

DUKE POWER COMPANY

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NUCLEAR PRODUCTION

April 12, 1983

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Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30303

Subject: Oconee Nuclear Station
Docket No. 50-270

Dear Mr. O'Reilly:

Please find attached Reportable Occurrence Report RO-270/83-05. This report is submitted pursuant to Oconee Nuclear Station Technical Specification 6.6.2.1.a(2) which concerns an operation subject to a limiting condition for operation which was less conservative than the least conservative aspect of the limiting condition for operation established in the Technical Specifications, 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,

H. B. Tucker / BT

Hal B. Tucker

JCP/php
Attachment

cc: Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Mr. J. C. Bryant
NRC Resident Inspector
Oconee Nuclear Station

INPO Records Center
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Atlanta, Georgia 30339

Mr. E. L. Conner, Jr.
Office of Nuclear Reactor Regulation
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Duke Power Company
Oconee Nuclear Station

Report Number: RO-270/83-05

Report Date: April 12, 1983

Occurrence Date: March 29, 1983

Facility: Oconee Unit 2, Seneca, South Carolina

Identification of Occurrence: Two fire doors were discovered open and unattended.

Conditions Prior to Occurrence: 100% FP

Description of Occurrence: On March 29, 1983, at 1420 and 1445, respectively, two fire doors off the Unit 1 and Unit 2 Upper Surge Tank (UST) platforms were discovered propped open with no fire watch. Because the area involved is safety related and a fire barrier was breached, a violation of Technical Specification 3.17.6 occurred. The doors were open and unattended for about one and one half hours.

Door 607A, located off the Unit 2 UST platform, was propped approximately 12 inches open so a drop-light could be plugged in. The roll-up door on the Unit 1 UST platform was propped open approximately 6 inches for communication purposes. Although the Instrumentation and Electrical (I&E) Technicians were working on the Unit 2 UST temperature transmitter, it was necessary to prop the roll-up door open since the instrument readout panel for the Unit 1 and Unit 2 USTs is located by the Unit 1 UST. Both doors were posted on both sides as fire doors, not to be left open unattended. There is no fire detection equipment in the areas on either side of the doors which were propped open.

Cause of Occurrence: When the personnel involved left the work area for lunch, they forgot to close the fire doors. All three technicians knew that these doors should not be left open and unattended. This incident is therefore classified as Personnel Error.

Analysis of Occurrence: Door 607A was open and unattended for one hour and twenty minutes. The roll-up door was open and unattended for one hour and forty-five minutes. The likelihood of a fire occurring in these areas during this time interval is low. The area of the turbine building adjacent and below the two open doors is along a route which is frequently traveled by plant personnel. Had a fire developed on the auxiliary building side of the open doors, any smoke would have been highly visible.

Per Station Directive, the use of any heat producing device/process in the area around the open doors would have required the establishment of fire prevention measures. Because of plant design and the Fire Brigade, a fire in the area near the USTs with these doors propped open would not jeopardize nuclear safety. The health and safety of the general public were not compromised.

Corrective Action: Both fire doors were closed immediately after each was discovered to be open. The personnel involved have received appropriate disciplinary action. I&E plans to change its work practices so that when a job involves opening fire doors, one person will be assigned the responsibility of assuring compliance with station fire regulations.

Closing the fire doors removed the breach of fire barrier. The Oconee Station annual Health Physics, Emergency, Security Training program is being changed to include a portion on fire protection. This will ensure that all employees are aware of and trained on requirements. This change was not a result of this incident but rather an effort to include all required training in the same time period (Block Training). This training was given during the annual safety meeting in past years. The supplemental and planned corrective action should help prevent recurrence.