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FILE: INCIDENT REPORT FILE

FROM: Iowa Elec. Light & Pwr. Co. Palo, Iowa <u>G.G. Hunt</u>		DATE OF DOC DATE REC'D		LTR	тwх	RPT -	OTHER			
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Regulatory Docket File

IOWA ELECTRIC LIGHT AND POWER COMPANY

General Office Cedar Rapids, Iowa DUANE ARNOLD ENERGY CENTER PALO, IOWA JULY 24, 1975 DAEC -75 -295



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Mr. James G. Keppler, Director Office of Inspection and Enforcement U. S. Nuclear Regulatory Commission - Region III 799 Roosevelt Road Glen Ellyn, Illinois 60137

Subject: Abnormal Occurrence No. AO 50-331/75-39

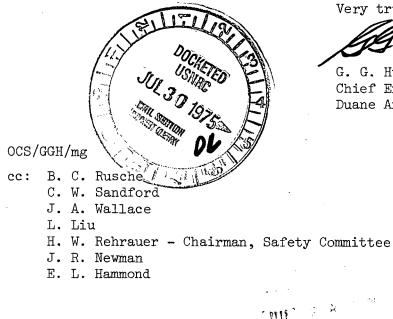
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Dear Mr. Keppler:

In accordance with Appendix A to 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. D. Feierabend, of your office, was notified of the abnormal occurrence by telephone on July 22, 1975.

JUL



Very truly yours,

G. G. Hunt Chief Engineer Duane Arnold Energy Center



IOWA ELECTRIC LIGHT AND POWER COMPANY

General Office Cedar Rapids. Iowa

Subject: Abnormal Occurrence

Sector 17-24-15

Report Number: A0 50-331/75-39

Report Date: July 24, 1975

Occurrence Date: July 21, 1975

Facility: Duane Arnold Energy Center

Identification of Occurrence

Core Spray Sparger Pressure Vessel Differential Pressure Trip Level Setting reportable per Appendix A, Operating License DPR-49, Specification 1.0.4.b and Table 3.2-B.

Description of Occurrence

During the performance of Surveillance Test Procedure (STP) 42B018, "Sparger High DP Instrument Functional Test/Calibration", it was found that Pressure Differential Indicating Switch (PDIS) 2139 was set at 3.2 psid. Table 3.2-B lists the correct value as 0.74 psid plus or minus 0.25 psid for instrument tolerance. To this setting (0.74) is added 2.0 psid for zero depression due to sensor line water density difference caused by the change in water temperature between rated reactor power and shutdown. The correct trip level setting is therefore 2.74 + 0.25 psid.

Designation of Apparent Cause of Occurrence

The apparent cause of the occurrence was instrument drift.

Analysis of Occurrence

Instrument Channel A was operable, so theoout-of-calibration condition of PDIS 2139 (Instrument Channel B) would not have prevented the system from performing its intended safety function and the occurrence did not present an unsafe plant condition.

Corrective Action

The switch was immediately recalibrated and functionally tested.

Conclusion

This report was reviewed and approved by the DAEC Operations Committee on July 24, 1975. The Committee concluded that the occurrence did not present a hazard to the health and safety of the public.

G. G. Hunt

Chief Engineer Duane Arnold Energy Center

OCS/GGH/mg