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Regulatory Docket File

50-331

IOWA ELECTRIC LIGHT AND POWER COMPANY

General Office CEDAR RAPIDS.IOWA DUANE ARNOLD ENERGY CENTER PALO, IOWA JULY 22, 1974 DAEC - 74 - 258

Mr. James G. Keppler, Regional Director Directorate of Regulatory Operations U. S. Atomic Energy Commission Region III 799 Roosevelt Road Glen Ellyn, Illinois 60137

SUBJECT: Abnormal Occurrence No. 50-331/74-21 FILE: A-118a

Dear Mr. Keppler:

In accordance with Appendix A, Operating License DPR-49, Technical Specifications and Bases for Duane Arnold Energy Center, please find enclosed a written report on the subject abnormal occurrence. Mr. C. Feierabend, of your office, was notified of the occurrence on July 18, 1974.

It was originally intended to make this report in accordance with Specification 6.11.2A.2. However, while in the process of preparing the report, a reevaluation of available data indicated that the occurrence should be reported under Specification 1.0.4.d.

Very truly yours,

G. G. Hunt Chief Engineer Duane Arnold Energy Center

OCS/GGH/bh Enclosure

- CC: John O'Leary
 - C. W. Sandford
 - J. A. Wallace
 - E. L. Hammond
 - B. R. York
 - D. L. Wilson
 - H. W. Rehrauer-Chairman, Safety Committee
 - L. D. Root
 - J. R. Newman
 - B. L. Hopkins



IOWA ELECTRIC LIGHT AND POWER COMPANY

General Office Cedar Rapids, Iowa

Subject:	Abnormal Occurrence				
Report Number:	A0 50-331/74-21				
Report Date:	July 22, 1974				
Occurrence Date:	June 22, 1974 and June 23, 1974				
Facility:	Duane Arnold Energy Center, Unit No. 1, Palo, Iowa				

Identification of Occurrence

On June 22, 1974, HPCI did not inject into the vessel while performing Startup Test Instruction No. 15 (HPCI Injection) (Event 1). On June 23, 1974, HPCI injection did not occur within the required minimum time specified by STI-15 (Event 2). These events were identified as an abnormal occurrence in accordance with Appendix A, Operating License DPR-49, Specification 1.0.4.d.

Conditions Prior to Occurrences

- June 22 Reactor and plant at steady state conditions, 725 MWt; preparing to commence STI-15 (Event 1).
- June 23 Reactor and plant at steady state conditions, 857 MWt; preparing to commence STI-15 (Event 2).

Description of Occurrence

June 22, 1974 (Event 1)

- 0858 Commenced reducing power from 268 MWe to 220 MWe in preparation for performing STI-15.
- 1030 HPCI did not inject into the vessel; HPCI stop valve failed to open.
- 1340 Initiated surveillance required by Specification 4.5.D.2.

1405 - Adjusted HPCI oil relief valve to 90 psi.

1515 - HPCI tested satisfactorily.

Abnormal Occurrence A0 50-331/74-21

Page 2

The Office of the Directorate of Regulatory Operations for Region III was notified by telephone on June 22, 1974.

June 23, 1974 (Event 2)

2029 - Plant at 285 MWe - Completed HPCI automatic start test - failed to inject within required time.

2130 - Initiated surveillance required by Specification 4.5.D.2.

June 24, 1974

1400 - RCIC Subsystem and ADS Subsystem logic demonstrated to be operable.

June 25, 1974

1400 - RCIC Subsystem and ADS Subsystem logic demonstrated to be operable.

June 26, 1974

- Mechanical overspeed trip device repaired.

1910 - HPCI operable

The Office of the Directorate of Regulatory Operations for Region III was notified by telephone on July 18, 1974, followed by written notification by telecopier on the same day stating that both events had been classified as an abnormal occurrence.

Designation of Apparent Cause of Occurrence

The cause of Event 1 on June 22 was thought to be a low relief valve (PSV-2288) setting on the HPCI oil control system. It was thought to be relieving before the turbine stop valve could open.

After Event 2 on June 23 it was determined that a faulty mechanical overspeed trip device was the actual cause of both events. The piston in the trip device was undersized which allowed oil to port through it and momentarily actuate the trip device.

Analysis of Occurrence

The cause of the reportable occurrence is specified above. Operability tests verified that the RCIC System, the LPCI Subsystem, both Core Spray Subsystems, and the ADS Subsystem were capable of performing their intended functions.

Abnormal Occurrence AO 50-331/74-21

Page 3

Corrective Action

After the event on June 22, 1974, the relief valve setting was adjusted to the correct setting and the HPCI System was operated satisfactorily.

After the event on June 23, 1974, the vendor was notified of the problem with the trip device; the piston in the device was replaced and the HPCI System was operated satisfactorily.

Conclusion

The contents of this report were reviewed and approved by the DAEC Operations Committee on July 22, 1974. The Committee concluded that the occurrence did not present a hazard to the health and safety of the public.

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G. G. Hunt Chief Engineer Duane Arnold Energy Center

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