while the site's Access Control Specialist was cross referencing a listing of individuals who have not used their site access badges within the last 30 days against a personnel data base identifying active Florida Power & Light Company (FPL) employees, three individuals with active site access no longer employed by FPL were identified. The site access card keys were unassigned from the site security computer. No further actions or notifications were taken.

Subsequent to July 28, 1996, one of the above described individuals sought and gained employment at Turkey Point Plant. St. Lucie Plant was requested to process the individual for re-hire on October 7, 1996. On October 9, 1996, the Security Access Control Specialist noted that the individual had gained access to St. Lucie Plant on August 7, 9, and 15, 1996, although his employment was terminated on July 28, 1996. The individual was interviewed concerning his entry to the site; he stated that the three events of site access were to interview for possible employment. The interviewers on these three dates were identified. The Access Control Specialist discussed the accesses with the Security Operations Supervisor and incorrectly concluded that there was no reportability requirement since access had been terminated by Security once the need for termination was identified and there was no malevolent intent with regard to the individual's access during the three events in August.

On October 11, 1996, the St. Lucie Plant Security Supervisor became aware of the unauthorized access. The Security Supervisor contacted the FPL personnel who had interviewed the subject to confirm the contacts and the individual's interviews. Further investigation at that time revealed that two other individuals who had been terminated on July 27, 1996 and August 24, 1996, respectively, had not had their site access unassigned. Neither of those individuals had accessed the site between their termination and October 11, 1996. On October 11, 1996, a Safeguards Event Log entry was made based on the fact that, upon discovery, employee site access was revoked. Additionally, it was concluded that there was no malevolent intent by the individual who had gained site access, that the individual was known to plant personnel, and that he had properly completed all necessary screening to allow access previously and had been authorized site access. Through interviews with his supervisors, it was determined that the employee was deemed trustworthy and reliable and that his employment had been terminated under favorable conditions.

Subsequent to this event, it was determined that a prompt notification was required which was made to the NRC Operations Center at 1617 hours on October 16, 1996.

CAUSE OF THE EVENT

The cause of the event was cognitive personnel error on the part of licensee department supervisors who failed to follow Administrative Procedure (AP) 0010509, Personnel and Material Control, which requires immediate notification to security upon employee terminations.

ANALYSIS OF THE EVENT

AP 0010509 requires that site Security be notified when an individual's site access is no longer needed. Additionally, each individual granted unescorted access to the site is required to read and sign a badge responsibility sheet which instructs them to notify Security when their access to the site is no longer needed. This requirement is also stated in signs posted at all site ingress and egress card readers. This requirement is also reinforced during plant access training. Contrary to the above requirements and training, Security was not notified of these terminations.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (8)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
ST. LUCIE UNIT 1	05000335	96	- S02	- 00	3 OF 4

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

ANALYSIS OF THE EVENT (Continued)

Between October 18, 1996 and October 30, 1996 a total of 11 individuals were identified where Security was not properly informed of termination of employment. None other of the 11 individuals had site access between the time of their termination of employment and when Security determined that site access remained in effect. These events were logged in the Safeguards Event Log. Safety systems were not affected or threatened by this event nor was there a threat to the public health and safety.

CORRECTIVE ACTIONS

1. Upon discovery of terminated employment, Security unassigned the card key for the individuals.
2. A letter was sent to all department heads requiring validation of the need for continued plant access for all licensee and contractor employees under their cognizance. The validation was completed by November 1, 1996.
3. The Access Control Specialist used a 30 day access non-use list to verify that individuals who had not used their card key within the last 30 days were still employed. This was completed on October 24, 1996 and no discrepancies were found.
4. Security verified, from a list supplied by FPL Human Resources, that all FPL Nuclear Division employees released since January 1, 1996 did not retain site access. This was completed on October 30, 1996.
5. Plant Administrative Procedure 0010509 was revised to include a requirement to identify employees as either full time or temporary. For temporary employees, a date when site access will be terminated is now required. This procedure will be further revised by November 22, 1996, to include a processing checklist that will specify the required actions which must be completed upon termination of employment.
6. The 31 day review for vital area access was revised to require a review by plant departments to ensure that listed personnel require ongoing access to the plant. The review is required to be returned to Security with such an endorsement.
7. Security personnel were re-instructed on security reportability requirements and a detailed review of all relevant regulatory documentation on reportability requirements was conducted. This was completed on November 4, 1996.
8. Site management and supervisory personnel will be trained on the existing procedures and requirements concerning the necessary interface between site departments and Security for gaining site access and termination. This topic will be included in the "Basics of Supervision" course which is scheduled for plant supervisors and managers between November 4, 1996 and December 31, 1996.
9. Nuclear Division guidance will be developed by December 31, 1996, to outline the interface requirements between Human Resources, Security, and site departments when terminating an individuals employment with FPL for any reason.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
ST. LUCIE UNIT 1	05000335	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	4 OF 4
		96	- 502	- 00	

TEXT (If more space is required, use additional copies of NRC Form 386A) (17)

ADDITIONAL INFORMATION

Failed component identification

No Security System failures existed for this event.

Previous Similar Events

None with regards to unauthorized access.