



# Nebraska Public Power District

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

CNSS820001

January 5, 1982

Mr. John T. Collins, Regional Administrator  
U.S. Nuclear Regulatory Commission  
Region IV  
611 Ryan Plaza Drive  
Suite 1000  
Arlington, Texas 76011



Dear Sir:

This report is submitted in accordance with Section 5.4.2.b of the Environmental Technical Specifications for Cooper Nuclear Station and discusses an environmental event that was discovered on December 28, 1981. Mr. Glen Madsen and Mr. Tom Westerman were notified of this event on December 30, 1981.

At approximately 1337 hours on December 24, 1981, a discharge from the Floor Drain Sample Tank was initiated as per CNS Operations Manual Procedure 2.5.2.3. On December 28, 1981, it was determined that the sample tank was sampled one half hour before the liquid waste had been completely processed from the Floor Drain Collector Tank to the Floor Drain Sample Tank. As a result, the tank discharge was not properly sampled and analyzed as required by Section 3.4.1.b.2 of CNS Environmental Technical Specifications.

Upon investigation of the above event, it was determined that the Floor Drain Sample Tank still contained approximately 2000 gallons of the liquid waste in question. It was verified by recorder readings in radwaste control that no additional liquid had been added to the tank since terminating the discharge. Thus, the liquid remaining in the sample tank was representative of the liquid discharged. A sample of the remaining volume was taken and analyzed for radioactive content. The analysis indicated a total of 15.2 MPC's which requires a dilution of at least 15.2:1. During the discharge, the average discharge rate had been 72.67 gpm with a dilution flow of 280,391 gpm, which provided a dilution rate of 3858:1. This is a factor approximately 253 times more conservative than required. Therefore, it was concluded that no radioactive release limits were exceeded and this occurrence presented no adverse consequences from the standpoint of public health and safety.

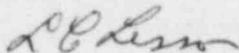
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The cause of this event has been attributed to personnel error. The procedure was correct, and if properly followed, would have prevented sampling of the Floor Drain Sample Tank before all the water had been processed into it. Verbal reprimands have been given to the persons involved with this event. Although the persons involved in this event clearly understand the procedures, the procedures are being revised to improve the clarity and understanding by new personnel. These procedure revisions will be completed within 30 days. This environmental event report will be routed to all Operations Department personnel.

Sincerely,



L. C. Lessor  
Station Superintendent  
Cooper Nuclear Station

LCL:cg

cc: Director, Division of Reactor Licensing  
Washington, D.C.