DSB

Iowa Electric Light and Power Company
February 20, 1980
DAEC - 80 - 81

Mr. James G. Keppler, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission - Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

Subject: Licensee Event Report No. 80-002
(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,

Daniel L. Wilson for

Daniel L. Mineck
Chief Engineer
Duane Arnold Energy Center

Docket 50-331

attachment

DLM/JCZ/n

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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NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | LICENSEE CODE: I A D A C 1 (2) | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT (5)

CON'T 01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 3 3 1 (7) | EVENT DATE: 0 2 0 6 8 0 (8) | REPORT DATE: 0 2 2 0 8 0 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 With the CO-2 system tagged out to permit maintenance in the cable sprea
03 ding room, site security shift supervision removed fire watch personnel
04 from the area without notifying the shift supervising engineer. The room
05 door was locked with no personnel inside when the fire watch was secured
06 . The cable spreading room was left unattended with the CO-2 system inop
07 for approximately six hours thus violating T.S.3.13.D.b. No similar
08 reports have been made.

09	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	A B (11)	A (12)	F (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 0	—	0 0 2	/	0 1	T	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Personnel error. Security shift supervision removed fire watch personnel
11 from post without notifying the shift supervising engineer. The CO-2 sys
12 tem was immediately returned to service when situation was recognized.
13 The persons involved have been reinstructed to adhere to T.S. requiremen
14 ts and associated surveillance procedures pertaining to fire watches.

15 | FACILITY STATUS: E (28) | % POWER: 0 7 8 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: Z (31) | DISCOVERY DESCRIPTION (32): Operator Observation

16 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

PERSONNEL EXPOSURES

17 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES

18 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)

19 | TYPE: Z (42) | DESCRIPTION: NA

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PUBLICITY

20 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

NAME OF PREPARER J. C. Zimmerman PHONE: 319-851-5611

DUANE ARNOLD ENERGY CENTER

Iowa Electric Light and Power Company

LICENSEE EVENT REPORT-Supplemental Data

Docket No. 050-0331

Licensee Event Report Date: 022080

Reportable Occurrence No: 80-002

Event Description:

At 0715 on February 6, 1980 the CO_2 System for the electrical cable spreading room was tagged out of service to permit maintenance in the room. A fire watch was established at that time per T.S.3.13.D.2.b. At approximately 0950, the fire watch was secured by Security Shift Supervision when maintenance personnel did not show up (no access to the spreading room had been made during the fire watch). This was done without notifying the Shift Supervising Engineer. As a result the cable spreading room was left unattended with the CO_2 system inoperable.

Cause Description:

Personnel Error.

Corrective Action:

At 1600 on February 6, 1980 the situation was recognized by operations, and the CO_2 system immediately restored to operability. The personnel involved have been reinstructed to adhere to the Technical Specification requirements and associated surveillance procedures pertaining to fire watches. No further corrective action is planned at this time.

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