



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION**

**REGION II  
SAM NUNN ATLANTA FEDERAL CENTER  
61 FORSYTH STREET SW SUITE 23T85  
ATLANTA, GEORGIA 30303-8931**

July 26, 2000

Duke Energy Corporation  
ATTN: Mr. G. R. Peterson  
Site Vice President  
Catawba Site  
4800 Concord Road  
York, SC 29745-9635

SUBJECT: ERRATA LETTER FOR NRC INSPECTION REPORT 50-413/00-03 AND  
50-414/00-03

Dear Mr. Peterson:

By letter dated July 10, 2000, our latest inspection report for your Catawba facility was provided to you. Your staff identified that Section 2PS3 of the subject inspection report contained an inaccurate statement. We have discussed this matter with members of your staff and made the necessary change to Section 2PS3. Accordingly, please replace effected page 13 of the subject inspection report with the one enclosed.

Thank you for pointing out this error. I apologize for any inconvenience it may have caused. If you have any questions about this matter, please contact Mr. Edwin Lea at (404) 562-4567.

Sincerely,

/RA/

Charles R. Ogle, Chief  
Reactor Projects Branch 1  
Division of Reactor Projects

Docket No: 50-413, 50-414  
License No: NPF-35, NPF-52

Enclosure: Page 13 of NRC Inspection Report  
50-413/00-03 and 50-414/00-03

cc w/encl: (See page 2)

DEC

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DATE	7/21/2000	7/21/2000	July 31, 2000	July 31, 2000	July 31, 2000	July 31, 2000	July 31, 2000
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY

DOCUMENT NAME: C:\erratacat003.wpd

b. Issues and Findings

No findings were identified.

**Cornerstone: Public Radiation Safety**

2PS3 Radiological Environmental Monitoring Program and Material Control Program

a. Inspection Scope

The inspectors reviewed the events and circumstances surrounding the April 7, 2000, unconditional release of a contaminated lanyard from the licensee's radiological control area (RCA) to determine the significance of the issue and if violations of regulatory requirements had occurred.

b. Issues and Findings

An NCV was identified for the licensee's failure to comply with the requirements of 10 CFR 20.1802, in that, on April 7, 2000, the licensee failed to prevent the release of radioactive byproduct material (i.e., a radioactive particle on a contract employee's lanyard) from the radiological control area and plant site.

On April 7, 2000, the presence of low level radioactive byproduct material, 81 nanocuries (nCi) of cobalt-60 and 12 nCi of cesium-137, was initially identified on a contract worker during a routine exit whole body count analysis. As directed by radiation protection personnel, subsequent whole body counts of the employee in both street clothes and in paper clothing (without personnel items) were conducted which determined that the byproduct contamination was on the employee's personal clothing or articles. However, before a health physics technician was dispatched to survey the employee's personal articles, the contract employee departed the site.

On April 10, 2000, the contract employee was contacted and arrangements were made for his personal articles to be analyzed for contamination at the Wolf Creek nuclear power station. On April 13, 2000, an analysis was performed by personnel at Wolf Creek, and on April 14, 2000, Catawba personnel were notified that the individual's clothing was clean, but a hot particle had been found embedded in the worker's lanyard. The lanyard was confiscated and shipped to the Catawba site on April 26, 2000. According to statements made by the contract employee and documented by the licensee, the contractor removed the lanyard from his body when he departed the Catawba site, and it had remained in the employee's automobile until the lanyard was delivered to the Wolf Creek power facility for analysis. This information indicated that the employee had not received a dose from the hot particle as a member of the public. From an occupational dose perspective, the licensee determined that the maximum hot particle dose for the employee was approximately 13.7 microCurie-hours ( $\mu\text{Ci-hrs}$ ). This is well below the NRC's 75  $\mu\text{Ci-hr}$  limit established for hot particles. The inspector determined that the licensee's dose assignment was appropriate and conservative and was included in the employee's dose record.

Enclosure