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

November 6, 1980

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. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/80-22. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(2), which constitutes operation less conservative than the least conservative aspect of an LCO, 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.

The corrective actions section of this report is incomplete due to a need for further investigation. A supplemental report will be provided upon completion of this investigation.

Very truly yours,

William O. Parker, Jr.

JLJ:scs
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 NUCLEAR STATION, UNIT 2

Report Number: RO-270/80-22

Report Date: November 6, 1980

Occurrence Date: October 22, 1980

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Fire Barrier Penetrations

Conditions Prior to Occurrence: Oconee 2, 100% FP

Description of Occurrence:

At approximately 1300 hours on October 11, 1980, penetrations were made in the fire barrier which separates the Unit 2 Cable Spread Room from the Turbine Building. Four (4) holes were knocked in the wall for the purpose of installing new conduit sleeves. An hourly fire watch was not established in conformance with Technical Specification 3.17.5. This deficiency was not discovered until approximately 1615 hours on October 21, 1980. The fire barrier was returned to functional status on October 21, 1980 by grouting the wall openings.

Apparent Cause of Occurrence:

This event appears to be the result of three related deficiencies:

1) The failure of the planning section to alert the execution personnel to the special work requirements.

2) The failure of the exectuion group to contact the shift supervisor prior to breaching the fire barrier.

3) The failure of the procedures to require notification of the shift supervisor prior to breaching the fire barrier.

Analysis of Occurrence:

During the implementation of two station modifications, it was necessary to route cable from the Turbine Building into the Unit 2 Cable Spread Room. This required four (4) holes to be knocked in the TR/AB wall to permit the installation of 4" pipe sleeves. This wall is designated as a fire barrier protecting the cable spread room and all penetrations must be sealed with an acceptable material or an hourly fire watch must be established in accordance with Technical Specification 3.17.5. Smoke detector instrumentation in the area was operable during this time.

Due to the fact that both sides of the openings were monitored by operable smoke detectors which would have provided early notification of incipient stage fires, and both manual hose lines and installed water spray systems were available to prevent the spread of fire through the opening, the fire protection capabilities of this area were not unduly compromised. Thus, this incident was of no significance with respect to safe opeation, and the health and safety of the public were not affected.

Corrective Action:

Upon discovery of the holes in the Unit 2 Cable Spread Room wall an hourly fire watch was established. The openings were enclosed with structural grout on October 21, 1980. Appropriate procedures concerning fire barrier penetrations are being revised to insure proper notifications are made prior to beginning work.

The establishment of an hourly fire watch in an area covered by operable smoke detector instrumentation is in accordance with Technical Specification 3.17.5. Enclosing the sleeves with structural grout returned the fire barrier to its functional status. Corrective actions to prevent reoccurrences of this type of event are currently under investigation. A supplemental report will be provided upon completion of this investigation.