NRC Form 366 (9.83)		LER)	U.S. NUCLEAR REGULATORY COMMISS APPROVED OMB NO 3150-0104 EXPIRES 8/31/85													
FACILITY NAME (1)								Tr.	DOCKET NUMBER	(2)	PAGE (3)					
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RPS Actuation	-		PV Pres	_					FACILITIES INVO	UVED (B)						
EVENT DATE (6) LER NUMBER (8)				-	DAY	YEAR		FACILITY NAM		DOCKET NUMBER(S)						
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			L	ICENSEE	CONTACT	FOR THIS	LER (12)									
Gary G. Rhoa	ıds, Ope	rational	Compli	lance	Engi	neer			5   1   6		4 813101					
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CAUSE SYSTEM COM	PONENT		EPORTABLE TO NPRDS			CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPROS						
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

YES III yes, complete EXPECTED SUBMISSION DATE!

SUPPLEMENTAL REPORT EXPECTED (14)

On June 6, 1985 at 1513 a RPS actuation occurred. The plant was in Operational Condition 4 with the mode switch in refuel and all rods inserted in the core. Operators were performing an inservice reactor pressure boundary leak test utilizing both the CRD (Control Rod Drive) system and the RWCU (Reactor Water Cleanup) blow down valve (G33-HCV-004) to regulate and maintain the RPV pressure at 1005 psig. I&C technicians were inspecting the blow down valve for leakage per an approved Maintenance Work Request (MWR). When the technician touched the feedback (which relays the actual valve position to the controller) due to the amount of play in the arm, the linkage was allowed to move up, telling the controller that the valve was not closed. valve then closed enough to cause an increase in RPV pressure above the high pressure scram trip set point (1043 psig) resulting in a high pressure scram. Control Room Operators the Emergency Shutdown Procedure. To reccurence, the valve positioner was adjusted and the incident was discussed with the entire Operations and I&C departments with a report generated, covering the incident in detail, and placed on their required reading list.

> 168 850703 DCK 05000322

MONTH

EXPECTED

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		364	

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104 EXPIRES 8/31/85

FACILITY NAME (1)			1	DOCKET NUMBER (2)								LER NUMBER (6)								PAGE (3)			
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TEXT Iff more space is required, use additional NRC Form 386A's/ (17)

On June 6, 1985 at 1513 a RPS actuation occurred. The plant was in Operational Condition 4 with the mode switch in refuel and all rod inserted in the core. Operators were performing an inservice reactor pressure boundary leak test (SP 22.009.01) utilizing both the CRD system and the RWCU blow down valve to regulate and maintain the RPV pressure at 1005 psig.

The initiating event occurred due to exceeding the RPV high pressure trip set point resulting in a high pressure scram. There was no safety significance to this event. All plant systems functioned as designed and no ECCS systems were challenged or required. The operators carried out all required actions. The maximum RPV pressure was 1047 psig, which was well below the lowest SRV (Safety Relief Valve) setpoint.

Reactor Pressure was being controlled at 1005 psig in accordance with SP 22.009.01 (inservice reactor pressure boundary leak The blow down valve was throttled to a flow rate of 80 test). gpm with the controller set at 0 (valve closed). Pressure control was therefore being achieved by varying the CRD cooling Per an approved MWR, two I&C technicians were dispatched to inspect the blow down valve for leakage but were told not to reposition the valve. The technician, upon looking at the valve, touched the linkage of the feedback arm (which relays the actual valve position to the controller) and due to the amount of free play in the linkage, the arm moved up telling the controller that the valve was not closed. The controller immediately reacted by bleeding air from the control loop (the valve operates on 3 to 15 psig control air signal with 3 psig for the closed position) and the valve started to close. The valve was closed long enough to cause pressure to increase to the high pressure scram trip point (1043 psig) resulting in a high pressure scram. The linkage arm then returned to the original position causing the controller to admit more air to the control loop and opened the valve to its original equilibrium point. The RPV pressure decreased to its original pressure. All work on the valve was ceased and Control Room Operators followed the emergency shutdown procedure (SP 29.010.01).

NRC Form 366A

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

US NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150--0104 EXPIRES 8/31/85

FACILITY NAME (1)				DOCKET NUMBER (2)								1	LEF	R NUMBER (6)	PAGE (3)							
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

To prevent recurrence the following actions were taken;

- The incident was discussed in detail with the technicians involved and the entire I&C section.
- To insure its proper operation, the positioner was readjusted.
- 3) A report was generated, describing the incident in detail, and placed on the Operations and I&C Sections required reading list. It was discussed in the report that the technicians should not have touched the valve linkage, and should not have been called to work on a valve that was being used to control reactor pressure.



## LONG ISLAND LIGHTING COMPANY

SHOREHAM NUCLEAR POWER STATION . P.O. BOX 628 . WADING RIVER, NEW YORK 11792

TEL. (516) 929-8300

July 3, 1985

PM 85-118

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

Dear Sir:

In accordance with 10CFR50.73, enclosed is a copy of Shoreham Nuclear Power Station Unit 1's Licensee Event Report 85-022.

Sincerely yours,

William E. Steiger, Jr.

Plant Manager

WES/gr

Enclosure

cc: Dr. Thomas E. Murley, Regional Administrator John Berry, Senior Resident Inspector Institute of Nuclear Power Operations, Records Center American Nuclear Insurers

SR. A21. 0200

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