

CONTROL BLOCK: 

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1

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

09		SYSTEM CODE Z Z		11	CAUSE CODE A	12	CAUSE SUBCODE E	13	COMPONENT CODE Z Z Z Z Z Z Z						18	COMP. SUBCODE Z	15	VALVE SUBCODE Z	16								
7	8	9	10		11		12		13						19		20										
17		LER/RO REPORT NUMBER		EVENT YEAR 7 9		21	22	SEQUENTIAL REPORT NO. 0 3 6		24	26	OCCURRENCE CODE 0 3		28	29	REPORT TYPE L		30	REVISION NO. 0		32						
ACTION TAKEN H		FUTURE ACTION H		EFFECT ON PLANT Z		33	34	SHUTDOWN METHOD Z		36	37	HOURS 0 0 0 0		40	ATTACHMENT SUBMITTED Y		41	NPRD-4 FORM SUB. N		42	PRIME COMP. SUPPLIER Z		43	COMPONENT MANUFACTURER Z 9 9 9		44	47
18		19		20				21				22		23		24		25				26					

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Construction had failed to remove the welding cable from the penetration and had failed to seal the penetration. A fire watch was posted approximately three hours after the hole was discovered and temporarily plugged. The hole was sealed soon after the fire watch was posted. Construction was reminded not to leave open penetrations unattended. Operations was reminded to take required compensatory action immediately if any future similar occurrences evolve.

FACILITY STATUS		1 5		E		(28)		1 0 0		(29)		NA		OTHER STATUS		(30)		METHOD OF DISCOVERY		B		(31)		Shift Foreman Inspection		DISCOVERY DESCRIPTION		(32)	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
ACTIVITY CONTENT		RELEASED		Z		(33)		Z		(34)		NA		AMOUNT OF ACTIVITY		(35)		LOCATION OF RELEASE		(36)									
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
PERSONNEL EXPOSURES		NUMBER		0		0		0		(37)		Z		(38)		NA		DESCRIPTION		(39)									
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
PERSONNEL INJURIES		NUMBER		0		0		0		(40)		NA		(41)		DESCRIPTION													
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
LOSS OF OR DAMAGE TO FACILITY		TYPE		Z		(42)		NA		(43)		DESCRIPTION																	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
PUBLICITY		ISSUED		N		(44)		NA		(45)		DESCRIPTION																	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
7 9 1 0 1 5 0 6 1 4		NRC USE ONLY																											
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36

NAME OF PREPARER R. B. Starkey, Jr.

PHONE: 803-383-4524

SUPPLEMENTAL INFORMATION

LER 79-036

Serial: RSEP/79-1117

Facility: HBR Unit No. 2

Event Date: 9-13-79

1. CAUSE DESCRIPTION AND ANALYSIS:

On September 13, 1979, at 0530 hours, the Shift Foreman discovered a welding machine cable passing through an open conduit between the Hagan Room and the Unit No. 2 Cable Spread Room. The welding machine had been used for welding pipe hangers on September 12 and apparently the construction personnel failed to remove the cable and did not post a fire watch. The Shift Foreman had the cable removed and plugged the hole with asbestos material. In his opinion, this constituted adequate temporary action to restore the penetration to operability. In fact, the asbestos material was not sufficient to restore the penetration to a 3-hour fire rating. A major cause for this decision was inadequate administration guidance on what constitutes adequate repair of conduit penetrations. This resulted in a degraded mode of operation permitted by Technical Specifications 3.14.5.

2. CORRECTIVE ACTION:

At 0815 hours on September 13, 1979, the new Shift Foreman and the Operating Supervisor decided to post a fire watch on the penetration as a conservative measure. The Maintenance Subunit was then directed to seal the penetration using a metal threaded conduit plug. This was considered as adequate to restore the penetration to a 3-hour fire rating and the fire watch was removed at 0900 hours on September 13, 1979.

3. CORRECTIVE ACTION TO PREVENT FURTHER OCCURRENCE:

Construction personnel were given explicit instructions on the necessity of ensuring that all fire barrier penetrations not be left in a degraded mode. In addition, operations personnel were reminded to take the most conservative immediate action as required by Technical Specifications, whenever any fire barrier penetration is discovered to be non-functional. Also, a revision will be made to the plant operating manual to provide adequate guidance for repairing all types of conduit penetrations.