LICENSEE EVENT REPORT

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0 2	I During normal operation surveillance testing, the 'A' LPCI injection val
_	ve, MOV-2003, failed to close completely. LPCI declared inop and 24-hr L
0 3	
0 4	LCO entered per T.S.3.5.A.6. LCO lifted after approx 2 hr when MOV-2003 s
0 5	Lhown operable. During invest, bolts for motor operator voke ring found 1
0 6	Loose. Second 24-br CO entered for approx 3 1/2 hours until MOV-2003 was
0 7	Lproven operable 'B' LPCI inject loop MOV-1905 was operable. There have
0 8	Lheen no previous similar occurrences with MOV-2003.
0 9	CODE CODE SUBCODE COMPONENT CODE SUBCODE SUBCO
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	ACTION FUTURE SHUTDOWN HOURS 22 ATTACHMENT NARCAMP SUPPLIER MANUFACTURER MANUFACTURER SHUTDOWN METHOD SUPPLIER SUPPLIER MANUFACTURER MA
110	I MOV-2003 closure halted by torque limit switch. Excessive torque from bi
	Inding operator due to loose yoke ring. Yoke ring bolts not torqued follo
1 2	wing last maintenance due to combination of inadequate personnel trainin
113	g and inadequate procedures. Bolts torqued to 150 ft-lbs. MOV-1905 bolts
-	I tight. To prevent recurrence, procedures and training will be upgraded.
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1 6	ACTIVITY CONTENT E (28) O 3 5 (29) NA E (28) O 3 5 (29) NA ACTIVITY CONTENT 12 13 ACTIVITY CONTENT 13 ACTIVITY CO
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DUANE ARNOLD ENERGY CENTER

Iowa Electric Light and Power Company
Licensee Event Report - Supplemental Data
Docket No. 050-0331

Licensee Event Report Date: 11-5-82

Reportable Occurrence No: 82-067

Event Description:

During normal operation surveillance testing, the 'A' LPCI injection valve, MOV-2003, failed to close completely. LPCI was declared inoperable and a 24-hour limiting condition for operation (LCO) was entered in accordance with Technical Specification 3.5.A.6. MOV-2003 was stroked under observation and met all requirements for valve operation. MOV-2003 was declared operable and the LCO was lifted after approximately 2 hours. Investigation continued into the root cause of the event. At this time it was believed that the valve stem had been binding due to lack of lubrication. During lubrication of the stem, mounting bolts for the motor operator yoke ring were found loose. LPCI was again declared inoperable and a second 24-hr LCO was entered for approximately 3 1/2 hours. The 'B' LPCI injection valve, MOV-1905, was operable, providing LPCI capabilities if there was no leakage from the 'B' reactor recirculation loop. There have been no previous similar occurrences with MOV-2003.

Cause Description:

The closure of MOV-2003 was halted by the motor operator torque limit switch. The loose yoke ring allowed the motor operator and stem to become misaligned. Because of this misalignment, excessive torque was required to operate the valve. The retaining bolts for the yoke ring had not been sufficiently tightened during the last maintenance on MOV-2003 due to a combination of inadequate personnel training and inadequate procedures.

Corrective Action:

To return MOV-2003 to operable status, the yoke ring retaining bolts were torqued to 150 ft-lbs. The related bolts on MOV-1905 were sufficiently tight. To prevent recurrence maintenance procedures are currently being reviewed to identify and correct those procedures which are deficient. Any deficient procedures found will be technically upgraded. In addition, maintenance personnel will be properly trained to perform these procedures.