



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

January 9, 1981
CPY-031-81

Mr. R. H. Engleken, Director
Nuclear Regulatory Commission, Region V
1990 North California Blvd.
Walnut Creek, California 94596

Dear Sir:

In accordance with the Trojan Plant Operating License, Appendix A, US NRC Technical Specifications, Paragraph 3/4.7.1.2, attached is Licensee Event Report No. 81-01, concerning a situation where the vent supply fan for the turbine-driven auxiliary feedwater pump room was inoperable due to a blown fuse in the breaker control power circuit.

Sincerely,

CPYundt
C. P. Yundt
General Manager

~~CPY~~
CPY/GGB:na
Attachments

c: LER Distribution List

A002
S
1/1

8101190443

5

REPORTABLE OCCURRENCE

1. Report No.: 81-01
2. a. Report Date: January 9, 1981
b. Occurrence Date: December 12, 1980
3. Facility: Trojan Nuclear Plant, PO Box 439, Rainier, Oregon 97048

4. Identification of Occurrence:

A blown fuse was found in the breaker control power circuit for the vent supply fan to the turbine-driven auxiliary feedwater pump room.

5. Conditions Prior to Occurrence:

The plant was in Mode 1 at 100% of rated power when the blown fuse was discovered.

6. Description of Occurrence:

During normal operations surveillance patrols, a blown fuse was found in the breaker control power circuit for the vent supply fan to the turbine-driven auxiliary feedwater pump room. The turbine-driven auxiliary feedwater pump would have operated normally upon receipt of an auto start signal, but the vent supply fan would not have started and the lack of ventilation would eventually cause the pump to overheat. Adequate ventilation could have been supplied by opening the door to the pump room.

7. Designation of Apparent Cause of Occurrence:

The cause of the occurrence was electrical fuse failure. Electrical checks of the circuit revealed no cause for the blown fuse.

8. Analysis of Occurrence:

This occurrence had no effect on plant or public safety. Both trains of auxiliary feedwater were available. The turbine-driven auxiliary feedwater pump could have operated long enough for ventilation to be restored.

9. Corrective Action:

Immediate corrective action was taken by performing electrical checks on the control power circuit for a short, ground, or overcurrent. The fuse was replaced and the fan was tested satisfactorily. No further corrective action is required.