Nebraska Public Power District

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

CNSS827133

August 10, 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 July 12, 1982. A licensee event report form is also enclosed.

Report No.: 50-298-82-16
Report Date: August 10, 1982
Occurrence Date: July 12, 1982
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 established in Section 3.9.B.3 of the Technical Specifications.

Conditions Prior to Occurrence:
The reactor was at a steady state power level of approximately 75% of rated thermal power.

Description of Occurrence:
During performance of Surveillance Procedure 6.3.12.1, #1 Diesel Generator (DG) breaker EG1 tripped after about three hours of operation. #1 DG was restarted and again tripped after about three hours of operation. No other alarms or indications for the breaker trip were received and #1 DG was declared inoperable.

Designation of Apparent Cause of Occurrence:
The apparent cause of the trip was determined to be failure of the safety trip valve.

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Analysis of Occurrence:

The safety trip valve is an AMOT Model 1476B-A½L-1A28 three-way control valve. The valve acts as the master control in the shutdown system. It trips the DG on loss of 30 psig sensing pressure from various controls or through mechanical linkage connected to the overspeed governor.

During a recent annual inspection, a problem was thought to exist with the overspeed governor. At that time, the governor was replaced. However, drifting of the safety trip valve overspeed trip lever was observed during followup investigation of the present problem. This occurred without an overspeed condition existing. The drift resulted in the holding mechanism releasing and tripping the DG.

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

Corrective Action:

A new safety trip valve was installed. During checkout of the new trip valve, a hole was discovered in the 125 psi control air system. A section of line was replaced. The complete air system on both engines was inspected for similar problems and none were found. #1 DG was tested satisfactorily and returned to service.

Sincerely,

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.