



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

NJK-75-31

January 15, 1975



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

REFERENCE: Quad-Cities Nuclear Power Station, Unit One
Docket No. 50-254, DPR-29
Appendix A, Sections 1.0.A.2, 3.5.E.1, 6.6.B.1.a

Dear Mr. O'Leary:

Enclosed please find Abnormal Occurrence Report No. 50-254/75-2 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Directorate of Regulatory Operations by telephone on January 6, 1975 and to you and Region III, Directorate of Regulatory Operations by telecopy on January 6, 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

J. Kalivianakis for
Mr. J. Kalivianakis
Station Superintendent

NJK:SH/dkp

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

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REPORT NUMBER: AO-50-254/75-2

REPORT DATE: January 13, 1975

OCCURRENCE DATE: January 6, 1975

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

IDENTIFICATION OF OCCURRENCE:

Unit 1 Reactor Core Isolation Cooling Valve 1301-17 failed to fully close.

CONDITIONS PRIOR TO OCCURRENCE:

Unit 1 Operating steady state at 822 MWe.
Unit 2 in refueling outage.

DESCRIPTION OF OCCURRENCE:

At 1:20 a.m. on January 6, 1975, during the RCIC monthly valve operability test, dual indication would not clear on outboard steam isolation valve 1301-17, indicating the valve had not fully closed. Upon investigation by electrical maintenance, it was found that the armature of the valve motor operator was open circuited, thus preventing valve movement. Technical Specification 3.5.E.1 was violated as a result of this occurrence.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE:

Equipment Failure - Investigation of the motor by electrical maintenance revealed that the brush rigging was not making proper contact with the armature. This caused the open circuit indication.

ANALYSIS OF OCCURRENCE:

The safety implications of this occurrence are minimized because all of the other emergency core cooling systems were completely operable at the time of the occurrence and HPCI operability was immediately verified.

CORRECTIVE ACTION:

The immediate corrective action in response to this occurrence was to close the inboard RCIC isolation valve 1301-16 and verify HPCI operability per Technical Specification 3.5.E.2. Brush tension was increased and the motor operator functioned properly. The valve was returned to service at 2:20 p.m. and RCIC was proven operable at 4:30 p.m. on January 6, 1975.

Further examination of the motor operator is being conducted during the current Unit 1 outage to verify proper brush alignment and motor operability (W.R. 75-206).

FAILURE DATA:

There have been no similar occurrences in the past and it is felt that the corrective actions taken should preclude any similar failures in the future.