PALISADES PLANT - 50-255
UPDATE REPORT
Previous Report Date: 070882

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 0 (3) | 4 1 1 1 1 (4) | | (5)

LICENSEE CODE 9–14; LICENSE NUMBER 15–25; LICENSE TYPE 26–30; CAT 57–58

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

DOCKET NUMBER 61–68; EVENT DATE 69–74; REPORT DATE 75–80

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	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	F (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 an alarm will be installed to warn that the inner door is open.

	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 (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

PUBLICITY

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

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PDR ADOCK 05000255
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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, several mechanical problems contributed to the personnel error:

1) The inner door handwheel has a "hard spot" just before it is 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.

3) There is no indication (ie, light or audible alarm) inside the personnel lock of inner door position.

To prevent recurrence, the interlock will be adjusted and an attempt will be made to reduce the "hard spot" on the inner door handwheel. Additionally, an alarm and indicating light system will be installed to warn the operator inside the personnel lock that the inner door is not fully closed.

Until the permanent corrective action can be completed, several interim measures have been taken:

1) An Operations Department memorandum has been 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 have been updated to indicate personnel lock problems.

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

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