NMC
Committed to Nuclear Excellence

Palisades Nuclear Plant
Operated by Nuclear Management Company, LLC

October 13, 2004

10 CFR 50.73(a)(2)(iv)(A)

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Palisades Nuclear Plant
Docket 50-255
License No. DPR-20

Licensee Event Report 04-001, Reactor Protection System and Auxiliary Feedwater System Actuation

Licensee Event Report (LER) 04-001 is attached. The LER describes a manual actuation of the reactor protection system and subsequent actuation of the auxiliary feedwater system. This event is reportable in accordance with 10 CFR 50.73(a)(2)(iv)(A).

Summary of Commitments

This letter contains no new commitments and no revisions to existing commitments.

for

Daniel J. Malone
Site Vice President, Palisades Nuclear Plant
Nuclear Management Company, LLC

Enclosure (1)

CC Administrator, Region III, USNRC
Project Manager, Palisades, USNRC
Resident Inspector, Palisades, USNRC

IE22

ENCLOSURE 1

LER 04-001, REACTOR PROTECTION SYSTEM AND AUXILIARY FEEDWATER SYSTEM ACTUATION

2 Pages Follow

NRC FORM 366 (6-2004) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 6-30-2007

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0066), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Palisades Nuclear Plant	05000-255	1 of 2

TITLE (4)

Reactor Protection System and Auxiliary Feedwater System Actuation

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
08	31	2004	2004	-- 001 --	00	10	13	2004	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	1
POWER LEVEL (10)	95%

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR .: (Check all that apply) (11)

	20.2201(b)		20.2203(a)(3)(ii)		50.73(a)(2)(ii)(B)		50.73(a)(2)(ix)(A)
	20.2201(d)		20.2203(a)(4)		50.73(a)(2)(iii)		50.73(a)(2)(x)
	20.2203(a)(1)		50.36(c)(1)(i)(A)	X	50.73(a)(2)(iv)(A)		73.71(a)(4)
	20.2203(a)(2)(i)		50.36(c)(1)(ii)(A)		50.73(a)(2)(v)(A)		73.71(a)(5)
	20.2203(a)(2)(ii)		50.36(c)(2)		50.73(a)(2)(v)(B)		OTHER
	20.2203(a)(2)(iii)		50.46(a)(3)(ii)		50.73(a)(2)(v)(C)		Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iv)		50.73(a)(2)(i)(A)		50.73(a)(2)(v)(D)		
	20.2203(a)(2)(v)		50.73(a)(2)(i)(B)		50.73(a)(2)(vii)		
	20.2203(a)(2)(vi)		50.73(a)(2)(i)(C)		50.73(a)(2)(viii)(A)		
	20.2203(a)(3)(i)		50.73(a)(2)(ii)(A)		50.73(a)(2)(viii)(B)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Barb Dotson	(269) 764-2265

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

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
D	SD	MO	A180	N					

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE).	X NO				

ABSTRACT

On August 31, 2004, at 0715 hours, the plant was operating at approximately 100% power. A rapid plant down power was commenced following report of a fire in the vicinity of the P-2B condensate pump lower motor bearing. At 0718 hours, the reactor was manually tripped from approximately 95% power, in conjunction with securing the P-2B condensate pump, and the imminent loss of main feedwater. Following the reactor trip, the auxiliary feedwater system started automatically to maintain steam generator water level. The plant was stabilized in Mode 3. Overheating, and ultimately fire, at the condensate pump lower motor bearing were caused by pump and motor misalignment following maintenance in July 2004. The pump and motor misalignment occurred as a result of inadequate maintenance instructions. Proper alignment criteria were established and incorporated into the work instruction when the repaired motor was reinstalled in September 2004.

The safety significance of this event was minimal. All safety systems functioned as expected during the plant trip.

This event is reportable in accordance with 10 CFR 50.73(a)(2)(iv)(A) as an event that resulted in a manual actuation of the reactor protection system and automatic actuation of the auxiliary feedwater system.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 of 2
Palisades	05000-255	2004	-- 001 --	00	

TEXT *(If more space is required, use additional copies of NRC Form 366A)* (17)

EVENT DESCRIPTION

On August 31, 2004, at 0715 hours, the plant was operating at approximately 100% power. A rapid plant down power was commenced following report of a fire in the vicinity of the P-2B condensate pump [P;SD] lower motor [MO] bearing. At 0718 hours, the reactor was manually tripped from approximately 95% power, in conjunction with securing P-2B condensate pump, and the imminent loss of main feedwater [SJ]. Following the reactor trip, the auxiliary feedwater system [BA] started automatically to maintain steam generator [SG] water level. The plant was stabilized in Mode 3.

This event is reportable in accordance with 10 CFR 50.73(a)(2)(iv)(A) as an event that resulted in a manual actuation of the reactor protection system [JC] and automatic actuation of the auxiliary feedwater system.

CAUSE OF THE EVENT

Overheating, and ultimately fire, at the condensate pump lower motor bearing were caused by pump and motor misalignment following maintenance in July 2004. The pump and motor misalignment occurred as a result of inadequate maintenance instructions.

SAFETY SIGNIFICANCE

The safety significance of this event was minimal. All safety systems functioned as expected during the plant trip.

CORRECTIVE ACTIONS

Proper alignment criteria were established and incorporated into the work instruction when the repaired motor was reinstalled in September 2004.

PREVIOUS SIMILAR EVENTS

None.