



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



NJK-74-342

October 22, 1974

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
Docket No. 50-254, DPR-29
Appendix A, Sections 1.0.A.5, and 6.6.B.1.a

Dear Mr. O'Leary:

Enclosed please find Abnormal Occurrence Report No. 50-254/74-33 for Quad-Cities Nuclear Power Station. This occurrence was previously reported to Region III, Directorate of Regulatory Operations by telephone on October 12, 1974 and to you and Region III, Directorate of Regulatory Operations by telecopy on October 12, 1974.

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/LDR/rhb

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

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REPORT NUMBER: 50-254/74-33

REPORT DATE: October 22, 1974

OCCURRENCE DATE: October 12, 1974

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

IDENTIFICATION OF OCCURRENCE:

Pin hole leak on 1 inch instrument sensing line 1-261-3C

CONDITIONS PRIOR TO OCCURRENCE:

Drywell inspection during Unit start-up. 0 megawatts electrical Rx critical.

DESCRIPTION OF OCCURRENCE:

At approximately 0040 hours on October 12, 1974, inspection of Unit One drywell equipment during start-up operations resulted in the discovery of a pin hole leak at an elbow socket fillet weld on 1 inch carbon steel instrument sensing line 1-261-3C. Start-up operations were terminated and Unit One shut-down. The weld was dye penetrant tested, completely ground out and rewelded. The new weld was then dye penetrant tested and visually inspected using a magnifying glass and found to be satisfactory.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE:

Installation/Construction.

The apparent cause of the pin hole leak was due to a slag inclusion developed at the time of the initial weld. Normal vibration of the line furthered the inclusion to develop into the resulting pinhole.

ANALYSIS OF OCCURRENCE:

Safety implications to safe operation of the plant, plant personnel, and the health and safety of the public were minimal. No reactor safety system was affected that would have prevented a safe shut down of the reactor.

CORRECTIVE ACTION:

Corrective actions included the unit shutdown and dye penetrant testing to find the cause of the pin hole leak. Further corrective actions included rewelding the elbow socket and inspecting the new weld to assure its acceptability. These corrective actions are considered to be sufficient to resolve this occurrence and no further corrective action is contemplated.

FAILURE DATA:

This is the first such occurrence involving weld imperfections affecting Instrument Sensing Lines or similar equipment. No cumulative experience can be forwarded within this report in light of this, and no safety implications can be concluded relating to cumulative experiences of similar systems or components.