Portland General Electric Company
Trojan Nuclear Plant
P.O. Box 439
Rainier, Oregon 97048
(503) 556-3713

October 31, 1980
CPY-1075-80

Mr. R. H. Engelken, Director
Nuclear Regulatory Commission, Region V
1990 North California Boulevard
Walnut Creek, CA 94596

Dear Sir:

In accordance with the Trojan Plant Operating License, Appendix A, US NRC Technical Specifications, Paragraph 6.9.1.9.b, attached is Licensee Event Report No. 80-23, concerning a situation where a main feedwater regulating valve did not close as required following a plant trip.

Sincerely,

C. P. Yundt
General Manager

JCP
CPY/JCP:mae

Attachments

c: LER Distribution List

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REPORTABLE OCCURRENCE

1. Report No.: 80-23

2. a. Report Date: October 31, 1980

   b. Occurrence Date: October 3, 1980

3. Facility: Trojan Nuclear Plant, PO Box 439, Rainier, Oregon 97048

4. Indentification of Occurrence:

   Following a plant trip, the "B" main feedwater regulating valve did not automatically close as required.

5. Conditions Prior to Occurrence:

   The plant was in Mode 1 at 100% of rated power prior to this occurrence.

6. Description of Occurrence:

   Following a plant trip, the "B" main feedwater regulating valve did not automatically close as required. It was determined that a manual throttle vent valve was not opened far enough to vent the air operator adequately. The vent valve was reset and the feedwater regulating valve tested satisfactorily.

7. Designation of Apparent Cause of Occurrence:

   The cause of this occurrence is undetermined. The throttle valve either was mispositioned, drifted closed or the air passage was obstructed by foreign material.

8. Analysis of Occurrence:

   This occurrence had no effect on either plant or public safety as the backup, redundant main feedwater isolation valve closed as required.

9. Corrective Action:

   The immediate corrective action taken was to manually open the throttle valve to allow the feedwater regulating valve to close. Subsequent corrective action was to reset the throttle valve to give the proper valve closing time, and the valve was tested. Permanent corrective action is under investigation.