



Nebraska Public Power District

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

CNSS810058

January 29, 1981

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 December 30, 1980. In accordance with the requirements of IE Bulletin 80-17, Mr. Tom Westerman was notified by telephone on December 31, 1980. A licensee event report form is also enclosed.

Report No.: 50-298-80-52
Report Date: January 29, 1981
Occurrence Date: December 30, 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 3.5.B of the Technical Specifications.

Conditions Prior to Occurrence:

Steady state power operation at approximately 99% reactor power.

Description of Occurrence:

During routine surveillance testing of the RHR service water system, the Loop "A" system throttle valve, SW-MO-89A, would not respond to the remote controller after opening to the minimum flow position. The minimum flow position of the valve corresponds to the minimum flow requirements of the RHR Service Water Booster Pumps.

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Designation of Apparent Cause of Occurrence:

The subject valve, SW-MO-89A, is a 18", 300# Globe valve manufactured by Anchor/Darling Valve Company. The operator is a Limatorque SMB-3. The apparent cause of the occurrence is unknown.

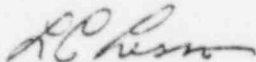
Analysis of Occurrence:

SW-MO-89A is the service water throttle valve on the discharge of the "A" Loop RHR heat exchanger. It controls the service water flow and maintains a minimum 20 psi differential between the service water and the RHR sides of the heat exchanger. Failure of this valve to operate made the "A" Loop of the RHR Service Water system inoperable. By not being able to open the valve, sufficient service water flow to heat exchanger could not be obtained. In the event of an emergency, the "B" Loop was operable as well as both diesel generators. This event presented no adverse consequences from the standpoint of public health and safety.

Corrective Action:

The subject system was initiated again in an attempt to evaluate the occurrence. During this test the system operated as designed. Further testing is being performed on the subject valve. Recorders have been used to monitor the output of the controller, feedback from the valve positioner, and the open and close contacts on the operator motor. These parameters will be monitored for five subsequent valve operations and operability verified.

Sincerely,



L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.