NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | NECPR1 (2) | 00-0000-000 (3) | 41111 (4) | (5)
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

CON'T
01 | REPORT SOURCE L (6) | 05000 2 9 8 (7) | 10 12 79 (8) | 11 09 79 (9)
7 8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal operation, a routine tour of the plant indicated a through-wall crack
03 of a weld in the REC supply to the south critical loop, upstream of the supply
04 isolation valve. This portion is isolatable from the critical loop. The redundant
05 REC loop and Service Water supply were available to supply this critical loop. If
06 the weld failed completely, it would be detectable. Reference LER Report No. 78-27
07 for an event of similar nature. This event presented no adverse consequences from
08 the standpoint of public health and safety.
7 8 9 80

09 | SYSTEM CODE SB (11) | CAUSE CODE E (12) | CAUSE SUBCODE X (13) | COMPONENT CODE XXXXXX (14) | COMP SUBCODE X (15) | VALVE SUBCODE Z (16)
7 8 9 10 11 12 13 18 19 20

(17) LER/RO REPORT NUMBER: EVENT YEAR 79 | — | SEQUENTIAL REPORT NO. 029 | / | OCCURRENCE CODE 03 | REPORT TYPE L | — | REVISION NO. 0
21 22 23 24 26 27 28 29 30 31 32

ACTION TAKEN X (18) | FUTURE ACTION C (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS 0000 (22) | ATTACHMENT SUBMITTED N (23) | NPRD-4 FORM SUB. (24) | PRIME COMP. SUPPLIER A (25) | COMPONENT MANUFACTURER J035 (26)
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The component involved is a weld. The failure is a through-wall crack which has sur-
11 faced as a pinhole leak of undeterminable cause. A soft patch has been applied and
12 the weld evaluated acceptable for continued service. During the next shutdown of
13 sufficient duration, the weld will be replaced. An evaluation of a similar failure
14 which was not reportable, will determine the cause. Update report will be submitted.
7 8 9 80

15 | FACILITY STATUS E (28) | % POWER 096 (29) | OTHER STATUS NA (30) | METHOD OF DISCOVERY A (31) | DISCOVERY DESCRIPTION (32) Operator Observation
7 8 9 10 12 13 44 45 46 80

16 | ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) NA | LOCATION OF RELEASE (36) NA
7 8 9 10 11 44 45 80

17 | PERSONNEL EXPOSURES NUMBER 0000 (37) | TYPE Z (38) | DESCRIPTION (39) NA
7 8 9 11 12 13 80

18 | PERSONNEL INJURIES NUMBER 0000 (40) | DESCRIPTION (41) NA
7 8 9 11 12 80

19 | LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) | DESCRIPTION (43) NA
7 8 9 10 80

20 | PUBLICITY ISSUED N (44) | DESCRIPTION (45) NA | NRC USE ONLY
7 8 9 10 68 69 80

POOR ORIGINAL

1398 184

7911270464

NAME OF PREPARER Paul Doan PHONE 402-825-3811

GPO 917-226

Nebraska Public Power District

COOPER NUCLEAR STATION
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CNSS790554

November 5, 1979

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 October 8, 1979. A licensee event report form is also enclosed.

Report No.: 50-298-79-28
Report Date: November 5, 1979
Occurrence Date: October 8, 1979
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:
A condition which lead to operation in a degraded mode permitted by a limiting condition for operation established in Section 3.19.B of the Technical Specifications.

Conditions Prior to Occurrence:
The reactor was at a steady state power level of approximately 95% of rated thermal power.

Description of Occurrence:
While inspecting the cable spreading room it was noted that a four inch diameter pipe sleeve in the fire wall between the cable spreading room and the cable expansion room was not properly sealed.

Designation of Apparent Cause of Occurrence:
Inadequate control of installation of fire seals during a microwave communications system installation in December 1978.

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Analysis of Occurrence:

The four inch sleeve, located in the wall between the cable spreading room and the cable expansion room, carries two 1 inch conduits through it. One conduit contains control cable for reactor recirculation motor generator set ventilation flow indication. The other conduit contains cable for microwave communication. The space inside the four inch sleeve and outside of the two one inch conduits was not adequately sealed. The possibility of a fire starting in this area is minimal because no combustible material was present. The cable spreading room is equipped with an automatic sprinkler system which could extinguish a fire if one started. The possibility of a fire spreading through the unsealed sleeve was remote because the sleeve contained no combustible material. This occurrence presented no adverse effect to public health and safety.

Corrective Action:

The four inch sleeve was immediately sealed and an adequate fire barrier established. All remaining sleeves in this area were inspected and verified to be properly sealed. The Technical Specifications also require that the penetrations in the cable spreading room be inspected every 18 months. This event was discussed with the appropriate personnel.

Sincerely,

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.

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LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | N E C P R 1 (2) | 0 0 - 0 0 0 0 0 - 0 0 0 (3) | 4 1 1 1 1 (4) | (5)
LICENSEE CODE | LICENSE NUMBER | LICENSE TYPE | CAT

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 2 9 8 (7) | 1 0 0 8 7 9 (8) | 1 1 0 5 7 9 (9)
DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During inspection of cable spreading room it was noted that one 4 inch pipe sleeve
0 3 in the wall between cable spreading room and cable expansion room was not sealed
0 4 T.S. 3.19.B. The possibility of a fire in this area is minimal because no combus-
0 5 tible material was present. Cable spreading room is equipped with an automatic
0 6 sprinkler system. No significant occurrence took place. This event had no effect
0 7 upon public health and safety. This event is not repetitive.
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	A B (11)	A (12)	E (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
7 9	—	0 2 8	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
B (18)	H (19)	Z (20)	Z (21)	0 0 0 0	N (23)	(24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Four inch sleeve in the wall has apparently been unsealed since December 1978.
1 1 The sleeve was immediately sealed. All other sleeves in this area were also in-
1 2 spected and verified to be properly sealed. The incident was discussed with ap-
1 3 propriate personnel.
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	0 9 5 (29)	NA	B (31)	Shift Supervisor Observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

POOR ORIGINAL

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

1398 187

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

NAME OF PREPARER Ladislav F. Bednar PHONE: 402-825-3811