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

Ladies and Gentlemen:

Subject: VIRGIL C. SUMMER NUCLEAR STATION
DOCKET NO. 50-395
OPERATING LICENSE NO. NPF-12
LICENSEE EVENT REPORT (LER 2003-S03-00)
ACCESS TO PROTECTED AREA BY AN INDIVIDUAL WITHOUT
PROPER AUTHORIZATION

Attached is Licensee Event Report (LER) No. 2003-S03-00, for the Virgil C. Summer Nuclear Station (VCSNS). The report describes an event in which an individual gained unauthorized access to the protected area and is being submitted in accordance with 10 CFR 73.71, Appendix G(1)(b).

Should you have any questions, please call Mr. Ronald Clary at (803) 345-4757.

Very truly yours,

Stephen A. Byrne

JWP/SAB
Attachment

c: N. O. Lorick
N. S. Carns
T. G. Eppink (w/o attachment)
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NSRC
RTS (0-C-03-3327)
File (818.07)
DMS (RC-03-0247)

IE22

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 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.

1. FACILITY NAME

Virgil C. Summer Nuclear Station

2. DOCKET NUMBER

05000395

3. PAGE

1 OF 3

4. TITLE

Access to Protected Area by an individual with an expired badge

5. EVENT DATE

MO DAY YEAR

10 11 2003

6. LER NUMBERYEAR SEQUENTIAL
NUMBER REV
NO

2003 - S03 - 00

7. REPORT DATE

MO DAY YEAR

12 11 2003

8. OTHER FACILITIES INVOLVED

FACILITY NAME

DOCKET NUMBER

05000395

FACILITY NAME

DOCKET NUMBER

**9. OPERATING
MODE**

4

**10. POWER
LEVEL**

0

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)

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)

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)

X

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)

12. LICENSEE CONTACT FOR THIS LER

NAME

R. B. Clary, Mgr., Nuclear Licensing

TELEPHONE NUMBER (Include Area Code)

(803) 345-4757

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

CAUSE	SYSTEM	COMPONENT	MANU- FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU- FACTURER	REPORTABLE TO EPIX
AX				No					

14. SUPPLEMENTAL REPORT EXPECTED

YES (If yes, complete EXPECTED SUBMISSION DATE).

X NO

**15. EXPECTED
SUBMISSION
DATE**

MONTH

DAY

YEAR

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

This report is being made pursuant to the requirements of 10CFR73.71(b)(1) for an incident described in Appendix G(1)(b).

On October 14, 2003, it was discovered that a contractor, who had not received the appropriate site orientation training to access the protected area, had been issued a vital badge.

The form utilized to alert Access Control and Dosimetry personnel that individuals have completed their site orientation training had been incorrectly signed by Training personnel. The individual was issued a vital badge and dosimetry. Upon discovery of the error, the individual's badge was pulled, he was notified that he was required to complete site orientation training, and a one-hour report was made to the NRC. The records of all personnel with current access to the site were reviewed to verify that all site orientation training was current. VCSNS believes that this event occurred unintentionally.

During the investigation of this event, it was discovered that this individual had entered vital areas of the plant on October 11, 2003. In accordance with our Security Procedures, Security performed a search of those vital areas and the protected area on October 14, 2003. The searches were negative.

LICENSEE EVENT REPORT (LER)

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
V.C.Summer Nuclear Station	05000395	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		2003	-- S03 --	00	

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

PLANT IDENTIFICATION

Westinghouse - Pressurized Water Reactor

EQUIPMENT IDENTIFICATION

N/A

IDENTIFICATION OF EVENT

On October 14, 2003, it was discovered that a contractor, who had not received the appropriate site orientation training to receive unescorted access the protected area, had been issued a vital badge.

Training personnel enter site orientation training attendance into the computer for tracking purposes and fill out a form to allow personnel to show Security and Dosimetry personnel that they have completed the required site orientation training for unescorted access to the protected area. Training personnel had incorrectly signed the form for this individual. As a result, the individual was issued a vital badge and dosimetry.

Dosimetry personnel questioned the fact that this individual's computerized allowable dose kept resetting itself and attempted to verify the individual's site orientation training status. Training personnel could not locate the computer entry for site orientation training classes attended and notified Security. The individual's badge was pulled, he was notified that he was required to complete site orientation training, and a one-hour report was made to the NRC. The records of all personnel with current access to the site were reviewed to verify that their site orientation training was current.

During the investigation of this event, it was discovered that this individual had entered vital areas of the plant on October 11, 2003. Security performed a search of those vital areas and the protected area on October 14, 2003 in accordance with VCSNS Security Procedures. The searches were negative.

VCSNS believes that this event occurred unintentionally. This event was documented in Condition Evaluation Report (CER) 03-3327.

DISCOVERY DATE

10/14/03

REPORT DATE

12/11/03

LICENSEE EVENT REPORT (LER)

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
V.C.Summer Nuclear Station	05000395	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 3
		2003	-- S03 --	00	

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

CONDITIONS PRIOR TO EVENT

Mode 4, 0% power

DESCRIPTION OF EVENT

On October 14, 2003, it was discovered that a contractor's site orientation training was not current. This individual had received a vital badge and accessed several vital areas of the plant.

CAUSE OF EVENT

The cause of this event is a human performance error on the part of Training personnel, such that neither access control nor dosimetry personnel were made aware of the incomplete status of his site orientation training.

ANALYSIS OF EVENT

During the investigation of this event, it was discovered that this individual had entered the protected area of the plant and did enter several vital areas of the plant on October 11, 2003.

CORRECTIVE ACTIONS

Upon discovery, this individual's badge was pulled so that no further access could be gained until the required site orientation training was completed. A full audit was conducted of site orientation training records for all badged individuals who have access to the protected area and no other occurrences were identified where an individual had gain access without completion of the required site orientation training.

In accordance with VCSNS Security Procedures, Security personnel conducted a search of the protected areas and those vital areas, which the individual had gained access. The searches were negative.

As part of the planned corrective action, Training will establish a process for ensuring site orientation training completion information is validated prior to signing qualification confirmation paperwork for badging and dosimetry.

PRIOR OCCURRENCES

LER 2003-S01