DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

February 20, 1980

USNRC REGION II
'80 FEB 25 AM 8:31

Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Re: RII:CMH
50-269/79-35
50-270/79-32
50-287/79-35

Dear Sir:

With regard to Mr. J. P. Stohr's letter of January 28, 1980 which transmits the subject inspection report, Duke Power Company does not consider the information contained therein to be proprietary.

With regard to the item in the cover letter Duke Power Company is concerned about raising such an issue after it has been addressed on several other occasions. Historically, inspections and the associated reports were limited in scope, in that they sought to compare the licensee's actions with the regulations, license conditions, commitments, etc. However, this report and the cover letter discuss the inspectors views on independent verification. On page 6 the report documents that licensee representatives were appraised of this opinion. Duke Power welcomes such dialogue and will continue to make every effort to explain our practices to the various inspectors and will give appropriate consideration to differing views. However, Duke Power is concerned that such views are elevated to a level requiring a 20-day response without any apparent justification. Absent any references to the contrary, it appears that the inspector was in agreement with our administrative controls and concurs that they were in full compliance with the regulations.

It should be noted that the subject of independent verification was covered in depth in response to your request documented in a letter to Mr. A. C. Thies, Senior Vice President, Production and Transmission dated October 25, 1979. As a result of this request a special audit of operating practices specifically associated with such areas as independent verification was carried out. Several recommendations resulted from this audit and are being pursued internally. The results of this audit and related areas was discussed in great detail in our meeting with Region II on November 30, 1979 (documented in Inspection Report 50-269/79-40, 50-270/79-37, and 50-287/79-39). It is therefore concluded that Region II management has been quite adequately informed of our positions and has had an opportunity to express their concerns, if any.

8003270233

OFFICIAL COPY

Please find attached our response to the cited items of noncompliance. This response is considered to address the aforementioned area of concern.

Very truly yours,

William O. Parker, Jr.

KRW:scs

DUKE POWER COMPANY
OCONEE NUCLEAR STATION

Response to IE Inspection Report 50-269/79-35, -270/79-32, -257/79-35

ITEM A

As required by Technical Specification 6.4, the station shall be operated and maintained in accordance with approved procedures.

1. Station Procedure HP/0/B/1000/10, "Working limits for contamination control" states that in areas where contamination exists above the working limits specified, a posted and/or roped-off contamination area will be established.

   Contrary to the above, procedure HP/0/B/1000/10 was not followed in that a posted and/or roped-off contamination area was not established on November 19, 1979 around four Unit 1 high pressure turbine holddown bolts contaminated above the limits specified by procedure.

2. Station Procedure OP/0/A/1102/06, "Removal and Restoration of Station Equipment," Enclosure 7.1, step 7.1.13 specified the proper valve or breaker position required for restoration of a system to service.

   Contrary to the above, on October 16, 1979, while restoring the Unit 3 low pressure injection system "B" train to service, vent valve 3GWD-152 was not closed as called for on the Removal and Restoration of Station Equipment Checklist, although the checklist was initialled and dated indicating the valve was left in the proper position.

This is an infraction.

RESPONSE

Item A.1

This item resulted from the failure of a vendor Health Physics Technician to follow the station procedure by posting a contaminated area after he tagged the bolts. The bolts were immediately moved to a posted contamination area. The area where the bolts were originally stored was surveyed with no contamination above limits detected. This incident and the importance of following procedures were discussed with all HP supervisors and technicians, and with the vendor site coordinator.

Item A.2

This item resulted from personnel error in that the Nuclear Equipment Operator involved failed to properly close valve 3GWD-152. As noted in the inspection report, the valve was subsequently closed properly and clean-up proceduresw were initiated. Temporary dams have been installed at the doorways of the Penetration Rooms to restrict water spillage. Additional corrective actions are being considered.

RESPONSE

Item A.2 Continued

The NEO involved was counseled about his deficient performance in this incident. All Operators will have reviewed this incident by February 22, 1980. The proper sequencing of valves or breakers prior to placing in service has been discussed at Shift Supervisors and crew meetings. In addition, revisions will be made to OP/O/A/1102/06, Removal and Restoration of Station Equipment, which will include instructions for the Operators to ensure alignment of valves or breakers are sequenced such that the system will not be placed in service prior to completion of the second verification. These revisions will be completed by April 1, 1980.

ITEM B

As required by 10 CFR 20.203(f), each container of licensed material shall bear a durable, clearly visible label identifying the radioactive contents and providing sufficient information to permit individuals handling or using the containers, or working in the vicinity thereof to take precautions to avoid or minimize exposures.

Contrary to the above, on November 27, 1979, five bags of radioactive material located on the Unit 3 low pressure injection deck, were observed without the proper labels.

This is a deficiency.

RESPONSE

This item resulted from Procedure HP/O/B/1000/9, Removal of Items from Radiation Control Zones or Radiation Control Areas, being unclear in defining tagging requirements for material removed from a RCZ or RCA. This procedure has been revised to clarify the labeling of radioactive material. The material cited was removed and disposed of as radioactive waste. The incident was reviewed by all HP supervisors and technicians, including vendor personnel. The clarified requirements were also reviewed by these personnel.