NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
0 1	LICENSEE CODE (9–14) (2)	M D C C N 2
0 1	LICENSE NUMBER (15–25) (3)	0 0 - 0 0 0 0 0 - 0 0
0 1	LICENSE TYPE (26–30) (4)	4 1 1 1 1
0 1	CAT (57–58) (5)	
CON'T 0 1	REPORT SOURCE (60) (6)	L
0 1	DOCKET NUMBER (61–68) (7)	0 5 0 0 0 3 1 8
0 1	EVENT DATE (69–74) (8)	0 4 2 6 8 3
0 1	REPORT DATE (75–80) (9)	0 5 2 5 8 3

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During normal operation at 0300, it was discovered that the salt water
0 3 inlet valves to the circulating water pump room air coolers (SW5250 and
0 4 SW5251) were open while the automatic SIAS signal was disabled (T.S.
0 5 6.9.1.9). These valves were immediately shut and tagged. The valves had
0 6 been opened at about 1400 on 4/25/83 after reinstallation following main-
0 7 tenance. The outlet valves from the air coolers were shut during this
0 8 event. Similar events: None.

Line	Field	Value
0 9	SYSTEM CODE (9–10) (11)	W E
0 9	CAUSE CODE (11) (12)	D
0 9	CAUSE SUBCODE (12) (13)	Z
0 9	COMPONENT CODE (13–18) (14)	V A L V O P
0 9	COMP. SUBCODE (19) (15)	A
0 9	VALVE SUBCODE (20) (16)	Z
(17) LER/RO REPORT NUMBER	EVENT YEAR (21–22)	8 3
	(23)	—
	SEQUENTIAL REPORT NO. (24–26)	0 2 5
	(27)	/
	OCCURRENCE CODE (28–29)	0 3
	REPORT TYPE (30)	L
	(31)	—
	REVISION NO. (32)	0
	ACTION TAKEN (33) (18)	E
	FUTURE ACTION (34) (19)	H
	EFFECT ON PLANT (35) (20)	Z
	SHUTDOWN METHOD (36) (21)	Z
	HOURS (37–40) (22)	0 0 0 0
	ATTACHMENT SUBMITTED (41) (23)	Y
	NPRD-4 FORM SUB. (42) (24)	N
	PRIME COMP. SUPPLIER (43) (25)	A
	COMPONENT MANUFACTURER (44–47) (26)	L 2 0 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Person opened valve preparing to reenergize it, believing valve was al-
1 1 ready open. Action occured due to confusing position indication resulting
1 2 from lack of instructions in installation procedure. Personnel have been
1 3 instructed on Operations responsibility regarding valve operation.Main-
1 4 tenance procedure will be changed to reflect this particular application.

Line	Field	Value
1 5	FACILITY STATUS (9) (28)	E
1 5	% POWER (10–12) (29)	1 0 0
1 5	OTHER STATUS (13–44) (30)	NA
1 5	METHOD OF DISCOVERY (45) (31)	A
1 5	DISCOVERY DESCRIPTION (46–80) (32)	Operator Observation
1 6	ACTIVITY RELEASED (9) (33)	Z
1 6	CONTENT OF RELEASE (10) (34)	Z
1 6	AMOUNT OF ACTIVITY (11–44) (35)	NA
1 6	LOCATION OF RELEASE (45–80) (36)	NA
1 7	PERSONNEL EXPOSURES NUMBER (9–11) (37)	0 0 0
1 7	TYPE (12) (38)	Z
1 7	DESCRIPTION (13–80) (39)	NA
1 8	PERSONNEL INJURIES NUMBER (9–11) (40)	0 0 0
1 8	DESCRIPTION (12–80) (41)	NA
1 9	LOSS OF OR DAMAGE TO FACILITY TYPE (9) (42)	Z
1 9	DESCRIPTION (10–80) (43)	NA
2 0	PUBLICITY ISSUED (9) (44)	N
2 0	DESCRIPTION (10–68) (45)	NA

8306170072 830525
PDR ADOCK 05000318
S PDR

IE22 1/1

NRC USE ONLY

NAME OF PREPARER R. L. Wenderlich/G. S. Pavis PHONE: 301-269-4776/4850

GPO 917-926

LER NO. 83-25/3L
DOCKET NO. 50-318
LICENSE NO. DPR 69
EVENT DATE 4/26/83
REPORT DATE 5/25/83
ATTACHMENT

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

Valve opening occured after motor operators were reinstalled with confusing position indication. Position indication is shown by an arrow which rotates with valve operation. Open and closed positions are marked by the mechanics for butterfly valves, since there are no hard seats involved. The motor operator for one valve was labeled closed with the arrow in the 12 o'clock position, requiring clockwise movement to open the valve. The second motor operator showed closed in the 3 o'clock position, requiring counterclockwise movement to open this valve. When an electrician arrived to electrically connect the valves, he observed the markings and the position arrows on both valves were pointed to the closed position. The electrician questioned the accuracy of the marked position on the valves and turned the handwheel slightly to verify correct valve position. He discovered that the arrows on both valves moved counterclockwise when the valve was operated. The normal convention for these operators would have the valve close when the arrow moved counterclockwise. Therefore, the electrician, believing the valves were actually open, operated the valves to what he believed was the shut position, which, in fact, opened the valves. Operations personnel were not notified of this action.

Corrective actions involved manually closing the valves, and subsequent repositioning of the butterfly valve to provide conventional position indication. Future corrective actions consist of informing electrical maintenance personnel that Operation personnel are responsible for valve manipulation that are not protected by tagging, and that Operations should be consulted if valve positions are questioned. Maintenance procedures regarding Limitorque operators will be revised to include a step to check position indication for reinstalling motor operators in this unique application. In addition, local position indication for motor operated valves will be examined and a more permanent means for establishing and labeling valve positions be established.

BALTIMORE GAS AND ELECTRIC COMPANY

P.O. BOX 1475

BALTIMORE, MARYLAND 21203

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

May 25, 1983

Mr. James M. Allan
Acting Regional Administrator
U.S. Nuclear Regulatory Commission
Region 1
631 Park Avenue
King of Prussia, PA 19406

Docket No. 50-318
License No. DPR 69

Dear Mr. Allan:

In accordance with Technical Specification 6.9 please find the attached thirty day report for LER 83-25/3L.

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

Very truly yours,

L. B. Russell
Plant Superintendent

LBR/GSP/mlk

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

IE27
1/1