Consumers Power Company

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

May 10, 1974

Mr. John F. O'Leary, Director
Directorate of Licensing
US Atomic Energy Commission
Washington, DC 20545

Re: Docket No 50-255
License DPR-20

Dear Mr. O'Leary:

Attached hereto is a copy of Abnormal Occurrence Report No AO-6-74 for the Palisades Plant.

The incident occurred on April 22, 1974. Therefore, it was required to be reported by May 2, 1974. On May 3, 1974 I contacted Mr. Ed Jordan of Region III of the Directorate of Regulatory Operations and informed him that the final review of this abnormal occurrence was not yet complete and that I would prefer to wait and submit the report the middle of the following week when complete information had been received. Mr. Jordan agreed with this course of action. The final review by the Plant Review Committee has now been completed and the report is now submitted.

Yours very truly,

Ralph B. Sewell (Signed)

RBS/ce

Ralph B. Sewell
Nuclear Licensing Administrator

CC: JGKeppler, USAEC

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ABNORMAL OCCURRENCE REPORT
Palisades Plant

1. Report No: AO-6-74, Docket 50-255

2a. Report Date: May 10, 1974

2b. Occurrence Date: April 22, 1974

3. Facility: Palisades

4. Identification of Occurrence: Containment high radiation 2/4 logic.

5. Conditions Prior to Occurrence: Refueling outage - plant was in cold shutdown condition.

6. Description of Occurrence: Containment high radiation 2/4 logic failed to operate and cause a containment isolation signal.

7. Description of Apparent Cause of Occurrence: Manufacturer and Personnel

8. Analysis of Occurrence: Investigation revealed that the manufacturer had failed to wire up the "switch line" terminal (which supplied power to the isolation relay) when they installed an improved design in the rate meter.

One unit RIA-1806 was installed on November 3, 1971. The checkout found this and the unit was corrected. On October 16, 1972 RIA-1805, -1807, and -1808 were installed. The technician that did the checkout failed to discover that the switch line was not wired internally in the rate meter.

In addition, refueling surveillance test RO-11 is required each refueling not to exceed 16 months per Table 4.1.2 of the Technical Specifications. At the end of the 16-month period, December 28, 1973, the plant was shut down in a refueling outage with no fuel in the reactor. Under those conditions, this test had no meaning and was not done.

This occurrence was reviewed by the Plant Review Committee to determine if similar situations might exist. It was concluded that they do not exist based on the fact that no similar situations were found during the refueling surveillance testing recently completed.

The inability of the containment high radiation 2/4 logic to cause a containment isolation signal resulted in a reduction of means by which containment isolation can be initiated. Containment isolation is also initiated by high pressure. In addition, containment isolation can be initiated by an operator based on remote indication of radiation levels, humidity, etc.

9. Corrective Action:

   A. Add switch line to the defective monitors and all others including spare so all units are interchangeable.

   B. Write a return to service type maintenance procedure for area monitors.

   C. Discuss this incident with the I&C Technicians to re-emphasize the importance of a complete checkout including an interlock check.

   D. In the one and one-half years that have elapsed since the installation of the three defective units, the plant maintenance program has been formalized and more emphasis placed on testing after maintenance has been completed.

10. Failure Data: No previous similar failures other than those described above.

Nameplate Data: Victoreen, Model 845