Nebraska Public Power District

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

October 13, 1978

Mr. K. V. Seyfrit
U.S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region IV
611 Ryan Plaza
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 September 18, 1978. A licensee event report form is also enclosed.

Report No.: 50-298-78-32
Report Date: October 13, 1978
Occurrence Date: September 18, 1978
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:
A condition which resulted in the limiting condition for operation established in Section 3.5.A.3(2) of the Technical Specifications.

Conditions Prior to Occurrence:
Reactor power level was steady state at approximately 70% of rated thermal power.

Description of Occurrence:
Upon completion of a torus cooling evolution, residual heat removal valve (RHR-MO-66B) was manually actuated to open. The valve did not fully open prior to receipt of a motor overload, ground alarm and breaker trip.

Designation of Apparent Cause of Occurrence:
A set screw on the valve stem retaining yoke of a Limitorque SMB-3 operator had loosened. The yoke rotated and mechanically bound the valve stem which overloaded and tripped the valve motor.

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Anal[illegible]s of Occurrence:
[illegible]-MO-66B (RHR Heat Exchanger Bypass) receives an "open" signal in event of a low pressure coolant injection (LPCI) initiation. valve failed partially open. This flow path, in addition to [illegible] through the heat exchanger, would have allowed flow in the vent of a LPCI initiation. Upon receipt of the control room indications, the valve was manually opened. There was a redundant system available. There were no adverse consequences from the standpoint of public health and safety.

Corrective Action:
The valve stem retaining yoke was repositioned and the set screw which had loosened was tightened. An additional set screw was installed to mechanically lock the first set screw. A review of past LER's indicate that this event is one-of-a-kind, therefore, additional inspection of other Limitorque operators is not warranted at this time.

Sincerely,

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.