nationalgrid

Incident Investigation Summary

Responsible Manager Andy Malins **Incident Reference No. 19845/08/NG**
Person Responsible for National Implementation GNCC Manager

Birch Heath, RVO Procedure
Incorrect valve closed during a remote valve operation

The Birch Heath RVO procedure involved testing a number of remotely operable and non critical valves on the site.

The NRO was well written and clearly set out the order in which the valves were to be operated. An authorised copy of the NRO was present in the control room. The NRO was being followed by the Network Technician on site and the Operations Engineer in GNCC who was operating the ROVs.

Communications between site and the control room worked well, with clarification routinely being sort over the actions required. When the Network Technician requested the GNCC close valve 05, the Operations Engineer clarified that valve 05 was to be closed but then, due to human error, closed valve 06.

The Network Technician identified that the incorrect valve had been operated and notified the Operations Engineer, who reopened the valve.

The two valves, 05 and 06, are on parallel interconnecting pipe work between two feeders and there was no impact on security of supply due to the error.

Although there was no impact on supply due to the incident incorrect valve movements could potentially have major safety or security of supply implications.
Learning Points –

- NROs should always be carefully followed.
- Communications between site and the control room should be clarified.
- When control actions are issued the Operations Engineer should observe follow up alarms to insure the correct command was sent.

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For further information regarding this bulletin please contact your Line Manager or Jacky Carroll 01926 652325