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November 10, 2003

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

SUBJECT: Duke Energy Corporation

Catawba Nuclear Station Unit 1 and Unit 2

Docket Nos. 50-413 and 50-414

Security Special Report 413/2003-S02 Revision 0

Pursuant to 10 CFR 73.71 Sections (b)(1) and Appendix G (I) (d), attached is a Security Special Report 413/2003-S02, concerning the inadequate search of material entering the protected area.

This Security Special Report does not contain any regulatory commitments. This event is considered to be of no significance with respect to the health and safety of the public. Questions regarding this Security Special Report should be directed to A. P. Jackson at (803) 831-3742.

Sincerely,

D. M. Jamil

Attachment

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TELEPHONE NUMBER (Include Area Code)

Anthony Jackson, Regulatory Compliance

803-831-3742

DATE

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT REPORTABLE TO EPIX MANU-FACTURER MANU-FA CTURER REPORTABLE TO EPIX SYSTEM CAUSE SYSTEM COMPONENT COMPONENT CAUSE 14. SUPPLEMENTAL REPORT EXPECTED MONTH DAY 15. EXPECTED SUBMISSION X No YES (If yes, complete EXPECTED SUBMISSION DATE).

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

On October 13, 2003 at 0800 hours, a security officer allowed three stacked food storage containers to enter the protected area of Catawba Nuclear Site without being searched in accordance with established security procedures and the DPC Nuclear Security and Contingency Plan. An on-site food service vendor employee was bringing in the containers from a location exterior to the protected area where they had been utilized in an onsite function. When the containers were processed through the metal detector an alarm was generated. When the vendor employee himself processed through the metal detector, he generated an alarm as well. vendor employee removed his shoes and other metal and again processed through the metal detector and did not create an alarm on his second walk through. was then allowed to enter the protected area without the food containers being This oversight was identified to security personnel and the subject containers were searched and no contraband was discovered. The causal factors for this event included perceived time pressure on the part of the responsible officer and the fact that the officer was the only barrier between success and failure of this activity. Taking the unsearched material into the protected area does not appear to have been done with any malicious intent with respect to the health and safety of the public. This event is considered to have no significance with respect to the health and safety of the public.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2) NUMBER (2)	L	ER NUMBER (6)	PAGE (3)				
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Catawba Nuclear Station, Unit 1	05000413	2003	- S02 -	00	2	OF	5	

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

BACKGROUND

Catawba Nuclear Station Units 1 and 2 are Westinghouse Pressurized Water Reactors [EIIS: RCT]. At the time this event was identified, Unit 1 and Unit 2 were both operating in Mode 1, Power Operation. This event is reportable per 10CFR 73.71(b)(1) and Appendix G(I)(d).

The cafeteria area for the site is located within the protected area. Therefore, vendor canteen employees frequently must enter through the Personnel Access Portal (PAP) with containers that are required to be searched. Upon initial entry, the containers pass through an explosives detector and a metal detector. The applicable security procedure states that the PAP officer shall ensure that all material being brought into the protected area is searched either physically or by the x-ray machine. In this event, this search was not performed nor was the material passed through the x-ray machine prior to entry into the protected area.

EVENT DESCRIPTION

(All times are approximate.)

The following is a chronology of the security event reported by Catawba Nuclear Station to the NRC Operations Center via the Emergency Notification System at 1259 hours on 10/13/2003.

- O755 An on-site food service vendor employee was bringing in the containers from a location exterior to the protected area where they had been utilized in an onsite function. As the vendor employee entered the search area, the security officer identified that he had material which would need to be searched and lowered the PAP search lobby administrative gate since he was the only officer available to perform the search function at that time.
- 0757 The security officer observed the vendor properly process the containers through the explosive detector and then through the metal detector. When the containers were processed through the metal detector, an alarm was generated.
- 0800 When the vendor employee himself processed through the metal detector, he generated an alarm as well. The vendor employee removed his shoes and other metal and again processed through the metal detector and did not create an alarm on his second walk through. As the vendor employee was putting his shoes back on, the security officer was in the process

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of requesting entry through the PAP1 alarm door in the PAP search area in order to allow entry of the containers.

- 0803 Vendor employee proceeded through the turnstiles and was united with the materials that had passed through the PAP1 door.
- Vendor employee arrived at the cafeteria area with the containers. He met a member of security's clerical support group and notified her of the concern he had regarding the degree of search that the security officer in the PAP had given the food containers.
- 1030 Upon return to the security support office area, the security clerical support person notified the Security Shift Captain of the concerns expressed by the vendor employee.
- 1110 The containers were searched by security and cleared.

CAUSAL FACTORS

The investigation of this event did not indicate any malevolent intent on the part of the vendor employee to transport contraband into the Protected Area or harm plant equipment. A barrier analysis revealed the failure of two barriers:

The security officer failed to physically search the storage containers even after they had generated an alarm on the path through the metal detector. The barrier that existed was based on the officer's knowledge acquired via experience and qualifications. He was the only officer in the area at that time. When he failed to perform the adequate search, the failure of the "single barrier" caused a failure of the process.

The vendor, who had previous knowledge of the proper search processes, was an additional "barrier" that could have prevented the event. Had he questioned the officer earlier in the event, the search could have been conducted at the entry turnstiles which would have decreased the level of significance of the event.

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

CORRECTIVE ACTIONS

Immediate:

1. Security distributed a "Human Performance Alert" communication to all security officers to make them aware of the event occurrence and to reiterate the need to utilize error prevention tools when performing all security activities.

Subsequent:

1. A "Daily Shift Order" was developed and distributed to all of security which outlined a revised process for allowing material entry into the protected area via the PAP1 door. When the security officer in the PAP notifies the alarm station and makes the request that the door be unlocked, the alarm station operator must verify, by 3-way communication with the posted officer, that the material has been searched prior to allowing the door to be opened.

Planned:

1. Revise applicable security procedures to implement a process to communicate with the controlling alarm station regarding the search status of any material being admitted through the PAP1 door.

SAFETY ANALYSIS

There was no safety significance associated with this event as the investigation of this event did not indicate any malevolent intent on the part of the contract employee to transport contraband into the Protected Area or harm plant equipment. The contract employee did not have access to any vital areas.

This event did not result in any uncontrolled releases of radioactive material, personnel injuries, or radiation over exposure. The health and safety of the public were not affected by this event.

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ADDITIONAL INFORMATION

A review of Duke Power events over the previous two (2) years identified one similar event. PIP 0-02-05502 documented an inadequate search of a pump being allowed access through the Vehicle Access Portal (VAP) of Oconee Nuclear Site. This event was caused by a miscommunication and misunderstanding of security and radiation protection personnel regarding whether the search of the pump could be exempted based on the high radiation levels of the pump.

Corrective actions from the previous event involved ensuring that security personnel understood the requirements to exempt material from required searches. These corrective actions could not be expected to have prevented this occurrence. Therefore, the event described in this LER is not a recurring event. This event did not involve an equipment failure and is not considered reportable to the Equipment Performance and Information Exchange (EPIX) program.