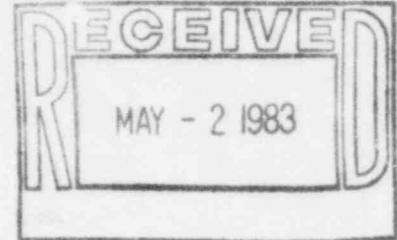


Nebraska Public Power District

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

CNSS830306

April 29, 1983



Mr. John T. Collins, Regional Administrator
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.3 of the Technical Specifications for Cooper Nuclear Station and discusses a reportable occurrence that was discovered on April 3, 1983. A licensee report form is also enclosed.

Report No.: 50-298-83-03
Report Date: April 29, 1983
Occurrence Date: April 3, 1983
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

IE-22

Identification of Occurrence:

A condition which led to operation in a degraded mode as indicated by a limiting condition for operation established in Paragraph 3.2.D.2 of the Technical Specifications.

Conditions Prior to Occurrence:

The reactor was operating at approximately 100% of rated thermal power and reactor pressure was approximately 1000 psig.

Description of Occurrence:

While conducting normal operational tours and inspections, on-shift personnel noted the reactor building outboard ventilation exhaust valve HV-260MV position indicating lights were extinguished and the fuse for the valve's control power circuit was blown.

Designation of Apparent Cause of Occurrence:

The apparent cause of this occurrence was attributed to a shorting of the indicating light bulb which caused the control and indicating circuit fuse for HV-260MV to blow.

Analysis of Occurrence:

Reactor building ventilation exhaust isolation valve HV-260MV is one of four reactor building ventilation exhaust valves in two parallel paths

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required to shut in order to establish secondary containment isolation. As a result of the blown fuse in the control and indicating circuit, this valve would not have responded to an automatic isolation signal. However, two redundant air operated valves in the two parallel exhaust flow paths were available had they been required for automatic containment isolation. Additionally HV-260MV could have been shut manually if required for isolation.

The first indication of a problem was failure of the local indicating light. When the lamp lens was removed, it was noted the lamp was broken. Apparently the bulb was stuck too tightly in the socket for normal removal and was broken when bulb replacement had been previously attempted. Other indications were normal and a work item tracking form was initiated. The subsequent day the remote indicator lamp was out and the control power fuse had blown. As soon as this was noticed, the fuse was immediately replaced and shortly thereafter (same day) the broken lamp base post was removed and a new lamp was installed. These repairs were implemented with satisfactory results. It was determined during the repair that the bulb filaments were in contact with each other, causing a direct short.

This occurrence presented no adverse consequences from the standpoint of public health and safety.

Corrective Action:

The broken lamp base post was removed and a new lamp was installed. The control power fuse was replaced. No further action is required.

Sincerely,

P. V. Thomason

P. V. Thomason
Acting Station Superintendent
Cooper Nuclear Station

PVT:KRW:cg
Attach.