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March 20, 2003

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-S01-00)
ACCESS TO PROTECTED AREA BY AN INDIVIDUAL WITH AN
EXPIRED BADGE

Attached is Licensee Event Report (LER) No. 2003-S01-00, for the Virgil C. Summer Nuclear Station (VCSNS). The report describes an event in which an individual gained access to the protected area after his badge had expired and is being submitted in accordance with 10 CFR 73.71, Appendix G(3)(b).

Should you have any questions, please call Mr. Mel Browne at (803) 345-4141.

Very truly yours,

Stephen A. Byrne

JWP/SAB
Attachment

c: N. O. Lorick
N. S. Carns
T. G. Eppink (w/o attachment)
R. J. White
L. A. Reyes
K. R. Cotton
NRC Resident Inspector
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NSRC
RTS (0-C-03-0635)
File (818.07)
DMS (RC-03-0068)

IE74

NRC FORM 366 (7-2001)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB NO. 3150-0104	EXPIRES 7-31-2004
LICENSEE EVENT REPORT (LER) <small>(See reverse for required number of digits/characters for each block)</small>		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
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4. TITLE
Access to Protected Area by an individual with an expired badge

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
02	25	2003	2003	- S01	- 00	03	20	2003		05000395
									FACILITY NAME	DOCKET NUMBER

9. OPERATING MODE	1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check all that apply)							
10. POWER LEVEL	100	<input type="checkbox"/> 20 2201(b)	<input type="checkbox"/> 20 2203(a)(3)(ii)	<input type="checkbox"/> 50 73(a)(2)(ii)(B)	<input type="checkbox"/> 50 73(a)(2)(ix)(A)	<input type="checkbox"/> 20 2201(d)	<input type="checkbox"/> 20 2203(a)(4)	<input type="checkbox"/> 50 73(a)(2)(iii)	<input type="checkbox"/> 50 73(a)(2)(x)
		<input type="checkbox"/> 20 2203(a)(1)	<input type="checkbox"/> 50 36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 73 71(a)(4)	<input type="checkbox"/> 20 2203(a)(2)(i)	<input type="checkbox"/> 50 36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73 71(a)(5)
		<input type="checkbox"/> 20 2203(a)(2)(ii)	<input type="checkbox"/> 50 36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input checked="" type="checkbox"/> OTHER	<input type="checkbox"/> 20 2203(a)(2)(iii)	<input type="checkbox"/> 50 46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	Specify in Abstract below or in NRC Form 366A
		<input type="checkbox"/> 20 2203(a)(2)(iv)	<input type="checkbox"/> 50 73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(D)		<input type="checkbox"/> 20 2203(a)(2)(v)	<input type="checkbox"/> 50 73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(vii)	
		<input type="checkbox"/> 20 2203(a)(2)(vi)	<input type="checkbox"/> 50 73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)		<input type="checkbox"/> 20 2203(a)(2)(vii)	<input type="checkbox"/> 50 73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
		<input type="checkbox"/> 20 2203(a)(3)(i)	<input type="checkbox"/> 50 73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)					

12. LICENSEE CONTACT FOR THIS LER

NAME M. N. Browne, Mgr., Nuclear Licensing	TELEPHONE NUMBER (Include Area Code) (803) 345-4141
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
AX				No					

14. SUPPLEMENTAL REPORT EXPECTED			15. EXPECTED SUBMISSION DATE		
YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/> NO		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, Appendix G(3)(b).

On February 25, 2003 during an audit of training records, it was discovered that a contractor's training had expired in October 2002. This individual visited the site infrequently and was not aware that his badge had expired. He did not access any vital areas of the plant. VCSNS believes that this event occurred unintentionally.

This event was due to a data entry error in the training files, neither access control personnel nor this individual were made aware of the expiration of his training. Upon discovery, the individual's badge was pulled, he was notified that his training had expired, and a one-hour report was made to the NRC. All training records were reviewed to verify that all other personnel were currently trained.

During the investigation of this event, it was discovered that this individual had entered the protected area of the plant on several occasions and did escort three individuals, on three separate dates. These individuals were escorted for the purpose of moving vending machines and looking at the vending products. They did not enter any vital areas of the plant at any time.

LICENSEE EVENT REPORT (LER)

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
V.C.Summer Nuclear Station	05000395	YEAR	SEQUENTIAL NUMB'R	REVISION NUMB'R	2 OF 3
		2003	-- S01 --	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 February 25, 2003 the station was conducting a verification audit of training records. It was discovered that a contractor's training had expired in October 2002. This individual visited the site infrequently and was not aware that his badge had expired. He did not access any vital areas of the plant.

This event was due to a data entry error in the training files so that neither access control personnel nor this individual were made aware of the expiration of his training. Upon discovery, the individual's badge was pulled, he was notified that his training had expired, and a one-hour report was made to the NRC. All training records were reviewed to verify that all other personnel were currently trained.

During the investigation of this event, it was discovered that this individual had entered the protected area of the plant on several occasions and did escort three individuals, on three separate dates. These individuals were escorted for the purpose of moving vending machines and looking at the vending products. They did not enter any vital areas of the plant at any time.

VCSNS believes that this event occurred unintentionally. This event was documented in Condition Evaluation Report (CER) 03-0635.

DISCOVERY DATE

02/25/03

REPORT DATE

03/20/03

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	--- S01 --	00	

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

CONDITIONS PRIOR TO EVENT

Mode 1, 100% power

DESCRIPTION OF EVENT

On February 25, 2003 during a 100% audit of training expirations, it was discovered that a contractor's training had expired in October 2002. This individual visited the site infrequently and was not aware that his badge had expired. He did not access any vital areas of the plant.

CAUSE OF EVENT

The cause of this event is a data entry error in the individual's training file, so that neither access control personnel nor this individual were made aware of the expiration of his training.

ANALYSIS OF EVENT

During the investigation of this event, it was discovered that this individual had entered the protected area of the plant on several occasions and did escort three individuals, on three separate dates. These individuals were escorted for the purpose of moving vending machines and looking at the vending products. They did not enter any vital areas of the plant at any time.

CORRECTIVE ACTIONS

Upon discovery, this individual's badge was pulled so that no further access could be gained until the required training was completed. A full audit was conducted of training records and no other occurrences were identified.

PRIOR OCCURRENCES

None