



**Consumers  
Power  
Company**

General Offices: 212 West Michigan Avenue, Jackson, Michigan 49201 • Area Code 517 78.

February 1, 1979

Mr James G Keppler  
Office of Inspection and Enforcement  
Region III  
US Nuclear Regulatory Commission  
799 Roosevelt Road  
Glen Ellyn, IL 60137

DOCKET 50-255 - LICENSE DPR-20 -  
PALISADES PLANT - LER's 79-001 & 79-002

Attached are Licensee Event Reports 79-001 and 79-002 which are reportable under Technical Specifications 6.9.2.b.3, and 6.9.2.b.2, respectively.

David P Hoffman (Signed)

David P Hoffman  
Assistant Nuclear Licensing Administrator

CC: Director, Office of Nuclear Reactor Regulation  
Director, Office of Inspection and Enforcement

*Handwritten:* A002  
1/1

7902066333

CONTROL BLOCK: 

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 ① (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	M	I	P	A	L	I	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4			5																
7	8	9							14										25										26					30					57					58	
		LICENSEE CODE							LICENSE NUMBER										LICENSE TYPE					CAT																					

**CON'T**

0 1  
7 8

REPORT SOURCE L 6 0 5 0 0 0 2 5 5 7 0 1 0 2 7 9 8 0 2 0 1 7 9 9  
60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

### EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During testing of RPS power range channels NIO5, 06 and 07, these channels  
0 3 were bypassed w/o first tripping NIO8 (which was considered at that time  
0 4 to be inoperable). Although it was later determined that NIO8 was  
0 5 operable at the time of the testing, the inadequacies in the administra-  
0 6 tive controls are reportable per T.S. 6.9.2.b.3. Upon discovery, firmer  
0 7 controls (caution tags) were used to control the use of the RPS bypass  
0 8 keys. No hazard to public health or safety existed.

SYSTEM CODE 0 9		CAUSE CODE I A 11		CAUSE SUBCODE A 12		COMPONENT CODE X 13		COMP. SUBCODE I N S T R U 14		VALVE SUBCODE X 15		Z 16	
17 LER/RO REPORT NUMBER		EVENT YEAR 7 9		SEQUENTIAL REPORT NO. 0 0 1		OCCURRENCE CODE 0 3		REPORT TYPE L		REVISION NO. 0			
ACTION TAKEN X 18		FUTURE ACTION H 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 22		ATTACHMENT SUBMITTED Y 23		NPRD FORM SUB. N 24	
										PRIME COMP. SUPPLIER N 25		COMPONENT MANUFACTURER C 4 9 0 26	

### CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 This occurrence resulted from the failure to use administrative controls  
1 1 which would provide a lasting reminder regarding the status of and  
1 2 special requirements related to testing the RPS power range channels.  
1 3 This occurrence will be reviewed with applicable personnel.

1	4																	80													
7	8																			9											80
FACILITY STATUS		% POWER				OTHER STATUS				(30)		METHOD OF DISCOVERY				DISCOVERY DESCRIPTION										(32)					
1	5	E	(28)	1	0	0	(29)	N/A	A	(31)	Review																				80
7	8																			9											80
ACTIVITY CONTENT		RELEASED OF RELEASE				AMOUNT OF ACTIVITY				(35)						LOCATION OF RELEASE										(36)					
1	6	Z	(33)	Z	(34)	N/A	N/A																					80			
7	8																			9											80
PERSONNEL EXPOSURES		NUMBER				TYPE				DESCRIPTION		(39)																			
1	7	0	0	0	(37)	Z	(38)	N/A																					80		
7	8																			9											80
PERSONNEL INJURIES		NUMBER				DESCRIPTION				(41)																					
1	8	0	0	0	(40)	N/A																					80				
7	8																			9											80
LOSS OF OR DAMAGE TO FACILITY		TYPE				DESCRIPTION				(43)																					
1	9	Z	(42)	N/A																					80						
7	8																			9											80
PUBLICITY		ISSUED				DESCRIPTION				(45)																					
2	0	N	(44)	N/A																					80						
7	8																			9											80
												NRC USE ONLY																			
7	8																			9											80

7902060334

#### Discussion/Description of Occurrence

During October 1978, reactor power range NI-08 failed. Investigation revealed a faulty electrical connector at the containment building electrical penetration. The connector was replaced, but because the replacement connector could not be certified to meet post-accident conditions, the channel was not declared operable. However, because the channel was operating satisfactorily and was capable of providing a trip signal to the Reactor Protection System (RPS) trip logic, it was placed in service. On January 2, 1979, during monthly testing of the RPS, the power range channels were bypassed one at a time in accordance with the test procedure. Because power range NI-08 had not yet been declared operable, the bypass of any of the other channels without first placing NI-08 in a tripped condition represented a condition which appeared to be less conservative than that permitted by the limiting condition for operation of Technical Specification 3.17. Prompt notification per the requirements of Technical Specification 6.9.2.a was made. Subsequent to this occurrence, it was determined that the containment penetration electrical connector for NI-08 was qualified for accident conditions, and that NI-08 has been capable of performing its intended safety function during both normal and accident conditions. As a result, during the testing on January 2, RPS operability requirements were met. However, there were inadequacies in the implementation of administrative controls which threatened to reduce the degree of redundancy within the RPS, and this condition is reportable per Technical Specification 6.9.2.b.3.

#### Cause Description

On November 1, 1978, instructions were placed in the Daily Orders Book to control use of the RPS bypass keys in a manner such that an RPS power range channel would not be bypassed unless NI-08 was first placed in a tripped condition. Because of the lengthy time span between the Daily Orders Book entry and the January 2 testing, supervisory personnel and personnel conducting the testing were no longer aware of Daily Orders Book requirements. Because NI-08 was in service and operating normally, testing personnel presumed it was operable. Better administrative controls in the form of caution tags on either the RPS bypass key or on the NI-08 drawer would have provided a lasting reminder of the NI-08 status, and would have prevented this occurrence.

#### Corrective Action

Upon discovery, the bypass keys were caution-tagged. This occurrence has been reviewed with technicians and will be reviewed with applicable operating personnel.