

Nebraska Public Power District

COOPER NUCLEAR STATION
P.O. BOX 98, BROWNVILLE, NEBRASKA 68321
TELEPHONE (402) 825-3811

CNSS790469

September 7, 1979

Mr. K. V. Seyfrit
U.S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region IV
611 Ryan Plaza
Suite 1000
Arlington, Texas 76011

Dear Sir:

This report is submitted in accordance with Section 6.7.2.B.1 of the Technical Specifications for Cooper Nuclear Station and discusses a reportable occurrence that was discovered on August 9, 1979. A licensee event report form is also enclosed.

Report No.: 50-298-79-23
Report Date: September 7, 1979
Occurrence Date: August 9, 1979
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:

Operation with an engineered safety feature instrument setting less conservative than those established in Table 3.2.A of the Technical Specifications.

Conditions Prior to Occurrence:

The reactor was in a cold shutdown condition due to a scram which had occurred earlier in the day.

Description of Occurrence:

While performing routine surveillance test procedure 6.2.1.4.2, differential pressure indicating switch MS-DPIS-119B was found set at a setpoint higher than allowed by Technical Specifications.

Designation of Apparent Cause of Occurrence:

The microswitch in the subject differential pressure indicating switch failed.

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Mr. K. V. Seyfrit
September 7, 1979
Page 2.

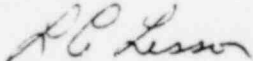
Analysis of Occurrence:

The function of MS-DPIS-1.9B is to monitor the steam flow in the "D" main steam line and initiate a main steam line isolation at 140% rated steam flow. There are three other differential pressure indicating switches on "D" main steam line, MS-DPIS-119A, 119C, and 119D. All three of these instruments were operating properly and would have provided the isolation if it had been required, consequently this occurrence presented no adverse consequences from the standpoint of public health and safety.

Corrective Action:

The switch was readjusted to the correct setpoint at the time of the occurrence. The setpoint of the switch was monitored periodically during the next few weeks. It was determined that the switch continued to drift. The microswitch assembly was replaced. The instrument was returned to service following calibration and performance of Surveillance Procedure 6.2.1.4.2.

Sincerely,



L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.

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