

Nebraska Public Power District

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

CNSS800581

October 1, 1980

Mr. K. V. Seyfrit, Director
U.S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region IV
611 Ryan Plaza Drive
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 September 8, 1980. Mr. Spangler was notified on September 8, 1980 in accordance with the requirements of IE Bulletin No. 80-17. A licensee event report form is also enclosed.

Report No.: 50-298-80-34
Report Date: October 1, 1980
Occurrence Date: September 8, 1980
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 3.5 A.4 of the Technical Specifications.

Conditions Prior to Occurrence:

The reactor was at a steady state power level of approximately 100% of rated thermal power.

Description of Occurrence:

During routine plant inspection, an operator observed the 4160V breaker for RHR pump 1D was not capable of automatically closing and starting the subject pump.

Designation of Apparent Cause of Occurrence:

The breaker's closing spring was not compressed (charged). The failure to charge was caused by the latch monitoring switch which did not close. The latch monitoring switch is operated by the closing latch stop. This stop failed to return to its normal position after the breaker tripped because of friction inside the spring release solenoid.

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Mr. K. V. Seyfrit
October 1, 1980
Page 2.

Analysis of Occurrence:

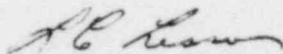
The inability of RHR 1D breaker to close automatically made RHR 1D pump inoperable for approximately 20 hours. The remaining three RHR pumps, both core spray pumps, and both diesel generators were operable.

This occurrence presented no adverse consequences from the standpoint of public health and safety.

Corrective Action:

Breaker RHR 1D was immediately removed and replaced with an identical spare. The breaker which failed to charge was disassembled and thoroughly inspected. The bracket holding the spring release solenoid was adjusted and the latch monitoring switch was replaced. Free travel of the closing latch stop assembly and correct operation of the latch monitoring switch were verified.

Sincerely,



L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.