Commonwealth Edison
Quad-Cities Generating Station
Post Office Box
Cordova, Illinois 61242
Telephone 309/654-2241

NJK-74-264

September 6, 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, Docket No. 50-265, DPR-30
Appendix A, Sections 1.0.A.2, 3.2.A, Table 3.2.1, and 6.6.B.1.a.

Dear Mr. O'Leary:

Enclosed please find Abnormal Occurrence Report No. AO-50-265/74-20 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Directorate of Regulatory Operations by telephone on August 29, 1974 and to you and Region III, Directorate of Regulatory Operations by telecopy on August 29, 1974.

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

Very Truly Yours,

COMMONWEALTH EDISON COMPANY
QUAD-CITIES NUCLEAR POWER STATION

N. J. Kalivianakis
Station Superintendent

NJK/RAR/rhb

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

50-265
inquiry

9458

COPY SENT REGION III

REPORT NUMBER: AO-50-265/74-20

REPORT DATE: 9-6-74

OCCURRENCE DATE: 8-28-74

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

IDENTIFICATION OF OCCURRENCE:

Unit 2 Main Steam Line High Flow Group One Isolation switch failure.

CONDITIONS PRIOR TO OCCURRENCE:

Run Mode
2400 MWt
732 MWe

DESCRIPTION OF OCCURRENCE:

While doing routine quarterly surveillance at 1400 hours on August 28, 1974, it was discovered that FIS-2-261-2G would not trip when a differential pressure in excess of that corresponding to a flow of 120% of rated flow was applied. This was in violation of Section 3.2.A, Table 3.2.1 of the Technical Specifications. No protective system or operator actions were required to bring the situation under control.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE:

(Other - instrument drift)

The instrument was inspected and no physical problems were detected. The calibration records for the first two quarters of the year were checked and no large setpoint adjustments were made. This ruled out any personnel error during a previous calibration. Since no other factors could be discovered, the apparent cause of the occurrence was attributed to instrument drift.

ANALYSIS OF OCCURRENCE:

There were no safety implications from this instrument failure. There are three additional high flow sensors in the same sub-channel as FIS-2-261-2G and each would have functioned properly if a high flow condition had occurred.

CORRECTIVE ACTION:

The immediate corrective action was to recalibrate and functionally test the switch in accordance with Surveillance Test #21. As was stated in the 24 hour written notification, the switch was examined during an outage on September 6, 1974. No defects were observed during this examination. This switch will be functionally tested weekly for one month to demonstrate its reliability. Normal scheduled surveillance will be resumed following this period if the results are satisfactory. The first weekly functional test proved the switch performance to be satisfactory.

FAILURE DATA:

FIS-2-261-2G is a Barton Model 278 with a 0-200 PSID range. There have been previous instances where the setpoint has drifted, but this is the first time that a Barton Model 278 has failed to trip at all; thus, there are no safety implications related to cummulative experience with these switches.

DATE	EPN	RANGE	DRIFT (PSID)
11/9/73	1-261-2G	0-200 PSID	+3
	-2J		+2½
	-2H		+2½
2/24/73	2-261-2C	0-200	+3
	-2G		+2½
11/18/72	1-261-2R	0-200	+5
	2-261-2G		+3
	-2L		+5
	-2N		+5