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### A. Event Description

On May 20, 1988, at 10:41 A.M. while shutdown for the 1988 Refueling Outage, an unplanned actuation of the Reactor Protection System (RPS) and several Engineered Safety Feature (ESF) Group Isolations occurred while preparing for acceptance testing of a newly installed level transmitter. The variable leg sensing line for the new Reactor Vessel level transmitter (NBI-LT-92), added as part of a design change, had been backfilled with demineralized water through an instrument sensing line drain connection. Venting of the instrument was being accomplished by opening the transmitter vent. The variable leg sensing line connected to the new transmitter also serves as the variable leg for several other level instruments (NBI-LIS-101A and B which are two of the four level indicating switches in the RPS trip logic and Primary Containment/Reactor Vessel isolation logic). When the CNS Instrument and Control Technician vented the new level transmitter, the localized effect sensed by the other nearby level instruments (LIS-101A and B) was a decrease in variable leg pressure; in effect, an apparent level decrease. The decrease was sufficient to trip both level transmitters, resulting in a trip of both RPS channels and, additionally, actuation of Groups 2, 3, and 6 Isolations (Primary Containment, Reactor Water Cleanup [RWCU], and Secondary Containment, including initiation of the Standby Gas Treatment [SGT] System).

## B. Plant Status

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

### C. Basis for Report

Unplanned actuations of the RPS and ESF Group Isolations, reportable in accordance with 10CFR50.73(a)(2)(iv).

### D. Cause

Procedural deficiency. While the design change installation instructions specified that the instrument sensing line was to be backf\_lled, no specific guidance was provided reflecting the steps to be taken or the potential interactions that could occur during the process.

# E. Safety Significance

None. The response of the RPS and actuation of Groups 2, 3, and 6 Isolations occurred as designed. Since the plant was shutdown, there was no impact on plant operational activities. While design change installation activities of this nature would only be accomplished during plant shutdown, replacement of level sensing instruments due to their failure could be required when at power. Such replacement efforts have been accomplished previously and completed with no impact on plant operation. However, if backfilling of the sensing line and venting of

NRC Form 366A (9483)	LICENSEE EVENT	U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/68					
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Cooper Nuclear Station

the instrument were not carefully controlled, the same sequence of events could occur. In that case, the resulting transient, while undesirable, would not be any more severe than any of the abnormal operational transients which have been analyzed.

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## F. Corrective Action

Venting of the newly installed transmitter was stopped, the RPS and Group Isolations were reset, and the affected systems were restored to their pre-tripped condition. The design change installation instructions were upgraded to provide specific guidance when backfilling the instrument lines and venting the newly installed instruments. Included in the guidance was the requirement to remove from service other instruments connected to the sensing line prior to any backfilling and venting activities. Work activities associated with the design change were then restarted.

In an effort to eliminate the potential for problems of this nature in the future, the circumstances associated with this event will be reviewed with offsite Engineering Group management. Their assistance in including detailed installation/acceptance testing instructions for specific activities, such as this, in design change documents will be solicited. Additionally, this LER will be routed to Engineering and I & C Supervisory personnel to promote dissemination of information regarding this event to all pertinent Nuclear Power Group individuals.

### G. Past Similar Events

Backfilling of the High Pressure Coolant Injection (HPCI) System high flow sensing lines resulted in closure of the HPCI Steam Supply valve as reported in LER 86-017, dated September 17, 1986.



COOPER NUCLEAR STATION P.O. BOX 98, BROWNVILLE, NEBRASKA 68321 TELEPHONE (402) 825-3611

CNSS886159

June 10, 1988

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

Gentlemen:

Cooper Nuclear Station Licensee Event Report 88-015 is forwarded as an attachment to this letter.

Sincgrely,

Sun NO G. R. Horn

Division Manager of Nuclear Operations

GRH:sg

Attachments

cc: R. D. Martin L. G. Kuncl 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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