

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 7910300206 DOC. DATE: 79/10/19 NOTARIZED: NO DOCKET #
 FACIL: 50-331 Duane Arnold Energy Center, Iowa Electric Light & Pow 05000331
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 VAN SICKEL, J. Iowa Electric Light & Power Co.
 RECIP. NAME RECIPIENT AFFILIATION
 Region 3, Chicago, Office of the Director

SUBJECT: LER 79-024/03L-0: on 790919, min flow valve for core spray pump A would not close. Caused by moving of shift lever on valve operator to neutral position, disengaging operator motor. Lever moved when drop cord was suspended from it.

DISTRIBUTION CODE: A002S COPIES RECEIVED: LTR 4 ENCL 4 SIZE: 1+1
 TITLE: Incident Reports

NOTES: -----

ACTION:	RECIPIENT ID CODE/NAME	COPIES		RECIPIENT ID CODE/NAME	COPIES	
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	05 BC ORB #3	4	4			
INTERNAL:	01 REG FILE	1	1	02 NRC PDR	1	1
	09 T&E	2	2	11 MPA	3	3
	14 TA/EDO	1	1	15 NOVAK/KNIEL	1	1
	16 EEB	1	1	17 AD FOR ENGR	1	1
	18 PLANT SYS BR	1	1	19 I&C SYS BR	1	1
	20 AD PLANT SYS	1	1	22 REAC SAFT BR	1	1
	23 ENGR BR	1	1	24 KREGER	1	1
	25 PWR SYS BR	1	1	26 AD/SITE ANAL	1	1
	27 OPERA LIC BR	1	1	28 ACIDENT ANLYS	1	1
	29 AUX SYS BR	1	1	E JORDAN/IE	1	1
	HANAUER, S.	1	1	STS GROUP LEADR	1	1
	TMI-H STREET	1	1			
EXTERNAL:	03 LPDR	1	1	04 NSIC	1	1
	29 ACRS	16	16			

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LICENSEE EVENT REPORT

CONTROL BLOCK: [] [] [] [] [] [] [] [] [] [] (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[01] I A D A C I [2] 0 0 0 - 0 0 0 0 0 0 - 0 0 0 [3] 4 1 1 1 1 1 [4] [] [5]

CON'T [01] REPORT SOURCE [6] 0 1 5 0 0 0 3 3 1 [7] 0 9 1 9 7 9 [8] 1 0 1 1 9 7 9 [9]

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[02] During daily surveillance testing as a result of another occurrence, the [03] minimum flow valve (MOV 2104) for the "A" core spray pump, 1P-211A, woul [04] d not close. "B" core spray system was operable. Reference Technical Spe [05] cification Section 3.5.A. Testing conducted 9/26/79 demonstrated that th [06] e "A" core spray pump would meet head requirements at rated flow even wi [07] th the minimum flow valve open. As a result this occurrence was reclassi [08] fied as a 30 day Reportable Occurrence.

[09] SYSTEM CODE [11] S F CAUSE CODE [12] A CAUSE SUBCODE [13] F COMPONENT CODE [14] V A L V I O P COMP. SUBCODE [15] A VALVE SUBCODE [16] Z [17] LER/RO REPORT NUMBER [21] 7 9 EVENT YEAR [22] [] SEQUENTIAL REPORT NO. [24] 0 2 4 OCCURRENCE CODE [28] 0 3 REPORT TYPE [30] L REVISION NO. [32] 0 [18] E ACTION TAKEN [19] Z FUTURE ACTION [20] Z EFFECT ON PLANT [21] Z SHUTDOWN METHOD [22] 0 0 0 0 HOURS [23] N ATTACHMENT SUBMITTED [24] N NPRO-4 FORM SUB. [25] A PRIME COMP. SUPPLIER [26] L 2 0 0 COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[10] An immediate investigation revealed the shift lever on the valve operator [11] had been moved to the neutral position which disengaged the operator mot [12] or. The lever was moved when craft personnel suspended a drop cord from [13] the lever. Shift lever restored to proper position and valve tested sat. [14] Other valves in torus area checked. Craft Supervisors reinstructed.

[15] FACILITY STATUS [28] F % POWER [29] 0 4 1 7 OTHER STATUS [30] NA METHOD OF DISCOVERY [31] B DISCOVERY DESCRIPTION [32] Surveillance Test

[16] ACTIVITY CONTENT [33] Z RELEASED OF RELEASE [34] Z AMOUNT OF ACTIVITY [35] NA LOCATION OF RELEASE [36] NA

[17] PERSONNEL EXPOSURES NUMBER [37] 0 0 0 TYPE [38] Z DESCRIPTION [39] NA

[18] PERSONNEL INJURIES NUMBER [40] 0 0 0 DESCRIPTION [41] NA

[19] LOSS OF OR DAMAGE TO FACILITY TYPE [42] Z DESCRIPTION [43] NA

[20] PUBLICITY ISSUED [44] N DESCRIPTION [45] NA

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