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W. G. Hairston, III
Senior Vice President
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ELV-04062
002402

Docket Nos. 50-424
50-425

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
REPLY TO A NOTICE OF VIOLATION

Pursuant to 10 CFR 2.201, Georgia Power Company submits the enclosed response to the violation identified in NRC Inspection Reports 50-424/92-16 and 50-425/92-16 concerning the inspection conducted by Mr. B. A. Parker and Ms. E. B. Pharr during the period of July 20-24 and 31, 1992.

Sincerely,

W. G. Hairston, III

WGH,III/JLL/gmb

Enclosure

xc: Georgia Power Company
Mr. W. B. Shipman
Mr. M. Sheibani
NORMS

U. S. Nuclear Regulatory Commission
Mr. S. D. Ebneter, Regional Administrator
Mr. D. S. Hood, Licensing Project Manager, NRR
Mr. B. R. Bonser, Senior Resident Inspector, Vogtle

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ENCLOSURE

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 AND 2
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424/92-16 AND 50-425/92-16

The following is a transcription of the violation as cited in the Notice of Violation (NOV):

"During an NRC inspection conducted on July 20-24 and 31, 1992, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violation is listed below:

Technical Specification (TS) 6.7.1(a) requires the licensee to establish, implement, and maintain written procedures described in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Appendix A, Paragraph 7.e.7, states that the licensee should have a procedure that establishes requirements and responsibilities for personnel monitoring.

Vogtle Procedure VEGP-00950-C, "Personnel Dosimetry Program," Revision 8, dated May 31, 1991, requires, in Paragraph 8.1.5, that the whole body Electronic Direct Reading Dosimeter (EDRD) be worn between the neck and waist on the front part of the body within a handwidth of the whole body thermoluminescent dosimeter (TLD), unless certain criteria is met for relocating the dosimetry as specified in VEGP-45013-C, "Issuance, Use and Collection of Personnel Monitoring Devices," Revision 6, dated May 23, 1991. In addition, Paragraph 8.2.3.c of VEGP-00950-C requires that if the EDRD starts alarming for total integrated dose, the individual will immediately leave the area and report to Health Physics.

Contrary to the above, on April 15, 1992, a worker performing Motor Operated Valve Analysis and Test System (MOVATS) testing in the Unit 2 Volume Control Tank (VCT) valve gallery:

- relocated his EDRD to his back without moving his TLD and without the specified criteria for dosimetry relocation being met;
- failed to immediately leave the area after the integrated dose alarm sounded on his EDRD; and
- muffled the alarm with tape and continued working in the area for several hours without notifying Health Physics.

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

ENCLOSURE (CONTINUED)

VOGTLE ELECTRIC GENERATING PLANT - UNITS 1 AND 2
REPLY TO A NOTICE OF VIOLATION
NRC INSPECTION REPORTS 50-424/92-16 AND 50-425/92-16

RESPONSE TO VIOLATION

Admission or Denial of the Violation

The violation occurred as stated. The electrician violated administrative requirements and controls provided in plant procedures.

Reason for the Violation

This violation occurred as a result of an individual's failure to follow the appropriate procedures that specify actions to be taken when his electronic direct reading dosimeter (EDRD) alarms. The electrician performing the MOVATs test noticed that when he turned his body to communicate with his co-workers, his dosimeter chirped at a faster rate, indicating higher dose rate. He then set his dosimeter in the "rate" mode and proceeded to monitor the dose rates in the area behind him. Since the source of dose was a pipe behind him he placed the EDRD on his back thinking this action would monitor the highest dose rate and yield the most conservative whole body dose. The electrician felt justified in remaining in the area after receiving the integrated dose EDRD alarm based on his determination of the dose rate as well as his knowldege of his quarterly dose and considerable remaining margin to administrative limits. Since the electrician could not contact Health Physics to reset his alarm and raise the job dose limits without undressing and leaving the area, he taped over the alarm. Additionally, he was concerned that stopping and restarting the work would lead to unnecessary added dose to several other workers assisting the task. Therefore, he felt it prudent to continue work. This was a cognitive personnel error because the individual had been trained in radiation protection procedures and in proper uses of EDRDs. Procedural compliance is of the upmost importance to GPC management.

Corrective Steps Which Have Been Taken and the Results Achieved

1. A Radiological Incident Report (RIR) was initiated subsequent to the discovery that the thermoluminescent dosimeter (TLD) dosimetry for the individual disagreed with his EDRD dose for the monitoring period of April 1-30, 1992.

2. The individual was counseled, and the procedural requirements for wearing dosimetry and responding to dosimetry alarm sounds were reemphasized. The individual was also required to read the RIR relating to this event. In addition, the General Manager - Vogtle has personally discussed management expectations regarding adherence to procedures with this individual.

3. Maintenance and Health Physics personnel were required to review the RIR and Procedure 00950-C, "Personnel Dosimetry Program" requirements for using dosimetry devices and the wearing of dosimetry devices. Additional guidance was provided to HP technicians on proper response to alarming dosimetry, upgrading and downgrading EDRD alarm setpoints, and resetting EDRD alarm settings which were modified.

Corrective Steps Which Will Be Taken to Avoid Further Violations

No further action is warranted at this time.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on June 24, 1992, at which time the individual responsible for this event was counseled and retrained on wearing and use of personnel dosimetry.