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the completion of this diaphragm failure evaluation. A similar failure of this control valve diaphragm was reported in Cooper Nuclear Station Licensee Event Report 84-011 and 84-011, Revision 1.

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NRC Form 366 (9.63)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 2150-0104 EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	1	LER NUMBER IN	PAGE (3)		
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At 1414, January 29, 1986, a station operator visually observed lube oil leaking from the High Pressure Coolant Injection (HPCI) system overspeed trip auto reset control valve diaphragm actuator. A HPCI system operability surveillance was being conducted at the time of this event, during which the HPCI system turbine driven pump is operated at design flow and pressure (in accordance with station Technical Specifications). The HPCI system operability surveillance was subsequently terminated at 1523. At 1537, the HPCI system was declared inoperable so that immediate corrective action could be initiated to replace the failed control valve diaphragm. Replacement of the control valve diaphragm was completed at 1628. Accordingly, HPCI system operability testing was performed and at 1751 the HPCI system was declared operable. The duration of this event was 134 minutes.

The function of the subject control valve is to regulate the duration of a turbine overspeed trip condition; i.e., the time period from an overspeed trip to an overspeed trip reset. Failure of the control valve diaphragm causes the control valve to close. This condition would preclude proper operation of the overspeed trip in the event of an overspeed condition. Additionally, this particular failure would not have prevented HPCI from automatically initiating; however, the resulting oil leak may not have allowed long-term HPCI operation.

The control valve diaphragm failure is being evaluated by the Terry Turbine Corporation. A supplemental report will be submitted pending the completion of this diaphragm failure evaluation. A similar failure of this control valve diaphragm was attributed to end of component design life and was reported in Cooper Nuclear Station Licensee Event Report 84-011 and 84-011, Revision 1. This event presented no adverse consequences from the standpoint of public health and safety. The generic significance of this event will be discussed in the supplemental report (after Terry Turbine Corporation has evaluated the failed diaphragm).

Form 386A



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

CNSS860156

February 28, 1986

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

Dear Sir:

Cooper Nuclear Station Licensee Event Report 86-002 is forwarded as an attachment to this letter.

Sincerely,

Duy HO

G. K. Horn Division Manager of Nuclear Operations

GRH:1b Attach. cc: R. D. Martin L. G. Kuncl J. D. Weaver L. R. Berry INPO Records Center ANI Library

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