Nebraska Public Power District

COOPER NUCLEAR STATION
P.O. BOX 98, BROWNVILLE, NEBRASKA 68321
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November 29, 1978

Mr. Karl V. Seyfrit, Director
U.S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region IV
611 Ryan Plaza
Suite 1000
Arlington, Texas 76011

Subject: Reportable Occurrence Initial Notification

Dear Sir:

At the time of the following occurrence on November 24, 1978, we did not consider the event to be reportable. After further review on November 27, 1978, we concluded that the occurrence may be reportable under Technical Specifications 6.7.2.A.4. I contacted Mr. Eric Johnson on November 27, 1978 and explained to him what we thought had occurred and that we were evaluating the cause and reportability. After interviewing personnel involved and after review of Station Safety Analysis Data in the FSAR, we now have concluded that the event should be reported under 6.7.2.A.4 of the Technical Specifications. Therefore, we are submitting this initial report to you. A more detailed report will follow.

Report No.: 50-298-78-35
Report Date: November 29, 1978
Occurrence Date: November 24, 1978
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:
A condition which probably resulted in a short term reactivity increase that corresponded to a reactor period of less than 5 seconds.

Conditions Prior to Occurrence:
Reactor was at a low power level of approximately 27% of rated thermal power.

Description of Occurrence:
The reactor power was at a reduced level so that surveillance testing of the turbine stop valves and a scheduled rod swap could be accomplished. While at this reduced power level, various pressure settings on Recirculation MG Set "B" Oil Lubrication System

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were being calibrated and reset if necessary. While performing this work on the lubrication system, Recirculation MG Set "B" was inadvertently tripped due to personnel error. After Recirculation Pump "B" was brought on line, it was discovered that MG Set "B" would not respond to an increase in speed demand. Troubleshooting this problem led to the possibility of a fuse being blown in the control circuitry. The fuse was pulled for examination and immediately thereafter MG Set "B" began ramping up in speed causing a rapid power increase. The exact time frame of this power increase cannot be determined though it is believed the duration was less than or equal to 10 seconds. The fuse was put back in as soon as reaction time permitted and also MG Set "B" was tripped by an operator very shortly thereafter; either one or both of these actions terminated the transient. The maximum thermal power observed during the transient was approximately 75% of rated power.

Designation of Apparent Cause of Occurrence:
Personnel error (pulling the fuse without a clear understanding of what would result).

Analysis of Occurrence:
The analysis for this event is presented in Section XIV.5.6 of the Cooper Final Safety Analysis Report. An examination of the off gas recorders after the event did not show a permanent increase in off gas activity; therefore, it is not believed any fuel damage resulted.

Corrective Action:
The fuse was reinserted as rapidly as possible and the personnel involved reviewed the events to prevent a recurrence.

Sincerely,

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

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