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TEXT (If more spece is required, use additional NRC Form 366A's) (17)

On 12/25/84, at approximately 1905 hours, a group 1 containment isolation was received as the result of a reactor high water level signal.

The event occurred when starting up after a refueling outage. At the time of the event, the RHR system had just been placed in the suppression pool cooling mode to facilitate a HPCI (uncoupled) surveillance test. In addition, reactor pressure was approximately 100 psig, the mode switch was in "startup," and the reactor water level was being manually controlled.

Cause of the high water level was an outboard LPCI injection valve, MO-1001-28A, leaking past its seat into the reactor. As an immediate corrective action, the inboard LPCI injection valve, MO-1001-29A, was then closed to isolate the reactor from the suppression pool cooling water.

Upon investigation on 12/26/84, maintenance personnel cycled MO-1001-28A and checked the torque switch settings which were found to be operating properly. Although the 28A valve indicated closed at the time of the event, it is believed that it did not fully seat on its last manual operation because the control switch was probably released when the open indication cleared and before the torque switch torqued out. Subsequent system operation in suppression pool cooling caused no further increase in reactor water level.

During the investigation of MO-1001-28A, it was necessary to again close the inboard LPCI injection valve, MO-1001-29A. When the control switch was actuated from Panel 903 in the control room, the valve would not close. At that time, a reactor shutdown was initiated in accordance with the requirements of T.S. 3.5.A. In addition, surveillance testing for an inoperable LPCI subsystem was initiated as required by T.S. 3.5.A. The faulty control switch was the first component failure identified during the event.

Cause of the 1001-29A not opening was determined to be faulty contacts in the hand-operated control switch. Corrective action was to rewire the control switch by moving the wiring terminations to the unused spare set of contacts. This modification was made in accordance with Station procedures (Reference: TM 84-089).

The 1001-29A valve was satisfactorily tested and returned to service on 12/26/84 at approximately 1700 hours. No further corrective action is planned. The SMB model control switch is manufactured by the General Electric Company. A search of records indicates no previous hand-operated control switch failures for M0-1001-29A.

On 12/26/84, during the above-mentioned surveillance testing for operation with an inoperable LPCI subsystem, it was discovered that LPCI injection valve, MO-1001-28B, would not close. This was the second and last component failure identified during the event.

| US-83) LICENSEE EVENT REPO | LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED OMB NO. 3150-01 EXPIRES: 8/31/85 | | | | | | | |
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Cause of the valve not closing was determined to be stiff grease in the Belleville spring pack of the Limitorque SMB-5 motor operator. Corrective action was to clean the motor operator and regrease it with new grease which is less susceptible to stiffening. In addition, a recently implemented preventive maintenance practice will require periodic inspection and/or changeout of the grease in selected motor operators. The valve was satisfactorily tested and returned to service on 12/26/84 at approximately 1750 hours.

A search of records indicates no previous occurrences of a similar nature for MO-1001-28B.

The events listed in this report did not impact the health and safety of the public.

BOSTON EDISON COMPANY BOD BOYLSTON STREET BOSTON, MASSACHUSETTS 02199

WILLIAM D. HARRINGTON SENIOR VICE PRESIDENT NUCLEAR

January 24, 1985 BECo Ltr. #85-015

Document Control Desk U.S. Nuclear Regulatory Commission Washington, D.C. 20555

> Docket Number 50-293 License DPR-35

Dear Sir:

The attached Licensee Event Report 84-020-00, "Containment Isolation Due to High Reactor Water Level," is hereby submitted in accordance with the requirements of 10CFR50.73.

If there are any questions on this subject, please do not hesitate to contact me.

Respectfully submitted,

W. D. Harrington

RS:caw

Enclosure: LER 84-020-00

cc: Dr. Thomas E. Murley
Regional Administrator, Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

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