Nebraska Public Power District

COOPER NUCLEAR STATION
P.O. BOX 98, BROWNVILLE, NEBRASKA 68321
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CNSS830193

March 17, 1983

Mr. John T. Collins, Regional Administrator
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 February 23, 1983. A licensee event report form is also enclosed.

IE-22

Report No.:	50-298-83-01
Report Date:	March 17, 1983
Occurrence Date:	February 23, 1983
Facility:	Cooper Nuclear Station Brownville, Nebraska 68321

Identification of Occurrence:
A condition which led to operation in a degraded mode permitted by a limiting condition for operation established in Paragraph 3.5.E.1 of the Technical Specifications.

Conditions Prior to Occurrence:
The reactor was operating at approximately 100% of rated thermal power and reactor pressure was approximately 1000 psig.

Description of Occurrence:
While performing Surveillance Procedure 6.2.2.2.4 (125V DC Control Power Transfer of Automatic Depressurization System), safety relief valve (SRV) 71-C failed to transfer to its alternate power source on loss of preferred power.

Designation of Apparent Cause of Occurrence:
The apparent cause of this occurrence was attributed to a normally open contact in a General Electric Type HFA relay failing to close on loss of power.

Analysis of Occurrence:
SRV 71-C is one of eight Target Rock pressure relief valves on the reactor vessel. These particular Target Rock valves are pilot operated

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valves each with an air operated solenoid valve. SRV 71-C is one of six SRVs associated with the Automatic Depressurization System (ADS).

While performing Surveillance Procedure 6.2.2.2.4 on the SRVs, SRV 71-C failed to transfer to its alternate source of control power on a simulated loss of primary power. Several attempts were made to initiate transfer by pulling fuse 945-2E-F3C, however, the control power would not transfer. Investigation revealed that the malfunction was caused by a normally open contact on relay 945-2E-K11C failing to make contact on loss of power.

After the above attempt to transfer control power failed, contact wipe and gap adjustments were performed on the relay contacts. This procedure was performed in accordance with General Electric Service Information Letter No. 44, S4, Attachment B.

Following the gap and wipe adjustments, Surveillance Procedure 6.2.2.2.4 was repeated satisfactorily, with SRV 71-C transferring to its alternate control power source when relay 945-2E-K11C was de-energized.

SRV 71-C remained operable during relay contact failure of 945-2E-K11C. Only the transfer function on loss of preferred power was rendered inoperable. All eight SRVs would have functioned in a pressure relief mode and could have been operated manually if required. With reference to USAR, Volume II, Section VI-7-6, only five of the six SRVs are required to be operable. This occurrence presented no adverse consequences from the standpoint of public health and safety.

Corrective Action:

Relay 945-2E-K11C was adjusted per General Electric Service Information Letter No. 44, S4, Attachment B. Surveillance Procedure 6.2.2.2.4 (Control Power Transfer of ADS System) was again performed on the subject valve with satisfactory results. No further action is required.

Sincerely,

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

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Attach.