

NRC FORM 366
(12-81)
10 CFR 50U.S. NUCLEAR REGULATORY COMMISSION
LICENSEE EVENT REPORTAPPROVED BY CMB
3150-0011

CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 M A P P S I 00 - 00 00 00 - 00 34 11 11 11 4 5
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 37 38 39 4001 REPORT SOURCE L 6 0 5 0 - 0 2 9 3 7 0 4 1 7 8 1 8 0 3 1 9 8 4 9
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 37 38 39 40

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On 4/17/81, at 1130 hours, routine surveillance testing was being conducted on

03 the Cardox System hose reels and nozzles. After successfully testing the 51 ft.

04 level hose station, a test was conducted on the 23 ft. level hose reel and noz-

05 zle. The nozzle failed to deliver an adequate stream. A fire watch was im-

06 mediately established as required by Technical Specifications. Approximately

07 two hours later, the system was satisfactorily retested and returned to service.

08 (Refer to attachment.) This event caused no threat to the public health and safety.

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
A B 11 A 12 B 13 P I P E X X 14 A 15 Z 16

17 LER/RO REPORT NUMBER 8 1 1 23 SHUTDOWN METHOD 0 1 5 26 HOURS 22 ATTACHMENT SUBMITTED 0 3 29 NRPD-4 FORM SUB. PRIME COMP. SUPPLIER X 31 COMPONENT MANUFACTURER 26

18 ACTION TAKEN H 18 X 19 EFFECT ON PLANT Z 20 Z 21 0 0 0 0 0 0 40 Y 23 L N 24 A 25 C 2 8 5 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Cause of this event was determined to be operator error. Engineering evaluation

11 has determined that the nozzles will not permit CO₂ discharge unless the trigger

12 on the hose station actuation valve is fully depressed. Fire Brigade training

13 was revised accordingly and Fire Brigade members were instructed on the correct

14 method of activating the Cardox System.

15 FACILITY STATUS E 28 % POWER 1 0 0 29 OTHER STATUS NA 30 METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION 32 Surveillance Testing

16 ACTIVITY CONTENT RELEASED Z 33 Z 34 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE NA 36

17 PERSONNEL EXPOSURES NUMBER 0 0 0 37 Z 38 DESCRIPTION 39 NA

18 PERSONNEL INJURIES NUMBER 0 0 0 40 DESCRIPTION 41 NA

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION 43

20 PUBLICITY ISSUED N 44 DESCRIPTION 45 NA

NAME OF PREPARER P. J. Hamilton

PHONE (617) 746-7900

8404030276 840319
PDR ADOCK 05000293
S PDR

BOSTON EDISON COMPANY
PILGRIM NUCLEAR POWER STATION
DOCKET NO. 50-293

Attachment 1 31-015-03X-1

Description

On April 17, 1981, the once a cycle surveillance (8.B.5) was being conducted on the Cardox Fire Protection System. This system consists of a storage unit having a capacity of four tons which maintains liquid CO₂ at a low temperature (-1°F) and low pressure (300 psig). The system is used for fire protection of the cable spreading room, as a supply source for three CO₂ fire hose stations (23' switchgear, 37' switchgear and 51' generator area) and for generator purge.

When a CO₂ hose nozzle is removed from its brackets the master selector valve for the hose system opens allowing CO₂ to reach all three nozzles. CO₂ can then be discharged by operating the squeeze trigger on the nozzle.

The CO₂ hose reel on the 51' elevation was the first tested and was satisfactory. The 23' elevation was then tested and failed. The 37' elevation was then satisfactorily tested. The testing at the 51' elevation permitted liquid and vaporous CO₂ to reach all three hose reels. Heavy frost coating was observed on the pipes during this testing. The 23' elevation was re-tested within minutes and again failed. This CO₂ station was declared inoperable, a maintenance request issued and a fire watch established. Two hours later this hose station was satisfactorily tested and declared operable.

Cause and Corrective Action

A review of the event by engineering revealed that the cause of the event was due to operator error and not a frozen hose station as described in the previous report. As a result of this followup investigation to the incident, it has been determined that the nozzles will not permit CO₂ discharge if the trigger or the handle is not fully depressed. To eliminate a recurrence of this incident, the Training Department has revised the Fire Brigade training curriculum and members of the Fire Brigade have been instructed on the correct method of activating the Cardox System.

BOSTON EDISON COMPANY
800 BOYLSTON STREET
BOSTON, MASSACHUSETTS 02199

WILLIAM D. HARRINGTON
SENIOR VICE PRESIDENT
NUCLEAR

March 19, 1984

BECO. #84- 043

Regional Administrator, Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Docket Number 50-293
License DPR-35

Gentlemen:

The attached updated License Event Report 81-015/03X-1 "CO₂ System Hose Inoperable", is hereby submitted in accordance with the requirements of Pilgrim Nuclear Power Station Technical Specification 6.9.B.2.b.

If there are any questions on this subject, please do not hesitate to contact the undersigned.

Very truly yours,

W D Harrington

William D. Harrington

WDH/mg

Enclosures: LER 81-015/03X-1

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