



May 26, 2006

10 CFR 50.73(a)(2)(i)(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 06-003, Completion Of Plant Shutdown Required By Technical Specifications

Licensee Event Report (LER) 06-003 is enclosed. The LER describes the completion of a plant shutdown required by the Technical Specifications and is reportable in accordance with 10 CFR 50.73(a)(2)(i)(A).

Summary of Commitments

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

Paul A. Harden
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

ENCLOSURE 1

LER 06-003, Completion Of Plant Shutdown Required By Technical Specifications

3 Pages Follow

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) Palisades Nuclear Plant	DOCKET NUMBER (2) 05000-255	PAGE (3) 1 of 3
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TITLE (4)
Completion Of Plant Shutdown Required By Technical Specifications

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
03	29	2006	2006	-- 003 --	00	05	26	2006	FACILITY NAME	DOCKET NUMBER
OPERATING MODE (9)		1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR . : (Check all that apply) (11)						
POWER LEVEL (10)		099		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)			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 Specify in Abstract below or in NRC Form 366A
				20.2203(a)(2)(iii)		50.46(a)(3)(ii)			50.73(a)(2)(v)(C)	
				20.2203(a)(2)(iv)	<input checked="" type="checkbox"/>	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 Daniel G. Malone	TELEPHONE NUMBER (Include Area Code) (269) 764-2463
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
X	BQ	V	C684	Y					

SUPPLEMENTAL REPORT EXPECTED (14)

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

On March 29, 2006, with the plant in Mode 1, left train high pressure safety injection system subcooling control valve CV-3070 failed to stroke open during a preventive maintenance activity, resulting in entry into Technical Specification (TS) LCO 3.5.2.B.1, for the inoperability of one Emergency Core Cooling System (ECCS) train.

On March 31, 2006, a shutdown was commenced when it was determined that the 72-hour completion time for restoring CV-3070 to operable status could not be met. On April 1, 2006, the shutdown was completed in accordance with TS LCO 3.5.2.C.1 and 2 required actions.

This event is reportable in accordance with 10 CFR 50.73(a)(2)(i)(A) as the completion of any nuclear plant shutdown required by the plant's Technical Specifications.

The failure of CV-3070 occurred from excessive valve stem interference that resulted from inadequate support of CV-3070's air operator, which occurred as a result of removal of a support hanger. Valve components for CV-3070 were subsequently replaced. A support hanger has been reinstalled to support the valve's air operator.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

EVENT DESCRIPTION

On March 29, 2006, with the plant in Mode 1, left train high pressure safety injection system subcooling control valve CV-3070 [V;BQ] failed to stroke open during a preventive maintenance activity, resulting in entry into Technical Specification (TS) LCO 3.5.2.B.1, for the inoperability of one Emergency Core Cooling System (ECCS) train.

On March 31, 2006, a shutdown was commenced when it was determined that the 72-hour completion time for restoring CV-3070 to operable status could not be met. On April 1, 2006, the shutdown was completed in accordance with TS LCO 3.5.2.C.1 and 2 required actions.

This event is reportable in accordance with 10 CFR 50.73(a)(2)(i)(A) as the completion of any nuclear plant shutdown required by the plant's Technical Specifications.

CAUSE OF THE EVENT

During initial investigation, CV-3070 stroked open following minor physical agitation. Subsequent diagnostic testing of CV-3070 showed that valve stem movement was not smooth. Inspection of the valve stem revealed galling along the underside of the stem that coincided with the length of the valve stroke; indicating that the stem was making excessive contact with the valve bonnet backseat surface along the underside of the stem.

CV-3070 is mounted in a vertical pipe section with its air operator oriented horizontally. Investigation revealed that the end of the valve's air operator was sagging approximately 1.5 inches from horizontal. A search of records revealed that the operator had previously been supported by a hanger that had been removed in 1994.

The failure of CV-3070 was determined to have occurred from excessive valve stem interference that resulted from inadequate support of CV-3070's air operator, following removal of the support hanger.

CORRECTIVE ACTIONS

Valve components for CV-3070 were replaced. A support hanger has been reinstalled to support the valve's air operator.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

SAFETY SIGNIFICANCE

The safety significance of this occurrence is considered minimal. The applicable required actions and associated completion times for one inoperable ECCS train were satisfied in accordance with Technical Specification LCO 3.5.2.

PREVIOUS SIMILAR EVENTS

None