



Commonwealth Edison  
Quad-Cities Nuclear Power Station  
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NJK-75-328

June 20, 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, 3.7.B.1, 6.6.B.2.b  
Abnormal Occurrence Report No. 50-265/75-18

The purpose of this letter is to provide you with details concerning an unusual event which occurred at Quad-Cities Nuclear Power Station, Unit 2, on May 22, 1975. This report is being submitted in accordance with the requirements of Technical Specification 6.6.B.2.b.

Circumstances leading to the discovery of this event were reported to you on May 30, 1975 in Quad-Cities Nuclear Power Station Abnormal Occurrence Report No. 50-265/75-18.

Very truly yours,

COMMONWEALTH EDISON COMPANY  
QUAD-CITIES NUCLEAR POWER STATION

N. J. Kalivianakis  
Station Superintendent

NJK/RAR/lk

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

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REPORT NUMBER: Unusual Event Letter

REPORT DATE: June 21, 1975

EVENT DATE: May 22, 1975

FACILITY: Quad-Cities Nuclear Power Station  
Cordova, Ill. 61242

IDENTIFICATION OF EVENT:

A single valve failure made the Standby Gas Treatment system inoperable.

CONDITIONS PRIOR TO EVENT:

Unit one was at 670 MWe and increasing at the rate of 3 MWe per hour. Unit two was at 495 MWe and increasing at the rate of 20 MWe per hour.

DESCRIPTION OF EVENT:

On May 22, 1975 a condition involving a single failure of a SBGT system inlet valve was discovered which could result in the loss of the capability of this system to perform its safety function. As the logic for the system is presently designed, an auto initiation signal for one unit automatically closes the inlet valve to the SBGT system from the other unit. If a failure occurs on the inlet valve for the unit that auto initiates, the condition is such that no inlet valve at all is open to the system. This is a violation of the "single failure" criteria for the SBGT system.

DESIGNATION OF APPARENT CAUSE OF EVENT:

Design Deficiency

Due to a design deficiency, the SBGT system will not remain operable under all conditions with a single component failure.

ANALYSIS OF EVENT:

There are no safety implications from the event. Due to a previous abnormal occurrence both inlet valves have been taken out of service in the open direction and the conditions described above will not affect SBGT system operability.

CORRECTIVE ACTION:

A modification request has been initiated and routed to the Station Nuclear Engineering Department. The modification request should result in a revision to the present logic scheme to preclude the possibility that a failure similar to that described above would render the system inoperable. Until the time that the modification is implemented, the inlet valves will remain positioned as described above.