PALISADES PLANT - 50-255
UPDATE REPORT
Previous Report Date: 082782

NRC FORM 366 (7.77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | M I P A L 1 (2) | 0 0 - 0 0 0 0 - 0 0 (3) | 4 1 1 1 1 1 (4) | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T
0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 5 5 (7) | 0 6 2 4 8 2 (8) | (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | During a containment entry through the personnel air lock, it was noted that
0 3 | the air lock inner door was not fully closed, as evidenced by the sound of
0 4 | air rushing past the inner door seals. Accordingly, containment integrity
0 5 | requirements were not met during the period of time that the outer door was
0 6 | open to gain access to the lock, and had apparently not been met during the
0 7 | previous exit from the airlock on June 22, 1982. Condition reportable per
0 8 | TS 6.9.2.A(3) and 3.6.1.

SYSTEM CODE | CAUSE CODE | CAUSE SUBCODE | COMPONENT CODE | COMP SUBCODE | VALVE SUBCODE
0 9 | S A (11) | A (12) | B (13) | P E N E T R (14) | A (15) | Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR | SEQUENTIAL REPORT NO. | OCCURRENCE CODE | REPORT TYPE | REVISION NO.
8 2 | — | 0 1 9 | / | 0 1 1 | X | — | 2

ACTION TAKEN | FUTURE ACTION | EFFECT ON PLANT | SHUTDOWN METHOD | HOURS (22) | ATTACHMENT SUBMITTED | NPRD-4 FORM SUB | PRIME COMP SUPPLIER | COMPONENT MANUFACTURER
H (18) | Z (19) | Z (20) | Z (21) | 0 0 0 0 | Y (23) | N (24) | N (25) | W 3 0 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | Containment integrity was lost because personnel did not properly shut the
1 1 | inner door on 6-22-82 and an interlock was out of adjustment, allowing the
1 2 | outer door to open before complete closure of inner door. To prevent recur-
1 3 | rence, operating instructions have been posted, the interlock was adjusted,
1 4 | and a modification to the interlock was completed.

FACILITY STATUS | % POWER | OTHER STATUS (30) | METHOD OF DISCOVERY | DISCOVERY DESCRIPTION (32)
1 5 | E (28) | 1 0 0 (29) | NA | A (31) | Operator Observation

ACTIVITY RELEASED | CONTENT OF RELEASE | AMOUNT OF ACTIVITY (35) | LOCATION OF RELEASE (36)
1 6 | Z (33) | Z (34) | NA | NA

PERSONNEL EXPOSURES
NUMBER | TYPE | DESCRIPTION (39)
1 7 | 0 0 0 (37) | Z (38) | NA

PERSONNEL INJURIES
NUMBER | DESCRIPTION (41)
1 8 | 0 0 0 (40) | NA

LOSS OF OR DAMAGE TO FACILITY
TYPE | DESCRIPTION (43)
1 9 | Z (42) | NA

PUBLICITY
ISSUED | DESCRIPTION (45) | NRC USE ONLY
2 0 | N (44) | NA

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During a containment entry on June 24, 1982, it was noted that the personnel air lock inner door status light indicated the inner door was not shut. The personnel making the entry verified by direct visual observation (through the viewing window) that the inner door was shut and then opened the outer door. After entering the lock and closing the outer door, the personnel heard air rushing through the inner door. When the inner door handwheel was turned approximately 1/8 turn, air inleakage stopped and the open indication light was extinguished.

Based on the as-found condition of the inner door, it is concluded that containment integrity was also broken during the previous containment exit on June 22,1982, when the inner door was apparently improperly closed and the outer door was opened.

The cause of the event was personnel error in that the inner door was not properly closed on June 22 and that the personnel making the entry did not notify the Shift Supervisor of the open indication prior to making the entry on June 24. However, certain mechanical problems contributed to the personnel error:

1) The inner door handwheel had a "hard spot" just before it was fully closed, giving the feeling of being closed.

2) The interlock which prevents both doors from being open at the same time was out of adjustment, allowing the outer door to open when the inner door was not fully closed.

To prevent recurrence, the interlock was adjusted and the "hard spot" on the inner door handwheel was minimized. In addition, a modification was completed on the interlock mechanism to provide a more positive lock during door operations.

Until the permanent corrective actions were completed, several interim measures were provided:

1) An Operations Department memorandum was issued to all Shift Supervisors instructing them on the proper procedures for personnel lock operation, including the existence of the "hard spot" and the interlock misadjustment.

2) Control Room status boards were updated to indicate personnel lock problems.

3) Caution tags were hung on the personnel lock doors warning of the problems.

4) Operating instructions were posted for the personnel lock doors and the door indicating lights were labeled to avoid confusion.

Consumers Power Company

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US Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

DOCKET 50-255 - LICENSE DPR-20 - PALISADES PLANT -
LICENSEE EVENT REPORT 82-019 REVISION 2 -
LOSS OF CONTAINMENT INTEGRITY

Licensee Event Report (LER) 82-019, Revision 2 (Loss of Containment Integrity) is attached. This revision is being submitted due to a change in the corrective action for this event.

Brian D Johnson

Brian D Johnson
Staff Licensing Engineer

CC Administrator, Region III, USNRC
NRC Resident Inspector - Palisades

Attachment

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