

Nebraska Public Power District

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

CNSS800588

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 17, 1980. Mr. Spangler was notified of this occurrence by telephone on September 17, 1980 in accordance with the requirements of IE Bulletin No. 80-17. A licensee event report form is also enclosed.

Report No.: 50-298-80-35
Report Date: October 1, 1980
Occurrence Date: September 17, 1980
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:

A condition occurred which resulted in operation in a degraded mode as permitted by the limiting condition for operation established in Section 3.5.C.2 of the Technical Specifications.

Conditions Prior to Occurrence:

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

Description of Occurrence:

During surveillance testing of the HPCI system a gasket in the oil supply to the HPCI stop valve actuator failed.

Designation of Apparent Cause of Occurrence:

Incorrect material. The gasket which failed was not made of the material recommended by the component manufacturer for this application.

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Analysis of Occurrence:

The HPCI turbine stop valve is a vertically mounted hydraulically operated piston type globe valve with the actuating cylinder on the bottom. In the actuator, oil is supplied to the hydraulic cylinder from the relay valve mounted directly beneath it.

During a surveillance test, operations personnel discovered oil leaking at the connection between the relay valve and the hydraulic cylinder. The HPCI system was shutdown and declared inoperable. The relay valve was removed from underneath the hydraulic cylinder for replacement of the failed gasket. At this time it was discovered that the replacement gaskets stored in the warehouse were not made of the same material. Discussion with the vendor indicated which material was recommended for this application. The failed gasket was not made of the approved material.

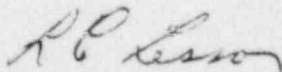
Subsequent investigation indicates that the failed gasket which has a black soft texture was installed in April 1977. The failed gasket was purchased from Schutte & Koerting by NPPD Purchase Order No. 102121 issued in December 1975. When the gasket was installed, replacements were ordered on Purchase Order No. 120260. These gaskets were received in July 1977 and are made of the recommended material which has an oil paper texture. The subject gasket is not identified by part number and no material specification is noted in the technical manual. The vendor stated that an error was made in supplying the gasket on P. O. #102121.

The HPCI system was inoperable for approximately 2.5 hours as a result of this occurrence. During this time the redundant system, ADS, was operable as were the low pressure injection systems. This occurrence had no adverse affect on the public health and safety.

Corrective Action:

The failed gasket was replaced with one made of the correct material. The system was tested and performed satisfactorily. No further action is planned.

Sincerely,



L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.