

DUKE POWER COMPANY

POWER BUILDING

422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.  
VICE PRESIDENT  
STEAM PRODUCTION

March 6, 1981

TELEPHONE: AREA 704  
373-4083

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

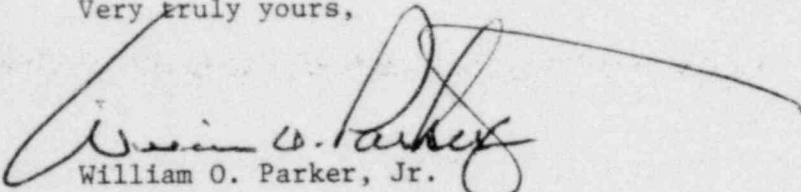
Re: RII:FJ  
50-269/80-38  
50-270/80-35  
50-287/80-32

Dear Sir:

With regard to R. C. Lewis' letter of February 11, 1981 which transmitted the subject inspection report, Duke Power Company does not consider the information contained therein to be proprietary.

Please find attached a response to the cited item of noncompliance.

Very truly yours,



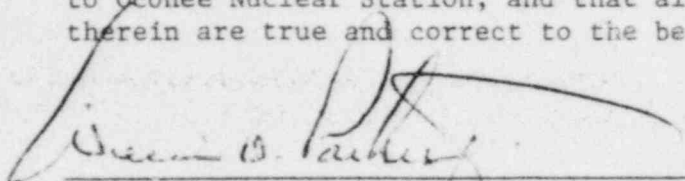
William O. Parker, Jr.

JLJ:pw  
Attachment

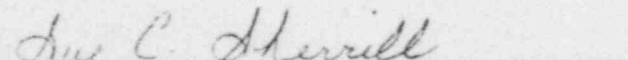
8109240 628

Mr. James P. O'Reilly, Director  
March 6, 1981  
Page Two

WILLIAM O. PARKER, JR., being duly sworn, states that he is Vice President of Duke Power Company; that he is authorized on the part of said Company to sign and file with the Nuclear Regulatory Commission this response to IE Inspection Report 50-269/80-38, 50-270/80-35, 50-287/80-32 with respect to Oconee Nuclear Station; and that all statements and matters set forth therein are true and correct to the best of his knowledge.

  
\_\_\_\_\_  
William O. Parker, Jr., Vice President

Subscribed and sworn to before me this 6th day of March, 1981

  
\_\_\_\_\_  
Notary Public

My Commission Expires:

September 20, 1984

DUKE POWER COMPANY  
OCONEE NUCLEAR STATION

Response to I.E. Inspection Report 50-269/80-38, -270/80-35, -287/80-32

Violation

Technical Specification 6.4.1 requires that the station be operated and maintained in accordance with current written approved procedures; including the operation of radioactive waste management systems.

Contrary to the above, on November 21, 1980, the Oconee Interim Radioactive Waste system was operated without an adequate procedure, resulting in a radioactive spill. No NRC limits were exceeded.

This is a Severity Level V Violation. (Supplement I. E.)

Response

This incident resulted from personnel error and procedural deficiency. As stated in the details of the inspection report, personnel were simultaneously draining the Condensate Demineralizer and purging the resin transfer line. The procedure used did not adequately specify valve lineups or address the purging of the resin line.

Immediate corrective action included stopping the actions causing the spill and containment of the spilled water. The contaminated area was then decontaminated. The personnel involved were counseled about their performance. All personnel involved have reviewed Station Directive 4.2.1, "Procedures", and the need for planning and coordination in the use of procedures has been stressed to them. The procedure used has been revised to address valve lineup while purging the resin line.

Dose calculations for airborne activity releases as a result of this event revealed that no Technical Specification or NRC limits were exceeded.