

APPROVED CASE NO. 2180-0104

EXPIRES: 6/31/00

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)										DOCKET NUMBER (2)										PAGE (3)									
Palisades Nuclear Plant										0 5 0 0 0										1 OF 0									

TITLE (4)

Spurious Safety Injection Actuation

EVENT DATE (6)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)											
MONTH	DAY	YEAR	YEAR		SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES					DOCKET NUMBER(S)					
											NA					0 5 0 0 0				
0 7	0 4	8 4	8 4	-	0 0 9	- 0 0	0 8	0 3	8 4	NA					0 5 0 0 0					

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 8: (Check one or more of the following) (11)					
N		20.402(b)	20.406(a)	X	80.73(a)(2)(iv)	73.71(b)	
POWER LEVEL (10)	01010	20.406(a)(1)(i)	80.36(a)(1)		80.73(a)(2)(v)	73.71(a)	
		20.406(a)(1)(ii)	80.36(a)(2)		80.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)	
		20.406(a)(1)(iii)	80.73(c)(2)(i)		80.73(a)(2)(vii)(A)		
		20.406(a)(1)(iv)	80.73(a)(2)(ii)		80.73(a)(2)(vii)(B)		
		20.406(a)(1)(v)	80.73(a)(2)(iii)		80.73(a)(2)(ix)		

LICENSEE CONTACT FOR THIS LEA (12)

NAME	TELEPHONE NUMBER	
David W. Rogers; Technical Engineer; Palisades	AREA CODE	
	6 1 6	7 1 6 4 - 1 8 9 1 3

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	

SUPPLEMENTAL REPORT EXPECTED 1141

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)		<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (18)

With the Plant shutdown on July 4, 1984, at 0940, maintenance work activity on the shutdown sequencers [EK] resulted in a spurious left channel Safety Injection Signal (SIS) actuation. The incident occurred while a technician was removing leads per the approved procedure for the work activity. One of the terminals for which a lead was to be removed also contained an additional lead providing power to the left channel SIS block relay [RLY;JE]. The procedure was inadequate in that it did not address the additional lead, or the fact that a loss of contact between the two leads would result in power interruption to the left channel SIS block circuitry. When the lead was lifted, the resulting power interruption caused the SIS block relay to drop out, allowing a previously present PCS low pressure signal to initiate a left channel SIS.

The procedure was subsequently revised to preclude recurrence of the incident. The appropriate personnel will be counselled regarding the incident and its generic consequences.

The incident was quickly terminated by Operations personnel with no adverse consequences. At power operation, the SIS block feature would not be in use, and a normal two out of four logic must be present for an SIS actuation to occur. No threat to public health or safety, or other safety consequence, resulted.

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S PDR



Consumers
Power
Company

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August 3, 1984

US Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

DOCKET 50-255 - LICENSE DPR-20 -
PALISADES PLANT - LICENSEE EVENT REPORT 84-009 - SPURIOUS SAFETY INJECTION
SIGNAL (SIS) ACTUATION

Attached please find Licensee Event Report 84-009 - Spurious Safety
Injection Signal (SIS) Actuation which is reportable to the NRC per
10 CFR 50.73(a)(2)(iv).

Ralph R Frisch
Senior Licensing Analyst

CC Administrator, Region III, USNRC
Director, Office of Nuclear Reactor Regulation
NRC Resident Inspector - Palisades

Attachment

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