

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

01 PASES1 00-000000-000 411111 45
7 8 9 14 15 25 26 30 37 38 39

CONT

01 REPORT SOURCE L 05000387 7011983 8021883 9
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 During the Startup Test Program, with the unit in power operation, recirc. pump

03 "A" motor-generator set tripped. This is reportable per Technical Specification

04 6.9.1.9.b. There were no adverse consequences due to the fact that this is an

05 analyzed transient, no thermal limits were approached and proper off-normal

06 procedures were followed to recover the unit.

07

08

09 SYSTEM CODE CB 11 CAUSE CODE X 12 CAUSE SUBCODE Z 13 COMPONENT CODE HEATER 14 COMP. SUBCODE Z 15 VALVE SUBCODE Z 16

17 LER/RO REPORT NUMBER 83 21 22 SEQUENTIAL REPORT NO. 014 24 26 OCCURRENCE CODE 03 27 29 REPORT TYPE L 30 31 REVISION NO. 0 32

ACTION TAKEN X 18 FUTURE ACTION X 19 EFFECT ON PLANT B 20 SHUTDOWN METHOD Z 21 HOURS 0003 22 ATTACHMENT SUBMITTED Y 23 NPD-4 FORM SUB. N 24 PRIME COMP. SUPPLIER N 25 COMPONENT MANUFACTURER G080 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 The m-g set trip was caused by an overload in the DC relay heater in the

11 exciter field circuit. The present work plan is to obtain data about various

12 voltage, current and speed parameters. Upon completion of this data accumulation

13 an investigation will be performed to establish necessary corrections.

14

15 FACILITY STATUS B 28 % POWER 075 29 OTHER STATUS N/A 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Circuit Activation 32

16 ACTIVITY CONTENT RELEASED OF RELEASE Z 33 Z 34 AMOUNT OF ACTIVITY N/A 35 LOCATION OF RELEASE N/A 36

17 PERSONNEL EXPOSURES NUMBER 000 37 TYPE Z 38 DESCRIPTION N/A 39

18 PERSONNEL INJURIES NUMBER 000 40 DESCRIPTION N/A 41

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION 43

20 PUBLICITY ISSUED DESCRIPTION N 44 DESCRIPTION 45

8303010567 830218
PDR ADOCK 05000387
S PDR
N/A

NRC USE ONLY

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ATTACHMENT

Licensee Event Report 83-014/03L-0

Within an hour after the m-g set trip occurred, an investigative committee convened to review and formulate an action plan to resolve the incidents related to the trip. The committee reviewed past work authorizations dealing with the "A" m-g set and the setpoint and data testing performed. Based on this data, it was concluded that the cause of the trip was a thermal overload in the exciter field circuit.

The course of action which was formulated to prevent future occurrences included prolonged measurement of the following data:

- exciter and generator field current
- generator field and terminal voltage
- generator terminal current
- per cent speed

It was recommended that the plant return to operation to allow monitoring of the data points under actual operating conditions. This data history will aid in the investigation of any future related occurrences.