

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

12/30/77

DATE RECEIVED

01/10/78

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DESCRIPTION  
  
PLANT NAME: DUANE ARNOLD  
jcm 01/10/78  
  
1p

ENCLOSURE Licensee Event Report (RO 50-331/77-095) on 12/20/77 concerning during surveillance testing the HPCI system discharge flow rate did not reach the required flow of 3000 GPM in the 25 seconds allowed by the surveillance test...  
  
2p  
  
NOTE: IF PERSONNEL EXPOSURE IS INVOLVED SEND DIRECTLY TO KREGER/J. COLLINS  
**1 cy ENCL Rec'd \***

FOR ACTION/INFORMATION

BRANCH CHIEF:	LEAR
N/ # COYS FOR ACTION	
MESSAGE:	

INTERNAL DISTRIBUTION

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EXTERNAL DISTRIBUTION

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LEDR: Cedar Rapids, IA.	
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No 4  
60

*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 30, 1977  
DAEC -77 - 656



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. 77-095  
(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,

*BR Hamond for ELH*

Ellery W. Hammond  
Chief Engineer  
Duane Arnold Energy Center

Docket 50-331

attachment

ELH/JVS/mg

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

780100050

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

JAN 3 1978

LICENSEE EVENT REPORT

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

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CON'T REPORT SOURCE L 6 0 5 0 0 0 3 3 1 7 1 2 2 0 7 7 8 1 2 3 0 7 7 9

0 2 During Surveillance testing the HPCI system discharge flow rate did not reach the required flow of 3000 GPM in the 25 seconds allowed by the surveillance test. Two additional restarts of the system were required to reach design flow rates and time. Flow rate requirement listed in Tech Spec 4.5.D.1. Repetitive occurrence (see RO 77-77). Redundant emergency core cooling systems operable.

0 9 S F 11 X 12 Z 13 T U R B I N 14 Z 15 Z 16 17 7 7 18 0 9 5 19 T 20 21 22 23 24 26 27 28 29 30 31 32 0 21 22 23 24 26 27 28 29 30 31 32 0 33 34 35 36 37 40 41 Y 23 42 N 24 43 N 25 44 T 1 4 7 47 26

1 0 Unknown. A check was made of system lube oil line throttling valve settings and system instrument settings and minor adjustments made where necessary. Following this the HPCI system operated satisfactory. Further surveillance testing will be done to see if the problem is recurring.

1 5 E 28 0 9 9 29 NA 30 B 31 Surveillance Test 32 1 6 Z 33 Z 34 NA 35 NA 36 1 7 0 0 0 37 Z 38 NA 39 1 8 0 0 0 40 NA 41 1 9 Z 42 NA 43 2 0 N 44 NA 45

DUANE ARNOLD ENERGY CENTER

Iowa Electric Light and Power Company

LICENSEE EVENT REPORT-Supplemental Data

Docket Number 50-331

December 30, 1977

Licensee Event Report Date: 123077

Reportable Occurrence No: 77-095

Description of Event

During Surveillance Testing on 12/20/77 the HPCI system did not attain the required flow rate of 3000 GPM in the 25 second period allowed by the Surveillance Test. On the second subsequent test the HPCI system reached the design flow rate in the time allowed. The system flow rate requirement is listed in Technical Specification 4.5.D.1. Redundant emergency core cooling systems were immediately tested and found operable. Repetitive occurrence (see RO 77-77).

Cause of Event

Unknown. No definite cause for this event could be determined. During subsequent testing the problem did not reappear.

Correction Action

Although the system lube oil throttling valve settings and system instrument settings were checked and a few minor adjustments made, no real definitive cause of this event was determined and, therefore, no corrective action could appropriately be taken. Further surveillance testing will be done to determine if the problem is recurring.

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