

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: _____ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 0RTNPLI 2 000-0000000-000 3 411111 4 5

CONT

01 REPORT SOURCE L 6 050-0344 7 0902811 8 120731 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 DURING NORMAL 100% POWER OPERATION, STS 3.7.6.1 WAS NOT MET WHEN PERFOR-
03 MANCE OF A PERIODIC OPERATING TEST REVEALED THAT THE CONTROL ROOM EMERGENCY
04 VENTILATION HUMIDISTAT PREHEAT COIL WOULD NOT ENERGIZE TO MAINTAIN CONTROL
05 ROOM HUMIDITY. AT THE SAME TIME, THE "A" TRAIN MAY HAVE INALVERTENTLY
06 BEEN OUT OF SERVICE DUE TO CLOSURE OF A MANUAL FILTER DAMPER. THERE WAS
07 NO EFFECT ON PLANT OR PUBLIC SAFETY SINCE NO CONDITIONS EXISTED WHICH
08 MIGHT HAVE REQUIRED THE EMERGENCY VENTILATION.

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
S G E F I N S T R U C

17 LER/RO REPORT NUMBER 18 ACTION TAKEN 19 FUTURE ACTION 20 EFFECT ON PLANT 21 SHUTDOWN METHOD 22 HOURS 23 ATTACHMENT SUBMITTED 24 NFRD-4 FORM SUB. 25 PRIME COMP. SUPPLIER 26 COMPONENT MANUFACTURER
81 81 0119 03 1 0000 Y N A P155

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 THE CAUSE OF THE OCCURRENCE WAS FAILURE OF A DIAPHRAGM IN THE HUMIDISTAT
11 PNEUMATIC DRIVE MECHANISM. THE DIAPHRAGM WAS REPLACED, THE PREHEAT COIL
12 WAS TESTED FOR OPERABILITY, AND THEN RETURNED TO SERVICE.

15 FACILITY STATUS % POWER OTHER STATUS 30 METHOD OF DISCOVERY DISCOVERY DESCRIPTION 32
E 1000 N/A 31 SURVEILLANCE TEST

16 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35 LOCATION OF RELEASE 36
Z Z NA NA

17 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 39
000 Z NA

18 PERSONNEL INJURIES NUMBER DESCRIPTION 41
000 NA

19 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION 43
Z NA

20 PUBLICITY ISSUED DESCRIPTION 45
N NA

NAME OF PREPARER M. L. Dawson (MJA)

PHONE: 503/556-3713,xt.315

UPDATE REPORT - PREVIOUS REPORT DATE October 16, 1981

1. Report No.: 81-22, Revision 1
2. a. Report Date: December 7, 1981
b. Occurrence Date: September 17, 1981
3. Facility: Trojan Nuclear Plant, PO Box 439, Rainier, Oregon 97048
4. Identification of Occurrence:

The manual filter inlet damper in the suction path from the Control Room to VC-142A was found completely closed. Closure of the damper isolated VC-142A which rendered "A" train of the Control Room Emergency Ventilation System inoperable.

5. Conditions Prior to Occurrence:

The plant was in Mode 1 at 100% power, steady-state operation.

6. Description of Occurrence:

In reviewing data for the Control Room Emergency Ventilation Periodic Operating Test (POT-20-1), a Plant Engineer determined that filter differential pressure was too low and began investigation as to why. The manual filter inlet damper to VC-142A was found closed, although the operator for the damper was in the "locked open" position. Closure of the damper isolated VC-142A which rendered "A" train of Control Room Emergency Ventilation System inoperable.

7. Designation of Apparent Cause of Occurrence:

The manual damper has an operating handle that attaches to the damper control cam by use of a setscrew. The setscrew had worked loose and allowed the handle to move freely, allowing false indication that the damper was open. Apparently, the damper was closed and the handle was then moved back to the open position, but the damper remained closed.

8. Analysis of Occurrence:

The setscrew attaching the operator to the damper was loose. The torsional forces required to reopen the damper caused the setscrew to slip, allowing the operator to move without moving the damper. The "A" train of the Control Room Emergency Ventilation had been verified operable on August 19, 1981, during normal monthly surveillance. When the "A" train failed the surveillance test on September 16, 1981, it may have been inoperable from August 19 until the damper was reopened on September 17, since no evidence can be found as to when the damper was closed. As a result, the heater failure which was discovered on September 2, 1981, which

rendered the "B" train of the Control Room Emergency Ventilation System inoperable, meant both trains may have been out of service at the same time. This event did not result in a hazard to health and safety of the public or to plant operations. No conditions requiring the emergency ventilation system operation existed during this time.

9. Corrective Action:

The damper was opened and positioned to the proper position for the operator and the setscrew tightened to reattach the operator to the damper. POT-20-1 was run again to verify the operability of Train "A." The system was declared operable after the 10-hour test was completed satisfactorily. Testing performed as a result of this occurrence has shown that the damper will not close due to air flow alone; it must be manually closed. Actual damper position is now verified monthly during performance of the surveillance test. Additionally, the damper being closed results in low flow which is detected by low filter delta P.