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Exelon Nuclear

10CFR73.71(d)

March 28, 2002

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Limerick Generating Station, Units 1 & 2
Facility Operating License No. NPF-39 & NPF-85
NRC Docket No. 50-352 & 50-353

Subject: SER 02-001-00 Unauthorized Access to the Protected Area

This Safeguards Event Report (SER) provides a 30-day written follow-up regarding the entry of an unauthorized worker into the protected area due to incomplete pre-employment screening and inadequate administrative controls. Additional administrative controls were instituted to correct and prevent recurrence.

Report Number:	02-001
Revision:	00
Event Date:	February 28, 2002
Discovered Date:	February 28, 2002
Report Date:	April 1, 2002
Facility:	Limerick Generating Station P.O. Box 2300, Sanatoga, PA 19464-2300

This SER is being submitted pursuant to the requirements of 10CFR73.71(d)

Very truly yours,

William Levis
Vice President-LGS

cc: H. J. Miller, Administrator Region I, USNRC
A. L. Burritt, USNRC Senior Resident Inspector, LGS

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NRC FORM 366 (1-2001) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 6-30-2001

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Limerick Generating Station Unit 1 & 2	05000 352 & 353	1 OF 3

TITLE (4)

Unauthorized Access to the Protected Area

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
										05000
02	28	02	02	0 01 1	00	04	01	02	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)			
POWER LEVEL (10)	100	20.2201(b)	20.2203(a)(3)(ii)	50.73(a)(2)(ii)(B)	50.73(a)(2)(ix)(A)
		20.2201(d)	20.2203(a)(4)	50.73(a)(2)(iii)	50.73(a)(2)(x)
		20.2203(a)(1)	50.36(c)(1)(i)(A)	50.73(a)(2)(iv)(A)	x 73.71(a)(4)
		20.2203(a)(2)(i)	50.36(c)(1)(ii)(A)	50.73(a)(2)(v)(A)	73.71(a)(5)
		20.2203(a)(2)(ii)	50.36(c)(2)	50.73(a)(2)(v)(B)	OTHER Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iii)	50.46(a)(3)(ii)	50.73(a)(2)(v)(C)	
		20.2203(a)(2)(iv)	50.73(a)(2)(i)(A)	50.73(a)(2)(v)(D)	
		20.2203(a)(2)(v)	50.73(a)(2)(i)(B)	50.73(a)(2)(vii)	
		20.2203(a)(2)(vi)	50.73(a)(2)(i)(C)	50.73(a)(2)(viii)(A)	
		20.2203(a)(3)(i)	50.73(a)(2)(ii)(A)	50.73(a)(2)(viii)(B)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Marino Kaminski Manager Experience Assessment	(610) 718-3400

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

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO				

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

On February 28, 2002 at 18:05 hours, it was discovered that a contractor had been allowed access into the protected area based on inadequate pre-employment screening and inadequate administrative control.

On February 25, 2002 a contractor requesting access to the site for refueling outage 1R09 provided a urine sample that gave indication of being adulterated (soap like odor). Per procedure, a second witnessed sample was provided. Both samples were sent to an offsite testing facility. Both sample numbers were entered into the computer tracking system in the "pending" status. When the results of the second (witnessed) sample returned as negative, the Fitness for Duty analyst updated the computer tracking system to indicate an acceptable result. The acceptable test result information was unknowingly carried forward to indicate "acceptable" on the badging screen. A badge was subsequently issued, and on February 28 the contractor entered the protected area for approximately 4 hours along with 4 other contractors who were appropriately badged.

There were no adverse consequences. The security access history for the contractor was reviewed. Corporate Security personnel interviewed all the individuals involved. Additional administrative controls were put in place until the computer tracking system logic was corrected.

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

Unit Conditions Prior to the Event

At the time of the event, Unit 1 was in Operational Condition (OPCON) 1 (power operations) at 87% power level in coastdown prior to the 1R09 refueling outage. Unit 2 was in Operational Condition (OPCON) 1 at 100% power level. There were no structures, systems or components out of service that contributed to the event. There were no radiological consequences associated with the incident.

Description of the Event

On February 25, 2002 a contractor requesting access to the site for refueling outage 1R09 provided a urine sample that gave indication of being adulterated (soap-like odor). Per procedure, a second, witnessed sample was provided. Both samples were sent to an off site testing facility. Both sample numbers were entered into the computer tracking system in the "pending" status.

The next day the fitness for duty analyst received a negative result on the second (witnessed) sample and updated the computer tracking system to reflect acceptable results for that sample. When the information for this second sample was input, the acceptable test result information was unknowingly carried forward to indicate "acceptable" on the badging screen, overwriting the "pending" indication.

On February 27 the badge fabrication clerk checked the computer tracking system, noted the acceptable result and loaded the badge information into the security computer.

The contractor was notified on February 28 that access was granted. The contractor entered the protected area at 11:41 hours. At 14:07 hours the contractor and 4 other contractors entered the Unit 2 area and exited the Unit 1 area at 14:25 hours. At approximately 15:23 hours the contractor exited the protected area.

On February 28 at 18:05 hours the Fitness for Duty analyst received notification from the Medical Review that the first sample was positive. The computer tracking system was reviewed. The badge was immediately pulled (inactive status). An investigation was initiated. On March 1, 2002 at 02:16 hours, a determination was made, based on guidance contained in NRC Generic Letter 91-03, that this event should be reported.

On Match 1, 2002 at 02:29 hours a one-hour emergency notification was made in accordance with 10CFR73.71(b)1. This SER is being submitted pursuant to the requirements of 10CFR73.71(d)

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

Cause of the Event

The event was caused by a logic flaw in the badging computer tracking system. When the Fitness for Duty analyst entered the negative result in the computer tracking system, the system overwrote the pending status on the badging screen that allowed badging personnel to issue a badge to the contractor. The badging personnel did not realize that there was a second sample taken.

Consequences of the Event

There were no adverse consequences As a result of the event. The contractor was accompanied by 4 other contractors for about 4 hours who were authorized. There was no evidence of sabotage or malevolent intent. There was no impact on plant safety.

Corrective Action Completed

The contractor's badge was pulled and placed in inactive status. It was confirmed that the individual was no longer in the protected area. The security computer access history for the contractor was reviewed to determine the contractor's activities while in the protected area. Corporate Security personnel interviewed all the individuals involved.
The computer tracking system was reviewed to ensure that no other individuals were in the pending status for fitness for duty status. None were found. An additional signoff step has been added for access authorization for "pending" fitness for duty issues. A Corrective Action Program (CAP) report was created to capture and track to closure all identified issues dealing with this event. A Nuclear Operations Notification (NON) was generated and distributed to all Exelon Nuclear sites.

Corrective Actions Planned

None

Previous Similar Occurrences

None