

DUKE POWER COMPANY

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June 8, 1984

0019 P12: 29

Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30303

Subject: Oconee Nuclear Station
IE Inspection Report
50-269/84-07
270/84-07
287/84-07

Dear Sir:

In response to your letter dated May 11, 1984 which transmitted the subject Inspection Report, the attached response to the cited item of non-compliance is provided. I declare under penalty of perjury that the statements set forth herein are true and correct to the best of my knowledge on June 8, 1984.

Very truly yours,



Hal B. Tucker

PFG/php

Attachment

cc: Mr. J. C. Bryant
NRC Resident Inspector
Oconee Nuclear Station

Violation

10 CFR 20.201(b) requires a licensee to make such surveys as may be necessary to comply with the regulation in each section of 10 CFR 20. A "survey" is defined in 10 CFR 20.201(a) as an evaluation of the radiation hazards incident to the production, use, release, disposal, or presence of radioactive materials or other sources of radiation under a specific set of circumstances.

Contrary to the above, the licensee did not make such surveys as were necessary to ensure that personnel exposures to radiation were properly recorded. Approximately ten percent of the extremity monitoring dosimeter data for the month of March and April 1984 was lost from the system and a similar potential existed for whole body exposure data.

This is a Severity Level IV violation (Supplement IV).

Response

1) Admission or denial of the alleged violation:

This violation is correct. Further review of the data for March 1984 revealed four instances of filing errors. Two sets of monitoring results were erroneously recorded on the summary sheet and in the computer files (both errors were conservative); two sets of monitoring results had been entered in the computer files but their summary sheets could not be located. Thus, the percentage of lost data for March 1984 was reduced to 5%.

It should be noted that in all cases, thermoluminescence dosimeters were used with the direct reading dosimeter. The TLD values replaced the direct reading dosimeter results at the monthly update to account for the extremity doses received.

2) Reasons for the violations:

This violation resulted from both personnel error and procedural/administrative deficiency. The Health Physics (HP) technicians involved failed to follow established procedures and supervisor instructions. Also, no procedural or administrative provisions were made to ensure that extremity monitoring results from outage work are submitted and updated in computer files.

3) Corrective actions taken and results:

An audit was performed of extremity monitoring results for personnel currently issued extremity dosimetry to assure procedural compliance. No discrepancies were noted. As noted in (1) above, further review of the exposure computer entry printouts reduced the number of instances of lost data for March 1984.

4) Corrective actions to be taken to avoid further violations:

Trained HP Technicians will be assigned and dedicated to managing the outage dosimetry work for all shifts. Procedure HP/O/B/1000/78, Multiple dosimetry issue, Dose Accounting, and Routing of dosimetry, will be revised to assign Health Physics the responsibility of submitting whole body direct reading dosimeters data for multiple badged outage workers. This procedure will also be revised to required random audit of monitoring results on Issue/Input forms versus computer records.

5) Date when full compliance will be achieved:

The actions described in (4) above will be completed by August 26, 1984.