KRIBUTION FOR PART 50 DOCKET MATERIAL (TEMPORARY FORM)

CONTROL NO:_

FILE: INCIDENT REPORT

FROM: Iowa Elec. Cedar Rapid		Light & Power	DATE OF DOC	DAT	E REC'D	LTR	TWX	RPT	OTHER	
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Letter trans the following					Abnormal Occurrence # 75-69, on 12-12-75, Concerning inoperable low pressure valve					
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- TIC (ABERNATHY) (1)(2)(10) - NATIONAL LABS

1 - W. PENNINGTON, Rm E-201 GT 1 - CONSULTANTS 1 - NSIC (BUCHANAN)

1 - ASLB

NEWMARK/BLUME/AGBABIAN

1 - Newton Anderson NEV ACRS SENT TO LIC ASST S. Teets

** SEND ONLY TEN DAY REPORTS

1 - PDR-SAN/LA/NY

1 - BROOKHAVEN NAT LAB

1 - G. ULRIKSON, ORNL

1 - AGMED (RUTH GUSSMAN) Rm B-127 GT

1 - J. D. RUNKLES, Rm E-201 GT



IOWA ELECTRIC LIGHT AND WER COMPANY

DUANE ARNOLD MERGY CENTER 3

P. OW BOX 3535

DUANE ARNOLD THERGEOCETHTER

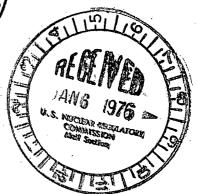
P. M. Box 3575

Cedar Rap Is, John 2406

December 22, 1975 1976

DAED 75 - MelioSection Docker Clerk

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



Subject: Abnormal Occurrence No.

AÒ 50-331/75-69

File: A-118a

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.

Very truly yours,

E. L. Hammond

Assistant Chief Engineer Duane Arnold Energy Center

DLW/ELH/mg

cc: B. C. Rusche

- D. Arnold
- J. Wallace
- L. Liu
- H. Rehrauer Chairman, Safety Committee
- J. Newman
- G. Hunt

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IOWA ELECTRIC LIGHT AND POWER COMPANY

DUANE ARNOLD ENERGY CENTER P. O. Box 351 Cedar Rapids, Iowa 52406

Subject:

Abnormal Occurrence

Report Number:

AO 50-331/75**-**69

Report Date:

December 22, 1975

Occurrence Date: December 12, 1975

Facility:

Duane Arnold Energy Center, Unit No. 1, Palo, Iowa

Identification of Occurrence

Closed low pressure instrument line valve (recircultion pump dP), reportable in accordance with Appendix A to Operating License DPR-49, Specification 1.0.4.d.

Description of Occurrence

During a routine plant inspection following a reactor shutdown, it was determined that the low pressure valve on the instrument line to PDIS 4626C was closed, this made the switch inoperative.

Designation of Apparent Cause of Occurrence

The cause of the occurrence was personnel error. The valve apparently was not returned to the open position following the completion of surveillance testing in November, 1975.

Analysis of Occurrence

The subject pressure differential indicating switch is a component of the LPCI loop selection logic and determines whether the recirculation pumps are running. Four switches are arranged in a one-out-of-two-twice logic across each recirculation pump. Since the November surveillance test was performed with the recirculation pumps running, PDIS 4626C would have remained in a tripped condition even if the respective recirculation pump were shutdown. However, a false "pump running" signal would not have been transmitted to the LPCI Loop Selection logic since a trip would have been required in the other trip system for the same pump. Therefore, the occurrence did not present an unsafe plant condition.

Corrective Action

The appropriate maintenance personnel will be reinstructed as to the requirements

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for positive verification that instrumentation isolation valves are returned to the open position following the completion of surveillance testing.

Conclusion

This report was reviewed and approved by the DAEC Operations Committee on December 22, 1975. The Committee concluded that the occurrence did not present a hazard to the health and safety of the public.

E. L. Hammond

Assistant Chief Engineer

DAEC

DLW/ELH/mg