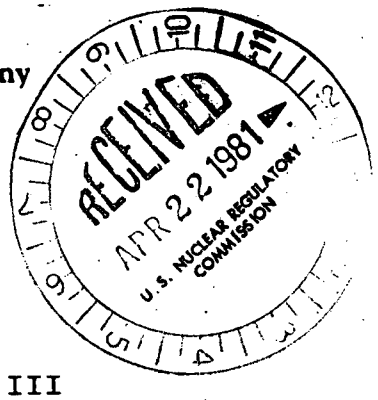
Iowa Electric Light and Power Company
April 20, 1981
DAEC-81-244



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. 81-010 (30 day)

UPDATE REPORT: Previous Report Date 3-25-81

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. Mineck
Chief Engineer
Duane Arnold Energy Center

DLM/MSR/pl

Docket 50-331

attachment

cc: Director, Office of Inspection and Enforcement (30)
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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Washington, D. C. 20555

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NRC Resident Inspector - DAEC

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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: 4-20-81

Reportable Occurrence No: 81-010 UPDATE REPORT: Previous Report Date 3-25-81

Event Description

During surveillance testing of the Standby Filter Units (SBFU), the "B" SBFU was discovered to be not running during a 10-hour operational run. Investigation revealed that the breaker for the Control Building Emergency Air Supply Fan, 1V-SF-30B, had been opened by Operations personnel. The breaker was closed and operational test restarted. The "B" SBFU was out of service for approximately 10.5 hours. Technical Specification 3.10.A.3 requires both SBFUs to be operable during reactor operation. The "A" train of SBFU had previously completed its 10-hour operational test satisfactorily. The "A" SBFU was operable and available for automatic initiation. No previous occurrences of this nature have been recorded.

Cause Description

Personnel error. Operations personnel had begun the 10-hour operational run of the "B" SBFU when its breaker was mistakenly opened. Maintenance personnel had been instructed to perform lubrication on the "A" SBFU. To provide for their safety the breaker for that unit's fan was to be opened prior to maintenance. Poor communications between ops personnel resulted in the wrong breaker being opened.

Corrective Action

Ops personnel discovered the "B" SBFU wasn't running at the scheduled completion of its 10-hour run. Investigation revealed the wrong breaker had been opened and not reclosed following maintenance. The breaker was closed and the operational test completed with satisfactory results. Plant procedures will be reviewed to determine if weaknesses which may have contributed to this event can be identified and eliminated. Operations personnel have been reinstructed on the need to monitor, more closely, maintenance on safety-related equipment.