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October 13, 1998

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555-0001

Subject: Duke Energy Corporation
Catawba Nuclear Station, Units 1 and 2
Docket Nos. 50-413 and 50-414
Special Report 413/98-001S

Pursuant to 10 CFR 73.71.(d), attached is Special Report 413/98-001S, Revision 0, involving a terminated vendor employee entering the protected area. This event is considered to be of no significance with respect to the health and safety of the public.

There are no regulatory commitments contained in this report. Questions regarding this Special Report should be directed to Skip Copp, Catawba Regulatory Compliance, at (803) 831-3622.

Sincerely,

G.R. Peterson

Attachment

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U.S. Nuclear Regulatory Commission
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cc: Mr. Luis Reyes
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
61 Forsyth Street, S.W., Suite 23T85
Atlanta, GA 30303

Mr. P. S. Tam
U.S. Nuclear Regulatory Commission
Mail Stop O-14 H25
11555 Rockville Pike
Rockville, MD 20852-2738

Mr. Darrell Roberts
NRC Senior Resident Inspector
Catawba Nuclear Station

INPO Records Center
700 Galleria Place
Atlanta, GA 30339-5957

Marsh & McLennan Inc.
Mr. Kenneth W. Gannaway
100 N. Tryon Street
Charlotte, NC 28202

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Catawba Nuclear Station, Unit 1	DOCKET NUMBER (2) 05000413	PAGE (3) 1 of 5
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TITLE (4)
Terminated Vendor Employee Entered the Protected Area due to a Computer Interface Malfunction

EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER(S)	
09	13	1998	1998	001S	0	10	12	1998	Catawba Unit 2	05000414	

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more of the following) (11)									
POWER LEVEL (10) 100	<input type="checkbox"/>	20.402(b)	<input type="checkbox"/>	20.405(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	<input type="checkbox"/>	73.71(b)		
	<input type="checkbox"/>	20.405(a)(1)(i)	<input type="checkbox"/>	50.36(c)(1)	<input type="checkbox"/>	50.73(a)(2)(v)	<input type="checkbox"/>	73.71(c)		
	<input type="checkbox"/>	20.405(a)(1)(ii)	<input type="checkbox"/>	50.36(c)(2)	<input type="checkbox"/>	50.73(a)(2)(vii)	<input type="checkbox"/>	OTHER (Specify in Abstract below and in Text, NRC Form 366A)		
	<input type="checkbox"/>	20.405(a)(1)(iii)	<input type="checkbox"/>	50.73(a)(2)(i)	<input type="checkbox"/>	50.73(a)(2)(viii)(A)	<input type="checkbox"/>			
	<input type="checkbox"/>	20.405(a)(1)(iv)	<input type="checkbox"/>	50.73(a)(2)(ii)	<input type="checkbox"/>	50.73(a)(2)(viii)(B)	<input type="checkbox"/>			
	<input type="checkbox"/>	20.405(a)(1)(v)	<input type="checkbox"/>	50.73(a)(2)(iii)	<input type="checkbox"/>	50.73(a)(2)(x)	<input type="checkbox"/>			

LICENSEE CONTACT FOR THIS LER (12) Skip Copp - Regulatory Compliance								TELEPHONE NUMBER			
								AREA CODE 704		831-3622	

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
				NA					

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED		MONTH	DA	YEA
YES (if yes, complete EXPECTED SUBMISSION DATE)				X	NO			
				SUBMISSION DATE (15)				

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

On September 13, at 0610 hours with Unit 1 at 100% power and Unit 2 in a refueling outage, Security was notified by a vendor supervisor to delete the unescorted access of a vendor employee whose employment was to be terminated. At 0614 hours, Security terminated the vendor employee's badge in the Video Badging Network (VBN) computer. However, Security did not terminate the badge in the plant Security computer in order to prevent future access. This latter action, a workaround, was necessary due to a previously identified malfunction in the interface between the VBN and plant Security computer. At 1647 hours, the terminated vendor employee obtained his badge and reported for work as scheduled. He had not yet been notified that he had been terminated. At 1721 hours, the vendor employee's supervisor notified Security that the terminated vendor employee was inside the protected area. Security escorted the vendor employee out of the protected area at 1732 hours.

Security retained the vendor employee's badge to prevent further access. The computer interface malfunction was repaired on September 15. The root cause of this event was a computer interface malfunction between the Video Badging Network computer and the plant Security computer.

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BACKGROUND

Catawba Nuclear Station utilizes a Video Badging Network (VBN) computer system that networks the access authorization and badging functions between Duke Power Company's three nuclear sites and the Access Services group in the General Office. At each nuclear site, the VBN computer is designed to interface with the plant Security Computer to transfer data regarding unescorted access authorization status changes (additions, updates, and removal). The plant Security computer controls access into the protected area based on the data received from the VBN computer. On August 19, 1998, a malfunction in the interface between the VBN computer and the plant Security computer was discovered. The malfunction prevented a certain type status change made in the VBN computer from being transferred to the plant Security computer unescorted access data base. This malfunction necessitated establishing a workaround process. On August 19, 1998, Security Officers responsible for entering data into the VBN computer were informed of this malfunction via Duke Power Company's internal E-mail system (Lotus Notes). Within the communication, instructions were provided to perform a workaround, which required the Security VBN computer operator to separately contact the plant Security computer operator (Security alarm station operator) to manually enter the status change in the plant Security computer. Hard-copies of this communication were also placed in the VBN computer work area.

DESCRIPTION OF EVENT

September 13, 1998

0525 hours

Vendor supervisor counseled vendor employee regarding inadequate performance (not being in assigned work area, arriving at work late, leaving the plant for over 30 minutes and signing his time-sheet which did not reflect the non-paid status). Vendor employee was not informed that he was to be terminated.

0530 hours

Vendor employee ended his work shift and exited the protected area.

0610 hours

Vendor supervisor notified Security via telephone to terminate vendor employee's badge.

0614 hours

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The Access Control Specialist who received the telephone notification terminated the vendor employee's badge in the VBN computer. However, the Access Control Specialist did not contact the alarm station operator to terminate the badge in the plant Security computer. Since the plant Security computer controls access into the protected area, the badge remained valid for access.

1647 hours

The vendor employee reported for work as scheduled, entered the protected area, and proceeded to his assigned work area. The vendor employee had not yet been notified that he had been terminated.

1715 hours

Vendor supervisor observed the terminated vendor employee inside the protected area.

1721 hours

Vendor supervisor notified Security via telephone that the terminated vendor employee was inside the protected area.

1732 hours

Security Officer escorted vendor employee out of the protected area. Vendor employee's badge was retained by Security to prevent further access.

1815 hours

Vendor employee's badge was placed on Hold in the plant Security computer pending inquiry into the event.

1821 hours

Event reported to NRC pursuant to the requirements of 10CFR73.71(b).

1919 hours

Vendor employee's badge was terminated in the plant Security computer.

CONCLUSION

The root cause of this event was the computer interface malfunction between the Video Badging Network computer and the plant Security computer.

A significant contributing factor to this event was inadequate communication of the required workaround to the Security Officers who were responsible for operating the VBN computer. Although the e-mail communication containing the necessary information and instruction was

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sent to all Access Control Specialists, and hard-copies were placed in the VBN work area, there was no process in place to ensure that the e-mail communication had been received and understood by the Access Control Specialists.

The Access Control Specialist who received the employee termination notification from the vendor supervisor, performed the required badge termination steps in the VBN computer. However, he did not notify the alarm station operator to manually enter the status change in the plant Security computer.

The Access Control Specialist had apparently opened the e-mail message, but stated he did not recall reading the message contents and was unaware of the required workaround. The Access Control Specialist departed the site on August 21 for a two week military duty leave (the e-mail communication was sent on August 19). The Access Control Specialist returned to work on September 5. He indicated that he had approximately 20 additional new e-mail messages upon his return. Although the August 19 workaround message was still in his e-mail In-Box, he did not open the message since it's color indicated he had already opened it. He instead focused on the new e-mail messages.

Operating experience databases were searched for information/events of a similar nature occurring with the past 24 months. Although there were several events involving improper termination of a Security badge, there was only 1 event whereby protected area entry was gained. That event occurred prior to the implementation of the current Video Badging Network and plant Security computer systems.

Due to the significantly different circumstances surrounding these events and the nature of the deficient processes, the subject event is not considered to be a repeat occurrence.

CORRECTIVE ACTION

Immediate

Upon receiving notification that the terminated vendor employee was onsite, a Security Officer was dispatched to escort the individual off-site. The vendor employee exited the protected area at 1732 hours.

Vendor employee's badge was placed on Hold (restricted) at 1815 hours, and subsequently terminated in the plant Security computer at 1821 hours.

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Subsequent

A comparison review of Access Control Daily Process Checklists (manual records), and VBN computer termination records indicate that no other events occurred during the time-frame the workaround was in force.

On September 16, Security implemented a documented process whereby all badge restriction transactions are verified as being properly completed within the plant Security computer.

The computer interface malfunction between the VBN computer and plant Security computer (which necessitated the workaround) was repaired on September 15. However, the badge restriction verification process described above will remain in effect until System Administrators and Information Technology personnel have determined that system reliability has been fully restored.

Security obtained server space on the Local Area Network (LAN) as a central information source for Security personnel. A "VBN Information" folder has been established for all communication regarding VBN activity. All assigned Access Control Specialists are required to review the information in the folder and initial a checklist when completed.

Security has also implemented a formal Communications Guideline that outlines how communications are to be performed within the Security section.

SAFETY ANALYSIS

Although the vendor employee accessed the protected area after his company had decided he was to be terminated, the vendor employee was unaware of the termination. There was no malevolence associated with the entry.

Subsequent review of Plant Security Computer System records determined that no vital areas had been accessed by the terminated vendor employee.

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