



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

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REGION V USE

December 7, 1981
CPY-967-81

Mr. R. H. Engelken, Director
Nuclear Regulatory Commission
Region V - Suite 210
1450 Maria Lane
Walnut Creek, CA 94596-5368



Dear Sir:

The attached are revisions to Licensee Event Report Nos. 81-19 and 81-22, concerning the Control Room Emergency Ventilation System. The inadvertent closure of a filter damper rendered the Train "A" Control Room Emergency Ventilation System inoperable. Additional information has shown that this train may have been inoperable from performance of the last acceptable surveillance, August 19, 1981, until the damper was reopened on September 17. As a result, the heater failure which rendered the "B" Train of the Control Room Emergency Ventilation System inoperable on September 2, 1981, meant both trains may have been out of service at the same time. No conditions requiring the Emergency Ventilation System operation existed during this time.

Sincerely,

C. P. Yundt
C. P. Yundt
General Manager

CPY/MLD
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Attachments

c: LER Distribution List

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UPDATE REPORT - PREVIOUS REPORT DATE October 2, 1981

1. Report No.: 81-19, Revision 1
2. a. Report Date: December 7, 1981
b. Occurrence Date: September 2, 1981
3. Facility: Trojan Nuclear Plant, P.O. Box 439, Rainier, OR 97048

4. Identification of Occurrence:

Technical Specification 3.7.6.1 was not met when the "B" Train Control Room Emergency Ventilation System preheat coil failed to energize as required, rendering that train inoperable.

5. Conditions Prior to Occurrence:

The plant was steady state in Mode 1 with reactor power at 100%.

6. Description of Occurrence:

During the performance of a periodic operating test to verify "B" Train Control Room Emergency Ventilation System operability, it was noted that the preheat coil did not energize. This coil is used to maintain Control Room humidity.

7. Designation of Apparent Cause of Occurrence:

The cause of the occurrence was failure of a diaphragm in the humidistat pneumatic drive mechanism. With the failed diaphragm, the preheat coil would not energize.

8. Analysis of Occurrence:

At the time of this occurrence, the "A" Train of the same system may have been inoperable due to closure of a manual filter damper. There was no effect on plant or public safety since no conditions existed which might have required the emergency ventilation.

9. Corrective Action:

Corrective action taken was to replace the diaphragm, conduct testing to verify operability, and return the system to service.