

LICENSEE EVENT REPORT

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

01 | N Y R E G 1 | 2 | 0 0 - 0 0 0 0 0 - 0 0 | 3 | 4 1 1 1 1 | 4 | _____ | 5

7 8 9 14 15 25 26 30 57 CAT 58

LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CON'T 01 | L | 6 | 0 5 0 0 0 2 4 4 | 7 | 0 1 0 4 8 3 | 8 | 0 2 0 3 8 3 | 9

7 8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | During the performance of procedure S-30.5, "Standby Auxiliary Feedwater Pump Valve |
 03 | and Breaker Position Verification", Valve 9626A, Service Water Suction to the "1C" |
 04 | Standby Auxiliary Feedwater Pump, was found mispositioned in the CLOSED position. |
 05 | The last verifications of the valve in the OPEN position were 12/21/82 by an |
 06 | Auxiliary Operator and 12/22/82 by a Shift Technical Advisor. This made the 1C |
 07 | SBAFW Pump inoperable and therefore an LCO based on Tech. Spec. 3.4.2d. |
 08 | _____ | 80

09	SYSTEM CODE	CAUSE CODE	CAUSE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
7 8	W A (11)	X (12)		V A L V E X (14)	E (15)	D (16)
9	10	11		13	18	20

17	LER/RO REPORT NUMBER	EVENT YEAR	SEQUENTIAL REPORT NO.	OCCURRENCE CODE	REPORT TYPE	REVISION NO.
7 8	8 3		0 0 1	0 3	L	0
9	21 22	23	24 26	27	28 29	30 31

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	X (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	A (25)	R 3 5 0 (26)
33	34	35	36	37	40	41	42	43

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | This event was evaluated by the Plant Operations Review Committee and the committee |
 11 | recommended a Security investigation be completed due to the potential for possible |
 12 | valve tampering. The results of this investigation are attached. Further corrective |
 13 | action is being tracked internally by Corrective Action Report CAR 1414. |
 14 | _____ | 80

15	FACILITY STATUS	% POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION
7 8	E (28)	1 0 0 (29)	NA (30)	B (31)	Performance of Procedure S-30.5 (32)
9	9	10 12	13	44 45	46

16	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY	LOCATION OF RELEASE
7 8	Z (33)	Z (34)	NA (35)	NA (36)
9	9	10 11	44	45

17	PERSONNEL EXPOSURES	DESCRIPTION
7 8	0 0 0 (37)	Z (38) NA (39)
9	11	12 13

18	PERSONNEL INJURIES	DESCRIPTION
7 8	0 0 0 (40)	NA (41)
9	11	12

19	LOSS OF OR DAMAGE TO FACILITY
7 8	Z (42) NA (43)
9	10

20	PUBLICITY ISSUED	DESCRIPTION
7 8	N (44)	NA (45)
9	10	

8302230723 830204
 PDR AD0CK 05000244
 S PDR

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NRC USE ONLY

INVESTIGATIVE SUMMARY

On January 4, 1983, at approximately 1730 hours R.E. Wood, Supervisor of Nuclear Security Ginna Station advised W.K. Dillon, RG&E Director of Security that a valve (V-9626-A) associated with the Standby Auxiliary Feedwater System had been found mispositioned (closed). This discovery had been made at 0615 hours January 4, 1983 during the course of a monthly valve and breaker check being performed on this system. The incident had been reported to the NRC and the valve returned to the proper position upon discovery. Wood, advised that the Operations section was making an inquiry into this incident and that additional security surveillances of unoccupied vital areas would be put into effect. The area where this valve is located has been under surveillance by firewatch personnel for over one year.

On January 5, 1983, at approximately 0015 hours Wood, advises Dillon, that in late November or early December 1982 a security officer had observed a firewatch person manipulating a fire system valve. Wood & Dillon respond to plant 0100 hours January 5, 1983, determine that fire system valve and mispositioned valve are within fifteen to twenty feet of one another. Firewatch involved interrogated by Wood and Dillon, reluctantly admits manipulating fire system valve, adamantly denies touching valve found mispositioned. Individuals access authorization terminated and he is escorted from site.

On January 5, 1983 1100 hours three additional Security Dept. investigators report to Ginna Station to assist Dillon & Wood, with the investigation. Briefing held with these investigators and they are apprised of circumstances leading up to discovery of the mispositioned valve and taken on a tour of the Aux. Building to inspect area where the valve found mispositioned is located.

January 5, 1983.

All personnel involved in the Performance Test (PT-36) performed on V-9626-A on 12/21/82, interviewed. Shift Technical Advisor who checked valve 12/22/82 interviewed. Personnel involved in discovery of mispositioned valve interviewed, 19 firewatch personnel interviewed. RG&E Project Liaison Engineer contacted & instructed to compile list of work projects performed in Aux. Building between 12/21/82 and 1/4/83.

January 6, 1983.

Four additional firewatch personnel interviewed. Coordinator Fire Protection & Safety interviewed. Operations Engineer interviewed. No new information developed.

Records of jobs performed in Aux. Building 12/21/82 thru 1/4/83, reviewed with Project Liaison Engineer. No jobs performed in or on Standby Aux. Feedwater System in that time frame. One modification to this system completed on 12/7/82, hydro test associated with this modification completed 12/21/82, in association with PT-36 testing. Interviewed personnel responsible for this modification & hydro test.

Attempts made to locate & reinterview firewatch person who manipulated fire valve meet with negative results.

Shift Supervisors "Hold Order" records reviewed for period 12/21/82, thru 1/4/83, no hold orders found on V-9626-A. Computer print out of entries to Aux. Building cross checked to verify information obtained.

January 7, 1983.

Two additional firewatch personnel interviewed, one claims to have observed someone manipulating valve V-9626-A on 12/24/82, this individual also places a H.P. Tech in the area at the same time. This lead investigated and it was determined that activity observed by firewatch was the PT-36 performed on 12/21/82, established by means of post assignments of this firewatch as well as the computer print out of entries to the Aux. Building.

Contact made with firewatch person responsible for manipulating fire system valve, subject continues to deny moving valve V-9626-A requests an opportunity to submit to a polygraph examination, "to clear his name".

Arrangements made with polygraph examiner to test firewatch on January 10, 1983, examiner is given background information necessary for his examination of firewatch.

Project Liaison Engineer interviewed regarding any possible painting that might have taken place in the vicinity of valve V-9626-A, no painting done in this area 12/21/82 thru 1/4/83.

Computer printout of entries to Aux. Building cross checked to verify information obtained.

January 10, 1983.

Reinterviewed Aux. Operator who conducted monthly PT-36 test on 12/21/82. Two investigators accompany this operator into Aux. Bldg. & have him walk through the procedures he followed during the 12/21/82, PT-test. Photographs of the area and valve V-9626-A taken. Reinterviewed Shift Technical Advisor who contended valve V-9626-A was in proper position on 12/22/82.

Interviewed the Operations Supervisor regarding the mispositioned valve and other work performed in this area between 12/21/82 and 1/3/83. Determined operations personnel had increased water level of the refueling water storage tank on 12/25/82.

Polygraph examiner advises that his examination of firewatch person indicates that this individual responded truthfully to questions posed in relation to the manipulation of valve V-9626-A. It is the opinion of the examiner that the firewatch has no guilty knowledge how valve V-9626-A came to be mispositioned.

January 11, 1983.

Interviewed operator involved in refueling water storage tank filling on 12/25/82. No valves associated with this system located in the immediate area of V-9626-A.

Interviewed H.P. Tech identified by firewatch as working in area of V-9626-A at the time the monthly PT test was performed on 12/21/82. Interviewed handy-man assigned to plant maintenance shop who has a work station in the vicinity of valve V-9626-A. No new information gained from these interviews.

Had Results and Test Foreman provide a list of all testing done in Aux. Building 12/21/82 thru 1/4/83. Checked this list for possibility that V-9626-A might have been mispositioned during one of these operations, negative results.

Computer print out of entries to Aux. Building cross checked to verify information obtained.

January 12, 1983

Review of investigative notes by investigative team, indexing the names associated with investigative interviews.

January 13, 1983.

Continuation of investigation note review, checking for any uncovered leads. Compilation of investigative data into logical sequence for preparation of detailed investigative report.

January 14, 1983.

Lead uncovered regarding repair of "A" waste gas compressor on 1/3/83. Several valves associated with this system placed on "hold" by mechanic personnel.

Interviewed two mechanics who performed this repair, ascertained valves placed on "hold" were manipulated by operations personnel.

January 15, 1983.

Interviewed operations personnel who manipulated valves during "A" waste gas compressor repair 1/3/83. Ascertained that valves associated with this test are located approximately fifty feet from valve V-9626-A and are small hand type valves as compared to V-9626-A which is a large wheel type valve. Operations personnel involved positive no errors made in relation to valve V-9626-A due to its location and size in comparison to valves held for compressor job.

January 17, 1983.

Recheck Shift Supervisors "Hold Order Book" to insure that all repairs & operations involving holds on any valves had been checked by investigative team, no new information developed.

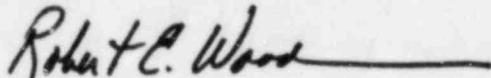
Report compilation.

INVESTIGATIVE CONCLUSIONS

Three possible causes exist for the mispositioning of valve V-9626-A:

- 1). Human error which might have occurred during the monthly PT test conducted on 12/21/82.
- 2). Human error which might have occurred when valve V-9626-A was closed in error during the course of other tests, repairs or operations conducted in the Aux. Building.
- 3). Deliberate tampering.

After exhausting all investigative leads and covering all investigative avenues no positive conclusions can be reached as to which of these three possibilities resulted in the mispositioning. The investigation will remain pending and any further information developed will be the subject of a supplemental report.



Robert E. Wood
Supervisor of Nuclear Security