

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 0 3
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TITLE (4)
Unplanned Actuation of Group 6 Isolation Due to a Fuse Failure While Shutdown

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

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)									
POWER LEVEL (10) 0 0 0	20.402(b)	20.405(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)					
	20.405(a)(1)(i)	50.38(c)(1)		50.73(a)(2)(v)	73.71(c)					
	20.405(a)(1)(ii)	50.38(c)(2)		50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)					
	20.405(a)(1)(iii)	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)						
	20.405(a)(1)(iv)	50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)						
20.405(a)(1)(v)	50.73(a)(2)(iii)		50.73(a)(2)(ix)							

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER
NAME Donald L. Reeves, Jr.		AREA CODE 4 0 2
		8 1 2 5 1 - 1 3 8 1 1 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFAC. TURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFAC. TURER	REPORTABLE TO NPROS		
X	J M	F U L	2 2 3	Y							

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)			<input checked="" type="checkbox"/> NO			

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On May 5, 1988, at 3:27 P.M., while shutdown for the 1988 Refueling Outage, an unplanned Group 6 Isolation (isolation of the Secondary Containment and initiation of the Standby Gas Treatment [SGT] System) occurred when a 24V DC fuse supplying power to the "A" Reactor Building Exhaust Plenum Radiation Monitor failed. Upon failure of the fuse, an unbalance in trip relay voltage resulted, causing the unit to fail upscale. Other than loss of normal Reactor Building ventilation, there were no related plant effects.

The fuse was replaced, the Group 6 Isolation was reset, and normal Reactor Building ventilation was restored. No additional corrective action was determined to be necessary.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
					0 2	OF 0 3

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

A. Event Description

On May 5, 1988, at 3:27 P.M., while shutdown for the 1988 Refueling Outage, an unplanned Group 6 Isolation (isolation of the Secondary Containment and initiation of the Standby Gas Treatment [SGT] System) occurred when a 24V DC fuse supplying power to the "A" Reactor Building Exhaust Plenum Radiation Monitor failed. Upon failure of the fuse, an unbalance in trip relay voltage resulted, causing the unit to fail upscale.

B. Plant Status

Shutdown for the 1988 Refueling Outage which had commenced March 5, 1988.

C. Basis for Report

An unplanned actuation of an Engineered Safety Feature, Group 6 Isolation, reportable in accordance with 10CFR50.73(a)(2)(iv).

D. Cause of Event

Equipment failure of a random nature.

E. Safety Significance

None. Other than loss of normal Reactor Building ventilation, there were no related plant effects. Had this failure occurred during power operation, due to the fact that Reactor Recirculation MG Set ventilation would have been interrupted, the following sequence of events could occur:

1. rapidly rising Recirculation MG Set temperatures, which could potentially have resulted in a trip of both MG sets due to high internal air temperatures either while the HVAC System was off or upon its restart,
2. trip of both Reactor Recirculation Pumps, causing reactor flow to be reduced to that available via natural circulation only, and
3. a potential reactor scram due to a reactor water level transient.

In any event, if both Reactor Recirculation pumps were lost, regardless of whether or not an automatic trip would have occurred, the reactor would have to be manually shutdown in accordance with plant procedures to reinitiate forced recirculation flow and effect recovery.

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			0 1 4	0 0	0 3	OF	0 3

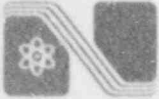
TEXT (If more space is required, use additional NRC Form 366A's) (17)

F. Corrective Action

The fuse was replaced, the Group 6 Isolation was reset, and normal Reactor Building ventilation was restored. No additional corrective action was determined to be necessary.

G. Similar Events

Fuse failures which have resulted in actuations of Engineered Safety Features (and which subsequently would require reporting as I.E.R.s) have not previously occurred.



Nebraska Public Power District

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

CNSS886147

June 2, 1988

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

Dear Sir:

Cooper Nuclear Station Licensee Event Report 88-014 is forwarded as an attachment to this letter.

Sincerely,

G. R. Horn
Division Manager of
Nuclear Operations
Cooper Nuclear Station

GRH:sg

Attachment

cc: R. D. Martin
L. G. Kunc1
R. E. Wilbur
V. L. Wolstenholm
G. A. Trevors
INPO Records Center
ANI Library
NRC Resident Inspector
R. J. Singer
CNS Training
CNS Quality Assurance

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