Nebraska Public Power District

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

CNSS800450

July 22, 1980

Mr. K. V. Seyfrit
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 June 29, 1980. A licensee event report form is also enclosed.

Report No.: 50-298-80-22
Report Date: July 22, 1980
Occurrence Date: June 29, 1980
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:
Conditions leading to operation in a degraded mode permitted by a limiting condition for operation as delineated in Section 3.7.D of the Technical Specifications.

Conditions Prior to Occurrence:
Steady state power operation at approximately 99% reactor power.

Description of Occurrence:
During routine discharge of water from the Residual Heat Removal System (RHR) to radwaste, the inboard throttle isolation valve (RHR-MO-57) failed to close either remotely or manually.

Designation of Apparent Cause of Occurrence:
The subject 4", 300#, motorized, globe valve was disassembled to determine the cause of the occurrence. Upon disassembly the valve seat, which is screwed into the body of the valve, had become unthreaded from the body and had lodged itself between the disc and body so that the valve disc could not move. Normally, the close fit of the threads is sufficient so that the seat does not work itself free; however, in this case system vibration was sufficient to produce the failure.

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Analysis of Occurrence:

As described, RHR-MO-57 is the inboard throttle isolation on the RHR drain to radwaste. Upstream of RHR-MO-57 is RHR-MO-67 which is the outboard isolation valve which was operable. In the event the valves had received an isolation signal, RHR-MO-67 would have closed.

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

Corrective Action:

Immediate action upon identification of occurrence was to tag shut RHR-MO-67 in accordance with the Technical Specifications. The damaged seat was removed and a new seat was installed. To prevent recurrence, the seat was tack welded into place.

Sincerely,

P. V. Thomason for

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.