

cinema
037179

BALTIMORE GAS AND ELECTRIC COMPANY

P.O. BOX 1475

BALTIMORE, MARYLAND 21203

NUCLEAR POWER DEPARTMENT
CALVERT CLIFFS NUCLEAR POWER PLANT
LUSBY, MARYLAND 20657

May 22, 1981

Mr. Boyce H. Grier, Director
Office of Inspection & Enforcement
U.S. Nuclear Regulatory Commission
Region 1
631 Park Avenue
King of Prussia, PA 19406

Docket No. 50-317
License No. DPR-53

Dear Mr. Grier:

Per Technical Specification 6.9.1.8.b please find attached the fourteen day follow-up report for LER 81-31/1T.

Should you have any questions regarding this report, we would be pleased to discuss them with you.

Very truly yours,

LBR
L. B. Russell
Plant Superintendent

LBR:SMD:mmr

cc: Director, Office of Management Information
and Program Control
Mems: A. E. Lundvall, Jr.
J. A. Tiernan

IE22
BACKFIT
ADD.
McCollins
LA-1210

LER NO. 81-31/IT
DOCKET NO. 50-317
LICENSE NO. DPR-53
EVENT DATE 05-11-81
REPORT DATE 05-22-81
ATTACHMENT

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

At 1945 with Units 1 and 2 at full power, it was discovered that less than the required number of hose stations were operable on the -10 foot elevation in the Auxiliary Building (T.S. 3.7.14.4). At approximately 1510, portions of the Auxiliary Building fire protection system were placed out of service to facilitate tying in new sprinkler systems. However, both -10 foot hose stations (HS (-)10 -22 and HS (-)10 - 63) were isolated and neither hose station was provided with a water supply from an operable hose station. Upon discovery, both hose stations were immediately returned to service and were verified operable at 2010. During this event, because of maintenance being performed in the -10 foot elevation, a continuous fire watch with an additional fire extinguisher had been provided even though one was not required. Similar event: none.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

The cause for the hose stations being isolated can be contributed to several factors. The plant's fire protection system has been undergoing extensive modification to bring it in compliance with new NRC requirements. Because of these modifications, the operator was unfamiliar with the location of new isolation valves. In addition, the new valves had not yet been provided with identification tags. In order to aid the operator in providing the necessary isolation for new sprinkler system tie-ins, and help him locate new isolation valves, the Fire Protection Inspector marked up drawings indicating a suggested isolation scheme and he provided marked up floor plans of the affected areas indicating the location of isolation valves and hose stations that would require a temporary water supply.

Unfortunately, the Fire Protection Inspector made an error when he identified the isolation valve that affected the (-)10 foot and (-)15 foot elevation hose stations. The error resulted in the operator isolating both (-)10 foot hose stations instead of one as the isolation scheme had intended. Also, when the operator isolated the system he did not question the accuracy of the marked up drawing even though he suspected an error had been made.

A number of actions have been taken to prevent recurrence. First, all new fire protection system isolation valves have been equipped with identifications tags. Second, the Fire Inspector's supervisor has instructed him of the importance for accuracy when he is suggesting fire protection isolation schemes. Also, the Fire Protector Inspector's supervisor has suggested that he seek an independent review before having fire systems isolated. The Operator who isolated the hose stations was reinstructed to stop and investigate suspected errors in instructions before he places a system out of service. Finally, all licensed personnel will be made aware of this effort.