NRC INSPECTION OF UNAUTHORIZED ACCESS INCIDENT AT MILLSTONE NUCLEAR POWER STATION

CASE NO. 97-07S 9/15/97

OFFICE OF THE INSPECTOR GENERAL
EVENT INQUIRY

NRC INSPECTION OF UNAUTHORIZED
ACCESS INCIDENT AT MILLSTONE
NUCLEAR POWER STATION

CASE NO. 97-07S

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

This Office of the Inspector General (OIG), U.S. Nuclear Regulatory Commission (NRC), investigation was initiated based on information provided by Donald DEL CORE, a former employee of Millstone Nuclear Power Station (Millstone). Millstone is owned and operated by Northeast Utilities, Incorporated (NU). DEL CORE provided information regarding Sherry HALPIN, a former contractor employee at Millstone. According to DEL CORE, NU fired HALPIN for allowing a co-worker, Patricia MUNDELL, to gain unauthorized on-site access through a security turnstile.

According to DEL CORE, HALPIN claimed that she and MUNDELL were unfairly treated by the NRC because they were not interviewed by NRC inspectors reviewing the incident. HALPIN also claimed that there were several serious lapses in the Millstone security system that allowed her to gain unauthorized access for MUNDELL.

DEL CORE alleged that the NRC did not perform an adequate review of the incident and that an inspection, conducted by Region I, was one-sided in that it did not address lapses in the Millstone security system.

OIG found that the Region I inspection report regarding the unauthorized access incident at Millstone, documented in combined inspection report number 50-245/96-06, 50-336/96-06, 50-423/96-06 dated October 9, 1996, was misleading as to the work performed by Region I. Although a reading of the inspection report gives the impression that NRC inspection activities developed the facts cited in the report, OIG determined that there was no on-site inspection effort of this incident by Region I. The NRC inspection consisted merely of documenting a telephone notification of the incident from the licensee with no verification by NRC Region I staff. Also, the inspection report indicates that the Region I inspection was conducted under NRC inspection procedure 81700. However, according to the Regulatory Information Tracking System (RITS), no inspection hours were charged to this procedure.

OIG further determined that Region I inspectors did not inquire into apparent problems with the Millstone security system which may have contributed to the unauthorized access. Specifically, the inspection did not address possible shortcomings in the licensee's NRC approved security program which allowed an individual to gain unauthorized access to Millstone Unit I for an extended period. These possible shortcomings include problems with: the antipassback system; potential training deficiencies; security badge control; alarm system; physical security and camera surveillance.

BACKGROUND

Donald DEL CORE, a former employee of Millstone Nuclear Power Station, Unit I (Millstone) contacted the NRC OIG and provided information regarding Sherry HALPIN, a former contractor employee at Millstone. According to DEL CORE, the licensee, Northeast Utilities (NU) fired HALPIN for allowing a co-worker, Patricia MUNDELL, to gain unauthorized on-site access through a security turnstile.

According to DEL CORE, HALPIN claimed that she and MUNDELL were unfairly treated by the NRC because they were not interviewed by NRC inspectors reviewing the incident. HALPIN also claimed there were several serious lapses in the Millstone security system that allowed her to gain unauthorized access for MUNDELL.

DEL CORE alleged that the NRC did not perform an adequate review of the incident and that the inspection, conducted by Region I was one-sided in that it did not address apparent lapses in the Millstone security system that allowed this incident to occur.

DEL CORE stated that the incident was the subject of a newspaper article in the Hartford Courant on October 28, 1996, which was based on information in Region I combined inspection report number 50-245/96-06, 50-336/96-06, 50-423/96-06 dated October 9, 1996. According to DEL CORE, HALPIN was upset because the article depicted her as a conspirator for her role in allowing a co-worker to enter the protected area of the plant.

At the time of the incident, HALPIN and MUNDELL were both working as contractors at Millstone in the Instrument and Control (I&C) shop. HALPIN and MUNDELL were employed at NU through Manpower Temporary Services (Manpower), New London, CT.

MUNDELL told OIG that she previously worked at Millstone on a temporary contract assignment from April 11, 1996 through July 19, 1996. Prior to beginning work in April, she had completed all security requirements for employment at Millstone which included fingerprinting, drug testing, and psychological testing. She said she also passed a training test which included questions about plant access. Upon terminating employment on July 19,1996, under favorable conditions, MUNDELL retained a key-card and an identification badge issued by Millstone. She said that no one advised her to turn in the key-card and badge, and no one asked her for them when she left the site.

MUNDELL told OIG that Manpower subsequently contacted her and offered her a position in the I&C shop starting on August 5, 1996. MUNDELL said she asked the Manpower representative if she needed to report to Millstone Security. MUNDELL was advised that she did not have to report as she had previously been processed and provided with a badge.

MUNDELL said that when she arrived at the Millstone North Access Point (NAP) on August 5, 1996, she called HALPIN for an escort. MUNDELL again checked with Millstone Security, and she was told that they did not require any information from her.

MUNDELL and HALPIN proceeded to the access inspection area and entered through the x-ray

machines. MUNDELL stated that she and HALPIN then attempted to enter through the Westside turnstiles to the protected area (PA). She said that she put her key-card into the slot, and the machine instructed her to proceed to the next step in the process: hand print identification. However, when she put her hand on the template nothing happened. MUNDELL stated that HALPIN's key-card also would not activate the turnstile and another Millstone employee was also trying to enter through a turnstile without success.

MUNDELL said they went to the Eastside turnstiles and again attempted to enter. MUNDELL said she tried her key-card in the card reader, but it would not permit entry. However, when HALPIN tried her key-card and placed her hand on the template, the turnstile was activated. According to MUNDELL, HALPIN told her to proceed, and MUNDELL went through the turnstile HALPIN had opened. MUNDELL said HALPIN repeated the process, and she entered through the same turnstile.

MUNDELL said that they then went to the I&C shop where they worked the entire day. About 3:30 p.m., MUNDELL and HALPIN left their work area and attempted to exit the same turnstiles through which they had entered. HALPIN exited the turnstile; however, when MUNDELL attempted to exit, her key-card would not activate the system.

MUNDELL said that while she was trying to exit through the turnstile, a Millstone Security Officer approached her. The Officer let her through the turnstile using his key-card and then asked how MUNDELL had entered the PA. MUNDELL related the circumstances of how they entered that morning. MUNDELL said that the Officer took her badge, went to the Westside turnstiles, and attempted to enter the PA. She said the Officer was talking on the radio, and she had the impression that he was not receiving notification of an alarm being activated. Security personnel then escorted both MUNDELL and HALPIN to an office where their badges were confiscated and their clearances revoked.

MUNDELL said the Millstone security system did not function properly, and the malfunctions contributed to her problems. First, Millstone Security did not take her badge when she left the plant after her first assignment ended on July 19, 1996. She said this left her with the impression that she still had an active badge and access to the plant. MUNDELL said that only after the August 5, 1996, security incident took place was she told her badge was deactivated. MUNDELL said she was told this did not occur until 10 days after she left the plant site (July 29, 1996). She also said that no alarms sounded and no guards responded when she attempted to use her deactivated key card at several gates during the morning of August 5, 1996.

OIG interviewed HALPIN. HALPIN's recountal of the unauthorized access incident supported that of MUNDELL. HALPIN recalled taking a test when she was first hired at Millstone, but she did not recall any other plant access training. She said she did not recall any training related to a situation similar to the one she and MUNDELL encountered. HALPIN explained her actions by stating that she believed MUNDELL had a valid badge and the security system was just not functioning properly. HALPIN also told OIG that no alarms sounded when MUNDELL attempted to enter the PA that morning and no Security personnel were present or dispatched during that time.

DETAILS

OIG Interviews at the Millstone site

Interviews of Manpower Temporary Services Employees

A Branch Manager at Manpower advised OIG that new hires at Millstone are given copies of the Plant Access Training (PAT) Manual. They also receive a videotape which addresses the same material contained in the PAT. This material is provided as part of the unescorted access training at Millstone. The Branch Manager said the restrictions on "tailgating and piggybacking" (terms used to describe unauthorized access by one individual on another's key-card/badge) are discussed in this training material.

The Branch Manager advised that the standard procedure in the office is for a Manpower representative to go over with new hires a check sheet which lists Millstone's new employee procedures. One item listed on the sheet is the requirement that employees turn in their badges if they terminate employment for any reason.

The Branch Manager further related that for new employees, a Manpower representative fills out an access authorization form and forwards it to the Millstone plant for completion of the badging process. The Branch Manager said that the Manpower office file contained a copy of an access authorization form for MUNDELL indicating it was faxed to Millstone on August 2, 1996.

A Manpower Account Representative, advised that contractors often return for other positions at Millstone. The standard procedure is that a Manpower representative will call Millstone Security and abide by their instructions regarding re-badging. The Manpower Representative said that in this case, she was told by Millstone Security that because MUNDELL's departure from Millstone was recent she did not need to report to Security when she began her assignment. The Manpower Representative said that she would have passed this information onto MUNDELL. She said Manpower procedures require that they tell temporary employees to turn in their badges to Security when the job is completed. She said the normal procedure is to deactivate a contractor's badge when they finish their assignments.

Interviews of Millstone Security Personnel

OIG interviewed a Security Manager at Millstone who related that MUNDELL and HALPIN received plant access training, they should have known better than to "piggyback" into the PA. When MUNDELL's badge did not work, they should have consulted with Security personnel who were present at the access area. The Security Manager said that HALPIN admitted in her statement to Security that she knew she could not allow double entry into the PA using her badge.

The Security Manager said contractors are issued badges at the time they report for work. She said Manpower personnel prepare a site access authorization form for all new employees at the time they hire them. These forms are then forwarded to Security. According to the Security Manager, the partially filled out access authorization form for MUNDELL was in the Security office pending completion.

The Security Manager told OIG that MUNDELL failed to turn her badge into Security when she left her previous assignment on July 19, 1996, and Security had removed the badge from the computer system and reported it lost. The Security Manager advised that NU employees and contractors are allowed to take their badges off-site when exiting the plant on a daily basis. She said that this exemption was put into effect in April 1995 when the hand geometry system was installed at Millstone.

The Security Manager advised that this incident revealed a problem with the antipassback (double entry) features of the security system. She said another problem was that the hand geometry system blocked the alarm signal from going to the security computer alarm when MUNDELL attempted to enter the PA. She said the Licensee Event Report (LER) submitted to Region I, NRC by Millstone security provided a full explanation of the problem.

A Burns International, Millstone Security Supervisor advised OIG that he was dispatched in response to an alarm at an exit turnstile. The alarm indicated that someone was exiting the PA with an inactive badge. He said he stopped MUNDELL and asked her how she had entered the PA. MUNDELL told him that HALPIN had let her into the PA that morning with HALPIN's key-card. The Security Supervisor said he called his supervisor who instructed him to use MUNDELL's key-card and attempt to enter the PA. He said he went to the Westside turnstiles where MUNDELL said she had attempted to enter the PA that morning and he tried to enter. The Security Supervisor said he tried using MUNDELL's key-card at least twice to access the PA. Both attempts were unsuccessful and no alarm sounded.

The Security Supervisor told OIG that the antipassback event with MUNDELL and HALPIN was not considered a security incident at that time and no alarm or notification of any kind registered when there was a double entry into the PA. The Security Supervisor stated that as a result of the incident with MUNDELL and HALPIN, antipassback events into the PA are now classified as security incidents and the security computer generates an alarm. He said prior to the incident the computer captured an antipassback event as an information notice only. The Security Supervisor explained that an antipassback event would occur anytime someone keyed a double entry into an alarmed area without exiting the area.

OIG Document Review

Draft Preliminary Notification (PN)

This draft document, dated August 6, 1996, was prepared by a Region I Branch Chief as the result of information supplied during a telephone call from a Millstone Security Manager. This draft documents the actions of MUNDELL and HALPIN on August 5, 1996, with respect to the unauthorized access into the PA at Millstone and the discovery of the incident by the security force when MUNDEL and HALPIN attempted to exit the PA.

Millstone Security Files

OIG reviewed the Millstone security files pertaining to circumstances surrounding the unauthorized access into the PA. Among the documents contained in the files were signed handwritten statements of MUNDELL and HALPIN dated August 5, 1996, attached to a Security Report. These statements reflect a similar account of their entry into the PA as they related to OIG. In her handwritten statement, HALPIN admitted that she should not have let MUNDELL enter the PA on her key-card and that she should have questioned further why MUNDELL's key-card would not function.

The file contained individual training records of MUNDELL and HALPIN which reflect that both passed Plant Access Training in 1996 with passing grades of 94 and 90 respectively. A partially completed "Access Authorization-CY/MP" form, in the name of MUNDELL, signed by a Manpower Representative, dated August 2, 1996, was also in the file.

The file also contained a three page computer printout for August 5, 1996, for the time period: 00:00 to 23:59:59 hours, listing antipassback incidents into the PA. The report indicates that on August 5, 1996, there were 120 antipassback incidents at the various turnstiles. The report indicates that at 08:04:56 hours at TS3AW, key card KY0777, issued to HALPIN, registered an antipassback incident going into the PA.

Licensee Event Report

As required by 10 CFR 73.71, NU issued Licensee Event Report (LER), number 96-047-00 dated September 4, 1996. This report provided an account of the circumstances surrounding the unauthorized access into the PA by MUNDELL and HALPIN on August 5, 1996. The report identified the immediate actions taken by the licensee to resolve the situation.

The report indicates that Millstone Security conducted an accountability review of all personnel in the PA which verified that all present were authorized. They also posted a security officer at each set of turnstiles to ensure that the event was not repeated.

Under section 10 of the LER “Corrective Actions” the licensee described a problem found with the hand geometry system. In summary, the Millstone security computer system did not identify the attempted unauthorized access into the PA by a unauthorized key card because the hand geometry system blocked the signal to the alarm system. NU initiated actions to modify the

security computer system software and posted security officers at each turnstile until the modifications were complete.

NU also modified the security computer system software to enable it to identify individuals who access the PA a second time without having exited. This antipassback enhancement will cause an alarm signal to be sent to the alarm station which will facilitate a Security response.

Combined Inspection Report 50-245/96-06; 50-336/96-06; 50-423/96-06

On October 9, 1996, Region I issued the above-cited combined inspection report. This inspection report (IR) covered an eight-week inspection by a team of inspectors at Millstone Nuclear Power Station between May 27, 1996 and August 26, 1996. Relevant sections of the report are contained under subsection S1.1 Unauthorized Entry Into the Protected Area. These are as follows:

> a. Inspection Scope (81700). "The inspectors reviewed the event associated with an unauthorized entry into Millstone station protected area (PA) by an administrative contract person."
>
> b. Observations and Finding. This section describes the activities of the contractors entering the PA on August 5, 1997, and the discovery of them exiting the PA when a alarm sounded, caused by the use of a deactivated key card.
>
> c. Conclusions. "During this event, an individual failed to comply with the licensee's requirement and conditions of unescorted access authorization. This issue is unresolved (URI 50-245/96-06-16) pending completion of the licensee's corrective actions and further NRC review."

OIG also noted that section V., Management Meetings, subsection V1.2, Final Safety Analysis Report Review of the IR states: "While performing the inspections which are discussed in this report the inspectors reviewed the applicable portions of the updated final safety analysis report (UFSAR) that related to areas inspected....Security requirements are not specifically included in the UFSAR; they are in the licensee's NRC-approved security plan. While performing inspections discussed in this report, the inspectors reviewed applicable portions of regulatory requirements that related to the areas inspected."

Combined Inspection Report 50-245/96-08; 50-336/96-08; 50-423/96-08

On December 3, 1996, Region I issued the above-cited combined inspection report for the inspection period August 27, 1996 - October 25, 1996. Section S8 "Miscellaneous Security and Safeguards Issues," S8.1 indicates that this report closed out LER number 50-245/96-47. This report references the event discussed in IR 50-245/96-06 and states that the LER revealed no new issues. No inspection activity into the incident is documented in this report.

Combined Inspection Report 50-245/96-09; 50-336/96-09; 50-423/96-09

On February 24, 1997, Region I issued the above-cited combined inspection report for the inspection period October 26 - December 31, 1996. Under section S8, Miscellaneous Security and Safeguards Issues, (S8.1) the report closed out URI 50-245/96-06-16. Under subsection S8.1.a, Inspection Scope (81700), the report reflects that the inspectors reviewed the event associated with the unauthorized entry and documented the results in NRC IR 50-245/96-06. The inspectors concluded (S8.1C) that this event was a violation of the Millstone Nuclear Power Station Physical Security Plan, Section 6.1 "Access Control." No inspection activity into this incident is documented in this report.

NRC Combined Inspection Report 50-245/96-09, Enclosure 1, "Notices of Violation," reads, "During an NRC inspection conducted on October 26, 1996 through December 31, 1996, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action," NUREG 1600, the violations are listed below:"

Section A documents the violations of NRC approved physical security plan requirements for access control, which covers the unauthorized entry of the protected area that occurred on August 5, 1996. (Note: This violation only documents the actions of MUNDELL and HALPIN. The violation does not address possible shortcomings of the Millstone security system that may have contributed to this event.)

OIG Interviews of NRC Region I Personnel

Interview of Chief, Emergency Preparedness and Safeguards Branch

OIG interviewed the Chief, Emergency Preparedness and Safeguards Branch (EPSB), Division of Reactor Safety (DRS), Region I. The Branch Chief stated he received a telephone call from a Millstone Security Manager on August 5, 1996, advising him of the unauthorized access to the PA. The Branch Chief said that he prepared a draft Preliminary Notification (PN) of the incident based on the information supplied by the Millstone Security Manager. The Branch Chief stated that he forwarded a copy of the draft PN to the Millstone Senior Resident Inspector (SRI). He requested that the SRI confirm the information in the draft PN and use it in his inspection report. The Branch Chief said that at the time, he did not have the inspection resources to send to Millstone to respond to the security incident.

The Branch Chief told OIG that the SRI wrote up the inspection of the unauthorized access incident and included it in Combined Inspection Report 96-06. He said he is not aware of what actions the SRI took to confirm the information before writing it up as part of the inspection report. He said the SRI listed the incident as an unresolved issue in the report. According to the Branch Chief, this was done because the resident inspector's office did not have the expertise to inspect the incident and to decide if it was a violation. The Branch Chief advised that there was an enforcement panel conducted on January 8, 1997. The panel decided the unauthorized access incident was a violation of NRC regulations at the severity four level.

The Branch Chief said that the unauthorized access incident revealed a problem with the hand geometry system at Millstone in that it failed to detect the use of the deactivated badge used by MUNDELL. He said the hand geometry system is designed to send a signal to the alarm center when a mismatch is created between the key-card and the hand image stored in the system. He said that because Millstone personnel had removed both MUNDELL's deactivated key-card and her hand image from the security system, no mismatch was created when MUNDELL's key card was used, therefore no alarm sounded. The Branch Chief added that Millstone was taking corrective action to fix the hand geometry system by making changes to their computer software.

Interview of Millstone SRI

OIG interviewed the Millstone SRI who acknowledged that he received the draft PN from the Region I Branch Chief. The Branch Chief told him that a Millstone Security Manager called and reported the incident on the day it happened. The SRI said he was aware of the incident from his morning meeting with plant management during a review of the Adverse Condition Reports (ACRs) that occurred the previous day.

The SRI advised that he did not contact the Millstone Security Manager to verify the information he received from the Region I Branch Chief nor did he conduct any inspection of the incident. He said he drafted the section of the inspection report on security and safeguards activities based upon the information that the Region I Branch Chief provided in the draft PN. He listed the incident as an Unresolved Item (URI) in Inspection Report 50-245/96-06. The SRI said the purpose of placing the item in the inspection report was to ensure it would be followed-up on at a later date. The SRI explained that NRC inspection procedures are designed to ensure that once the NRC captures a URI in an inspection report, it will be followed-up on at a later date. The URI also must be closed out in a subsequent inspection report.

The SRI advised that he participated in the January 8, 1997, enforcement panel where they decided to issue a violation to Millstone for the unauthorized access incident. The enforcement panel was accomplished by a conference call between NRC Region I and Millstone based officials. He commented that the enforcement panel lasted two days because of the large number of inspection issues discussed.

Interview of Region I Security Inspector

OIG interviewed a Region I Senior Physical Security Inspector. At the request of OIG, a copy of the Millstone Physical Security Plan was made available for the interview. The Inspector told OIG that any possible violation of NRC regulations would also be a violation of the Millstone Physical Security Plan. The Inspector acknowledged that when a deactivated key card is used to gain entry into the PA, the Physical Security Plan requires that an alarm be sounded. The Inspector pointed out that while the problem with the hand geometry system prevented an alarm from sounding, the system did not permit entry into the PA. The Inspector said that the Physical Security Plan requires that access points into the PA be manned by Security personnel. He said the plan was revised and this requirement was met through the use of closed circuit televisions that are required to be monitored in the central alarm center. The Inspector said this revision was approved by the NRC.

The Inspector advised that as the assigned Physical Security Inspector for Millstone, he conducted a core inspection of the security system on February 3-7, 1997. As part of that inspection, he reviewed the corrective action taken by the licensee concerning the unauthorized access on August 5, 1996. He said that he did not review the security files nor did he talk to the two individuals involved. This was the first inspection activity by the Inspector into the unauthorized access incident.

OIG asked the Inspector if he had any knowledge regarding a Millstone Security computer printout listing 120 antipassback events that occurred on August 5, 1996, the same day of the antipassback incident involving HALPIN and MUNDELL. The Inspector said that he had not seen the printout. After examining the printout provided by OIG, the Inspector explained that the list was a record of incidents where someone keyed into a card reader more than once without having keyed out or exited that area. He said oftentimes an individual will insert their key card into the card reader more than once while trying to enter the plant and cause the computer to generate an antipassback incident. The Inspector said that he could not tell from examining the computer printout if any of the incidents listed there had resulted in more than one person entering the PA.

Interview of DRS Director

The Director, DRS, Region I, was interviewed and said that the incident at Millstone was inspected by NRC Region I using the Region's reactive inspection procedures.

The Director explained that under Region I reactive inspection procedures, it would be a judgement call as to how to proceed in such a situation. This decision is made by the assigned regional inspector and his management. He said NRC inspection procedures do not require an on-site inspection of every reportable incident. The Director pointed out, as an example, that inspection procedures require that all LERs be closed out in an inspection report, but all that the inspection requires is a review of the LERs.

The Director stated that typically the resident inspector would follow-up on what the Region reported as an inspection item. He said the utility, at regular morning meetings, notifies the resident inspectors of all reportable incidents. The extent of the follow-up would be based on the experience of those receiving the notification. The Director said that when the Region receives a notification, it is a judgement call, based on the experience of the inspector, as to how to react.

The Director advised that in the security section of Inspection Report 50-245/96-06, there is a reference to Inspection Scope (81700). He explained that this references the procedure that was used by the inspectors during this inspection. The Director said that the Regulatory Information Tracking System (RITS) requires that the inspectors account for the inspection time charged to an inspection procedure.

OIG Review of Inspection Tracking Records

OIG contacted headquarters, Office of Nuclear Reactor Regulation (NRR), and requested a review of inspection hours charged to inspection procedure 81700 for Inspection Report 50-

245/96-06. NRR advised that RITS was queried and revealed that there were no hours charged to inspection procedure 81700.

FINDINGS

OIG found that the Region I inspection report regarding the unauthorized access incident at Millstone, documented in combined inspection report number 50-245/96-06, 50-336/96-06, 50-423/96-06 dated October 9, 1996, was misleading as to the work performed by Region I. Although a reading of the inspection report gives the impression that NRC inspection activities developed the facts cited in the report, OIG determined that there was no on-site inspection effort of this incident by Region I. The NRC inspection consisted merely of documenting a telephone notification of the incident from the licensee with no verification by NRC Region I staff. Also, the inspection report indicates that the Region I inspection was conducted under NRC inspection procedure 81700. However, according to the RITS, no inspection hours were charged to this procedure.

OIG noted that the region issued two subsequent inspection reports and held an enforcement panel based on information provided during the telephone notification without any independent action to examine the circumstances surrounding the unauthorized access incident. Although the region discussed this incident involving the two individuals in their inspection reports and in the enforcement action, they did not mention possible problem areas with the security system at Millstone identified by the licensee in the LER.

OIG further determined that Region I inspectors did not inquire into apparent problems with the Millstone security system which may have contributed to the unauthorized access. Specifically, the inspection did not address possible shortcomings in the licensee's NRC approved security program which allowed an individual to gain unauthorized access to Millstone Unit I for an extended period. These possible shortcomings include problems with: the antipassback system; potential training deficiencies; security badge control; alarm system; physical security and camera surveillance.

LIST OF EXHIBITS:

1. ROI of Patricia A. MUNDELL, dated November 26, 1996
2. ROI of Patricia A. MUNDELL, dated February 12, 1997
3. ROI of Sherry A. HALPIN, dated November 25, 1996
4. ROI of Dianne M. CHADWICK, dated January 15, 1997
5. ROI of Rene KELLY, dated February 13, 1997
6. ROI of Patricia WEEKLY, dated January 14, 1997
7. ROI of Bruce BARBER, dated February 13, 1997
8. Draft Preliminary Notification , dated August 6, 1996
9. Security Report No. 96-0627, dated August 5 1996, w/attachments
10. Plant access training record of Patricia A. MUNDELL
11. Plant access training record of Sherry A. HALPIN
12. Access Authorization form, for Patricia MUNDELL
13. Computer printout of Antipassback Incidents, dated August 15, 1996
14. Licensee Event Report No. 96-047, dated September 4, 1997
15. NRC Combined Inspection Report 96-06, dated October 9, 1996
16. NRC Combined Inspection Report 96-08, dated December 3, 1996
17. NRC Combined Inspection Report 96-09, dated February 24, 1997
18. Enclosure 1, Notice of Violation, 50-245/96-09, dated February 24, 1997
19. ROI of Richard KEIMIG, dated January 24, 1997
20. ROI of Richard KEIMIG, dated March 4, 1997
21. ROI of Theodore EASLICK, dated January 14, 1997
22. ROI of Theodore EASLICK, dated February 13, 1997
23. ROI of James WIGGINS, dated April 1, 1997
24. E-Mail from Beverly JONES, dated April 9, 1997 RE: RITS data
25. ROI of G. Smith, dated April 2, 1992