REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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AUTH.NAME AUTHOR AFFILIATION
STARKEY,R.B. Carolina Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
Region 2, Atlanta, Office of the Director

SUBJECT: LER 80-026/01T-0:on 801030,valve SI-892A found shut.Caused by normally locked-open spray additive tank educator feed isolation valve mistaken for valve on operating work procedure & inadvertently closed.Procedure will be revised.

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TITLE: Incident Reports

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	A/D PLANT SYS	10	1	1	A/D RAD PROT	11	1	1
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	I&C SYS BR	29	1	1	I&E	05	2	2
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	MECH ENG BR	33	1	1	MPA		3	3
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NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Field	Value
0 1 Licensee Code (2)	S C H B R 2
License Number (3)	0 0 - 0 0 0 0 0 - 0 0
License Type (4)	4 1 1 1 1
CAT (5)	
CON'T 0 1 Report Source (6)	L
Docket Number (7)	0 5 0 0 0 2 6 1
Event Date (8)	1 0 3 0 8 0
Report Date (9)	1 1 1 3 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 At 2004 hours on October 30, 1980, while returning "B" containment spray pump to
03 normal lineup per Operating Work Procedure (OWP-CS-2), valve SI-892A was found shut.
04 Valve SI-892A is the common isolation valve for the sodium hydroxide addition line.
05 The plant was operating at 68% power and isolation of the sodium hydroxide system,
06 under this plant condition, is contrary to Technical Specification 3.3.2.1.e which is
07 reportable pursuant to 6.9.2.a(2).
08

Field	Value
09 System Code (11)	S B
Cause Code (12)	A
Cause Subcode (13)	A
Component Code (14)	V A L V E X
Comp. Subcode (15)	F
Valve Subcode (16)	D
LER/RO Report Number (17) — Event Year	8 0
Sequential Report No.	0 2 6
Occurrence Code	0 1
Report Type	T
Revision No.	0
Action Taken (18)	E
Future Action (19)	G
Effect on Plant (20)	Z
Shutdown Method (21)	Z
Hours (22)	0 0 0 0
Attachment Submitted (23)	Y
NPRD-4 Form Sub. (24)	N
Prime Comp. Supplier (25)	N
Component Manufacturer (26)	E 0 9 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 During the isolation of containment spray pump "B", the normally locked open spray
11 additive tank educator feed isolation valve SI-892A was mistaken for a valve on the
12 OWP and inadvertently closed. This discrepancy was identified and corrected at 2004
13 hours on October 30, 1980. The procedure will be revised to incorporate double
14 valve lineups.

Field	Value
15 Facility Status (28)	C
% Power (29)	0 6 8
Other Status (30)	NA
Method of Discovery (31)	B
Discovery Description (32)	Operator Observation
16 Activity Released (33)	Z
Content of Release (34)	Z
Amount of Activity (35)	NA
Location of Release (36)	NA
17 Personnel Exposures Number (37)	0 0 0
Type (38)	Z
Description (39)	NA
18 Personnel Injuries Number (40)	0 0 0
Description (41)	NA
19 Loss of or Damage to Facility Type (42)	Z
Description (43)	NA
20 Publicity Issued (44)	N
Description (45)	NA

8011170 444

NRC USE ONLY

NAME OF PREPARER R. B. Starkey, Jr. PHONE: (803) 383-4524

GPO 917-926

SUPPLEMENTAL INFORMATION

FOR

LICENSEE EVENT REPORT 80-026

1. Cause Description and Analysis: On October 30, 1980 at 2004 hours while returning containment spray pump "B" to normal lineup as per Operating Work Procedure, OWP-CS-2, valve SI-892A was found to be shut. This closed valve caused isolation of the Sodium Hydroxide Addition Tank which is contrary to Technical Specification 3.3.2.1.e and is reportable pursuant to 6.9.2.a(2). The plant was operating at 68% power and startup physics testing following refueling was in progress.

   "B" containment spray pump had been declared inoperable and isolated for repair using OWP-CS-2 at 0420 hours on October 30, 1980. This procedure requires the normally locked open containment spray pump "B" educator suction valve SI-892G to be closed. However, the normally locked open spray additive tank feed isolation valve SI-892A (common to both pumps) was inadvertently closed instead of SI-892G. This resulted in the isolation of the Sodium Hydroxide Spray Additive Tank from the operable "A" containment spray pump for fifteen hours and forty-four minutes. These two valves are similar two inch globe valves located in close proximity to one another. No adverse consequences resulted from this misalignment and the system was restored to full operability when valve SI-892A was reopened at 2004 hours on October 30, 1980.

2. Corrective Action: When SI-892A was found shut, it was reopened, thereby regaining automatic sodium hydroxide addition to "A" containment spray pump.

3. Corrective Action to Prevent Recurrence: The plant procedures will be revised to require double valve lineup verification on all Operating Work Procedures associated with safety systems. This redundancy should provide for immediate identification of this type of event. The appropriate revisions to the applicable procedures will be implemented by January 31, 1981.

   In addition, the operator involved in this error has been admonished and the circumstances surrounding this incident and the lessons to be learned have been reviewed in detail with all operations personnel as further action to preclude recurrence.