

## Nebraska Public Power District

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

CNSS790696

December 28, 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 November 29, 1979. A licensee event report form is also enclosed.

Report No.: 50-298-79-39  
Report Date: December 28, 1979  
Occurrence Date: November 29, 1979  
Facility: Cooper Nuclear Station  
Brownville, Nebraska 68321

### Identification of Occurrence:

A condition which resulted in operation in a degraded mode permitted by a limiting condition for operation established in Section 3.7.D.2.

### Conditions Prior to Occurrence:

The reactor was at steady state power level of approximately 87% of rated thermal power.

### Description of Occurrence:

The suppression chamber inboard vent isolation valve (PC-230MV) would not operate with the control switch and there was no position indication in the control room.

1829 006

A002  
S  
1/1

8001290 460 S

Mr. K. V. Seyfrit  
December 28, 1979  
Page 2.

Designation of Apparent Cause of Occurrence:

Examination of the geared limit switch on the motor operator for the subject valve revealed that rotor controlling the position indication and opening control circuit had cracked. The rotor was lodged in its limit switch assembly.

Analysis of Occurrence:

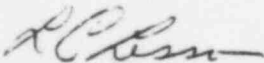
PC-230MV is the suppression chamber inboard vent isolation valve. PC-230MV failed in the closed position which is its normal operating position. It is one of two butterfly valves in this ventilation line which receives a closure signal by a Group 2 isolation signal. The other valve in line (PC-245AV) was operable and would have provided isolation if required. Since it also is normally closed, this occurrence presented no adverse consequences from the standpoint of public health and safety.

The limit switch assembly of the Limitorque SMB00 operator was carefully inspected. No particular reason for the failure could be determined. The rotor was broken near one set of contacts. This type of failure has not been experienced at Cooper Nuclear Station. Discussion with the vendor indicates that this rotor may break if it is subjected to high vibration or shock. This valve is not subjected to high vibration or shock.

Corrective Action:

PC-245AV was tagged in the closed position. The Limitorque operator was inspected and repaired with a qualified replacement part. All assemblies in the operator were inspected for alignment and proper tightness. The Limitorque operators will be closely monitored for further problems. This event was discussed with the appropriate maintenance personnel.

Sincerely,



L. C. Lessor  
Station Superintendent  
Cooper Nuclear Station

LCL:cg  
Attach.

1029 007