# Duke Power Gompany <br> P.O. box 33189 <br> CHABLOTTE, N.G. 28942 

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May 5, 1988

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U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D,C. }2055
Subject: McGuire Nuclear Station
    Docket Nos. 50-369, -370
    NRC/OIE Inspection Report Nos. 50-369,370/88-06
    Reply to a Notice of Violation
    Violation 50-369,370/88-06-01
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Gentlemen:
Pursuant to 10CFR 2.201, please find attached (Attachment 1) Duke Power Company's
response to the violation identified in the subject inspection report.
During the course of reviewing the subject inspection report, Duke identified
several statements which we would like to clarify. Accordingly, please find
Attachment 2 which provides our comments on certain items within the subject NRC
Inspecticn Report.

Very truly yours,


Hal B. Tucker

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SEL/270/bh?
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Attachment

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xc: Dr. J. Nelson Grace
    Regional Administrator, Region II
    U.S. Nuclear Regulatory Commission
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    Atlanta, GA 30323
    Mr. Darl Hood
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    NRC Resident Inspector
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ATTACHMENT 1
DUKE POWER COMPANY
McGuIre nuclear station
REPLY TO A NOTICE OF VIOLATION
VIOLATION 50-369,370/88-06-01

During the NRC inspection conducted by T. R. Collins on March 7-11, 1988, the following violation was identified:

Technical Specification 6.12 requires that each high radiation area, as defined in 10 CFR Part 20, in which the intenaity of radiation is equal to or less than 1,000 mrem/hour at 45 CM ( 18 inches) from the radiation source or from any surface which the radiation penetrates be barricaded and conspicuously posted as a high radiation area. It further requires that any individual permitted to enter such areas be provided with a radiation monitoring device which continuously indicates the radiation monitoring device which continuously indicates the radiation dose rate in the area or radiation monitoring device which continuously integrates the radiation dose race in the area and alarms when a preset integrated does is received.

Contrary to the above, on March 8, 1988, the licensee falled to barricade and post a high radiation area at the Unit 2 pipe chase entrance in Room 647 on the $716^{\prime}$ elevation. Dose rates in the pipe chase were up to 800 mrem/hour at 18 inches. A health physics technician, correcting the as found condition, entered the high radiation area without a radiation monitoring device which continuously indicated the radiation dose rate or integrated the dose rate and would have alarmed when a preset dose was received.

This is a Severity Level ir violation (Supplement IV).
Reply To Violation,:

1. Admission or denial of violation:

Duke Power Company admits the violation occurred.
2. Reason for the violation if admitted:

The violation occurred because two Health Physics (HP) Technicians independently failed to properly apply basic knowledges and skills. Technician "A" falled to close an access door and Technician "B" falled to properly access the area to close the door.
3. Corrective steps which have been taken and results achieved:

HP Technician A and B had previously signed a statement verifying that they had read and understood Technical Specification (T.S.) 6.12 on October 16, 1986 and on June 18, 1987, respectively. Each technician had subsequently received trainin regarding the requirements of T.S, 6.12 and how to properly post and barricade an area as described in the violation. Immediately after the violation occurred, HP Supervision verified that the technicians understood the T.S, requirements. All HP personnel received a written description of the incident and were reminded of the T.S, requirements during HP crew meetings.
4. Corrective steps planned to avoid further violations:

A11 HP Technfeians, Supervision, and Staff will attend formal case studies to further analyze T.S, requirements and to evaluate the incident. The case study is designed to point out what happened, when it happened, potential causes, short term preventative actions taken, most probable root cause, and to provide an opportunity for group analysis. Each attendee will be able to provide input on how further violations can be avoided. Management will evaluate these recommendations and implement appropriate changes.
5. The date when full compliance will be achieved:

Duke is in full compliance now. The case study will be completed by June 1, 1988.

The following information is offered to clarify and/or correct information contained in the referenced report.

1. Page 2, Section 4 of the report stated that, "It was also stated that corporate ALARA staff support should increase in the future due to the recent change in corporate supervisory personnel responsible for that group."

## Clarification

The Duke Power Company corporate ALARA staff will be providing increased support to McGuire as requested by station management due to concerns over high station doses; however, the corporate ALARA supervisor has not changed.
2. Page 3, Section 6 of the report stated that, "Plant procedures require an investigation of all pocket ion chamber (PIC)/TLD correlations that are different by $\pm 10 \%$.

Correction
Duke does not use fixed percentages for comparing monthly TLD and pocket dosemeter (PD) totals. Sliding percentages are used with a positive bias to accommodate rounding off errors, Example: For TLDs equaling 100 mrem, PD totals between 55 and 170 mrem are permitted. For TLDs equaling 300 mrem, PD totals from 240 to 375 mrem are allowed. For TLDe greater than 500 mrem, the permitted range is $0.9 \times$ TLD to $1.25 \times$ TLD. No TLD/PD comparisons are made for TIDs less than 60 mrem and PD totals less than 85 mrem.
3. Page 5, Section 7 stated that, "The NaI chair counter currently in use will remain in service after the purchase for backap and positive count verification."

## Correction

Duke has determined that the NaI chair counter will remain in service depending upon space available following installation of the standup whole-body quick counter. If space is not avallable, Duke will remove the NaI chair counter from service.
4. Page 6, Section 9 of the report stated that, "An individual from the corporate ALARA group will be added for the May 1988 outage.

## Correction

In response to station requests, two individuals have been provided from the Duke corporate Health Physics staff to assist with ALARA planning for the May 1988 outage. These individuals will work with station maintenance during job planning and execution to resolve exposure problems, perform dose tracking functions, and provide interface with station Health Physics as necessary.
5. Page 7, Section 9 of the report stated that the inspector discussed "the negative effect that the setting of apparently unattainable goals may have on workers drive and desire to achieve those goals".

## Clarification

Collective dose goals for Duke Power Company are based on national averages for pressurized water reactors. The collective dose goals for each Duke nuclear station is adjusted based on the anticipated workload using the best available industry data. The dose goals for McGuire of 1,043 person-rem is an aggressive goal that will be challenging for the station to achieve. However, tremendous progress has been made in job planning, available resources, and worker awareness of exposure. As a result, there is increasing optimism both on the corporate and station management level that the station dose goal can be achieved.

