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February 9, 2009

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

Subject: Duke Energy Carolinas, LLC (Duke)
Catawba Nuclear Station, Units 1 and 2
Docket Nos. 50-413 and 50-414
Security Special Report 413/2008-S01, Rev. 0

Pursuant to 10 CFR 73.71 Sections (b)(1) and Appendix G- I (b), attached is a Security Special Report 413/2008-S01, Rev. 0 concerning a contract worker being granted unescorted access authorization based upon erroneous psychological assessment information.

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) 701-3742.

Very truly yours,



James R. Morris

Attachment

IE74
NRR

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xc: w/attachments

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Catawba Document Control File: 801.01 - CN04DM

Catawba RGC Date File

ELL-EC050

NCMPA-1

NCEMC

PMPA

LICENSEE EVENT REPORT (LER)

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

Estimated burden per response to comply with this mandatory 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 and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@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 an 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.

1. FACILITY NAME Catawba Nuclear Station, Unit 1	2. DOCKET NUMBER 05000 413	3. PAGE 1 OF 6
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4. TITLE
Contract Worker Granted Unescorted Access Authorization Based Upon Erroneous Psychological Assessment Information.

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	11	2008	2008	S01	00	02	09	2009	Catawba Unit 2	05000 414
									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 type="checkbox"/>			
	<input checked="" type="checkbox"/>	20.2203(a)(2)(iii)	<input type="checkbox"/>	50.46(a)(3)(ii)	<input type="checkbox"/>	50.73(a)(2)(v)(C)	<input checked="" type="checkbox"/>	OTHER 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"/>			
	<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"/>			
	<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"/>			
<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)	<input type="checkbox"/>				

12. LICENSEE CONTACT FOR THIS LER

NAME Anthony P. Jackson - Regulatory Compliance	TELEPHONE NUMBER (Include Area Code) 803-701-3742
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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 15. EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/>	NO	<input type="checkbox"/>	MONTH	DAY	YEAR

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

A vendor contract worker (CW1) was granted unescorted access authorization on 12/1/08 based upon erroneous psychological assessment information. Following the granting of unescorted access and being allowed Protected Area access at Catawba, it was discovered on 12/11/08 that the worker should have been denied access due to a failed psychological screening. The Vendor Screening Company (VSC) discovered the error during a routine monthly audit of the November 2008 files and contacted Duke's Access Services Group. The individual accessed the site on the following dates: 12/1, 12/2, 12/4, 12/5, 12/8, and 12/9/08. However, based upon information from the security computer, CW1 had no access to and did not enter any vital areas of the site. This event does not involve any human error or programmatic failure on the part of security personnel at Catawba or Access Services personnel at the Duke Energy General Offices. This event is reportable per 10CFR 73.71(b)(1) and Appendix G-I(b).

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Catawba Nuclear Station, Unit 1	05000413	2008	- S01 -	00	2 OF 6

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

BACKGROUND

Catawba Nuclear Station (CNS), Units 1 and 2 are Westinghouse Pressurized Water Reactors [EIIIS: RCT]. At the time this event was identified, Unit 1 and Unit 2 were both operating in Mode 1, Power Operation.

Duke Energy out-sources some of the background elements for Unescorted Access Authorization (UAA) screenings to approved vendor companies that have demonstrated the ability to meet regulatory and industry requirements. Duke has contracted with the Vendor Screening Company (VSC) to evaluate the Minnesota Multiphasic Personality Inventory (MMPI) and clinical assessments, and to provide certification of their assessment findings to Access Services. This out-sourcing is a standard industry practice.

EVENT DESCRIPTION

Approx. 1640 hours on 12/11/08, Psychologist 1 notified Access Services that a contract worker (CW1) had not passed the MMPI/clinical assessment, and that they had sent the wrong certification document to Access Services. The VSC discovered this problem during a routine audit/validation of their "Administrative Processing" files. VSC's investigation revealed the following:

On 11/20/08 Psychologist 2 determined that CW1 should not be granted access based on information from the MMPI test and interview findings. Psychologist 2 faxed his rejection recommendation to Psychologist 1. A VSC employee misread the fax from Psychologist 2 and erroneously prepared a psychological acceptance letter for Psychologist 1's approval. Psychologist 1 failed to recognize the administrative error and approved the erroneous approval letter, which was then faxed to Duke Access Services.

At Approx. 1641 hours, Access Services notified CNS Security to place CW1's badge on Security Clearance Hold. CW1's security badge was immediately placed on Security Clearance Hold in the Video Badging Network (VBN) system, pending evaluation. This status prevented CW1 from gaining access to the CNS Protected Area. In Addition, his badge was placed on "Administrative Hold" in the Personnel Access Data System (PADS).

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Approx. 1645 hours, the Access Services Manager was notified of the situation by phone, and that based on the information available, this appeared to meet the 1 hour reportability criteria.

Approx. 1650, Access Services called CNS Security and described the problem, and that it appeared this met the 1 hour Report criteria. CNS Security initiated actions to prepare the NRC 1-Hour Report.

Approx. 0820 hours on 12/12/08, the Access Services Reviewing Official communicated the UAA denial decision to CW1, and his security badge was terminated and denial flags placed in VBN and PADS.

CAUSAL FACTORS

Apparent Cause:

This event was caused by human performance errors by an off-site approved vendor company. The apparent cause appears to be a combination of inattention to detail, and failure to verify/self-check prior to providing Access Services with MMPI/clinical assessment results.

Culpable Group: Off-Site Vendor Screening Company (VSC)

Extent of Condition:

No other similar events are known or identified by Access Services or VSC. This is considered an isolated human performance error by a contractor who has been providing quality work to Duke Energy since 1998.

CORRECTIVE ACTIONS:

Immediate:

1. CW1's security badge was immediately placed on Security Clearance Hold on 12/11/08, pending evaluation. This status prevented CW1 from gaining access to CNS Protected Area.
2. CW1's badge was placed on "Administrative Hold" in PADS on 12/11/08.

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3. Notifications were made to Access Services Management and CNS Security Management on 12/11/08.
4. CNS initiated a 1 hour report to the NRC on 12/11/08.
5. VSC faxed a revised letter to Access Services indicating rejection status for CW1 on 12/12/08.
6. CW1's security badge was terminated on 12/12/08.
7. CW1 was notified that he was being denied access authorization on 12/12/08.
8. CW1's record was flagged as a denial in VBN on 12/12/08.
9. CW1's record was flagged as a denial in PADS on 12/12/08.

Subsequent:

1. Obtained detailed statement from Psychologist 1 at VSC regarding their:
 - Description of the event
 - Immediate corrective actions
 - Long term corrective actions
2. Access Services worked with Psychologist 1 at VSC to evaluate their internal processes and corrective actions. As a result, VSC states that the following changes to their processes were implemented:
 - a) Initiated a review of all records currently contained in their "Administrative Processing" files. No other instances of misclassification were identified during this review.
 - b) Included an additional step in which VSC immediately notifies Access Services when a Rejection recommendation is received from the interviewing psychologist.
 - c) Added an additional review process before Psychologist 1's initial review of a person's MMPI results.
 - d) Included an additional review process before Psychologist 1's review and signing of the letter sent to Access Services.

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e) VSC provided each interviewing psychologist with a set of two rubber stamps (reading "Accept" and "Reject", respectively). Interviewing psychologists have been instructed to imprint each report with the applicable stamp, before sending it to VSC.

Planned:

1. Duke's Audit Group (INOS Procurement Quality) will conduct a review of VSC's processes and Corrective Actions in 2009. (Note: VSC is included in the Nuclear Energy Institute annual audit process.) This corrective action is captured in the CNS corrective action program.

There were no programmatic errors or concerns identified during this evaluation. The event investigation reflects that the process in place at Duke Energy is in compliance with requirements in the Duke Energy Nuclear Security Plan and NEI 03-01, "Nuclear Power Plant Access Authorization Program".

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 have authorized access to vital areas and 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.

ADDITIONAL INFORMATION

Operating Experience Database (OEDB) Search:

A search of the Duke Energy OEDB and the Problem Investigation Process (PIP) databases for all Duke nuclear sites produced no similar events. Dates of search were from December 1, 2006 until December 1, 2008. Based upon this determination, the event described in this report is not a recurring event across the Duke nuclear system. This event did not involve an equipment

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