

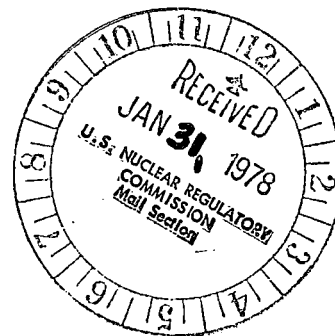


**Consumers
Power
Company**

D. Lankham
REGULATORY DOCKET FILE COPY

General Offices: 212 West Michigan Avenue, Jackson, Michigan 49201 • Area Code 517 788-0550

January 20, 1978



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 - EVENT REPORTS 77-63,
78-001 AND 78-002

Attached are three reportable occurrences for the Palisades Plant.

Edish McKnight for

David P Hoffman
Assistant Nuclear Licensing Administrator

CC: ASchwencer, USNRC

JAN 23 1978

A002/s *
1/1

LICENSEE EVENT REPORT[illegible]

Attachment to LER 78-002/01T-0
Consumers Power Company
Palisades Nuclear Plant
Docket Number 050-255

As required by Technical Specification 4.2, Table 4.2.2 (item 4) setpoint testing of five main steam safety valves was performed. Unacceptable test results required testing of additional valves, and ultimately, all twenty-four main steam safety valves were tested. Five valves had setpoints outside the Technical Specification allowable pressure band of 975 psig - 1035 psig. Technical Specification 3.1.7.c requires twenty-three main steam safety valves to be operable; 19 valves met the operability requirements of this specification. The "as found" setpoints of the unacceptable valves were:

RV-0703 1061 psig	RV-0719 956 psig
RV-0705 1041 psig	RV-0720 957 psig
RV-0706 1036 psig	

The consequences of this condition are considered to be minimal for the following reasons:

1. The out of specification condition of RV-0703 can be ignored, since specification 3.1.7.c permits one valve to be inoperable.
2. Because the setpoints of RV-0719 and 0720 were low, they would have opened early in the event of a high pressure condition, thereby tending to result in an early achievement of required blowdown.
3. The setpoints of RV-0705 and 0706, although high, were close to the required pressure band. The effect of their lifting late in the event of a high pressure condition would delay blowdown, but it is considered that this effect would be off-set by the early lifting of RV-0719 and 0720.
4. On September 24, 1977 an event similar to that discussed in the basis for specification 3.1.7 occurred. A loss of turbine load with a delayed tripping of the reactor took place. (For details, see LER 77-047). Secondary system pressure was adequately controlled by use of the atmospheric steam dumps and no main steam safety valves lifted.

To correct the condition, the valves with out of specification setpoints were reset and retested. Future corrective actions will be based on the results of future testing. As reported to the Commission by letter dated February 11, 1974, previous test failures of the main steam safety valves have occurred. However, the 1974 testing employed nitrogen as the test medium. Since the valves are now tested with steam, the occurrences are not considered to be similar for purposes of trend analysis. There are no other valves of this type in use at the Palisades Plant.

CONTROL BLOCK: 1 2 3 4 5 6 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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 46

CON'T

0	1
---	---

REPORT SOURCE

L	6	0	5	0	0	2	5	5	7	0	1	0	7	7	8	8	0	1	2	0	7	8	9
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

DOCKET NUMBER

EVENT DATE

REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02	During an entry into containment through the personnel airlock, the door
03	interlock failed, allowing both airlock doors to be simultaneously open
04	This breach of containment with PCS temperature at 278 degrees violated
05	TS 3.1.6.A. No radioactive release occurred. This event is similar to
06	LER 77-39. If this condition occurred with the containment building
07	under pressure, a radioactive release could result. This event had no
08	effect on public health and safety.

7 8 9

09		SYSTEM CODE S A		11	CAUSE CODE E		12	CAUSE SUBCODE B		13	COMPONENT CODE P E N E T R					14	COMP. SUBCODE A		15	VALVE SUBCODE Z		16				
7	8	9	10		11	12		13	14	15	16	17	18	19	20											
17 LER/RO REPORT NUMBER		EVENT YEAR 7 8		21	22	SEQUENTIAL REPORT NO. 0 0 1		23	24	25	26	OCCURRENCE CODE 0 1		27	28	29	REPORT TYPE T		30	31	REVISION NO. 0		32			
ACTION TAKEN X		18	FUTURE ACTION A		19	EFFECT ON PLANT Z		20	SHUTDOWN METHOD Z		21	HOURS 0 0 0		22	ATTACHMENT SUBMITTED Y		23	NPRD-4 FORM SUB. Y		24	PRIME COMP. SUPPLIER A		25	COMPONENT MANUFACTURER W 3 0 1 2		26
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	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Simultaneous opening of both airlock doors was permitted by the locking
1 1 mechanism being out of adjustment. This condition resulted from
1 2 normal use. The doors are tagged to warn personnel of the condition, the
1 3 worn components will be repaired or replaced when material availability
1 4 and scheduling permit. Airlock manufactured by WJWooley, Co. Model CSM-1.

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

Attachment to LER-78-001
Consumers Power Company
Palisades Nuclear Plant
Docket 050-255

On January 7, 1978, during an entry into the containment building through the personnel airlock, the interlock mechanism which normally functions to prevent simultaneous opening of both the inner and outer door failed. Because the inner door had already been opened from inside the containment building, both doors of the airlock were simultaneously opened, thereby causing a breach of containment. The reactor was shutdown and plant cooldown was in progress with primary coolant system temperature at 278 degrees Fahrenheit. This occurrence is a violation of Technical Specification 3.1.6.a, which requires containment integrity to be maintained whenever primary coolant system temperature is greater than 210 degrees. At the time of the occurrence, air was flowing into containment; as a result, no radioactive release through the airlock occurred.

Upon discovery that both doors were open, the outer airlock door was immediately closed. It is estimated that containment integrity was violated for less than one minute. The airlock doors have been marked with signs which caution personnel to verify that the opposite door is closed prior to entering the lock.

To permit understanding the method by which the interlock failed, a brief explanation of the operation of the interlock is provided as follows:

When either door is opened, a cable connected to the door moves a pawl into a sawtooth gear, which when engaged by the pawl, prevents the second door from being unlocked. The failure on January 7, 1978 was caused by the cable coming out of adjustment (i.e., not moving the pawl sufficiently to insure adequate engagement with the sawtooth gear) and by the pawl becoming worn such that it does not always securely engage the sawtooth gear. The cable will be adjusted and when both material availability and scheduling permit, the cable and pawl will be replaced.

Licensee Event Report 77-039 describes a similar occurrence.

LICENSEE EVENT REPORT

CONTROL BLOCK:										(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)									
LICENSEE CODE		M I P A L			LICENSE NUMBER		0000000000000000		LICENSE TYPE	411111		CAT 58							
CON'T																			
REPORT SOURCE		L 050000255712227780120789																	
		DOCKET NUMBER EVENT DATE REPORT DATE																	
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES																			
During functional testing of iodine removal system components, open links were found in the circuit which operates one of the outlet valves to T-102 (iodine removal system hydrazene tank). This condition represents a degradation of the LCO of TS 3.19.1.c. Event non-repetitive. Redundancy provided by CV-0437A, which can pass full flow of hydrazene; therefore, this event by itself did not result in loss of hydrazene injection capability. Event had no effect on public health and safety.																			
SYSTEM CODE		S H	CAUSE CODE		A	CAUSE SUBCODE		C	COMPONENT CODE		Z Z Z Z Z Z	COMP. SUBCODE		Z	VALVE SUBCODE		Z		
LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.									
X X		77		0613		03		L		0									
FACILITY STATUS		X	% POWER		098	OTHER STATUS		N/A	METHOD OF DISCOVERY		B	DISCOVERY DESCRIPTION		Operator Observation					
ACTIVITY TAKEN		X	EFFECT ON PLANT		Z	SHUTDOWN METHOD		Z	HOURS		000	ATTACHMENT SUBMITTED		N	NPRD-4 FORM SUB.		N		
PRIME COMP. SUPPLIER		Z		COMPOUND MANUFACTURER		999													
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS																			
It is believed the links were left open through personnel error. Upon discovery, the links were closed and the circuit tested. Terminal links in the Control Room and safety related switchgear were inspected; no problems in critical circuits were found. Existing link/jumper controls will be reviewed. A PM to inspect wiring boards will be established.																			
RELEASED OF RELEASE		Z	CONTENT		Z	AMOUNT OF ACTIVITY		N/A	LOCATION OF RELEASE		N/A								
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION													
000		0		Z		N/A													
PERSONNEL INJURIES		NUMBER		TYPE		DESCRIPTION													
000		0		Z		N/A													
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION															
Z		N/A																	
PUBLICITY ISSUED		DESCRIPTION																	
N		N/A																	

NRC USE ONLY