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ROBERT C. MECREDY
Vice President
Nuclear Operations

January 22, 2002

U.S. Nuclear Regulatory Commission
Document Control Desk
Attn: Robert L. Clark
Project Directorate I
Washington, D.C. 20555

Subject: Safeguards LER 2001-S01, Safeguards Event
R.E. Ginna Nuclear Power Plant
Docket No. 50-244

Dear Mr. Clark:

The attached Safeguards Licensee Event Report LER 2001-S01 is submitted in accordance with 10 CFR 73.71 and Section I(a)(3) of Appendix G, Reportable Safeguards Events.

Very truly yours,

Robert C. Mecredy

xc: Mr. Robert L. Clark (Mail Stop O-8-E9)
Project Directorate I
Division of Licensing Project Management
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Regional Administrator, Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

U.S. NRC Ginna Senior Resident Inspector

IE 74

1000400

NRC FORM 366 (7-2001) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 7-31-2004

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

LICENSEE EVENT REPORT (LER)

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

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4. TITLE

Safeguards Event

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
12	24	2001	2001	– S01 –	00	01	22	2002		05000
									FACILITY NAME	DOCKET NUMBER
										05000

9. OPERATING MODE	1
10. POWER LEVEL	100

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)	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)		

12. LICENSEE CONTACT FOR THIS LER

NAME	TELEPHONE NUMBER (Include Area Code)
Ronald C. Teed - Manager, Nuclear Security	(585) 771-3232

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

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

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

On December 24, 2001, at approximately 0722 EST, a plant employee reported to the on-duty Security Shift Supervisor (SSS) that he had observed what appeared to be an unattended security weapon or training aid in a plant restroom. The SSS immediately dispatched an Assistant Security Shift Supervisor to the area of that restroom. The assistant supervisor discovered a loaded security weapon leaning against the wall between the sinks in that restroom. The assistant supervisor immediately inspected and secured the weapon. The discovery of an unattended security weapon within the Protected Area (PA) was determined to be reportable to the Nuclear Regulatory Commission in accordance with 10 CFR 73.71 and 10 CFR 73 Appendix G.

I. PRE-EVENT PLANT CONDITIONS

The plant was in Mode 1, at approximately 100% steady state reactor power.

II. DESCRIPTION OF EVENT

On December 24, 2001, at approximately 0722 hours, a plant employee reported to the on-duty Security Shift Supervisor (SSS) that he had observed what appeared to be an unattended security weapon or training aid in a plant restroom. The SSS immediately dispatched an Assistant Security Shift Supervisor to the area of that restroom. The assistant supervisor discovered a loaded security weapon leaning against the wall between the sinks in that restroom. The assistant supervisor immediately inspected and secured the weapon. The weapon had all ammunition accounted for, the "chamber checker" (a device used to readily identify if the chamber is empty) was in place, and it appeared that nothing had been done to or with the weapon during the time it was unattended in that restroom. All other weapons and ammunition were immediately inventoried and all were accounted for. The SSS began making proper notifications, started a preliminary investigation, and took immediate corrective actions.

Upon notification by the SSS, security management personnel responded to the plant to direct the investigation and identify and implement additional preliminary corrective actions. The initial security investigation consisted of interviews with all personnel that may have been involved, including all plant personnel that may have been a witness (i.e., noticed someone using that plant restroom). December 24th was Christmas Eve and was a company holiday. Since the event occurred on a holiday, the number of personnel on site was limited to security personnel and the on-duty operations and operations support personnel. Thus, the number of individuals that may have had information to contribute to the investigation was limited. Access reports were run on all on-duty security personnel, and post assignment logs were reviewed to ascertain activities and look for opportunities for security personnel to have left the weapon unattended in that restroom.

Upon conclusion of this initial investigation, which spanned two days, the security officer who inadvertently left the weapon unattended was identified. In reconstructing the officer's activities, the following sequence of events occurred. At approximately 0110 EST on December 24, 2001, the officer was transitioning from a response post inside a plant building to the Access Control Facility (ACF). The officer was feeling ill and partially vomited into his hand. He proceeded into a plant restroom and leaned the weapon between the sinks while he washed his hands. He then wiped his hands and proceeded to his next station in the ACF, forgetting to retrieve the weapon. Since the next station (the ACF) did not require the officer to carry a weapon, he did not realize what he had done and the weapon remained where he had left it in that restroom until the weapon was observed by the plant employee.

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

III. EVENT SUMMARY

The weapon was inadvertently left unattended by the security officer at approximately 0110 EST on December 24, 2001, and the weapon was observed, unattended, in the plant restroom at approximately 0722 EST. The time the weapon was unattended in the restroom was determined to be approximately six hours and ten minutes. During the time that the weapon was unattended (midnight shift on a holiday), the staffing levels at the plant consisted of security personnel and on-duty operations and operations support personnel (for a total of nine "non-security" personnel on site). The unattended weapon had no impact on the effectiveness of the security force to respond to a contingency event, since other weapons were readily available should the need arise. Immediate corrective actions and investigations were initiated upon discovery of the event.

NRC Regulatory Guide 5.62 ("Reporting of Safeguards Events", Revision 1, November 1987) was reviewed, and it was determined that this event was reportable to the Nuclear Regulatory Commission, based on the examples listed in Section 2.2 of the regulatory guide. The SSS and the Operations Shift Supervisor notified the NRC Operations Center, per 10 CFR 73.71 and 10 CFR 73 Appendix G, at approximately 0939 EST on December 24, 2001.

IV. CORRECTIVE ACTION

The event was entered into the plant corrective action program. This event is being evaluated in detail as part of a plant event evaluation by the Nuclear Assessment group and security management. Concurrent with this ongoing evaluation, corrective actions were immediately taken to prevent recurrence. Shift meetings were conducted on December 24th with all security personnel on duty at the time of the event, and also with the relief shift on the same date, to raise awareness of the issue and the seriousness of the event. A detailed report on the event was prepared, and all other security personnel (those not on site on December 24th) received a thorough briefing prior to commencing their next work shift. The evaluation team looked for other areas and opportunities where there was an increased risk of leaving a weapon unattended. Administrative controls were enhanced and additional administrative and physical barriers were established to reduce the potential for leaving a weapon unattended. The details of these administrative controls have been shared with NRC Region I staff and the NRC Resident Inspector.

Additional corrective actions continue to be evaluated as a part of the ongoing event evaluation.