Nebraska Public Power District

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

December 27, 1978

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 December 8, 1978. A licensee event report form is also enclosed.

Report No.: 50-298-78-38
Report Date: December 27, 1978
Occurrence Date: December 8, 1978
Facility: Cooper Nuclear Station
Brownville, Nebraska 68321

Identification of Occurrence:
Conditions leading to operation in a degraded mode permitted by a limiting condition for operation as delineated in Section 3.12.C of the Technical Specifications.

Conditions Prior to Occurrence:
Steady state power operation at approximately 98% reactor power.

Description of Occurrence:
During performance of the Service Water Motor Operated Valve Operability Test, one of four service water (SW) to reactor equipment cooling (REC) cross connect valves, SW 888 MV, failed to open.

Designation of Apparent Cause of Occurrence:
Manufacturing error. The actuator assembly for the torque switch jammed in the torqued out position not permitting the valve to open. The torque actuator was received from the manufacturer with a machining error that caused it to jam the torque switch.

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Analysis of Occurrence:

There are two independent supply lines from service water (SW) to reactor equipment cooling (REC) with individual isolation valves (supply and discharge). The subject valve was the discharge on one supply line. Had the service water backup to reactor equipment cooling been necessary, the second supply line was operable and capable of providing an adequate cooling water supply or the subject valve could have been manually opened.

The machining error previously noted has been defined as a misoriented threaded hole which allowed mechanical binding of the torque switch actuating arm. This occurrence presented no adverse consequences from the standpoint of public health and safety.

Corrective Action:

The actuating assembly for the subject valve was re-machined to correct the manufacturing error. The torque switch was replaced by one with a heavier lever arm supplied by the vendor. The three other valve operators of the same design were inspected for the same error and their respective torque switches replaced. The machining error previously noted was not present in the three other valve operators.

Sincerely,

L. C. Lessor
Station Superintendent
Cooper Nuclear Station

LCL:cg
Attach.