

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Cooper Nuclear Station	DOCKET NUMBER (2) 0 5 0 0 0 2 9 8	PAGE (3) 1 of 13
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TITLE (4)
Radioactive Liquid Discharge Not Monitored

EVENT DATE (8)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		
0 6	0 9	8 4	8 4	0 0	8 0	0 7	1 0	8 4	DOCKET NUMBER(S) 0 5 0 0 0		

OPERATING MODE (9) N

POWER LEVEL (10) 0 6 9

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

20.402(b)	20.405(e)	<input type="checkbox"/> 60.73(a)(2)(iv)	73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 60.36(a)(1)	<input checked="" type="checkbox"/> 60.73(a)(2)(v)	73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 60.36(a)(2)	<input checked="" type="checkbox"/> 60.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 60.73(a)(2)(i)	<input type="checkbox"/> 60.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 60.73(a)(2)(ii)	<input type="checkbox"/> 60.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 60.73(a)(2)(iii)	<input type="checkbox"/> 60.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Robert Brungardt, Operations Supervisor	TELEPHONE NUMBER 4 0 1 2 8 1 5 1 3 1 8 1 1
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUF. TURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUF. TURER	REPORTABLE TO NPRDS
A				N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

A discharge of liquid radioactive effluent occurred with the liquid radioactive effluent discharge monitor outlet valve shut which violated the Technical Specification requirement that the activity of the discharge be continuously monitored. No discharge limits were exceeded. During the subsequent investigation, three personnel errors were identified:

- a. A Station Operator incorrectly positioned a valve which resulted in a false indication of radioactive discharge flow through the monitor. The operator incorrectly assumed the mispositioned valve was mechanically defective.
- b. The Station Operator's supervisor did not question the incorrect assumption that the repositioned valve was mechanically defective.
- c. Apparently, two days before this event, a technician shut the outlet valve from the discharge monitor while performing maintenance on the same system and did not request permission to change the valve's position nor inform operations personnel of this change in valve lineup.

This occurrence will be discussed at length with appropriate supervisors. Procedures are being revised which will prevent recurrence of this event. This LER will be routed to all operators and will be discussed with all personnel who contributed to this occurrence.

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

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

On June 9, 1984, the contents of the floor drain sample tank were discharged from the plant radwaste system to the river. A "radwaste effluent monitor system flow disturbance" annunciator was noted by the Control Room Operator. This alarm indicated to the Control Room Operators that the flow through the radwaste discharge monitor was not adequate to accurately monitor the activity being discharged. The requirement with this annunciator alarm present was to discontinue the discharge and to check the system valve lineup. In compliance with the alarm requirements, a station operator was dispatched to the discharge monitor to check the valve lineup. The operator repositioned a three way valve (SW-1243) which resulted in a recirculation flow path being set up through the radwaste discharge monitor which cleared the low flow alarm but did not, in fact, set up a sample flow of the liquid being discharged through the monitor. Even though the position of valve SW-1243 was required by the pre-discharge valve lineup verification to be lined up for discharge rather than recirculate, the operator incorrectly assumed the now mispositioned valve (or valve indication) was mechanically defective. Neither the Control Room Operators nor the Shift Supervisor questioned repositioning the valve and whether the assumption that the valve was defective was, in fact, a valid assumption. The discharge was then continued with only an activity lower than normal indicating a problem existed in the discharge monitor valve lineup. An alert, inquisitive operator could have concluded repositioning the three-way valve (SW-1243) to recirculate coupled with a lower than normal discharge activity provided ample evidence that the discharge was not being properly monitored. A work item was issued by the Shift Supervisor to repair the three-way valve.

Subsequently, on June 11, 1984, while investigating the operation of the three-way valve as required by the work item, it was determined that valve SW-795, the radwaste monitor discharge valve, was shut and that no mechanical problem existed with the three-way valve. It was also concluded then that the discharge conducted two days previously was completed with valve SW-795 shut. Apparently, valve SW-795, the radwaste monitor discharge valve, was shut while making repairs on the same system on June 7. Valve SW-795 was probably shut to prevent back leakage from the river during valve repair. No one had requested permission to have the valve shut nor had anyone informed Control Room Operators of the change in valve position. Had the technician informed Control Room Operators of the need for SW-795 to be repositioned, this valve would have been added to the clearance order (tagging procedure) and this event would not have occurred.

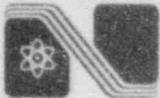
In that the floor drain sample tank is routinely recirculated for two hours and then sampled prior to discharge, both the quantity and activity level of the discharge in question were quite well known. Conservative calculations have shown that the activity level was approximately a factor of 26 times below the discharge limit as the discharge progressed.

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TEXT (If more space is required, use additional NRC Form 368A's) (17)

Procedure revisions have been initiated to add verification of SW-795 position prior to each discharge procedure. An approved pre-discharge valve lineup had been in effect for many years which was, up to this point, effective in ensuring proper system control. Valve SW-795 is normally checked on initial system lineup and subsequently controlled by tagging procedures. The personnel errors of the Shift Operator, Shift Supervisor, and technician were discussed directly with the individuals and supervisors involved. A copy of this LER will be routed to all operators. This occurrence presented no adverse consequences from the standpoint of public health and safety and has no generic implication.



Nebraska Public Power District

COOPER NUCLEAR STATION
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TELEPHONE (402) 825-3811

CNSS840294

July 10, 1984

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Dear Sir:

Cooper Nuclear Station Licensee Event Report 84-008 is forwarded as an attachment to this letter.

Sincerely,

A handwritten signature in cursive script that reads "P. V. Thomason".

P. V. Thomason
Division Manager of
Nuclear Operations

PVT:lb

Attach.

cc: J. T. Collins
L. G. Kunc1
J. D. Weaver
L. R. Berry
INPO Records Center
ANI Library

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