DUKE POWER COMPANY
POWER BUILDING
422 SOUTH CHURCH STREET, CHARLOTTE, N. C. 28242

WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

January 2, 1981

Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Re: Oconee Nuclear Station
Docket No. 50-287

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-287/80-20. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.b(2), which concerns operation in a degraded mode permitted by a limiting condition for operation, and describes an incident which is considered to be of no significance with respect to its effect on the health and safety of the public.

Very truly yours,

William O. Parker, Jr.

JLJ:njs
Attachment

cc: Director
Office of Management & Program Analysis
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. Bill Lavallee
Nuclear Safety Analysis Center
P. O. Box 10412
Palo Alto, California 94303

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DUKE POWER COMPANY
OCONEE Unit 3

Report Number: RO-287/80-20

Report Date: January 2, 1981

Occurrence Date: December 4, 1980

Facility: Oconee Unit 3, Seneca, South Carolina

Identification of Occurrence: Breach of Fire Barrier in Unit 3 cable room floor

Conditions Prior to Occurrence: 50% FP

Description of Occurrence:
On December 4, 1980, the locations of several pieces of switchgear were being checked in the Unit 3 cable room. While making some handwritten notes, an operations trainee leaned against the south wall of the cable room next to the door and placed his foot on penetration #3-M-F-81 (this penetration is not used). He then stood on the penetration. The force of his total body weight forced the block of Firewall 50" out of the pipe sleeve and down into the personnel elevator lobby on the third floor. This was reported to the Shift Supervisor at 1415, within 5 minutes of the incident. The Shift Supervisor set a fire watch and instructed the fire watch personnel to check other penetrations in the cable room floor. Force was applied to the other penetrations, and two others (3-M-F-78 and 3-M-F-79) were found to move downward. This constitutes operation in a degraded mode per Technical Specification 3.17.5 and is thus reportable pursuant to Technical Specification 6.6.2.1.b(2).

Apparent Cause of Occurrence:
This event was the result of an unusual service condition in that the Operator trainee placing his foot on the penetration resulted in the firewall being dislodged from the sleeve.

Analysis of Occurrence:
This breach of the fire barrier could possibly have allowed the spreading of a fire from the personnel elevator lobby to the cable room. This is of a low probability because of the small amounts of flammable material in these two areas. All of the penetrations were four inch pipe sleeves, and although only one of these was declared a complete breach, all three were repaired. There are also smoke detectors located near the penetrations which would have warned of any fire. Also, a fire watch was initiated immediately and maintained until the fire barriers were restored. Thus, this incident was of no significance with respect to safe operation, and the health and safety of the public were not affected.

Corrective Action:
The repair was made by welding a piece of carbon steel plate on top of the pipe sleeves where they protruded through the floor into the cable room. Appropriate personnel will be made aware of the fact that the penetrations are not made to stand on. All unused penetration fire barriers which are located where they could be stepped on will be similarly protected.