

LICENSEE EVENT REPORT (LER)

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|---|---|-----------------------------|
| FACILITY NAME (1) PALISADES PLANT | DOCKET NUMBER (2) 0 5 0 0 0 2 5 5 1 | PAGE (3) 1 OF 0 3 |
|---|---|-----------------------------|

TITLE (4)
INADVERTENT SAFETY INJECTION SIGNAL ACTUATION

| EVENT DATE (5) | | | 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) |
| 01 | 25 | 86 | 86 | 007 | 0 | 02 | 24 | 86 | N/A | | 0 5 0 0 0 |
| | | | | | | | | | N/A | | 0 5 0 0 0 |

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|----------------------------------|---|---|---|--|--|--|--|--|--|--|
| OPERATING MODE (9) N | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11) | | | | | | | | | |
| POWER LEVEL (10) 0.0 b | <input type="checkbox"/> 20.402(b) | <input type="checkbox"/> 20.408(e) | <input checked="" type="checkbox"/> 90.73(a)(2)(iv) | <input type="checkbox"/> 73.71(b) | | | | | | |
| | <input type="checkbox"/> 20.408(a)(1)(i) | <input type="checkbox"/> 90.36(a)(1) | <input type="checkbox"/> 90.73(a)(2)(v) | <input type="checkbox"/> 73.71(a) | | | | | | |
| | <input type="checkbox"/> 20.408(a)(1)(ii) | <input type="checkbox"/> 90.36(a)(2) | <input type="checkbox"/> 90.73(a)(2)(vi) | OTHER (Specify in Abstract below and in Text, NRC Form 308A) | | | | | | |
| | <input type="checkbox"/> 20.408(a)(1)(iii) | <input type="checkbox"/> 90.73(a)(2)(i) | <input type="checkbox"/> 90.73(a)(2)(vii)(A) | | | | | | | |
| | <input type="checkbox"/> 20.408(a)(1)(iv) | <input type="checkbox"/> 90.73(a)(2)(ii) | <input type="checkbox"/> 90.73(a)(2)(vii)(B) | | | | | | | |
| | <input type="checkbox"/> 20.408(a)(1)(v) | <input type="checkbox"/> 90.73(a)(2)(iii) | <input type="checkbox"/> 90.73(a)(2)(ix) | | | | | | | |

LICENSEE CONTACT FOR THIS LER (12)

| | |
|--|--|
| NAME R A Fenech, Technical Engineer, Palisades | TELEPHONE NUMBER |
| | AREA CODE: 6 1 6 NUMBER: 7 6 4 - 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 |
|-------|--------|-----------|--------------|---------------------|-------|--------|-----------|--------------|---------------------|
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SUPPLEMENTAL REPORT EXPECTED (14)

| | | | | |
|--|-------------------------------|-------|-----|------|
| <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) (16)

On January 25, 1986, with the plant shutdown for refueling, I&C Technicians pulled the connector on the wrong Pressure Indicator (PIA) resulting in a loss of Safety Injection Signal (SIS) block signal and then initiating SIS. Since this initiating event was not identified, the loss of various electrical load centers and motor control centers resulted in a Main Transformer Trouble Alarm. This resulted in the prudent action to start and load the diesel generators.

Upon verifying that the electrical system appeared proper, the I&C Technician again pulled the connector on the wrong PIA resulting again in a loss of SIS block signal and then initiating SIS. This time the initiating event was realized.

The I&C Technicians and Supervisors were given instructions regarding attention to actions and testing.

No additional threat to the public health or safety resulted from this event.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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| FACILITY NAME (1) PALISADES PLANT | DOCKET NUMBER (2) 0 5 0 0 0 2 5 5 8 6 | LER NUMBER (8) | | | PAGE (3) | | |
| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | | | |
| | | 8 6 | 0 0 7 | 0 0 | 0 2 | OF | 0 3 |

TEXT (if more space is required, use additional NRC Form 365A x) (17)

Description of Event

At 2252 hours on January 25, 1986, with the plant shutdown for refueling, I&C Technicians pulled the connector for Pressure Indicator PIA-0102DLL [PI;BQ] rather than PIA-0102D, resulting in loss of the SIS block and initiating SIS.

The fact that the wrong PIA was disconnected and thus causing the SIS was not discovered until later. Since the initiating event was not known by the control room personnel, when the SIS tripped the incoming feeder breaker to bus 1E resulting in the loss of numerous Load Centers because of crossties due to outage work, and the loss of Motor Control Center, 5 which brought in the Main Transformer Trouble Alarm, it was thought there was a potential Main Transformer problem.

At that time, buses 1C and 1D were being fed from the main transformer. Although switchyard readings did not indicate a problem, control room personnel did not know the cause of the event and determined that the most prudent course of action was to start and load the diesel generators until the switchyard and main transformer were proven to be operating correctly. Buses 1C and 1D were deenergized and the loads picked up by the diesel generators. When evaluating the incident, control room personnel determined that the most likely cause of the event was a load shed signal of unknown origin. The Electrical Supervisor was requested to determine the status of the 1C and 1D undervoltage relays. At 2400 hours, it was reported that everything appeared proper and that no standing load shed signal was in effect.

The I&C Technician resumed his work and at 0050 hours on January 26, 1986 a second SIS occurred for the same reason when the connector for the wrong PIA was pulled. This time, however, the initiating event was realized to be the action by the I&C Technician.

Cause of Event

The cause of the event in both cases was the I&C Technician pulling the connector for the wrong PIA (the two PIA are installed side by side), which resulted in loss of the SIS block signal and initiates SIS. The I&C Technician was confident he had the correct instrument because of previous testing conducted by Operations. When the first SIS was initiated, he was unaware that his action had caused it, and, because of control room operator activity that was taking place, he restored the connection and got out of the way of the control room operators.

Analysis of Event

There were no additional risks to the health and safety of the public as a result of this event since the reactor was in cold shutdown. Also, prudent action was taken to protect the electrical system by starting and loading the diesel generators when the cause for the Main Transformer Trouble Alarm was not known.

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

Corrective Action

The I&C Technicians and Supervisors were instructed to increase their awareness of ongoing control room activities and to know the importance of assuring that they are working on proper devices. They were also instructed on the importance of knowing the impact of the test being performed upon plant activities.

Additional Information

Previous similar events regarding loss of SIS block signal and subsequent SIS signal initiation are LERs 85-011 and 85-028.



Consumers
Power
Company

General Offices: 1945 West Parnall Road, Jackson, MI 49201 • (517) 788-0550

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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 86-007 - INADVERTENT SAFETY INJECTION SIGNAL ACTUATION

Licensee Event Report (LER) 86-007, (Inadvertent Safety Injection Signal Actuation) is attached. This event is reportable to the NRC per 10CFR50.73(a)(2)(iv).

Brian D. Johnson
Staff Licensing Engineer

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

Attachment

LER 86-007
1/1

OC0286-0030-NL02