



## Nebraska Public Power District

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

CNSS790290

June 26, 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 May 31, 1979. A licensee event report form is also enclosed.

Report No.: 50-298-79-16  
Report Date: June 26, 1979  
Occurrence Date: May 31, 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 paragraph 3.5.A.4 of the Technical Specifications.

### Conditions Prior to Occurrence:

Steady state power operation at 650 MWe.

### Description of Occurrence:

During performance of surveillance procedure 6.3.5.3, RHP Pump 1A tripped during start due to overcurrent in phase C.

### Designation of Apparent Cause of Occurrence:

A small particle of debris was found lodged between the operating disc and the magnet inside the phase C overcurrent relay. This prevented the disc to return to its normal position and resulted in a shorter time delay for the relay to close its contact. The relay, having its time delay reduced, closed its contact due to the normal high current required for pump start and initiated a pump trip.

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Mr. K. V. Seyfrit  
June 26, 1979  
Page 2.

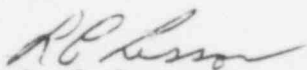
Analysis of Occurrence:

The subject overcurrent relay is one of two overcurrent relays monitoring the A & C phase current to the 4160V AC breaker for RHR pump 1A. The two relays are physically located on the door of breaker cabinet RHR 1A. It is believed a particle of debris got into the subject relay while a hole was being cut in the cabinet door to install an additional undervoltage relay adjacent to the overcurrent relay. The undervoltage relay was 1 of 5 being installed in accordance with an approved minor design change. The tripping of RHR pump 1A did not affect the operation of other safety systems and the 3 redundant RHR pumps were verified operable. This occurrence presented no adverse consequences to the public health and safety.

Corrective Action:

The overcurrent relay time delay assembly was cleaned and the relay tested satisfactorily. RHR pump 1A was started and verified operable. The remaining 4 breaker cabinets which had undervoltage relays installed were inspected for cleanliness and the respective overcurrent relays were verified operable. All personnel involved with the work on the subject breaker cabinets have been informed of this occurrence.

Sincerely,



L. C. Lessor  
Station Superintendent  
Cooper Nuclear Station

LCL:cg  
Attach.

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