

50-331

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

FILE NUMBER

INCIDENT REPORT

TO: Mr. James G. Keppler

FROM: Iowa Elect Light & Power Co.
Cedar Rapids, Iowa 52406
Ellery L. Hammond

DATE OF DOCUMENT

12/29/77

DATE RECEIVED

01/10/78

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DESCRIPTION

ENCLOSURE

Licensee Event Report (RO 50-331/77-94) on 12/15/77 concerning RHR cross tie valve was in the closed position when the valve position lights indicated open in the control room during routine plant inspection...

1p 2p

PLANT NAME: DUANE ARNOLD
jcm 01/10/78

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED
SEND DIRECTLY TO KREGER/J. COLLINS

LCY ENCL Rec'd *

FOR ACTION/INFORMATION

BRANCH CHIEF: **LCAR**
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LEDR: **Cedar Rapids, IA.**
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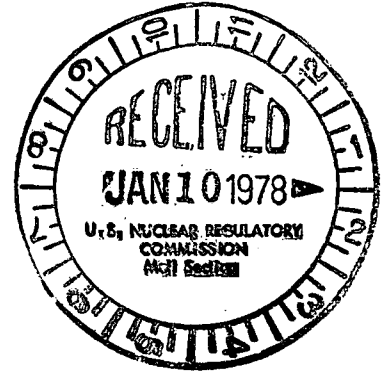
D. Lanham

REGULATORY DOCKET FILE COPY

IOWA ELECTRIC LIGHT AND POWER COMPANY

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

December 29, 1977
DAEC -77 - 654



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: Licensee Event Report No. 77-94
(14 day)

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 and Regulatory Guide 10.1, please find attached a copy of the subject Licensee Event Report. (Total of 3 copies transmitted)

Very truly yours,

Ellery L. Hammond

Ellery L. Hammond
Chief Engineer
Duane Arnold Energy Center

Docket 50-331

attachment

ELH/DLW/mg

cc: Director, Office of Inspection and Enforcement (40)
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

Director, Management Information and Program Control (3)
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

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DUANE ARNOLD ENERGY CENTER

Iowa Electric Light and Power Company

LICENSEE EVENT REPORT-Supplemental Data

Docket Number 50-331

December 29, 1977

Licensee Event Report Date: 77-094

Reportable Occurrence No: 121577

Description of Occurrence

During a routine plant inspection a plant operator observed that normally open RHR crosstie valve, MOV 2010, was in the closed position. The valve position lights in the control room indicated that the valve was in the "open" position. Operating personnel attempted to open the valve manually but the handwheel turned "freely". Since the closed crosstie valve would inhibit the capability for full LPCI injection to either recirculation loop, the LPCI system was declared inoperable and appropriate surveillance testing was initiated.

Cause of Occurrence

A preliminary inspection of the limitorque valve operator (SMB-1) internals revealed mechanical damage to the worm and worm gear. Fractured teeth were observed on both the worm and worm gear. The damaged components have been shipped to the vendor for evaluation. Final determination of cause of occurrence will be included in a supplemental report.

Corrective Action

Replacement parts for the valve operator are on order. In the interim, the valve has been locked in the open position and the LPCI system declared operable. (The closing function of the crosstie valve performs no safety function).

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