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May 22, 1972

Mr. E. J. Bloch, Director
Directorate of Licensing
United States Atomic Energy
Commission
Washington, DC 20545

Re: Docket No 50-255
License No DPR-20

Dear Mr. Bloch:

This letter is to apprise you of two malfunctions which occurred recently at the Palisades Plant. One involved a check valve on the outlet of the "D" safety injection tank and the other involved the motor operator of a six-inch low-pressure safety injection valve, MO-3012.

On May 11, 1972, check valve No 3147 on the outlet of the "D" safety injection tank was disassembled to check the seating surfaces. At this time, the valve internals were found to be incorrectly assembled.

At the time the incorrect assembly was discovered, the plant was in a cold shutdown condition with the primary system drained down to the lower portion of the "hot leg" for inspection of the steam generator. We had experienced leakage through this check valve when routine flow tests were performed on the safety injection pumps. The check valve flange was removed to check the seating surfaces. A similar inspection had been accomplished on a prior outage last year; however, the incorrect assembly of the valve was not noted and the valve returned to service in the identical condition it was found. The leakage noted remained.

The valve has been correctly assembled and returned to service.

The flow from the "D" safety injection tank to the reactor vessel obtained during several preoperational tests demonstrated that the blockage by the improperly assembled valve parts did not prevent the safety function of the unit from being effective.

The second malfunction occurred April 23, 1972 and involved the motor operator of MO-3012, a six-inch low-pressure safety injection valve.

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At the time the malfunction occurred, the plant was cooled down to the point where shutdown cooling is placed into service as the means for continuing to a cold shutdown condition in preparation for a three-week outage for modifications to the charging system piping.

The operator found he could not open the valve from the control room as he attempted to use the valve as a flow path to initiate shutdown cooling. After several unsuccessful attempts were made, an operator inspected the valve and, finding no apparent trouble, he engaged the manual clutch and turned the handwheel a dozen turns in the open direction. An attempt to use the motor operator was then successful and the valve opened.

Later inspection of the valve disclosed a position switch to be out of adjustment. This switch opened the open control circuit when the valve was closing until the torque switch terminated the closing signal. If properly adjusted, this position switch contact is closed except when the valve is fully open.

The position switches have now been correctly adjusted and other similar valves have been checked to insure their ability to function properly.

A new yoke assembly was installed on this valve during June of 1971 (refer to our letter to Dr. P. A. Morris dated June 25, 1971). It is felt that the improper adjustment of the limit switch assembly was made at this time. However, the adjustment was close enough to allow the valve to function several times in a normal manner.

If the position switch is out of adjustment to the point the opening circuit contact is open, the light contact will also be open. Thus, if the green light is on with the valve fully closed, the valve should function correctly when given an open signal. Operators have been alerted to the significance of the closed position indication light not being lighted.

Yours very truly,

Robert L. Haueter (Signed)

RBS/dmb

CC: BHGrier
USAEC

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Electric Production
Superintendent - Nuclear