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SOUTHERN COMPANY
Energy to Serve Your World℠

January 26, 2001

Docket No.: 50-348
50-364

NEL-01-0024

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

Joseph M. Farley Nuclear Plant
Licensee Event Report 2001-001-00
Safeguards Information Mishandled

Ladies and Gentlemen:

Joseph M. Farley Nuclear Plant – Licensee Event Report (LER) No. 2001-001-00 is being submitted in accordance with 10 CFR 73.71 Appendix G. There are no NRC commitments in the LER.

If you have any questions, please advise.

Respectfully submitted,

D Morey

Dave Morey

DWD/mar.doc
Attachment

IE74

cc: Southern Nuclear Operating Company
Mr. L. M. Stinson, General Manager – Farley

U. S. Nuclear Regulatory Commission, Washington, D. C.
Mr. L. M. Padovan, Licensing Project Manager – Farley

U. S. Nuclear Regulatory Commission, Region II
Mr. L. A. Reyes, Regional Administrator
Mr. T. P. Johnson, Senior Resident Inspector – Farley

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)
Joseph M. Farley Nuclear Plant Unit 1	05000 348	1 OF 3

TITLE (4)
Safeguards Information Mishandled

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
01	03	2001	2001	001	0	01	26	2001	Farley Unit 2	05000364
				-	-				FACILITY NAME	DOCKET NUMBER 05000

OPERATING	1
POWER LEVEL (10)	100

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

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)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
L. M. Stinson, General Manager Nuclear Plant	334-899-5156

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	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)

This report is submitted in accordance with 10CFR73 Appendix G paragraph I.(c).

On January 3, 2001 it was discovered that safeguards information (SGI) had been mishandled. No known loss of SGI occurred, however it remained unsecured for between one and two days.

A revision to the Security Plan had been sent to the corporate offices for approval. The revision was sent to an SGI authorized individual; however this individual was not assigned to the document management group responsible for processing the revision. This individual delivered the SGI to the incorrect office for approval, and transferred it to a secretary who was not SGI authorized. The secretary's manager was not available and the secretary locked the information in her desk. The next afternoon the secretary delivered the information to the manager, who was SGI authorized. Upon receiving the material the manager determined that the SGI had been mishandled, secured the information and notified plant management of the event.

This event was caused by personnel error in that an FNP Document Control clerk forwarded the SGI document to the incorrect corporate office person and that person transferred it to an unauthorized individual.

Contributing to these personnel errors were incomplete procedural guidance, inadequate retraining and poor communications. Individuals involved have been retrained or determined to no longer have need of SGI access and removed from the access list. FNP has implemented interim controls on transfer of SGI until procedural guidance enhancements are complete.

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

Requirement for Report

This report is required per 10CFR73 Appendix G paragraph I.(c) as a supplement to a one hour telephone notification. This event represents vulnerability in a safeguards system that could have aided in undetected or unauthorized access to a vital or protected area.

Description of Event

On December 22, 2000, a plant document control clerk was requested to send a revision of the Security Plan to the corporate general office for approval. The plant clerk was unsure of whom to send the document to, and asked another employee for guidance. Due to poor communication he was advised incorrectly, and transmitted the Security Plan to a corporate secretary who was authorized to receive SGI but was not responsible for processing the SGI revision. The correct person to receive and process the revision was the Document Management Supervisor. The secretary receiving the document assumed that the material should be given to the SAER Manager for approval, and delivered it to his secretary. The secretary was not on the approved SGI list and therefore should not have had possession of the material. The SAER Manager was not available and the secretary locked the information in her desk. The next afternoon the secretary delivered the information to the SAER manager, who was SGI authorized. He realized that the document had been mishandled, secured the information and promptly notified the appropriate personnel.

Cause of Event

This event was caused by personnel error in that an FNP Document Control clerk forwarded the SGI document to the incorrect corporate office person and that person transferred it to an unauthorized individual. Contributing to these personnel errors were incomplete procedural guidance, inadequate retraining and poor communications.

Significance

This event is of minimal security significance because neither target sets nor defensive strategies are contained in the Security Plan. Therefore it would not have increased the probability of loss of the facility to a threat. In addition, the material was accounted for and there is no reason to suspect that persons with harmful intent had access to the information contained in the plan.

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

Corrective Action

The clerk in the corporate office who was involved was determined to no longer have a need for SGI authorization and was therefore removed from the SGI access list.

All FNP document control personnel and corporate personnel authorized to handle FNP project SGI have been retrained on SGI handling.

Available FNP DC personnel have been trained on formal communications. The remainder of the personnel (one individual) will be retrained when they return to the site.

Procedure changes will be made to enhance guidance on transmitting SGI material offsite.

Interim instructions have been issued until the procedural changes have been completed. These instructions direct that all safeguards information will be brought to Document Control for transmittal approval by specified plant supervision before it leaves the plant site.

A retraining program for FNP site personnel authorized to handle SGI will be established by April 20, 2001.

Additional information

There have been no LERs pertaining to SGI within the past three years.