Consumers Power Company

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

December 26, 1974

Directorate of Licensing
US Atomic Energy Commission
Washington, DC 20545

Re: Docket 50-255
License DPR-20
Palisades Plant
AO-28-74

Gentlemen:

Attached is Abnormal Occurrence Report AO-28-74 which covers the improper release of a laundry waste tank. Post-analysis of the release showed that it was within acceptable limits.

Yours very truly,

Ralph B. Sewell
Nuclear Licensing Administrator

DAB/ce

CC: JGKeppler, USAEC

13093

ABNORMAL OCCURRENCE REPORT
Palisades Plant

1. Report No: AO-28-74, Docket 50-255

2a. Report Date: December 26, 1974

2b. Occurrence Date: December 15, 1974

3. Facility: Palisades Plant, Covert, Michigan

4. Identification of Occurrence: Release of north filtered waste tank, laundry waste, without prior sampling.

5. Conditions Prior to Occurrence: The reactor was in cold shutdown.

6. Description of Occurrence: On 12-14-74 at 1420 the south filtered waste tank containing laundry waste was placed on recycle for analysis. On 12-15-74 at 0845 the chem lab sampled the tank, analyzed it, and gave the data to the RMC Department. The RMC technician transferred the data to the batch release form and calculated the release. On 12-15-74 at 2329 the operator released the north filtered waste tank also containing laundry waste as authorized by Batch 74-073-L. The release should have been the south filtered waste tank.

7. Apparent Cause: Technician/operator error.

8. Analysis of Occurrence: The RMC technician when transposing the data to the batch card 74-073-L wrote down the wrong tank identification. He wrote down the north filtered waste tank, T63A, instead of the south filtered waste tank, T63B. The south tank level was at 92 percent. The north tank level was at 81 percent. Operating Procedure B17.3.4 should have noted this difference. RMC Procedure 4A, Part 1.2, was also violated. The cause for the wrong tank being released was in transposing the data. No safety limits were violated as neither the monitor used for released, R1A 1049, nor the final circulating water monitor alarmed during the release. The R1A 1049 alarm was set based on the south filtered waste tank analysis. A sample of the water remaining in the north tank was analyzed for activity, and a comparison made to the south tank analysis. No significant differences were found. The total activity released was determined and accounted for based on the remaining water sample. The total release amounted to 12.065 millicuries.

9. Corrective Action: A review of RMC procedures was held with the RMC technician, since the primary cause was in his transposing the wrong tank number from the analysis sheets to the release form.

A review of the incident will be conducted with the operators involved.

10. Failure Data: Not applicable.