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

USNRC REGION II
ATLANTA, GEORGIA

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WILLIAM O. PARKER, JR.
VICE PRESIDENT
STEAM PRODUCTION

TELEPHONE: AREA 704
373-4083

May 8, 1981

81-015-03

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. 50-269

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-269/81-07. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(2). which concerns 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.

Very truly yours,

William O. Parker, Jr.

William O. Parker, Jr.

JLJ:pw
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 UNITS 1 & 2

Report Number: RO-269/81-07

Report Date: May 8, 1981

Occurrence Date: April 10, 1981

Facility: Oconee Units 1 & 2, Seneca, South Carolina

Identification of Occurrence: Fire Barriers Breached Without Proper Fire Watch Maintained

Conditions Prior to Occurrence: Unit 1 - 100% FP
Unit 2 - 100% FP

Description of Occurrence: From 1400 hours on March 27, 1981, until 1200 hours on April 10, 1981, one fire barrier door each for Unit 1's and Unit 2's West Penetration Room were inoperable without proper fire watches having been maintained. The fire barrier doors had been propped open to permit the temporary routing of hoses through the doors. This constituted operation less conservative than the least conservative aspect of an LCO and is reportable pursuant to Technical Specification 6.6.2.1(a)2.

Apparent Cause of Occurrence: This occurrence was the result of a personnel error. The individual responsible for coordinating the work involved failed to properly communicate the requirements for the fire watch to the craft personnel. This resulted in uncertainty as to (1) How to perform watch? (2) At what frequency? (3) Specifically which doors involved? The responsible individual also failed to follow up and assure the fire watch was being performed properly.

Analysis of Occurrence: Prior to the breaching of the fire barriers, several meetings were conducted to discuss the various aspects of the work. During one of these meetings, the requirements for establishing and maintaining the fire watch while the doors remained propped open were addressed. However, due to poor communication, the requirements were not made clear to the craft personnel. As a result when the work was done, the required fire watch was not initiated.

During the period of time that the doors were propped open, the fire detector instrumentation in the West Penetration Room was operable. Also personnel were periodically working in the areas involved, and during these periods could have observed any fire. Therefore, the health and safety of the public were not affected.

Corrective Action: The individual involved has been counseled concerning the importance of specific and complete communication in this type of evolution. Station administrative procedures will be reviewed as to their adequacy in controlling this type of event.