

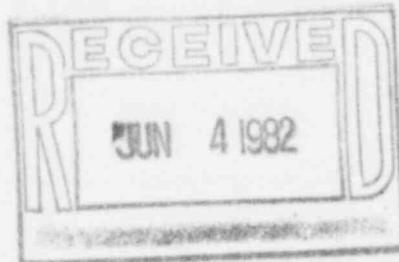


Nebraska Public Power District

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

CNSS820297

June 1, 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 6.7.2.B.2 of the Technical Specifications for Cooper Nuclear Station and discusses a reportable occurrence that was discovered on May 17, 1982. A licensee event report form is also enclosed.

Report No.: 50-298-82-10
Report Date: June 1, 1982
Occurrence Date: May 17, 1982
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:

A condition which resulted in not meeting a limiting condition for operation established in Table 3.9.B.4 of the Technical Specifications.

Conditions Prior to Occurrence:

The reactor was operating at a steady state power level of approximately 82% of rated power.

Description of Occurrence:

During normal operation while performing Diesel Generator Operability Test, the Diesel Generator #1 and its output breaker tripped.

Designation of Apparent Cause of Occurrence:

The apparent cause of this occurrence has been attributed to the potential transformer (PT) disconnect switch. One of its contacts apparently opened, interrupting voltage to the overcurrent relay restraining coil which tripped the diesel and its output breaker.

IE-22

8206100140 820601
PDR ADOCK 05000298
S PDR

Mr. John T. Collins
June 1, 1982
Page 2.

Analysis of Occurrence:

There are two Emergency Diesel Generators which supply vital power in the event of a loss of offsite power. Each diesel generator is independent of the other. The potential transformer disconnect switch is mounted on a metal door inside the 4160V switchgear next to the diesel generator output breaker. It is believed that an improperly closed PT door vibrated ajar and opened one contact of the PT disconnect switch. The door is believed to have been improperly closed after the last diesel generator inspection. The overcurrent relay restraining coil must receive 120V AC from the PT when the generator is producing a current flow. Since 120V AC to the restraining coil was lost the relay operated and tripped the diesel and its output breaker.

Operability of the Diesel Generator #2 was immediately verified. This occurrence presented no adverse consequences from the point of public health and safety.

Corrective Action:

The PT disconnect switch contacts were inspected and adjusted. PT doors were properly closed and Diesel Generator #1 retested. The diesel generator was returned to service within 15 hours. The PT cabinet was labeled with a precaution to securely close the door to prevent its inadvertent opening.

Sincerely,



L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.