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L. T. Gucwa
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SL-116
0166C

December 16, 1985

U. S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region II - Suite 2900
101 Marietta Street, NW
Atlanta, Georgia 30323

REFERENCE:
RII: JNG
50-321
Special Report No.
50-321/1985-005

ATTENTION: Dr. J. Nelson Grace

Gentlemen:

Attached is Special Report No. 50-321/1985-005. This event appears to meet the reporting requirements of 10 CFR 73.71(c) because the event described in the report is deemed to lessen the effectiveness of the physical security system due to an administrative error.

It has been determined that this letter contains no safeguards information.

Very truly yours,

L. T. Gucwa

CBS/lc

Attachment

c: Mr. J. T. Beckham, Jr.
Mr. H. C. Nix, Jr.
Senior Resident Inspector
GO-NORMS

IE 19

Special Report No. 50-321/1985-005

On December 10, 1985, at 1545 CST, Plant Hatch security personnel reported to management that an individual employed by a contractor performing work during our current Hatch 1 outage had been granted access authorization (on December 7, 1985 at 1949 CST) into the plant's protected and vital areas without escort prior to documented completion of the plant's procedural requirements for granting access to these areas.

Management personnel promptly reviewed information on the event (contained in Deficiency Report number 1-85-735) and:

1. Made an initial conservative determination that the event constituted a major loss of physical security effectiveness. Subsequent investigation determined that, in fact, only a lessening of physical security effectiveness had occurred;

2. Made an immediate notification to the NRC of the event on December 10, 1985, at 1628 CST, as required by 10CFR 73.71(c).

Initial corrective actions taken by the plant were:

1. The Plant Security Department pulled the individual's yellow badge (allows unescorted access) within approximately five minutes of determination that premature issuance of the badge had occurred;

2. Within 12 hours of the determination of the premature issuance of the badge, the following actions were taken:

   a. Operations personnel performed a walkdown of the power block (with the exception of the control room and the cable spreading room, which computer records indicate had not been accessed by the individual in question);

   b. Security personnel performed a walkdown of the power block (with the exception of the control room and the cable spreading room, which computer records indicate had not been accessed by the individual in question);

   c. Security personnel interviewed the person and those principal individuals with whom he had worked during the two shifts in which he had premature unescorted access to the protected and vital areas. The validity of the interviews was verified by a polygraph examination of the prematurely badged individual.

No observable degradation of plant systems or components was found by the walkdowns noted in 2.a and 2.b above.

The event was due to the following:

1. Two individuals with similar names (i.e., G. Wood & G. Woods) were photographed on the same day, and both completed new employee general training on the same day. Had either individual failed their employee general training, he would have been retrained;

2. When security personnel made the picture badges for access authorization for these two individuals, they inadvertently assigned one individual's badge number to both of the Authorization For Badge Issue cards;

3. The Authorization for Badge Issue cards were apparently utilized in preparing the background investigation file folders. Thus, both file folders in question had the same badge number (i.e., OCD-522);

4. When access authorization was transmitted via the telephone for one of those employees, the similarity of the last names, dates of training, and the identical badge number on the Authorization for Badge Issue cards allowed the premature issuance of the yellow badge for the other employee.

Mitigating factors to be considered are:

1. New employee drug screening had been completed prior to the event for both individuals. These tests revealed no evidence of drug abuse by either employee;

2. Previous criminal investigations had been completed prior to the event for both individuals. These reviews did not identify any evidence of past criminal activity by either employee;

3. Neither individual had been reported to have exhibited any signs of adverse behavior that might affect his ability to perform his duties. Had such behavior been noted in their records, they would have been denied access;

4. The individual in question was authorized escorted access to perform work in the subject protected and vital areas, and was subsequently authorized unescorted access.

The following Corrective Actions have been taken:

1. Access badge issuance authorization is no longer transmitted via the telephone;

2. The document now used to release a yellow badge from the badge office includes the individual's full name and social security number;

3. On December 11, 1985, at approximately 1600 CST, the individual in question had satisfied the procedural requirements to be properly accessed into protected and vital areas of the plant without escort.

Subsequent investigation showed that both individuals satisfied the requirements listed in the plant's Security Plan at the time they had access to the plant, thus, actually meeting regulatory criteria. We wish to note, however, that due to the administrative error discussed above, the complete results of the background investigation were not known to cognizant security department individuals at the time of the event.