



Commonwealth Edison
Quad-Cities Generating Station
Post Office Box 216
Cordova, Illinois 61242
Telephone 309/654-2241



NJK-74-194

August 2, 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. 50-254, DPR-29, Appendix A
Sections 1.0.A.2, 3.2.B, and 6.6.B.1.a

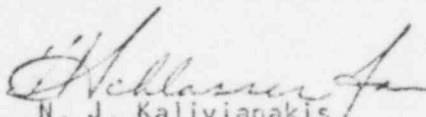
Dear Mr. O'Leary:

Enclosed please find Abnormal Occurrence Report No. A0-50-254/74-25 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Directorate of Regulatory Operations by telephone on July 23, 1974, and to you and Region III, Directorate of Regulatory Operations by telecopy on July 23, 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/RAR/jeh

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

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REPORT NUMBER: AO-50-254/74-25

REPORT DATE: August 2, 1974

OCCURRENCE DATE: July 23, 1974

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

IDENTIFICATION OF OCCURRENCE:

Reactor low pressure instrument PS-1-263-52B setpoint drift.

CONDITIONS PRIOR TO OCCURRENCE:

Unit 1 in cold shutdown.

DESCRIPTION OF OCCURRENCE:

At 1100 hours on July 23, 1974, while doing routine instrument department surveillance on Unit One, the left hand switch of PS-1-263-52B was found to trip at a setpoint which exceeded the limiting condition for operation as given in section 3.2.B of the Technical Specifications. The switch tripped at 355 psig; the limit is $300 \leq P \leq 350$ psig.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE:

The cause of this occurrence is attributed to instrument drift.

ANALYSIS OF OCCURRENCE:

Auto start of the low pressure ECCS pumps was not impaired by this occurrence. Both the Core Spray and RHR Systems would have performed properly in the event of an accident with this switch at the as found setpoint. The injection valves for those pumps would have opened at 355 psig instead of between 350 psig and 300 psig. This means that injection to the vessel would have started slightly sooner than the analyzed case. Since the pressure was only 5 psig above the limit, the integrity of the low pressure piping for the system was not threatened. Consequently, the setpoint drift experienced by this switch did not compromise the safe operation of the plant, and thus had no adverse effects on the health and safety of the public.

CORRECTIVE ACTION:

The switch was immediately recalibrated and functionally tested according to the instrument department procedure. Since this is the first time this switch has drifted beyond its limiting setpoint, an additional calibration check will be made within 30 days of this occurrence. If continuing drift of this switch is experienced, further action will be taken as is necessary to prevent further occurrences of this problem.

The pressure switch discussed in this report is a Barksdale Model No. D2T-M1255. Since this is the first failure of this switch, there is no cumulative experience on which to base any safety implications. Studies are in progress by various groups to try to resolve the continuing problem of instrument setpoint drift.