



Commonwealth Edison
Quad-Cities Nuclear Power Station
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NJK-75-290

May 23, 1975

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

Reference: Quad-Cities Nuclear Power Station
Docket No. 50-265, DPR-30, Unit 2
Appendix A, Sections 1.0.A.4, 3.2.B, 6.6.B.1.a

Enclosed please find Abnormal Occurrence Report No. A0 50-265/75-16 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Directorate of Regulatory Operations by telephone on May 19, 1975 and to you and Region III, Directorate of Regulatory Operations by telecopy on May 19, 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/FJG/1k

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

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REPORT NUMBER: AO 50-265/75-16

REPORT DATE: May 23, 1975

OCCURRENCE DATE: May 16, 1975

IDENTIFICATION OF OCCURRENCE:

Received "Reactor Vessel Low Pressure" alarm while operating U-2 at normal pressure. Pressure switch PS-2-263-52A was found to be valved out.

CONDITIONS PRIOR TO OCCURRENCE:

Reactor in RUN mode, 2254 MWt, 717 MWe

DESCRIPTION OF OCCURRENCE:

At 6:50 p.m. on May 16, 1975 the U-2 operator received a "Reactor Vessel Low Pressure" alarm. The actual reactor pressure was normal at the time.

DESIGNATION OF APPARENT CAUSE:

Operator Error

The apparent cause of this occurrence is designated as operator error. On the afternoon of May 16, 1975, surveillance testing was performed which required isolation of pressure switch PS 2-263-52A. Upon completion of the surveillance, the Instrument Mechanic inadvertently left the switch valved out.

ANALYSIS OF OCCURRENCE:

The isolation of pressure switch 2-263-52A caused an erroneous signal to one half of the Core Spray and RHR systems; however, because of the logic arrangement of the redundant pressure switch and the respective relay contacts, both systems would have properly functioned if needed in the event of an ECCS initiation signal.

Had an initiation occurred while the reactor pressure was above the low pressure set point, with the isolated switch actuated, a false injection signal would have been present to both low pressure ECCS systems. However, the low pressure piping of these systems would have been protected against overpressurization by the reverse flow check valves in the injection lines.

Had an initiation occurred with reactor pressure below the low pressure set point, and the isolated switch not actuated, the redundant pressure switch would have properly allowed injection from both loops of the ECCS systems.

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There were thus no safety implications from this occurrence; therefore, the health and safety of the public were not endangered.

CORRECTIVE ACTION:

The pressure switch was valved in and the alarm cleared.

FAILURE DATA:

This is the first time this pressure switch has been inadvertently isolated. No safety implications based upon previous data exist.