



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

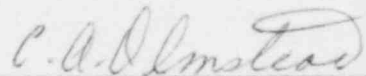
September 3, 1982  
CPY-701-82

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

Dear Sir:

In accordance with the Trojan Plant Operating License, Appendix A, USNRC Technical Specifications 6.9.1.8F, attached is Licensee Event Report No. 82-15 concerning a situation where both trains of the automatic safety injection signals were blocked for 43 hours and 39 minutes while in Modes 3 and 4 which is in excess of the 6-hour time limit specified in the Technical Specification limiting conditions for operation, paragraph 3.3.2.1. Upon discovery both reactor trip breakers were closed which unblocked both trains of the automatic safety injection system and effectively returned them to service.

Sincerely,

  
for C. P. Vundt, General Manager

  
R. L. Steele, Manager  
Nuclear Projects Engineering

CPY/DJK:ga

Attachments

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REPORTABLE OCCURRENCE

1. Report No: 82-15
2. Report Date: September 3, 1982
3. Occurrence Date: August 20, 1982
4. Facility: Trojan Nuclear Plant, PO Box 439, Rainier, Oregon 97048
5. Identification of Occurrence:

The plant entered Mode 4 at 1651 hours on August 18, 1982 and subsequently Mode 3 at 2122 hours on August 18, 1982 with both trains of automatic safety injection blocked. Both trains of automatic safety injection were returned to service at 1130 hours on August 20, 1982.

6. Conditions Prior to Occurrence:

The plant was in Mode 4 and subsequently Mode 3 reaching a condition with RCS temperature at 557°F and a pressure of 2235 psig. The RCS was borated to 2028 ppm. Preparations were being made to return the plant to power from a refueling outage which began March 30, 1982.

7. Description of Occurrence:

Prior to entering Mode 4 both trains of automatic safety injection were unblocked in accordance with General Operating Instruction (GOI-1). These were subsequently reblocked prior to entering Mode 4 without the use of a safety-related equipment outage work sheet as required by Administrative Order 3-14. They were blocked to prevent a spurious safety injection while still in Mode 5 while preparations for plant heatup were still underway. Both trains remained blocked upon entry into Mode 4 and subsequent entry into Mode 3 for a total duration of 43 hours and 39 minutes. Operations shift personnel knew that automatic safety injection was blocked and had discussed the contingency action to be taken should safety injection be required. They did not realize that STS 3.2.2.1, which requires automatic safety injection actuating logic be operable in Modes 1-4, was being violated. This occurrence was discovered by the operations supervisor during a routine walk-down of the control room.

8. Designation of Apparent Cause of Occurrence:

The cause of this event was personnel error in that the operators on shift were not cognizant of the fact that both trains of ECCS (automatic safety injection) were required to be in service before entering Mode 4 as required by the Technical Specifications 3.3.2.1. Contributing to this error was the fact that both trains of automatic safety injection were blocked and effectively placed out of service without utilizing a safety-related equipment outage work sheet as outlined in AC-3-14. The safety-related equipment outage work sheet would have alerted the Operations personnel to the STS significance of this safety feature.

9. Significance of Occurrence:

This event had no effect on plant or public safety. Although both trains of automatic safety injection were blocked, the shift operating personnel were aware of this and manual safety injection capability was available at all times during this event. At no time was a safety injection required to maintain the plant in a safe condition. The RCS was borated in excess of 2000 ppm and decay heat was minimal because of the extended shutdown.

10. Corrective Action:

The reactor trip breakers were closed at 1130 hours on August 20, 1982 which unblocked the automatic safety injection signals. A special report concerning this event was prepared by the assistant operations supervisor on August 20 and was routed to all shift supervisors for their review. A meeting was held on September 1, 1982 by the operations supervisor with the shift supervisors during which time this event was discussed in detail. They were directed to be more aware of the potential for similar events. In addition, the Operations staff was directed that any time safety-related equipment, components, or systems are removed from service, the safety-related equipment outage work sheet in AO-3-14 must be used regardless of who requests or initiates the outage. This was delineated by the operations supervisor in a night order on September 3, 1982.

During the period under review, it was noted that testing of main steam line safety valves could cause pressure changes which might initiate an automatic safety injection on high steam line differential pressure. This matter is still under review and PGE may request a change to the Technical Specifications special test exceptions which would allow prevention of an inadvertent safety injection during main steam line safety valve testing by blocking the steam line high differential pressure trip.