

FGE



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


September 14, 1982
CPY-711-82

Mr. R. H. Engelken
Regional Administrator
US Nuclear Regulatory Commission
1450 Maria Lane - Suite 210
Walnut Creek, California 94596-5300

Dear Sir:

In accordance with the Trojan Plant Operating License, Appendix A, USNRC Technical Specifications 6.9.1.9.c, Licensee Event Report No. 82-14 concerning a situation where the 'B' train residual heat removal (RHR) pump was left in the pull-to-lock position for approximately five hours following ECCS valve inservice testing is attached. During this time the pump would not have auto started on an ECCS actuation but was available for manual starting. This occurrence is similar to that outlined in Licensee Event Report 82-04 dated April 2, 1982 although the cause of the events is different.

Sincerely,


C. P. Yandt, General Manager


R. L. Steele, Manager
Nuclear Projects Engineering

CPY/GGB/MJA:ga

Attachments

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REPORTABLE OCCURRENCE

1. Report No: 82-14
2. Report Date: September 14, 1982
3. Occurrence Date: August 24, 1982
4. Facility: Trojan Nuclear Plant, PO Box 439, Rainier, Oregon 97048

5. Identification of Occurrence:

The 'B' train RHR pump control switch was left in the pull-to-lock position at 0520 hours on August 24 for approximately five hours following ECCS valve inservice testing. This would have prevented the pump from starting automatically, and as a result the requirement of Technical Specification 3.5.2.a to have two operable RHR pumps was not met.

6. Conditions Prior to Occurrence:

Prior to the occurrence the plant was in Mode 2. Reactor power was at 1% and preparations were being made for initial turbine roll following the annual refueling outage.

7. Description of Occurrence:

A periodic test to cycle ECCS valves for inservice testing was conducted on August 24, 1982 at 0520 hours. During this test, valves in the RHR system including the pump suction valve are closed and then reopened. Although not required to do so by the test procedure, the control operator placed the 'B' train RHR pump control switch in the pull-to-lock position to prevent pump damage should an auto start be received while the suction valve was closed. Upon completion of the valve testing, the pump was left in the pull-to-lock position. This would have prevented an automatic start of the pump. During a walk-down of the control boards approximately five hours later (at 1020 hours), the oncoming shift technical adviser found the RHR pump in the pull-to-lock position. The shift supervisor was informed and the pump was immediately returned to automatic control.

8. Designation of Apparent Cause of Occurrence:

The cause of the occurrence was personnel error in that the control operator deviated from the ECCS valve inservice testing procedure without initiating the required documentation to do so as outlined in the plant operating manual procedures for safety-related equipment outages or procedure deviation. Although the intent of the control operator was to prevent possible equipment damage, taking the RHR pump switch to pull-to-lock was an action that was not outlined in the controlling procedure and should have been documented by initiating a procedure deviation or safety-related equipment outage form.

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9. Significance of Occurrence:

There was no effect on plant or public safety since the redundant train RHR pump was operable at all times and the affected pump was available for manual starting if necessary.

10. Corrective Action:

Corrective action taken was to counsel the personnel involved on August 24 and to require each shift supervisor to review the occurrence during the week of August 24 with all crew operators emphasizing the importance of following procedures and documenting any necessary plant test deviations. A revision to the ECCS valve test procedure has been submitted to add specific sign-off steps for necessary pump control switch manipulations.