

CONTROL BLGCK:

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 (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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REPORT SOURCE

L	6	0	5	0	-	0	3	2	4	7	0	9	0	5	8	3	8	0	9	1	6	8	3	9
60	61									68	69						74	75						80
DOCKET NUMBER											EVENT DATE							REPORT DATE						

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | While performing a weekly fire protection operability periodic test, PT-35.1, it

0 3 | was discovered that the supply valve, (2-FP-V39), to the deluge systems of both

0 4 | SBGTS was shut. Further review indicated that the valve had a clearance tag on it

0 5 | for the potable water valve 2-PWT-V5. The health and safety of the public were

0 6 | affected by this event.

0 7 |

0 8 | Technical Specifications 3.7.7.2, 6.9.1.8b

09		SYSTEM CODE A B		CAUSE CODE A		CAUSE SUBCODE B		COMPONENT CODE V A L V E X				COMP. SUBCODE E		VALVE SUBCODE D	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
LER/RO REPORT NUMBER 17		EVENT YEAR 8 3		SEQUENTIAL REPORT NO. 0 8 3		OCCURRENCE CODE 0 1		REPORT TYPE T		REVISION NO. 0					
23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
ACTION TAKEN X		FUTURE ACTION X		EFFECT ON PLANT Z		SHUTDOWN METHOD Z		HOURS 0 0 0 0		ATTACHMENT SUBMITTED Y		NPRD-4 FORM SUB. N		PRIME COMP. SUPPLIER Z	
18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
ACTION TAKEN X		FUTURE ACTION X		EFFECT ON PLANT Z		SHUTDOWN METHOD Z		HOURS 0 0 0 0		ATTACHMENT SUBMITTED Y		NPRD-4 FORM SUB. N		PRIME COMP. SUPPLIER Z	
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48
ACTION TAKEN X		FUTURE ACTION X		EFFECT ON PLANT Z		SHUTDOWN METHOD Z		HOURS 0 0 0 0		ATTACHMENT SUBMITTED Y		NPRD-4 FORM SUB. N		PRIME COMP. SUPPLIER Z	
ACTION TAKEN X		FUTURE ACTION X		EFFECT ON PLANT Z		SHUTDOWN METHOD Z		HOURS 0 0 0 0		ATTACHMENT SUBMITTED Y		NPRD-4 FORM SUB. N		PRIME COMP. SUPPLIER Z	
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ACTION TAKEN X		FUTURE ACTION X													

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The auxiliary operator (AO) assigned to hang the tag on 2-PWT-V5 mistakenly closed
1 1 and tagged 2-FP-V39. Neither valve had valve identification and the AO failed to
1 2 follow procedures concerning operation of valves not positively identified. The
1 3 AO was appropriately disciplined and the associated valves were tagged for
1 4 identification.

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
1	5	E	28	0	8	7	29	NA	B
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE			
1	6	E	33	Z	34	NA	NA		
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION			
1	7	0	0	0	37	Z	38	NA	
PERSONNEL INJURIES		NUMBER		DESCRIPTION					
1	8	0	0	0	40			NA	
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION					
1	9	Z	42			NA			
PUBLICITY		ISSUED		DESCRIPTION					
2	0	Z	44			NA			

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PDR ADDCK 05060324
S PDR

NRC USE ONLY

LER ATTACHMENT - RO #2-83-83

Facility: BSEP Unit No. 2

Event Date: September 5, 1983

While performing the weekly fire protection operability and valve alignment test, Periodic Test 35.1, on September 5, 1983, it was determined that 2-FP-V39 was shut and tagged with a clearance tag. This valve isolated water to both Unit No. 2 SBTG deluge systems. Further review of this clearance tag by the Operations personnel performing the test revealed that the clearance tag should have been hung on 2-PWT-V5, a potable water isolation valve. The Shift Operating Supervisor was immediately notified, the valve reopened, and an investigation initiated.

To support construction of the new Emergency Operations Facility (EOF), it was requested by plant Construction personnel on September 1, 1983, that potable water valve 2-PWT-V5 be shut and placed under clearance. A clearance tag was made and an auxiliary operator proceeded to locate, shut, and tag 2-PWT-V5. When he arrived at the area where he expected the valve to be located, he noted that the valve did not have a label tag to allow for positive identification. This valve, in addition to others located in the general area between the Reactor Building and the Maintenance Shop, are underground valves with stems that are operated by a removable reach rod handle. Since the valve was not marked and the piping could not be traced, the auxiliary operator discussed the valve identification with the Construction personnel who would be accepting the clearance and with the Fire Protection Support Group as to whether the valve in question was 2-PWT-V5. Because the valve actuator extension was not painted red (indicating a fire protection valve) and was located where the auxiliary operator expected it to be, he shut and hung the clearance tag on the valve. The potable water was actually secured to the EOF coincidental with closure of 2-FP-V39. This was accomplished as a result of a separate evolution which deenergized the potable water pumps and thereby secured the potable water system.

The subsequent incident investigation revealed the following problems which contributed, or potentially contributed, to this event:

1. The auxiliary operator failed to follow plant procedure OI-13. Operating Instruction 13 (OI-13) was developed to establish requirements for the operation of valves throughout the plant. This instruction requires that valves have positive identification attached (i.e., valve identification tags) prior to any manipulation except in an emergency situation. Training on OI-13 had been provided to Operations personnel prior to this event.
2. The Piping and Instrument Diagram (P&ID) was incorrectly used as a reference. The P&ID was used to review the position of other valves on the associated line and to obtain piping orientation. Isometric drawings should have been used for this purpose and were available in the Control Room.

3. The fire protection valve (2-FP-V39) was not painted red. Plant operating philosophy is to paint fire protection valves red so that they are readily identifiable. Had the valve actuator stem been painted red, the auxiliary operator would have recognized the association with fire protection rather than potable water.
4. The clearance was not expeditiously cancelled. Work on the EOF Potable Water System was completed and authorization to cancel the clearance was provided by the Construction personnel on September 2, 1983. Due to other work items and the noncriticality of restoring potable water to the EOF, the clearance was not removed until September 5, 1983, after the valve mispositioning was identified by PT-35.1.
5. The addition of valve 2-PWT-V5 to an existing clearance was not properly performed. The controlling procedure requires that a new approval/cover sheet be established; however, in this case, this was not done and the valve was added to the existing clearance sheet.

In order to improve operator performance in handling clearances and to avoid the possibility of confusing fire protection valves with other plant systems, the following actions have been or will be taken:

1. The auxiliary operator associated with this event was appropriately disciplined as a result of his actions in not assuring by positive means (violating OI-13) that the valve he was shutting and placing under clearance was in fact 2-PWT-V5.
2. A special session of Real Time Training, conducted immediately following this event and continued over a four-day period, was provided to the Operating Shift personnel concerning OI-13 and its applicability to this event.
3. Real time training will be scheduled for additional training to Operations personnel on proper methods for valve identification and proper actions to take when a valve is found without proper identification. Administration of clearance procedures, the proper use of P&IDs, and an integrated review of this event will also be addressed in this training. The next series of real time training is scheduled to start in October 1983 and will be conducted over approximately a five-week period (one shift per week).
4. A program has been initiated to assure that fire protection valves are properly labeled and painted red. Previous efforts by plant personnel resulted in the identification and painting of fire protection valves with handwheels. However, this effort failed to take into account those valves without handwheels requiring the use of remote actuators for positioning. Operations personnel are working with Engineering to assure underground valves (such as 2-PWT-V5 and 2-FP-V39) are identified, properly labeled, and painted as required. This project is expected to be completed in November 1983. Proper utilization of OI-13 will assure correct valve manipulations while this project is being completed.



Carolina Power & Light Company

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Brunswick Steam Electric Plant
P. O. Box 10429
Southport, NC 28461-0429

September 16, 1983

FILE: B09-13510C
SERIAL: BSEP/83-3138

Mr. James P. O'Reilly, Administrator
U. S. Nuclear Regulatory Commission
Region II, Suite 3100
101 Marietta Street N.W.
Atlanta, GA 30303

BRUNSWICK STEAM ELECTRIC PLANT, UNIT NO. 2
DOCKET NO. 50-324
LICENSE NO. DPR-62
LICENSEE EVENT REPORT 2-83-83

Dear Mr. O'Reilly:

In accordance with Section 6.9.1.8b of the Technical Specifications for Brunswick Steam Electric Plant, Unit No. 2, the enclosed Licensee Event Report is submitted. This report fulfills the requirement for a written report within fourteen (14) days of a reportable occurrence and is in accordance with the format set forth in NUREG-0161, July 1977.

Very truly yours,

C. R. Dietz, General Manager
Brunswick Steam Electric Plant

RMP/pms/LETPS1

Enclosure

cc: Mr. R. C. DeYoung
NRC Document Control Desk

OFFICIAL COPY

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