- LOCAL PDR CEDAR RAPIDS, IO

VOLLMER

/STEELE

1 - NSIC

1 - ASLB

1 - P. R. DAVIS

(ABERNATHY) 1 - TIC

√16 - ACRS SENT TO LIC ASST TEETS 7-24-74

(BUCHANAN)

(1)(2)(10)-NATIONAL LABS

EXTERNAL DISTRIBUTION

1-ASLBP(E/W Bldg, Rm 529)

1-W. PENNINGTON, Rm E-201 GT 1-G. ULRIKSON, ORNL

1-B&M SWINEBROAD, Rm E-201 GT 1-AGMED (RUTH GUSSMAN)

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1-CONSULTANTS - Rm **B-127** GT

NEWMARK/BLUME/AGBABIAN

1-RD..MUELLER, Rm F-309

GT

IOWA ELECTRIC LIGHT AND POWER COMPANY

General Office

CEDAR RAPIDS, IOWA

DUANE ARNOLD ENERGY CENTER
PALO, IOWA
JULY 16, 1974
DAEC - 74 - 251

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. 50-331/74-16

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 6, 1974.

Very truly yours,

G. G. Hunt Chief Engineer

Duane Arnold Energy Center

DLW/GGH/mek 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

JUL 1 8 1974

B. L. Hopkins

IOWA ELECTRIC LIGHT AND POWER COMPANY

General Office

CEDAR RAPIDS, IOWA

Subject:

Abnormal Occurrence

Report Number:

AO 50-331/74-16

Report Date:

July 16, 1974

Occurrence Date:

July 6, 1974

Facility:

Duane Arnold Energy Center, Unit #1, Plao, Iowa

Identification of Occurrence

Outboard Core Spray Injection Valve (MOV 2115) Condition, reportable per Appendix A, Operating License DPR-49, Specification 1.0.4.d.

Conditions Prior to Occurrence

- 1. Reactor in Hot Shutdown condition.
- 2. HPCI System inoperable.

Description of Occurrence

At approximately 0030 hours, during the performance of Core Spray System operability surveillance testing, normally open outboard injection valve (MOV-2115, Loop "A") did not close upon signal from the Control Room. Investigation revealed that the valve motor operator casing was fractured and that the motor had seperated from the clutch housing. The motor was subsequently removed and the valve manually operated to complete operability testing. After completion of the testing, the valve was physically locked in the open position.

Designation of Apparent Cause of Occurrence

The apparent cause of the occurrence was a mechanical fault in the housing between the motor and valve operator on MOV 2115. The fault allowed the motor to rotate and fall away from the valve operator when MOV 2115 was energized for surveillance testing. Investigation into the cause of the fault in the housing is continuing. The housing has been sent to the valve manufacturer for analysis and results of that analysis will be submitted in a supplementary report.

Analysis of Occurrence

Core Spray Loop "A" would have been capable of performing its' intended design function since MOV 2115 was in the open position when it was found to be inoperable. If MOV 2115 would have been in the <u>closed</u> position when the malfunction occurred, Core Spray Loop "A" would not have performed its' intended design function. However, it should be noted that even if Core Spray Loop "A" would have been non-operative, Core Spray Loop "B" would have provided redundant capabilities.

There was no apparent damage to the valve portion of MOV 2115 as a result of the occurrence.

Corrective Action

Following completion of the Core Spray operability tests, MOV 2115 was manually opened and locked in the open position. The valve will remain locked open, except for manual cycling during operability testing, until replacement parts are obtained and the valve motor is repaired, reinstalled, and tested.

Further corrective action to prevent repetition of the occurrence may be initiated after review of the manufacturers report on the examination of the fractured portions of the housing.

Failure Data

There have been no other occurrences of this type to date at this facility.

Following is equipment identification data for the valve motor operator:

Manufacturer: Limitorque Corporation Identification No: Y 249 590 A2 LW

G. G. Hunt

Chief Engineer

Duane Arnold Energy Center

DLW/GGH/pd