LER 50-298/81-12

Nebraska Public Power District

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

CNSS810360

June 18, 1981

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

Dear Sir:

This report is submitted in accordance with Section 6.7.2.B.1 of the Technical Specifications for Cooper Nuclear Station and discusses a reportable occurrence that was discovered on May 19, 1981. A licensee event report form is also enclosed.

Report No.: 50-298-81-12
Report Date: June 18, 1981
Occurrence Date: May 19, 1981
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:
Operation with an engineered safety feature instrument setting less conservative than those established in Table 3.2.B of the Technical Specification.

Conditions Prior to Occurrence:
The reactor was in cold shutdown for refueling.

Description of Occurrence:
While performing routine Surveillance Testing Procedure 6.2.2.3.3, a HPCI Low Steam Supply Pressure Switch, HPCI-PS-68D, was found to trip at lower pressure than allowed by Technical Specifications.

Designation of Apparent Cause of Occurrence:
The apparent cause of this occurrence was setpoint drift.

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Analysis of Occurrence:

The function of pressure switch HPCI-PS-68D is to monitor the reactor pressure and to contribute to HPCI System turbine trip when the reactor pressure is at or below 100 psig. The switch setpoint had drifted to 11 psig below the Technical Specification limit. The redundant pressure switches, HPCI-PS-68A,B, and C were available and operable at the time of the occurrence and were found set within Technical Specification limits. These switches would have provided for a turbine trip if it were required due to low reactor pressure. This occurrence presented no adverse affect on the public health and safety. A similar occurrence was reported previously. Reference AO-74-58.

The switch was examined and no apparent cause for the setpoint drift could be found. A review of the records indicates the switch has drifted outside of Technical Specification limits only one other time in plant life.

Corrective Action:

The switch was immediately readjusted to the correct setpoint. The switch has been re-tested three times since the occurrence and was within the Technical Specification limits on all three occasions. No further action is planned.

Sincerely,

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.