



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



*D. LANHAM*

IE FILE COPY

NJK-76-354

September 24, 1976



J. Keppler, Regional Director  
Office of Inspection and Enforcement  
Region III  
U. S. Nuclear Regulatory Commission  
799 Roosevelt Road  
Glen Ellyn, Illinois 60137

Reference: Quad-Cities Nuclear Power Station  
Docket No. 50-265, DPR-30, Unit 2  
Appendix A, Sections 3.2.B., 6.6.B.2.b., and Table 3.2-2

Enclosed please find Reportable Occurrence Report No. RG 50-265/76-12  
for Quad-Cities Nuclear Power Station.

This report is submitted to you in accordance with the requirements  
of Technical Specification 6.6.B.2.

Very truly yours,

COMMONWEALTH EDISON COMPANY  
QUAD-CITIES NUCLEAR POWER STATION

N. J. Kalivianakis  
Station Superintendent

NJK/1k

10977

8306130195 761001  
PDR ADOCK 05000265  
S PDR

SEP 28 1976

A horizontal number line with arrows at both ends. There are six major tick marks labeled 1, 2, 3, 4, 5, and 6 from left to right. There are also four minor tick marks between each pair of major tick marks, dividing each unit into five equal intervals.

[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME										LICENSE NUMBER										LICENSE TYPE					EVENT TYPE		
0	1									0	0	-	0	0	0	0	0	-	0	0	4	1	1	1	1	0	1
7	8	9							14	15									25	26					30	31	32

  

CATEGORY		REPORT TYPE	REPORT SOURCE	DOCKET NUMBER								EVENT DATE					REPORT DATE								
0	1	P	0	T	L	0	5	0	-	0	2	6	5	0	8	2	5	7	6	0	9	2	4	7	6
7	8	57	58	59	60	61							68	69					74	75					80

[illegible]

02	During routine monthly surveillance testing of ECCS drywell high pressure sensors,	80
7 8 9		
03	pressure switch PS 2-1001-90B was found valved out. The wire seal, normally used by	80
7 8 9		
04	the instrument mechanic to lock open the isolation valve, was in place but was not	80
7 8 9		
05	stamped and locked. Since redundant pressure switch PS-2-1001-90D was operable,	80
7 8 9		
06	RHR LPCI initiation and Core Spray initiation logic were available. Each system	80
7 8 9		

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

SYSTEM CODE CAUSE CODE COMPONENT CODE PRIME COMPONENT SUPPLIER COMPONENT MANUFACTURER VIOLATION

07 1 B A I N S T R U N B 0 7 0 N

## CAUSE DESCRIPTION

08	(Proximate Cause-Personnel Performance) The subject pressure switch was inadvertently	80
7 8 9		
09	left isolated after the completion of the surveillance testing for the prior month.	80
7 8 9		
10	(RO 50-265/76-12)	80
7 8 9		

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
11	E	076		NA		B		Routine surveillance testing	
7	8	9	10	11	12	13	14	15	16
FORM OF ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY				LOCATION OF RELEASE	
12	Z	Z		NA				NA	
7	8	9	10	11	12	13	14	15	16

## PERSONNEL EXPOSURES

NUMBER			TYPE	DESCRIPTION
1	3	0 0 0	Z	NA

## PERSONNEL INJURIES

NUMBER  
14 000  
7 8 9 10  
NA

## OFFSITE COORDINATOR:

1	5	NA										
7	8	9	80									

LOSS OR DAMAGE TO FACILITY

TYPE		DESCRIPTION
16	7	NA

## PUBLICITY

17	NA
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### ADDITIONAL FACTORS

18 (EVENT DESCRIPTION CONT'D) would have performed as designed had a high drywell

19 | pressure condition presented itself. The switch was successfully (see attachment)

NAME: John Vahrenwald

PHONE: 309-654-2241

## ADDITIONAL FACTORS

### (EVENT DESCRIPTION CONT'D)

tested, and the instrument isolation valve was left open and lock-wire sealed.

### Corrective Action to Prevent Recurrence

The importance of closely following approved Station procedures was stressed to the Instrument Department. Also, the importance of opening and sealing the instrument valves upon completion of surveillances was re-emphasized to the department personnel.

The last occurrence of this type was in October of 1975 (AO 50-254/75-21). At that time, the requirement of the surveillance procedure to place wire security seals on Safety-Related instrument isolation valves was supplemented with unscheduled audits by instrument supervisors. Since that time, there has not been a reoccurrence of improperly positioned instrument valves until now. It is thus felt that the corrective measures taken are adequate. No further action is deemed necessary at this time.