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June 7, 2007

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

Subject: Duke Power Company LLC d/b/a Duke Energy
Carolinas, LLC (Duke)
Catawba Nuclear Station, Units 1 and 2
Docket Nos. 50-413 and 50-414
Security Special Report 413/2007-S01, Rev. 0

Pursuant to 10 CFR 73.71 Sections (b)(1) and Appendix G -
(I) 3(b), attached is a Security Special Report 413/2007-
S01 concerning an unauthorized entry into 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.

Very truly yours,

James R. Morris

Attachment

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June 7, 2007

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xc: w/attachments

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1. FACILITY NAME Catawba Nuclear Station, Unit 1	2. DOCKET NUMBER 05000 413	3. PAGE 1 OF 7
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4. TITLE
Unauthorized Escorted Entry into the Protected Area

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
04	11	2007	2007	S01	00	06	07	2007	Catawba Unit 2	05000414
									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%	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)								

12. LICENSEE CONTACT FOR THIS LER

NAME Anthony P. Jackson, Regulatory Compliance	TELEPHONE NUMBER (Include Area Code) 803-831-3742
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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

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

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

On 4/11/07 at approximately 1405 hours it was discovered that on 3/1/07 at 0853 hours, a vendor was inadvertently allowed entry into the protected area of the Catawba Nuclear Site even though they had been previously denied nuclear site unescorted access as reflected within the Personnel Access Data System (PADS). In order to comply with the requirements of the security plan, security officers assigned to the badging area must check the Personnel Access Data System (PADS) to determine if an individual requesting escorted access has ever been denied unescorted access at any nuclear site. If the requesting individual has been denied access, a "Contact Access" message will be returned and reflected within PADS. On the day of the event occurrence, the assigned security officer conducted a check of the PADS. Even though the "Contact Access" message was returned, the security officer overlooked the message and allowed escorted entry to the vendor. The vendor was allowed eight additional entries between 3/2/07 and 3/21/07. This event was identified when the same vendor returned to Catawba on 4/11/07 for escorted access and PADS was checked. Site access records demonstrated the visitor did not enter into any vital areas. This event is considered to have no significance with respect to the health and safety of the public.

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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)3(b).

Personnel Access Database System (PADS) Overview

PADS is an industry shared computer application that is used to record access authorization, training, and radiation protection (RP) information. Additionally, PADS provides user information to security personnel and other individuals with a need to access PADS information for a "Visitor ID Check Application."

PADS Search Process

All individuals in PADS are listed by Social Security Number (SSN) or an assigned PADS ID if they have no SSN (e.g. non-U.S. resident). If an individual has a SSN, the search must be conducted using the SSN. If the person does not have a SSN, the search must be conducted using the "name" process. When the "name" process is used, the system is designed to convert the name to the assigned PADS ID for search purposes.

Visitor Badge Issuance

Prior to issuing Visitor Badges, Security must check PADS to determine if the visitor is currently denied access at any other United States (U.S.) commercial nuclear sites. If access denial information is displayed in PADS, the visitor shall not be allowed access to Duke Power nuclear sites unless the denial information is cleared or adjudicated by Duke, or the denial information is removed from PADS.

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EVENT DESCRIPTION (Certain event times are approximate.)

Date/Time	Event Description
3/01/07 0830	A visitor with an escort approached the Personnel Access portal (PAP) requesting escorted access.
3/01/07 0841	PADS check returned a "Contact Access" message on the screen.
3/01/07 0853	Visitor Badge #008 was issued to the individual and entry was allowed into the Catawba site protected area.
4/11/07 1345	Visitor with escort in PAP requested escorted access. (EVENT DISCOVERY)
4/11/07 1350	PADS check returned a "Contact Access" message on the screen.
4/11/07 1353	Officer notified individual of need to contact Access Services and was informed of the individual's earlier entry.
4/11/07 1400	A Check of historical visitor badge paperwork on the individual reflected entries into the Catawba site protected area on the following dates: 3/1/07, 3/2-3/07, 3/15-19/07, and 3/21/07.
4/11/07 1405	Security officer notified Security Supervision of the finding.
4/11/07 1415	Security supervision verified with Duke Energy Access Services personnel that the individual had been flagged in PADS with the "Contact Access" message prior to any of the entries identified in March. The "Contact Access" message was provided to Catawba Security on February 14, 2007.

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CAUSAL FACTORS

On March 1, 2007 the individual requesting escorted access and his escort arrived at the PAP area to obtain a visitor badge and subsequently gain entry into the protected area. The Video Badging Network (VBN) Operator assigned to the badging office provided the individual with the Badge Authorization Form to be completed and signed prior to badge issue. Based upon a review of the completed Badge Authorization Form, the Operator ensured that all the necessary areas of the form were completed and the form reflected that he appropriately initialed all of the areas that he checked such as photo identification, the VBN system, Instant ID check, and PADS check. Documentation supplied by a PADS Central administrator verified that the VBN Operator assigned to badging that morning did make an inquiry into the PADS system for the requesting individual at 08:41:34:03 on March 1, 2007. This documentation also reflected that the status returned for that individual was "Contact Access." The VBN Operator apparently did not see the "Contact Access" message and subsequently issued the individual Visitor Badge #008 and allowed escorted access into the Catawba protected area at 0853.

Interviews with the assigned Operator could not determine the cause for not identifying the "Contact Access" message. The Operator could not remember the particular event but did state that he had never seen a "Contact Access" message returned on a PADS check. He estimated that he had accessed PADS for visitor verification approximately 12-15 times.

Training records reflect that this was a newly qualified VBN Operator. His initial qualification date was November 9, 2006. This event occurred less than four (4) months following his initial qualification.

In determining the root cause of this event, a barrier analysis method was utilized. In this event occurrence there were three (3) barriers that should have prevented these events: The first barrier is the officer's knowledge and skill gained through on-the-job training (OJT) and qualification regarding his responsibility for visitor badge issuance (i.e. photo identification verification, VBN check, and check of PADS). The second barrier is the "Contact Access" message returned from the PADS check.

Given that the above barriers should have acted together to prevent the initial event of unauthorized entry, a third barrier, had it been in place as it is now - See Subsequent Action #2, would have prevented the additional

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entries. This third barrier is the implementation of the daily check of PADS for each daily initial entry of the visitor.

CORRECTIVE ACTIONS

Immediate:

1. Security distributed a "Catawba Security Training Bulletin" communication to all security supervisors and VBN operators to make them aware of the event and to implement corrective actions in response to the occurrence.

Subsequent:

1. Security implemented a second verification by a separate officer of the visitor badge identification verification in PADS.
2. Security implemented a daily check of PADS for each initial entry of a visitor for his/her entire authorization timeframe.
3. Security revised the applicable procedure to reflect the daily PADS check and the process for second verification of the PADS identification verification.

Planned:

1. Security will revise the VBN Operator Training & Qualification Guide to demonstrate specific elements of the visitor badge issuance process.

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 individuals involved to harm plant equipment. The contract employee did not enter into 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

The PADS system is an industry system and the Operating Events Database (OEDB) was searched for similar events. Duke Energy's Problem Identification Process (PIP) database was also searched for similar events at each of the three nuclear sites.

OEDB Search:

The OEDB was searched using a combination of the following keywords: "unauthorized," "security," "access control," "VBN," "PADS," "visitor," "vendor," "unauthorized access," and "unescorted." Of the more than 300 items reviewed as a result of these searches, only the following item was identified:

OEDB 07-044838, OE23943 - Vendor Employee Was Inappropriately Granted Escorted Access to McGuire protected area. This item was posted 1/2/2007. This is the same type event as the subject event of this report.

PIP Search:

The Duke Energy PIP database was also searched for all three nuclear sites. There were two (2) events identified as a result of these searches:

PIP M-06-04456 Brief Problem Description: Protected Area (PA) access granted to visitor while "Contact Access" showing in PADS. (This is the same event reflected in the Operating Experience Database (OEDB) search)

PIP M-07-02237 Brief Problem Description: Vendor was allowed escorted (visitor) access to the protected area despite the Personnel Access Data System (PADS) indicating a "Contact Access" flag in the ID look up screen.

As a result of this review, it was determined that the event documented and reflected in this Security Special Report is the same type event with the same primary cause as the McGuire event documented in PIP M-06-04456. If Catawba security had implemented the second verifier corrective action following review of the McGuire Operating Experience (OE), this event may have been prevented. Based upon this determination, the event described in this report is a recurring event across the Duke system. Thus, the evaluation of the event and subsequent corrective actions will be shared with the Security organizations at the other Duke sites. This event did

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not involve an equipment failure and is not considered reportable to the Equipment Performance and Information Exchange (EPIX) program.