REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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ACCESSION NBR:8908080304 DOC.DATE: 89/07/28 NOTARIZED: NO DOCKET # FACIL:50-331 Duane Arnold Energy Center, Iowa Electric Light & Pow 05000331 AUTH.NAME AUTHOR AFFILIATION AXLINE,J.S. Iowa Electric Light & Power Co. HANNEN,R.L. Iowa Electric Light & Power Co. RECIP.NAME RECIPIENT AFFILIATION											
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NOTE TO ALL "RIDS" RECIPIENTS:

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Iowa Electric Light and Power Company

July 31, 1989 DAEC-89-0534

Mr. A. Bert Davis Regional Administrator Region III U. S. Nuclear Regulatory Commission 799 Roosevelt Road Glen Ellyn, IL 60137

> Subject: Duane Arnold Energy Center Docket No: 50-331 Op. License DPR-49 Licensee Event Report #89-010

Gentlemen:

In accordance with 10 CFR 50.73 please find attached a copy of the subject Licensee Event Report.

Very truly yours, Daich Wilson for

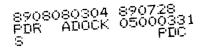
Rick L. Hannen Plant Superintendent - Nuclear

RLH/JSA/gt

cc: Director of Nuclear Reactor Regulation Document Control Desk U.S. Nuclear Regulatory Commission Mail Station P1-137 Washington, D. C. 20555

NRC Resident Inspector - DAEC

File A-118a



NRC Form (9-83)	384					LIC	ENSE	E EVEN	T REI	PORT	LER)		Ű		LEAR REGU PPROVED (XPIRES: 8/3	OMB NO.			
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During Performance of Steam Leak Detection Surveillance																			
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On July 5, 1989, with the plant operating at 100% power, the Reactor Core Isolation Cooling (RCIC) inboard isolation valve closed following receipt of the "B" logic isolation signal. The isolation signal was generated during performance of the RCIC Steam Leak Detection System Surveillance Test Procedure (STP).																			
The root cause of this event was personnel error on the part of the utility apprentice instrument technician who lifted temperature switch input leads prior to completing the procedure steps which place the appropriate keylock test switch in the test position. Contributing factors in this event were a communication error between the journeyman instrument technician and the apprentice and the fact that the apprentice, although trained in general on performing STPs, had not performed this specific test previously.																			
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Immediate corrective actions were to determine the cause of the RCIC isolation. Upon determination, the STP was stopped and the RCIC system was unisolated. The STP was restarted following a discussion of the event between the shift supervisors and the Instrument Technicians performing the test. To prevent recurrence of this type of event, discussion of the July 5, 1989 RCIC isolation has been incorporated in the Maintenance Personnel Continuing Training Program.																			

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U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER	NUMBER(6)		PAGE(3)							
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER								
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TEXT (If more space is required, use additional NRC Form 366A's) (17)	· · · · · · · · · · · · · · · · · · ·											

I. DESCRIPTION

NRC Form 366A (9-83)

> On July 5, 1989, with the plant operating at 100% power, the Reactor Core Isolation Cooling (RCIC) (EIIS System Code BN) inboard isolation valve (BN-ISV-2400, DAEC M02400) closed following receipt of the "B" logic isolation signal. The isolation signal was generated during performance of the RCIC Steam Leak Detection System (SLDS) (EIIS System Code JM) Surveillance Test Procedure (STP) at 1642 hours following lifting of input leads to a temperature switch (JM-TDS-2450B, DAEC TDS2450B). Prior to lifting instrument input leads the Instrument Technician working the STP failed to put the appropriate keylock test switch in the test position. This allowed the temperature switch to feed a trip signal to the downstream trip logic when the input leads were lifted.

II. CAUSE OF EVENT:

The root cause of this event was personnel error on the part of the utility apprentice instrument technician who lifted the temperature switch input leads prior to completing the procedure steps which place the appropriate keylock test switch in the test position. A major contributing factor in this event was a communication error between the journeyman instrument technician and the apprentice. Prior to momentarily leaving the area the journeyman instructed the apprentice to re-terminate the input leads on the instrument they had just finished calibrating and de-terminate the input leads on the next instrument. What had been intended by this statement was "complete the STP steps up to and including the step which de-terminates the next instrument." What was actually performed was de-termination of the next instrument on the Temporary Modification Clearance Form immediately following re-termination of the previously worked instrument. Another contributing factor was the fact that the apprentice, although trained in general on performing STPs, had not performed this specific test previously.

III. ANALYSIS OF EVENT:

This event had no effect on the safe operation of the plant. The isolation of RCIC was immediately identified and the appropriate actions were taken. The RCIC isolation valve responded as expected to the inadvertent isolation signal. During any other plant conditions this event would have had no effect on the safe operation of the plant as the RCIC system could rapidly be unisolated and put into service if required. In addition, no credit is taken for RCIC performance in the DAEC Emergency Core Cooling System analysis.

NRC Form 366A (9-83)

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Duane Arnold Energy Center	0 5 0	00	33	1	89		010	-	00	3	OF	3		
 TEXT (If more space is required, use additional MRC Form 306A*s)(17) IV. IMMEDIATE CORRECTIVE ACTIONS Immediate corrective actions were isolation. Upon talking with the the SLDS STP, the cause (keylock before lifting of leads) for the Supervisor. The STP was stopped its normal standby condition (app isolation). Prior to allowing cd Supervisors discussed this event involved. The instrument technic on the importance of performing S supervisor. V. LONG TERM CORRECTIVE ACTIONS To minimize the possibility of tl future, the importance of prevent in the weekly Instrument Shop mee been incorporated in the Maintend personnel continuing training pre error can occur. VI. ADDITIONAL INFORMATION: Previous Similar Events Three similar events, LERs 86- actuation due to personnel fa steps) have occurred in the pa personnel errors existed. This event is being reported	e to de e instru switch isolati and th proxima ompleti with t cians i STPs, w : his typ ting pe eting on ance (E ogram as -027, 8; iling t ast, how	ument not ion b e RC itely on o he i nvol itho e of rson n Ju lect s an 7-01 to fo weve	t tec take ecame IC sy 10 m f the nstru ved w ut er even nel e ly 7, rical exam 7 and 110w r, no	hni t en t sap vste inu en st o s r o s r o s r o s c o c o	cians to tes paren m was ites a P the t tec also s, by ccurr wa 89. lechan of h of h	and start st	nd revie positio to the S returned ter the Shift nicians counsell their ng in th discuss is even tal, I&C a perso	ewi Shid led led sed th conn ystur r t	ing ift o nas nel cem ure che					

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