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: N E C P R 1 (2) LICENSE NUMBER: 0 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 2 9 8 (7) EVENT DATE: 1 0 1 2 7 9 (8) REPORT DATE: 1 1 0 9 7 9 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal operation, a routine tour of the plant indicated a through-wall crack
03 of a weld in the REC supply to the south critical loop, upstream of the supply
04 isolation valve. This portion is isolatable from the critical loop. The redundant
05 REC loop and Service Water supply were available to supply this critical loop. If
06 the weld failed completely, it would be detectable. Reference LER Report No. 78-27
07 for an event of similar nature. This event presented no adverse consequences from
08 the standpoint of public health and safety.

09 SYSTEM CODE: S B (11) CAUSE CODE: E (12) CAUSE SUBCODE: X (13) COMPONENT CODE: X X X X X X (14) COMP. SUBCODE: X (15) VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR: 7 9 — SEQUENTIAL REPORT NO.: 0 2 9 / OCCURRENCE CODE: 0 3 REPORT TYPE: L — REVISION NO.: 0

ACTION TAKEN: X (18) FUTURE ACTION: C (19) EFFECT ON PLANT: Z (20) SHUTDOWN METHOD: Z (21) HOURS (22): 0 0 0 0 ATTACHMENT SUBMITTED: N (23) NPRD-4 FORM SUB.: (24) PRIME COMP. SUPPLIER: A (25) COMPONENT MANUFACTURER: J 0 3 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The component involved is a weld. The failure is a through-wall crack which has sur-
11 faced as a pinhole leak of undeterminable cause. A soft patch has been applied and
12 the weld evaluated acceptable for continued service. During the next shutdown of
13 sufficient duration, the weld will be replaced. An evaluation of a similar failure
14 which was not reportable, will determine the cause. Update report will be submitted.

15 FACILITY STATUS: E (28) % POWER: 0 9 6 (29) OTHER STATUS (30): NA METHOD OF DISCOVERY: A (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

POOR ORIGINAL

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

7911270464

NRC USE ONLY

NAME OF PREPARER: Paul Doan PHONE: 402-825-3811

Nebraska Public Power District

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

CNSS79Ø554

November 5, 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.2 of the Technical Specifications for Cooper Nuclear Station and discusses a reportable occurrence that was discovered on October 8, 1979. A licensee event report form is also enclosed.

Report No.: 50-298-79-28
Report Date: November 5, 1979
Occurrence Date: October 8, 1979
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:
A condition which lead to operation in a degraded mode permitted by a limiting condition for operation established in Section 3.19.B of the Technical Specifications.

Conditions Prior to Occurrence:
The reactor was at a steady state power level of approximately 95% of rated thermal power.

Description of Occurrence:
While inspecting the cable spreading room it was noted that a four inch diameter pipe sleeve in the fire wall between the cable spreading room and the cable expansion room was not properly sealed.

Designation of Apparent Cause of Occurrence:
Inadequate control of installation of fire seals during a microwave communications system installation in December 1978.

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Analysis of Occurrence:

The four inch sleeve, located in the wall between the cable spreading room and the cable expansion room, carries two 1 inch conduits through it. One conduit contains control cable for reactor recirculation motor generator set ventilation flow indication. The other conduit contains cable for microwave communication. The space inside the four inch sleeve and outside of the two one inch conduits was not adequately sealed. The possibility of a fire starting in this area is minimal because no combustible material was present. The cable spreading room is equipped with an automatic sprinkler system which could extinguish a fire if one started. The possibility of a fire spreading through the unsealed sleeve was remote because the sleeve contained no combustible material. This occurrence presented no adverse effect to public health and safety.

Corrective Action:

The four inch sleeve was immediately sealed and an adequate fire barrier established. All remaining sleeves in this area were inspected and verified to be properly sealed. The Technical Specifications also require that the penetrations in the cable spreading room be inspected every 18 months. This event was discussed with the appropriate personnel.

Sincerely,

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.

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

01	LICENSEE CODE (2): N E C P R 1	LICENSE NUMBER (3): 0 0 - 0 0 0 0 0 - 0 0 0	LICENSE TYPE (4): 4 1 1 1 1	CAT (5)		
CON'T 01	REPORT SOURCE (6): L	DOCKET NUMBER (7): 0 5 0 0 0 2 9 8	EVENT DATE (8): 1 0 0 8 7 9	REPORT DATE (9): 1 1 0 5 7 9		

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During inspection of cable spreading room it was noted that one 4 inch pipe sleeve
03 in the wall between cable spreading room and cable expansion room was not sealed
04 T.S. 3.19.B. The possibility of a fire in this area is minimal because no combus-
05 tible material was present. Cable spreading room is equipped with an automatic
06 sprinkler system. No significant occurrence took place. This event had no effect
07 upon public health and safety. This event is not repetitive.
08

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

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 9	—	0 2 8	/	0 3	L	—	0

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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Four inch sleeve in the wall has apparently been unsealed since December 1978.
11 The sleeve was immediately sealed. All other sleeves in this area were also in-
12 spected and verified to be properly sealed. The incident was discussed with ap-
13 propriate personnel.
14

	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
15	E	0 9 5	NA	B	Shift Supervisor Observation

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

POOR ORIGINAL

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE (42)	DESCRIPTION
19	Z	NA

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PUBLICITY

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

NAME OF PREPARER Ladislav F. Bednar PHONE: 402-825-3811