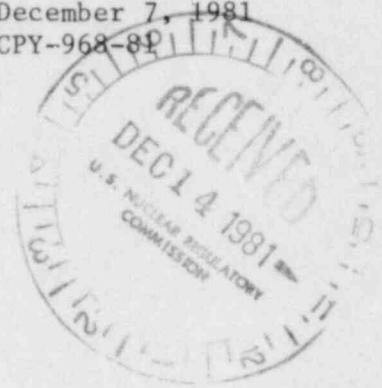




Portland General Electric Company  
Trojan Nuclear Plant  
P.O. Box 439  
Rainier, Oregon 97048  
(503) 556-3713

December 7, 1981  
CPY-968-82



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

Dear Sir:

The attached is Revision 1 to Licensee Event Report No. 81-24 concerning a situation where DC control power was lost to the "A" train emergency diesel generator, rendering the unit inoperable. Additional evaluation has demonstrated that the apparent cause of the occurrence was not due "to normal wear and tear," but rather to an over-voltage condition in the plant 125 VDC system.

Sincerely,

C. P. Yundt  
General Manager

*WDM*  
CPY/MLD:na  
Attachments

c: LER Distribution List

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PDR ADOCK 05000344  
S PDR

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UPDATE REPORT - PREVIOUS REPORT DATE November 2, 1981

1. Report No.: 81-24, Revision 1
2. a. Report Date: December 7, 1981  
b. Occurrence Date: October 3, 1981
3. Facility: Trojan Nuclear Plant, PO Box 439, Rainier, Oregon 97048
4. Identification of Occurrence:  
DC control power for the "A" Train Emergency Diesel Generator (EDG) was lost which rendered the unit incapable of starting. The EDG is required to be operable by Technical Specification 3.8.1.1.
5. Conditions Prior to Occurrence:  
The plant was in Mode 1, power operations, at 100% power.
6. Description of Occurrence:  
The "AUTO" indicating lamp socket for the "AUTO/MAINTENANCE" switch located on the local control panel for the "A" Train EDG had broken and had fallen back into the panel, shorting the DC control circuitry which blew the fuse. This caused a loss of control power to that EDG, which rendered the unit incapable of starting and actuated the annunciator in the Control Room.
7. Designation of Apparent Cause of Occurrence:  
The apparent cause of the occurrence was an over-voltage condition which lead to thermal breakdown of the lamp socket. The 125 VDC system subjects these components to operation at their maximum design operating voltage. This condition ultimately leads to overheating and potential thermal damage.
8. Analysis of Occurrence:  
There was no effect on either plant or public safety since the redundant train EDG was verified operable and no conditions requiring Emergency Diesel Generator operation existed during the time the "A" EDG was out of service.
9. Corrective Action:  
The immediate corrective action taken was to replace the socket, lamp, and fuse. An engineering evaluation is being made to determine a final solution to the over-voltage condition.