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October 16, 2000

Docket No. 50-321

HL-6000

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Edwin I. Hatch Nuclear Plant - Unit 1
Licensee Event Report
Unauthorized Person Enters Protected and Vital Areas

Ladies and Gentlemen:

In accordance with the requirements of 10 CFR 73.71, Southern Nuclear Operating Company is submitting the enclosed Licensee Event Report (LER) concerning an unauthorized person entering protected and vital areas.

Respectfully submitted,


H. L. Sumner, Jr.

IFL/sp

Enclosure: LER 50-321/2000-S01

cc: Southern Nuclear Operating Company
Mr. P. H. Wells, Nuclear Plant General Manager
SNC Document Management (R-Type A02.001)

U.S. Nuclear Regulatory Commission, Washington, D.C.
Mr. L. N. Olshan, Project Manager - Hatch

U.S. Nuclear Regulatory Commission, Region II
Mr. L. A. Reyes, Regional Administrator
Mr. J. T. Munday, Senior Resident Inspector - Hatch

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IE22

NRC FORM 366 (06-1998)	U.S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)	APPROVED BY OMB NO. 3150-0104 EXPIRES 06/30/2001 Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Information and Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If a document used to impose an 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.
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TITLE (4)
Unauthorized Person Enters Protected and Vital areas

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(S)
09	25	2000	2000	S01	00	10	16	2000	Plant Hatch, Unit 2	05000366
										DOCKET NUMBER(S) 05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § : (Check one or more) (11)								
POWER LEVEL (10)	95.2	20.2201(b)			20.2203(a)(2)(v)			50.73(a)(2)(i)		50.73(a)(2)(vii)
		20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)		50.73(a)(2)(ix)
		20.2203(a)(2)(i)			20.2203(a)(3)(ii)			50.73(a)(2)(iii)		<input checked="" type="checkbox"/> 73.71
		20.2203(a)(2)(ii)			20.2203(a)(4)			50.73(a)(2)(iv)		OTHER
		20.2203(a)(2)(iii)			50.36(c)(1)			50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
20.2203(a)(2)(iv)			50.36(c)(2)			50.73(a)(2)(vii)				

LICENSEE CONTACT FOR THIS LER (12)

NAME Steven B. Tipps, Nuclear Safety and Compliance Manager, Hatch	TELEPHONE NUMBER (Include Area Code) (912) 367-7851
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/>	NO					

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

On 09/25/2000 at 1400 EDT, Unit 1 was in the Run mode at a power level of approximately 2630 CMWT (95.2% rated thermal power), and Unit 2 was in the Run mode at a power level of 2763 CMWT (100% rated thermal power). At that time, plant security personnel determined that an unauthorized person had entered the plant protected area at 1458 EDT on 09/22/2000, exiting at 1604 EDT. The worker re-entered the protected area at 1913 EDT, remaining until 0658 EDT on 09/23/2000. This person, a contract worker, had entered the protected and vital areas to perform normal activities. Although the worker used the normal ingress point in the usual manner after being subjected to the typical search procedures, the worker had not been authorized to enter the protected and vital areas; that is, the required checks were not performed prior to the worker entering these areas.

This event was the result of personnel error. An individual in the site badging office apparently confused an unauthorized worker with a properly authorized worker (employed by the same company) in the security computer database and entered the unauthorized worker into the plant's access control system, thus allowing the worker to enter the protected and vital areas. Upon discovery of the error, the unauthorized contract worker's access was prevented. The individual in the badging office is being disciplined under the Positive Discipline Program. The required background and behavior checks performed indicated that the worker would have been granted unescorted access to the protected and vital areas.

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

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor
Energy Industry Identification System codes appear in the text as (EIIIS Code XX).

DESCRIPTION OF EVENT

On 09/25/2000 at 1400 EDT, Unit 1 was in the Run mode at a power level of approximately 2630 CMWT (95.2% rated thermal power) and Unit 2 was in the Run mode at a power level of 2763 CMWT (100% rated thermal power). At that time, plant security personnel determined that an unauthorized person had entered the plant protected area at 1458 EDT on 09/22/2000, exiting at 1604 EDT. The worker re-entered the protected area at 1913 EDT, remaining until 0658 EDT on 09/23/2000. This event was discovered when another nuclear plant requested background information on the same individual as part of their access authorization process. This request was made when the individual informed personnel at the second plant that he had been granted unescorted access at Plant Hatch. When Plant Hatch personnel attempted to find the requested information, they discovered the information did not exist even though the individual was granted unescorted access and actually entered the protected and vital areas.

The unauthorized contract worker entered the protected area at 1458 EDT on 09/22/2000 to obtain a dosimeter needed to begin work that evening. Although the worker used the normal ingress point in the usual manner after being subjected to the typical search procedures, the worker had not been authorized to enter the protected and vital areas. Specifically, the standard background and behavior checks were not performed prior to the worker entering the protected and vital areas. The worker exited the protected area at 1604 EDT. The worker entered the protected area at 1913 EDT to perform normal work activities, remaining until 0658 EDT on 09/23/2000. He made no more entries until the event was discovered. Subsequent worker access was prevented by disabling the worker's badge in the security computer system, and obtaining and destroying his access badge on 09/25/2000.

CAUSE OF EVENT

This event was the result of cognitive personnel error. An individual in the site badging office took the contract worker's picture and apparently either created an access badge without first obtaining an approved Authorization for Badge Issue form or lost the badge authorization form after making the badge. The Authorization for Badge Issue form is the administrative tool used to ensure an individual granted access to the protected and vital areas successfully passed the required background and behavior checks, and received approval for access from the appropriate persons. Creating an access badge without an approved form is contrary to plant procedure requirements which state that no access badge can be made without an approved form. Since the badge issue form was not found among the forms for the same company issued on the same day, it is apparent the worker's form either was not available when the badge was made or was lost subsequent to making the badge.

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

Subsequently, the individual in the site badging office apparently confused the unauthorized worker's badge with the badge issue form of a properly authorized worker employed by the same company and entered the unauthorized worker's biometric access information into another worker's database record within the plant's access control system, thus allowing the worker to enter the protected and vital areas. This confusion appears to be the result, at least in part, of both individuals working for the same company.

REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT

This event is reportable per 10 CFR 73.71(d) because an event occurred for which a one-hour telephone notification of a safeguards events was made to the NRC pursuant to the requirements of 10 CFR 73.71(b)(1). Such events are required by 10 CFR 73.71(d) to be reported in writing within thirty days. In this event, an unauthorized person actually entered the plant protected and vital areas, an event listed in Appendix G to 10 CFR 73.71 and, therefore, required to be reported within one hour of discovery, followed by a written report within 30 days.

As required by 10 CFR 73.56, Plant Hatch maintains an access authorization program granting appropriate persons unescorted access to the protected and vital areas as necessary to perform needed work. The objective of the authorization program is to provide a high degree of assurance that persons granted unescorted access are trustworthy and reliable, and do not constitute an unreasonable risk to the health and safety of the public. The program consists of the elements described in and required by 10 CFR 73.56(b)(2).

In this event, an individual was granted unescorted access to the protected and vital areas without first successfully completing the access authorization program. This was the result of cognitive personnel error: a site Security Department person, apparently confused the unauthorized worker with a properly authorized worker (employed by the same company) in the security computer database and entered the unauthorized worker into the plant's access control system, thus allowing the worker to enter the protected and vital areas. The individual inappropriately granted unescorted access was unaware he was not authorized to enter the protected and vital areas. He accessed the protected and vital areas only after being subjected to the usual search procedures and, because of unfamiliarity with the site, was in the presence of a properly authorized person most of the time he was in the protected and vital areas. Moreover, subsequent background and behavior checks revealed the individual would have been granted unescorted access. The individual was subsequently granted unescorted access to a nuclear plant on 09/29/2000.

Based upon the preceding information, it can be concluded that this event did not result in any degradation of the security of the protected and vital areas.

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CORRECTIVE ACTIONS

Upon discovery of the error, security personnel verified the worker was not in the protected area and the unauthorized contract worker's access was prevented. Specifically, the worker's badge was confiscated and destroyed. The required background and behavior checks were initiated, the results of which indicated that the worker would have been granted unescorted access to the protected and vital areas. The worker was granted unescorted access to a nuclear plant on 09/29/2000, and has subsequently been granted access to the Hatch Protected Area.

The individual who mistakenly granted the contract worker unescorted access will be disciplined under the Company's Positive Discipline Program.

A check of persons having access to the protected and vital areas, and employed by the same company as the worker incorrectly given access was performed. No additional problems were found; that is, properly completed authorization forms, and background and behavior checks existed for persons having unescorted access to the protected and vital areas. Additionally, a check of approximately 35 to 40 other contract workers having unescorted access to the protected and vital areas, and employed by another company was performed. Properly completed authorization forms, and background and behavior checks existed for these persons as well. Therefore, it appears this event was an isolated occurrence.

ADDITIONAL INFORMATION

Other Systems Affected: No systems other than those already mentioned in this report were affected by this event.

Failed Components Information: No failed components caused or resulted from this event.

Commitment Information: This report does not create any permanent licensing commitments.

Previous Similar Events: There have been no previous similar events reported in the last two years in which an unauthorized person entered the protected and vital areas.