



## Nebraska Public Power District

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

October 18, 1979

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

Subject: NPPD Response to IE Inspection Report  
50-298/79-14

Dear Mr. Seyfrit:

This letter is written in response to the letter dated October 12, 1979, transmitting IE Inspection Report 50-298/79-14 which indicated that certain of our activities were not conducted in full compliance with NRC requirements.

### Statement of Deficiency A

Technical Specification 6.6.1 requires that records of normal station operation shall be kept in a manner convenient for review. Further Cooper Nuclear Station Administrative Procedure 1.4, Section 1.4.4.1.1 requires that entries are to be made to the Shift Supervisor's Log regarding changes in status of critical station components, malfunction of equipment, and items of significant historical value. Further, Cooper Nuclear Station Administrative Procedure 1.4, Section 1.4.4.1.4 requires that the Control Room Log contain information regarding Reactor Power and Recirculation Loop Flows.

Contrary to the above, on or about September 18, 1979, while the reactor operator was attempting to reset a scoop tube lockout on the Reactor Recirculation Motor Generator (RRMG) set, the RRMG ran back to minimum speed and then returned to 93 percent. This operational transient caused a significant, unexpected change in reactor power and Recirculation Loop Flows. Neither the Shift Supervisor's Log nor the Control Room Log contained any reference to this event.

### Discussion

RR MG Set "A" was being operated using a temporary electrical and mechanical stop installed per Special Test Procedure 79-9. The temporary electrical and mechanical stop was installed to limit an unexpected speed increase to approximately 3% to 5%, at which time the electrical stop limit switch would open the control loop which would initiate a scoop tube lockout.

1388 080

7911230 198

Mr. Karl Seyfrit  
October 18, 1979  
Page 2.

On September 18, 1979, during a power increase, the limit switch was inadvertently tripped, opening the control loop initiating a scoop tube lockout. When the lockout was reset, the RR MG Set "A" ran back to minimum and then ramped back to approximately 93% speed at a controlled rate where it had been previously set.

The Operations Supervisor was immediately informed of the transient. At his request, the Instrument and Control Engineer evaluated the cause of the event and provided a written response to him which was routed to the Shift Supervisors with instructions to discuss the occurrence and proper corrective action with their shift personnel. The event was also brought to the attention of the Station Superintendent and SORC members. Thus, even though the event was not logged as per procedures, it was brought to the attention of appropriate personnel for necessary review and action.

Corrective Steps Which Have Been Taken And The Results Achieved

This deficiency was discussed with the Shift Supervisor and Licensed Operators involved and a general entry was made in the Night Orders Log to remind all personnel of making proper log entries. To date, there has been an improvement in the log entries made by Operations personnel.

Corrective Steps Which Will Be Taken To Avoid Further Noncompliance

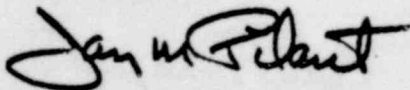
This incident was brought to the attention of the Operations personnel. The importance of complete log entries was stressed as well as the need to follow plant procedures.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved as of October 18, 1979.

If you have any questions regarding this response, please contact me.

Sincerely,



J. M. Pilant  
Director of Licensing  
and Quality Assurance

JMP:MGW:cg

1388 081