

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: 1 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 A R A N O 2 0 0 - 0 0 0 0 - 0 0 4 1 1 1 1 4 5

7 8 9 14 15 25 26 30 37 CAT 58

CON'T

01 L 0 5 0 0 0 3 6 8 7 0 5 2 9 8 2 0 6 2 5 8 2 9

7 8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On 5/29/82 while in Mode 1 at 12% full power during power escalation,

03 battery bank 2D01 voltage dropped to 121 V.D.C. versus the required 129 V.

04 D.C. Also, battery charger 2D31 breaker was found to be de-energized.

05 This caused entry into action b of T.S.3.8.2.3. The voltage of 2D01 was

06 returned to technical specification requirements within 20 minutes. This

07 occurrence is reportable per T.S.6.9.1.9.b. Redundant battery bank 2D02

08 and battery charger 2D32 were operable during this occurrence. Occurrence

7 8 9 60

(continued on Attachment)

09 E C 11 E 12 A 13 B A I T T R I Y 14 Z 15 Z 16

7 8 9 10 11 12 13 14 15 16 17 18 19 20

17 8 2 0 2 0 0 3 L 0

21 22 23 24 25 26 27 28 29 30 31 32

18 X 19 Z 20 Z 21 0 0 0 0 Y 23 N 24 A 25 C 1 7 3 26

33 34 35 36 37 38 39 40 41 42 43 44 45

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Apparently a voltage drop caused the primary voltage supply to the inverters

11 2Y-11, 2Y-13 and 2Y-25 to switch to battery bank 2D01. When the inverters

12 were returned to their normal power supply, the A.C. feeder breaker for

13 battery charger 2D31 was found tripped. Battery charger 2D31 was returned

14 to service, and the 2D01 voltage was brought to technical specification

7 8 9 44 45 46 80

(continued on Attachment)

15 C 28 0 1 1 2 29 NA 30 A 31 OPERATOR OBSERVATION 32

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

16 Z 33 Z 34 NA 35 NA 36

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

17 0 0 0 0 37 Z 38 NA 39

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

18 0 0 0 40 NA 41

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

19 Z 42 NA 43

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

20 N 44 NA 45

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

ATTACHMENT

LER NO. 50-368/82-020/03L-0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (Continued)

is similar to LER 81-039.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (Continued)

requirements. Troubleshooting, which included checks for grounds and wire checks, were performed, but the failure cause was not determined. Further investigation will be performed.