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SUBJECT: LER 88-007-00:on 880518,Tech Spec violation due to missed firewatches resulting from personnel error & mgt deficiency.
W/8 ltr.

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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Oconee Nuclear Station, Unit 1	0 5 0 0 0 2 6 9	1 OF 1 0

TITLE (4) Technical Specification Violation Due To Missed Firewatches Resulting From Personnel Error And Management Deficiency

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
									Oconee, Unit 2	0 5 0 0 0 2 7 0
0 5 1 8	8	8	8 8	- 0 0 7	- 0 0	0 7	0 6	8 8	Oconee, Unit 3	0 5 0 0 0 2 8 7

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Philip J. North, Licensing	7 0 4 3 7 3 - 7 4 5 6

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
-											
		-	-								

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On May 19, 1988, at 1600 hours with Units 1, 2 and 3 at 100% power, an audit of Controlled Access Door (CAD) computer printouts versus the Firewatch Surveillance Log Sheets by an NRC Resident Inspector, revealed that five hourly firewatch tours had not been performed as required by Technical Specification 3.17 on May 18 and 19, 1988. In addition, on June 6, 1988 it was discovered that multiple firewatches had been missed from May 25, 1988 to June 4, 1988.

The root cause of the missed firewatch tours was personnel error and management deficiency. Operations personnel failed to make the firewatch tours, after having been informed that the tours were required. Mechanical Maintenance supervisors did not review Technical Specifications or Station Directives to become familiar with the firewatch responsibilities. The subsequent corrective actions included placing the Cable Room and Equipment Room firewatch tours on separate Firewatch Surveillance Log Sheets, discussion of the Station Directive on firewatch tours with all Operations personnel conducting these tours and providing Mechanical Maintenance Technicians with written guidance on the requirements and responsibilities of the hourly firewatch tours.

IE22
1/1

Background

The Cable Rooms and Equipment Rooms house various equipment necessary for the safe shutdown of the plant. These two rooms are located adjacent to one another on each unit and are separated by a wall with fire barrier material in each of the wall penetrations. This fire barrier material had recently been found inadequate and were declared inoperable (see LER 269/88-05). The functional integrity of the penetration fire barriers ensures that fires will be confined or adequately retarded from spreading to adjacent portions of the facility. Both the Cable and Equipment Rooms are also equipped with fire detection [EIIS:IC] and suppression [EIIS:KP] equipment. Fire detection and suppression equipment was operable at the time of this event.

Station Directives provide guidance on the compensatory actions required when a fire barrier in the Cable or Equipment Room is inoperable. Per Station Directives, the area shall be inspected at least once per hour if the fire detection instrumentation in the area is operable. Station Directives describe the normal interval between inspections as sixty (60) minutes. The maximum allowable time between inspections due to unforeseen circumstances or delays is seventy-five (75) minutes. However, the combined interval for any three (3) consecutive inspections shall not exceed one hundred ninety-five (195) minutes.

Technical Specification 3.17 (Fire Protection and Detection Systems) applies to the operability of fire protection and detection systems when equipment protected by those systems is required to be operable. The objective of this specification is to assure the operability of fire protection and detection systems which protect systems and equipment required for safe shutdown. If a fire barrier protecting a safety related area is determined to be inoperable, with the fire detection system in the area operable, an hourly firewatch patrol of the area is required to be established.

SEQUENCE OF EVENTS

May 18, 1988

0930	o Hourly firewatch tours established in Unit 1, 2 and 3 Cable Room and Equipment Room.
1900	o Firewatch tour Station Directive covered in Operations pre-shift meeting on Units 1 and 2.
2100	o Nuclear Operator Technician (NOT) "A" questioned reason for firewatch tours.
	o Unit Supervisor "C" informed NOT "A" of Technical Specification requiring firewatch tours.
2200	o NOT "A" failed to perform hourly firewatch tour in Unit 1 and 2 Cable Rooms.
2222	o NOT "A" began performance of Secondary System Protection Test.
2230	o NOT "A" entered Unit 1 and 2 Cable Room during performance of Secondary System Protective Test.
	o NOT "A" performed firewatch tour of Unit 1 and 2 Cable Room.

May 18, 1988 (continued)

2200 o NOT "A" signed 2200 hour Unit 1 and 2 Cable Rooms firewatch tour as complete.

2300 o NOT "A" failed to perform hourly firewatch tour in Unit 1 and 2 Cable Rooms.

2349 o Secondary System Protection Test completed.

2400 o NOT "A" completed hourly firewatch tour in Unit 1 and 2 Cable Rooms.

o NOT "A" signed complete 2300 and 2400 hour firewatch tours of Unit #1 and #2 Cable Rooms on Firewatch Surveillance Log Sheet.

May 19

0800 o NOT "B" failed to perform hourly firewatch tour in Unit 3 Cable Room.

o NOT "B" signed Firewatch Surveillance Log Sheet for Unit 3 Cable Room hourly firewatch tour complete.

0830 o Unit Supervisor "B" asked NOT "B" about the status of NOT "B" rounds.

o NOT "B" informed Unit Supervisor "B" that rounds are going okay.

0900 o NOT "B" completed firewatch tour of Unit 3 Equipment Room.

o NOT "B" requested by Control Room Senior Reactor Operator "A" to assist with isolation of Plant Drinking Water leak.

0900 o NOT "B" signed Firewatch Surveillance Log Sheet complete for hourly firewatch of Unit 3 Equipment and Cable Rooms.

o NOT "B" left Unit 3 Equipment Room to assist with Plant Drinking Water leak isolation.

1300 o NOT "B" left Unit 3 Control Room, without badging out, to perform hourly firewatch tour of Unit 3 Cable Room.

1305 o NOT "B" performed hourly firewatch tour of Unit 3 Equipment Room.

o NOT "B" went to Unit 3 Cable Room door.

o NOT "B" realized possible Security violation if he badges in Unit 3 Cable Room, having not badged out of Unit 3 Control Room.

1310 o NOT "B" inspected penetrations from Unit 3 Equipment Room into Unit 3 Cable Room, from Unit 3 Equipment Room side.

1400 o NOT "B" performed hourly firewatch tour of Unit 3 Equipment and Cable Rooms.

1415 o NOT "B" signed 1300 and 1400 hour, hourly firewatch tours of Unit 3 Cable and Equipment Rooms as complete on the Firewatch Surveillance Log Sheet.

1600 o NRC Resident Inspector audit revealed discrepancies in hourly firewatch tours of Unit 1, 2 and 3 Cable Rooms.

o Discrepancies reported to Operations' staff.

May 20

0755 o Operations transfers firewatch responsibility to the Construction an Maintenance Department (CMD).

May 23

1715 o CMD transfers firewatch responsibility to Mechanical Maintenance (MM).

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TEXT *(If more space is required, use additional NRC Form 366A's)* (17)

May 25

0417 o MM Technician "A" exceeds time limit for the 0400 firewatch of the Unit 3 Equipment Room.

0717 o MM technician "B" exceeds time limit for the 0700 firewatch of the Unit 1 Equipment Room.

1915 o MM technician "A" exceeds time limit for the 1900 firewatch of the Unit 3 Equipment Room.

1912 o MM technician "A" exceeds time limit for the 1900 firewatch of the Unit 3 Cable Room.

May 26

0716 o MM technician "C" exceeds time limit of the 0700 firewatch for the Unit 1 Cable Room.

0717 o MM technician "C" exceeds time limit of the 0700 firewatch for the Unit 2 Cable Room.

0924 o MM technician "D" exceeds time limit of the 0900 firewatch for the Unit 3 Cable Room.

May 30

0715 o MM technician "E" exceeds time limit of the 0700 firewatch for the Unit 1 Equipment Room.

May 31

2423 o Time limit for the 2400 firewatch of the Unit 3 Equipment Room expires.

0110 o MM technician "F" performs the 0100 firewatch of the Unit 3 Equipment Room.

1815 o MM technician "E" exceeds time limit of the 1800 firewatch for the Unit 1 Cable Room

June 1

0412 o MM technician "A" exceeds time limit for the Unit 1 Equipment Room.

June 4, 1988

2219 o MM technician "G" exceeds time limit for the Unit 2 Cable Room.

June 6

0730 o Safety Assistant (SA) "A" discovers possible violations.

1500 o SA "A" and Fire Protection Specialist (FPS) "A" determine that there are numerous violations of Technical Specification 3.17 firewatches.

o FPS "A" initiates a Problem Investigation Report.

o Violations reported to Mechanical Maintenance management.

June 7

o Mechanical Maintenance Engineer "A" sends a letter to the shift crews giving the specific time limits and responsibilities to the crews.

Description of Incident

On May 18, 1988, at 0930 hours, with Units 1, 2 and 3 operating at 100% power, an hourly firewatch tour was established in all three units' Cable and Equipment Rooms by Operations. These hourly firewatch tours were in response to the discovery of inoperable penetration fire barriers between the Cable Rooms and Equipment Rooms. The operability of these penetration barriers is required by Technical Specification 3.17.

At 1845 hours on May 18, 1988, Nuclear Operations Technician (NOT) "A" reported to work feeling sick. At 1900 hours, an Operations pre-shift meeting was held between supervisors, control room personnel and NOT's. During this meeting, Unit Supervisor "A" covered the required Cable and Equipment Room firewatch tours and the time limit for these tours as described in plant Station Directives. NOT "A" was present at this pre-shift meeting. Later that evening, at 2100 hours, NOT "A" asked for an explanation of the reason for the firewatch tours, and Unit Supervisor "C" provided him with that explanation.

At 2200 hours NOT "A" failed to perform the hourly firewatch tour in Unit 1 and 2 Cable Rooms. Through discussions with NOT "A", he stated that he was feeling sick after he finished his round at 2145 hours. He then sat down to rest and inadvertently failed to perform the 2200 hour firewatch tour of Unit 1 and 2 Cable Room.

At 2220 hours, NOT "A" was assigned to perform the Unit 1 Secondary System Protection Test (SSPT). At 2230 hours, while performing the SSPT, NOT "A" realized he had missed the 2200 hour, Unit 1 and 2 Cable Room firewatch tour and performed a firewatch tour at this time. After performing the tour, he continued with the SSPT. At 2300 hours, NOT "A" again failed to perform the hourly firewatch tour of the Unit 1 and 2 Cable Rooms. NOT "A" stated that he was busy with the SSPT and forgot to perform the firewatch tour. The SSPT was completed at 2350 hours. At 2400 hours, NOT "A" performed the hourly firewatch tour of Unit 1 and 2 Cable Rooms and realized that he had missed the 2300 hour tour. He reasoned that since there wasn't a fire at 2400 hours, there had not been a fire at 2300 hours. With this reasoning, NOT "A" completed the paperwork for the 2200 and 2300 hour firewatch tours along with the 2400 hour firewatch tour.

At 0645 hours on May 19, 1988, NOT "B" received turnover that an hourly firewatch tour was required in the Unit #3 Cable and Equipment Rooms. No pre-shift meeting was held on this shift between supervision and shift personnel to discuss upcoming Unit 3 events or the required hourly firewatch tours.

At 0800 hours, NOT "B" failed to make the hourly firewatch tour of Unit 3 Cable Room. NOT "B" stated that he believed that he did make the tour. However, a review of the Controlled Access Door [EIIS:IA] printout does not indicate that NOT "B" entered or exited the Unit #3 Cable Room in the 0800 hour time frame. Security personnel have stated that their computer is practically 100% reliable at recording the door openings and closings. At 0830 hours, Unit Supervisor "B" asked NOT "B" about the hourly fire tours. He responded by saying that he had just completed the 0800 hour tour.

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TEXT *(If more space is required, use additional NRC Form 366A's)* (17)

At 0900 hours, while performing the hourly firewatch tour of Unit 3 Equipment Room, NOT "B" was paged by Control Room Senior Reactor Operator (SRO) "A". Upon responding to the page, he was told by Control Room SRO "A" to assist with the isolation of a Plant Drinking Water [EIIS:KK] leak. When NOT "B" exited the Unit 3 Equipment Room, he signed off the 0900 hour firewatch tour as complete, without having performed the Unit 3 Cable Room portion of the tour. At 1000 hours, NOT "B" completed the firewatch tours of Unit 3 Cable and Equipment Rooms. He stated that he reasoned that if there wasn't a fire in Unit 3 Cable Room at 1000 hours, there had not been a fire there at 0900 hours.

Later, on May 19, 1988, at 1300 hours, NOT "B" prepared to leave Unit 3 Control Room. Upon reaching the Control Room door, he discovered that the Control Room door was propped open by welding leads, and a security guard was stationed at the door. He repeatedly attempted to badge out of the Control Room door, but was unsuccessful. This badging problem was not reported to the security guard or a supervisor. He then exited the Control Room without successfully badging out and proceeded to the Unit 3 Equipment Room to perform the hourly firewatch tour. Upon completion of the tour there, he went to the Unit 3 Cable Room entrance. When he reached the entrance to Unit 3 Cable Room, he realized that if he badged into the Cable Room without having badged out of the Control Room, the security computer would record this, thus resulting in a security violation. For this reason, NOT "B" did not enter Unit 3 Cable Room. He returned to the Equipment Room and inspected the fire barrier penetrations using his flashlight, in an attempt to verify their integrity. He then returned to the Unit 3 Control Room.

At 1400 hours, NOT "B" performed the hourly firewatch tour of Unit 3 Cable and Equipment Rooms. At this time, he completed the Firewatch Surveillance Log Sheet for 1300 and 1400 hours reasoning that if there wasn't a fire in the Cable Room at 1400 hours, there had not been one there at 1300 hours.

Later, on May 19, 1988, at approximately 1600 hours, an NRC Resident Inspector identified the missed hourly firewatch surveillances in Unit 1, 2 and 3 Cable Rooms and notified Operations Management. Operations Management then reviewed the Controlled Access Door security computer printout and confirmed the missed surveillances.

On May 20, 1988, at 0755 hours, Operations transferred the firewatch tours to the Construction and Maintenance Department (CMD) due to lack of manpower. CMD agreed to maintain the firewatch through May 23, 1988 at which time it would be transferred back to Nuclear Production Department personnel. The CMD personnel were informed by Operations personnel what their responsibilities would be and then were given the Firewatch Surveillance Log Sheets. CMD maintained the firewatches until 1715 on May 23, 1988 when they transferred the firewatch tours to the Mechanical Maintenance (MM) shift crews. In a meeting held in Planning and Scheduling it was decided that MM would support the firewatch. During this meeting it was stated that the allotted time was 80 minutes in which to perform each firewatch. This time limit was distributed to the field as the actual limit without any personnel in the meeting verifying this time limit in the Station Directive. The MM technician who was to assume the firewatch responsibility was

taken over the route by the CMD technician performing the firewatches to ensure that he knew where the affected areas were located. He was then presented with the Firewatch Surveillance Log Sheets and the turnover from CMD to MM was considered complete.

The Mechanical Maintenance (MM) technicians are qualified to the Burning and Welding task under the Employee Training and Qualification System which provides them with training to perform a continuous firewatch. However, the MM technicians have no training on performing an hourly firewatch.

Upon receiving the firewatch tour assignment, the MM Supervisors did not review the Station Directive to ensure they were cognizant of their crew's responsibility when performing a firewatch. It was not uncommon for MM technicians to perform firewatches and it was assumed that all technicians were familiar with their responsibilities. The supervisors assigned the tours to their personnel without giving them any direction other than the firewatch sheets.

On May 25, MM technicians exceeded the time limit for the 0400 and 1900 hour firewatch tours in the Unit 3 Equipment Room, the 0700 hour firewatch tour of the Unit 1 Equipment Room, and the 1900 firewatch tour of the Unit 3 Cable Room on the Firewatch Surveillance Log Sheet times (FST). On May 26, MM technicians exceeded the time limit for the 0700 firewatch of the Unit 1 and 2 Cable Rooms and the 0900 firewatch of the Unit 3 Cable Room on the FST. On May 30, a MM technician exceeded the time limit for the 0700 firewatch of the Unit 1 Equipment Room. On May 31, MM technicians did not document the performance of the 2400 firewatch for the Unit 3 Equipment Room and exceeded the time limit for the 1800 firewatch of the Unit 1 Cable Room on the FST. On June 1, a MM technician exceeded the time limit for the 0400 firewatch of the Unit 1 Equipment Room on the FST. On June 4, a MM technician exceeded the time limit for the 2100 firewatch of the Unit 2 Cable Room on the FST.

The MM technicians missed a total of ten (10) firewatches from May 25, 1988 to June 4, 1988. Of these ten (10), nine (9) were due to the time limit being exceeded and one (1) was due to the time not being logged on the firewatch sheet. During the interviews which were conducted, it was discovered that all technicians involved in this event did not know the correct Station Directive time limits prior to this event. It was believed that the time limits were: no time limit on each hourly firewatch tour, eighty (80) minutes in which to perform each firewatch tour, or seventy-five (75) minutes in which to perform each firewatch tour.

On June 6, 1988, Safety Assistant (SA) "A" began reviewing a stack of Firewatch Surveillance Log Sheets which covered a two (2) week period. These sheets had been allowed to accumulate in MM. It was a violation of Station Directives to allow the Firewatch Surveillance Log Sheets to accumulate for greater than a 24 hour period. Each sheet is required to be sent to Safety daily. SA "A" discovered numerous possible violations. He consulted Fire Protection Specialist "A" and they reviewed the Controlled Access Door computer printouts, where possible, to determine if violations had occurred. It was determined that ten

(10) violations had occurred and a Problem Investigation Report was initiated. Upon learning of the violations, Mechanical Maintenance Engineer "A" wrote a letter which outlined the time limits and responsibilities for the crews who were responsible for the firewatch.

Cause of Occurrence

It is concluded that the root cause of the missed Technical Specifications required hourly firewatch tours of Unit 1, 2 and 3 Cable Rooms on May 18 and 19, 1988, was personnel error due to the failure of Operations personnel to perform the tours as required. The need for the hourly firewatch tours was understood by both the personnel involved and their supervision. The need for the tours was covered in shift turnover and/or pre-shift meetings. A review of a recent Operations training package, "Security Refresher and Fire Watch Time Requirements", indicated that all personnel involved were aware of the required time frame for hourly firewatch surveillances. Since the personnel involved were cognizant of their firewatch tour responsibilities but failed to perform them, this incident is classified as a personnel error, due to lack of attention to detail.

A contributing cause to Nuclear Operations Technician (NOT) "A" not performing the 2300 hour, May 18, tour was his assignment to perform the Secondary Systems Protection Test (SSPT). The SSPT took approximately 1½ hours to perform, and the test requires a coordinated effort on the part of the personnel involved.

One contributing cause to NOT "B" not performing the 0900 hour, May 19, firewatch tour of Unit 3 Cable Room was his involvement with a Plant Drinking Water leak. Isolation of this leak required NOT "B" to stop his firewatch tour when it was only partially complete. A second contributing cause was the lack of covering the firewatch tour requirements in a pre-shift meeting.

A contributing cause to all the missed firewatch tours is the lack of importance placed on the tours by the personnel involved and some supervision. Discussions with the personnel involved revealed that they did not place a very high level of importance on these firewatch tours. Discussion with one supervisor also indicated a lower level of importance was placed on these tours. This attitude may stem from the fact that the fire detection systems were operable in all the areas covered by the firewatch tours.

The root cause of the missed Technical Specifications required firewatch tours of Unit 1, 2, and 3 Cable Rooms and Equipment Rooms from May 25, 1988 through June 4, 1988, is a Management Deficiency due to lack of Mechanical Maintenance (MM) supervisor involvement with the MM shift crews. This is due to the failure of management personnel to read and review the Station Directive prior to assigning this work to the MM shift crews. This assignment was communicated to the MM Supervisor from Planning and Scheduling. None of the MM supervisors who were interviewed had reviewed Station Directives to become familiar with the requirements of a firewatch tour.

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TEXT *(If more space is required, use additional NRC Form 366A's)* (17)

A contributing cause to this incident is inadequate administrative control over the transfer of firewatch tours to another group. The original transfer of the firewatch tours from Operations to Construction and Maintenance Department (CMD) was handled in such a way as to familiarize CMD with the responsibilities of the firewatch and the time limits of the firewatch tours. Since CMD had no violations while they were maintaining the firewatch, this turnover of responsibility was adequate. The transfer of the firewatch tours to MM was not handled by Operations. This transfer occurred with less instruction to the receiving group, and therefore MM was not cognizant of their responsibilities and the Station Directive time limits.

Another contributing cause to this incident was the assignment of these hourly firewatch tours to personnel who were not qualified to the task. MM Technicians are qualified to the Burning and Welding Task which covers the requirements of a continuous firewatch.

Another contributing cause to this incident was the accumulation of 2 weeks of Firewatch Surveillance Log Sheets by MM. If these sheets had been turned in daily as specified in the Station Directive, there would have been fewer violations.

A review of the past three years revealed no other incidents in which a Technical Specification required firewatch tour was missed. Since this event did not involve a component failure it is not NPRDS reportable. In addition, no radioactive material releases, radiation exposures or personnel injuries occurred as a result of this incident. The health and safety of the public were not compromised.

CORRECTIVE ACTIONS

Supplemental corrective actions were:

- To place firewatch tour documentation for each unit's Cable Room and Equipment Room on separate Firewatch Surveillance Log Sheets;
- To instruct Assistant Shift Supervisors to discuss the Station Directive on firewatch tours with all personnel performing these tours;
- For Operations personnel involved in the missed firewatch tours to receive disciplinary action;
- To counsel all Mechanical Maintenance Supervisors to review Station Directives and other documentation to ensure that requirements are being met;
- To give all Mechanical Maintenance Technicians written guidance on the requirements and responsibilities of the hourly firewatch tours;
- To counsel personnel involved in the missed firewatch tours on the correct manner in which to perform an hourly firewatch.

Planned corrective actions are for:

- o Operations to change the administrative control of firewatch tours so personnel performing firewatch tours are cognizant of their fire tour responsibilities;

- o Operations to issue a training package on these changes in administrative controls so as to emphasize the importance of firewatch tours to all Operations personnel involved in making these tours;

- o Operations to counsel Shift Supervisors and Assistant Shift Supervisors to ensure that they are sensitive to the problems that may be encountered when personnel are pulled off one job to perform another;

- o Station Management to review Station Directives and redefine and enhance the Management Controls of the firewatch program. This review will address the transfer of firewatch responsibility;

- o Mechanical Maintenance Supervisors to be counseled in the importance of understanding the responsibilities and requirements of any job assignment which they accept and assign.

Analysis of Occurrence

No fires occurred in any Cable Room during the time period of interest. All equipment in the Cable Room remained operable throughout this event. Fire detection and suppression systems were also operable in this time period. There were no unplanned safety system actuations and no limits were exceeded.

There were no exposures, radiation releases or injuries associated with this event. The health and safety of the public were not affected by this event.

DUKE POWER COMPANY
P.O. BOX 33189
CHARLOTTE, N.C. 28242

HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

TELEPHONE
(704) 373-4531

July 6, 1988

U. S. Nuclear Regulatory Commission
Attention: [redacted]
Washington, D. C. 20555

Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
LER 269/88-07

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a)(1) and (d), attached is Licensee Event Report (LER) 269/88-07 concerning missed firewatches. By letter dated June 22, 1988 Duke informed the NRC of the delay in submitting this report.

This report is submitted pursuant to 10 CFR 50.73(a)(2)(i)(B). This event is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

Hal B. Tucker

Hal B. Tucker

PJN/81/sbn

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