



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

NJK-75-160

March 27, 1975



Mr. John F. O'Leary, Director
Directorate of Licensing Regulation
U. S. NUCLEAR REGULATORY COMMISSION
Washington, D. C. 20545

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

Dear Mr. O'Leary:

Enclosed please find Abnormal Occurrence Report No. A0-50-254/75-7 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Directorate of Regulatory Operations by telephone on March 21, 1975 and to you and Region III, Directorate of Regulatory Operations by telecopy on March 21, 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:RAR/dkp

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

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REPORT NUMBER: AO-50-254/75-7

REPORT DATE: March 27, 1975

OCCURRENCE DATE: March 20, 1975

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

IDENTIFICATION OF OCCURRENCE:

Instrument setpoint drift of an EHC Fluid Low Pressure sensor.

CONDITIONS PRIOR TO OCCURRENCE:

The unit was in the RUN mode at 2472 MWt and 824 MWe.

DESCRIPTION OF OCCURRENCE:

On March 20, 1975, at 3:00 p.m., while doing routine quarterly surveillance calibrations of the EHC Fluid Low Pressure sensors one of them tripped at 885 psig decreasing. This was less than the Technical Specifications limit of \geq 900 psig. The three other switches were all within the Technical Specification limit. No operator actions were required.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE:

Component Failure - The apparent cause of the occurrence was a worn piston assembly or worn O-ring seals. This was supported by the fact that the instrument mechanic did not have to make any setpoint adjustments to bring the switch within limits; exercising the switch caused the setpoint to change to within the limit.

ANALYSIS OF OCCURRENCE:

The reactor protection system is arranged in a one out of two twice logic. Although one sensor in the "B" channel was less than the limit, the other sensor was not; thus, the "B" channel would still have tripped before the lower limit was reached. Since the "A" channel sensors were also within limits the unit would have scrambled before the limit was reached. Therefore there are no safety implications arising from this occurrence.

CORRECTIVE ACTION:

When the occurrence was discovered, the switch was exercised and the setpoint went from the as-found value of 885 psig to 935 psig. On March 22, 1975 the piston assembly of the pressure switch was disassembled and inspected. Only a slight scoring of the piston was noted. As a precautionary measure the piston assembly and o-rings were replaced and the switch was recalibrated to 935 psig.

FAILURE DATA:

Equipment Identification -

Equipment Piece Number	1-5600-PS-2
Manufacturer	Barksdale
Model	C9612-2
Range	135-1500 psi

Previous Failures -

<u>DATE</u>	<u>UNIT</u>	<u>SWITCH NUMBER</u>
8-22-72	1	1-5600-PS-1&4
8-31-72	2	2-5600-PS-2
11-9-72	1	1-5600-PS-4
12-20-72	2	2-5600-PS-1, 2, & 3
12-29-72	1	1-5600-PS-2
9-14-74	1	1-5600-PS-4

Most of the failures occurred before the setpoints of the switches were raised from 900 psig to 935 psig on January 12, 1973. Since this time there have been only two failures. Redundancy of the tripping circuit allows for occasional instrument failure or drift with minimal safety implications.