Portland General Electric Company
Trojan Nuclear Plant
71760 Columbia River Hwy
Rainier, Oregon 97048
(503) 556-3713

February 19, 1990
CPY-063-90

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington DC 20555

Gentlemen:

Licensee Event Report No. 90-03 is attached. This report discusses an event in which both Centrifugal Charging Pumps were inoperable for short periods of time while in Mode 4 due to surveillance test procedural errors.

Sincerely,

C. P. Yundt

C. P. Yundt
General Manager
Trojan Nuclear Plant

c: Mr. John B. Martin
Regional Administrator, Region V
U.S. Nuclear Regulatory Commission

Mr. David Stewart-Smith
State of Oregon
Department of Energy

Mr. R. C. Barr
USNRC Resident Inspector
Trojan Nuclear Plant

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NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

# LICENSEE EVENT REPORT (LER)

| FACILITY NAME (1) | DOCKET NUMBER (2) | PAGE (3) |
|---|---|---|
| Trojan Nuclear Plant | 0 5 0 0 0 3 4 4 | 1 OF 0 1 |

TITLE (4) Procedural Inadequacy Caused Both Centrifugal Charging Pumps To Be Inoperable During Mode 4 Due To Closure Of Nonactive Motor Operated Valve

| EVENT DATE (5) | | | LER NUMBER (6) | | | REPORT DATE (7) | | | OTHER FACILITIES INVOLVED (8) | |
|---|---|---|---|---|---|---|---|---|---|---|
| MONTH | DAY | YEAR | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | MONTH | DAY | YEAR | FACILITY NAMES | DOCKET NUMBER(S) |
| 0 1 | 1 9 | 9 0 | 9 0 | 0 0 3 | 0 0 | 0 2 | 1 9 | 9 0 | N/A | 0 5 0 0 0 |
| | | | | | | | | | | 0 5 0 0 0 |

| OPERATING MODE (9) | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11) | | | |
|---|---|---|---|---|
| 1 | 20.402(b) | 20.405(c) | X 50.73(a)(2)(iv) | 73.71(b) |
| POWER LEVEL (10) 1 0 0 | 20.405(a)(1)(i) | 50.36(c)(1) | 50.73(a)(2)(v) | 73.71(c) |
| | 20.405(a)(1)(ii) | 50.36(c)(2) | 50.73(a)(2)(vii) | OTHER (Specify in Abstract below and in Text, NRC Form 366A) |
| | 20.405(a)(1)(iii) | 50.73(a)(2)(i) | 50.73(a)(2)(viii)(A) | |
| | 20.405(a)(1)(iv) | 50.73(a)(2)(ii) | 50.73(a)(2)(viii)(B) | |
| | 20.405(a)(1)(v) | 50.73(a)(2)(iii) | 50.73(a)(2)(x) | |

LICENSEE CONTACT FOR THIS LER (12)

| NAME | TELEPHONE NUMBER |
|---|---|
| S Stephen Howze, Compliance Engineer | AREA CODE 5 0 3 — 5 6 1 - 5 7 7 7 |

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

| CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NPRDS | | CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NPRDS | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
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| SUPPLEMENTAL REPORT EXPECTED (14) | | EXPECTED SUBMISSION DATE (15) | MONTH | DAY | YEAR |
|---|---|---|---|---|---|
| X YES (If yes, complete EXPECTED SUBMISSION DATE) | NO | | 0 3 | 1 0 | 9 0 |

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)


On January 19, 1990, the Plant was in Mode 1 (Power Operation) with the Reactor Coolant System (RCS) at 583°F, and 2240 psig. During a Design Basis Document review, it was determined that because of procedural inadequacies, both Boron Injection Tank (BIT) Inlet Isolation Valves, MO-8803A and B, could be closed during Modes 3 or 4, which would make both Centrifugal Charging Pumps (CCPs) inoperable. This condition could violate Trojan Technical Specification (TTS) 3.5.2 or 3.5.3.1. In fact, TTS 3.5.3.1, which requires one operable CCP during Mode 4, was violated during the performance of a surveillance test on two occasions. An investigation was initiated, and found that an analysis had concluded that the high concentration boron solution in the BIT was not necessary for accident mitigation. A design change was implemented which removed portions of the BIT subsystem, and the MO-8803A and B were made normally open valves. These valves were no longer considered to be active components, and surveillance testing of the valves was stopped. Consequently, when the valves were closed during Safety Injection Signal (SIS) Functional Tests, then both CCPs were inoperable, because there was no assurance the valves would open on a valid SIS. The cause of this event was a failure to place the MO-8803A and B under adequate administrative and procedural control to prevent their use as active components following the design change. The immediate corrective action was to place the valves under an appropriate clearance and to revise the applicable procedures. Further discussion of the cause, long-term corrective action, and significance of occurrence will be addressed in a supplemental report by March 10, 1990.