

LICENSEE EVENT REPORT

CONTROL BLOCK: 1 2 3 4 5 6

(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME: 01 I L Q A D I 1 14 15 0 0 - 0 0 0 0 0 - 0 0 25 26 4 1 1 1 1 30 31 0 1 32

CATEGORY: 01 CONT 57 53 59 60 61 0 5 0 - 0 2 5 4 68 69 74 75 80

EVENT DESCRIPTION

02 7 8 9 12 RPS High Drywell Pressure alarm switches were found in reset out 80
03 7 8 9 While performing a surveillance test, Redundant Press. switches 80
04 7 8 9 were available and operable. The switches were immediately 80
05 7 8 9 latched and returned to normal. This latched condition was 80
06 7 8 9 noted at Quad 4, but no alarming value was observed. 80

SYSTEM CODE: 07 7 8 9 10 11 12 17 43 44 47 48

CAUSE DESCRIPTION

08 7 8 9 The Transducer + Mechanism failed properly. All the sensor 80
09 7 8 9 isolation valve closed after power was lost. 80
10 7 8 9 80

FACILITY STATUS: 11 7 8 9 10 12 13 44 45 46 80

FORM OF ACTIVITY RELEASED: 12 7 8 9 10 11 44 45 80

PERSONNEL EXPOSURES: 13 7 8 9 11 12 13 80

PERSONNEL INJURIES: 14 7 8 9 11 12 80

OFFSITE CONSEQUENCES: 15 7 8 9 80

LOSS OR DAMAGE TO FACILITY: 16 7 8 9 10 80

PUBLICITY: 17 7 8 9 80

ADDITIONAL FACTORS: 18 7 8 9 80

19 7 8 9 Reduce the probability of such occurrences. (AO-50-265/75-21) 80

NAME: Dave Rajcevic PHONE: 309-454-2241 EXT. 227



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

NJK-75-524

October 24, 1975

Director of Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Washington, D. C. 20555

References: Quad-Cities Nuclear Power Station
Docket No. 50-254, DPR-29, Unit 1
Appendix A, Sections 1.0.A.4, 3.1.A, 6.6.B.1.a

Enclosed please find Abnormal Occurrence Report No. A0-50-254/75-21 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Office of Inspection and Enforcement by telephone on October 15, 1975 and to you and Region III, Office of Inspection and Enforcement by telecopy on October 15, 1975.

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/HGL/vmb

cc: Region III, Office of Inspection and Enforcement
G.A. Abrell

10003

COPY SENT REGION III

REPORT NUMBER: AO 50-254/75-21

REPORT DATE: October 24, 1975

OCCURRENCE DATE: October 14, 1975

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

IDENTIFICATION OF OCCURRENCE:

Reactor Protection System Drywell High Pressure scram switches PS-1-1001-88A&B were found valved out.

CONDITIONS PRIOR TO OCCURRENCE:

The reactor mode switch was in the "RUN" position, and Unit 1 was operating at 1850 MW_t and 570 MW_e.

DESCRIPTION OF OCCURRENCE:

During routine surveillance testing on October 14, 1975, at 3:00PM, it was noted that the isolation valves for PS-1-1001-88A and PS-1-1001-88B were closed, rendering the instruments inoperable and not in compliance with the technical specification 3.1.A, Table 3.1.1.c.

DESIGNATION OF APPARENT CAUSE:

OPERATOR ERROR: The apparent cause of this occurrence is designated as operator error. The instrument mechanic inadvertently left the pressure switch isolation valves closed upon completion of the last test which had been performed on September 10, 1975.

ANALYSIS OF OCCURRENCE:

The system would have performed its designated reactor scram function, if needed, since the redundant pressure switches PS-1-1001-88C and D were operable. Therefore the safety implications are minimal and the health and safety of the public were not affected as a result of this occurrence.

CORRECTIVE ACTION:

The pressure switches were immediately tested and proven operable. The isolation valves were then opened, thus allowing the instruments to perform their normal function.

FAILURE DATA:

The affected pressure switches have not been found valved out before, but other occurrences of this nature have been discovered in the past. A program previously described in response to an NRC inspection report and in AO-50-265/75-30 has been fully implemented which should preclude further occurrences of this type. At

the time of this occurrence, the instrument valves involved were sealed, but not with the uniquely identified seal now being used. To supplement the seal program, unscheduled audits of the instrument valve positions are being performed by the Instrument supervisors to verify and insure that the valves are properly positioned.