



Commonwealth Edison  
Quad-Cities Generating Station  
Post Office Box 216  
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Telephone 309/654-2241



NJK-74-278

September 13, 1974

Mr. John F. O'Leary, Director  
Directorate of Licensing Regulation  
U. S. Atomic Energy Commission  
Washington, D. C. 20545

Reference: Quad-Cities Nuclear Power Station, Unit 2  
Docket No. 50-265, DPR-30, Appendix A  
Sections 1.0.A.4, 4.1.A, Table 4.1.1, and 6.6.B.1.a


Dear Mr. O'Leary:

Enclosed please find Abnormal Occurrence Report No. AO-50-265/74-23 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Directorate of Regulatory Operations by telephone on September 3, 1974, and to you and Region III, Directorate of Regulatory Operations by telacopy on September 3, 1974.

This report is submitted to you in accordance with the requirements of Technical Specification 6.6.B.1.a.

Very truly yours,

COMMONWEALTH EDISON COMPANY  
QUAD-CITIES NUCLEAR POWER STATION

  
N. J. Kalivianakis  
Station Superintendent

NJK/CWS/jeh

cc: Region III, Directorate of Regulatory Operations  
J. S. Abel

Enclosure: Abnormal Occurrence Report 50-265/74-23

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REPORT NUMBER: AO-50-265/74-23

REPORT DATE: September 13, 1974

OCCURRENCE DATE: September 3, 1974

FACILITY: Quad-Cities Nuclear Power Station  
Cordova, Illinois 61242

IDENTIFICATION OF OCCURRENCE:

Failure of MSIV Closure Test to initiate half scram and annunciator alarm

CONDITIONS PRIOR TO OCCURRENCE:

Unit 2 in cold shutdown

DESCRIPTION OF OCCURRENCE:

At 4:30 a.m. on September 3, 1974, during routine monthly surveillance testing on MSIV closure, fuse 590-702F (panel 902-17 "TBE" F-3) was pulled to simulate a closed MSIV on "B" steam line. The MSIV test closure switch was used to operate the MSIV 2-203-1D solenoid. The valve closed to the 10% closed position and reversed to the full open position as expected. However, a half scram and annunciator alarm were not received at the 10% closed position.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE:

The exact cause of this occurrence cannot be determined. It is possible that the operators did not properly execute the steps of the test procedure. Or it is possible that the valve travel during the test did not fully actuate the alarm and scram microswitch. Since the investigations by the electrical maintenance personnel showed there were no malfunctions, and since the test was performed successfully three times later in the day, no cause for the reported occurrence can be determined.

ANALYSIS OF OCCURRENCE:

The safety implications of this occurrence are considered minimal based on the fact that the valve did operate to the 10% closed position as evidenced by the test circuit functioning properly. If an actual isolation signal had been present, the proper

alarm and scram signals would have been received either by complete closure of this MSIV or by closure of the remaining MSIV's. The tests performed later showed that the test circuit and the scram and alarm circuits did function properly.

CORRECTIVE ACTION:

The corrective action taken to correct this occurrence was to repeat the surveillance test at 10:00 a.m. on September 3, 1974. The test was performed successfully three times. Later during the day investigations were made by electrical maintenance personnel and no abnormalities were found. If any similar failures are reported in the future, they will be investigated and resolved.

FAILURE DATA:

No failure data is reported since there is no known cause for this failure.