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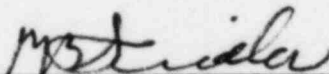
TO: Mr. Ronald C. Haynes, Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

FROM: GPU Nuclear Corporation  
Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Forked River, NJ 08731

SUBJECT: Reportable Occurrence Report No. 50-219/82-56/01P  
  
The following is submitted in accordance  
with Technical Specification 6.9.2.a.2, and  
confirms our telephone notification made to  
Mr. John Thomas of the NRC at approximately 1530  
hours on Saturday, 11/20/82, by Mr. J. Sullivan.

DATE: November 23, 1982

Preliminary Approval:



Peter B. Fiedler  
Vice President and Director  
Oyster Creek

Director (2)  
Office of Management Information and  
Program Control  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

NRC Resident Inspector  
Oyster Creek Nuclear Generating Station  
Forked River, NJ 08731

OYSTER CREEK NUCLEAR GENERATING STATION  
Forked River, New Jersey 08731

Licensee Event Report  
Reportable Occurrence No. 50-219/82-56/01P

Report Date

November 23, 1982

Occurrence Date

November 20, 1982

Identification of Occurrence

The stack gas was not continuously monitored as required by Technical Specification 3.6.A.3.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.a.2.

Conditions Prior to Occurrence

The major plant parameters at the time of the occurrence were:

Reactor critical in run mode  
Reactor Power - 996.9 MWt  
Generator Output - 312 MWe

Description of Occurrence

On Saturday, November 20, 1982 at approximately 1525 hours, an electrician doing an inspection on 24V D.C. battery charger A2 found the breaker in the tripped position. The electrician checked, reset and closed the breaker. Subsequently, the condition, indication, and alarm for the system returned to normal. Placing the A2 battery on equalize mode on Friday, November 19, 1982, caused an alarm in the control room due to high D.C. voltage. Since the annunciator was already in an alarm mode and since there is only one annunciator for the 24V DC system, a low D.C. voltage condition due to the A2 battery charger trip will not cause an additional alarm in the control room. This prevented the operators from recognizing the condition immediately, and rendered nuclear instrumentation and process radiation monitors for the stack gas and service water system on Panels 1R, 2R, and 3R inoperable after a period of time (approximately 24 hours) when the battery's voltage degraded to a low voltage situation.

Apparent Cause of Occurrence

The apparent cause of the occurrence was due to drift of the setpoint for the over-voltage relay on the battery charger output breaker. The over-voltage trip setpoint was apparently lower than the equalizing voltage causing the output breaker to trip when the battery charger was placed on equalize mode.

Analysis of Occurrence

The 24V DC system provides power to nuclear instrumentation and process radiation monitoring on Panels 1R, 2R and 3R. Failure of the output circuit breaker on A2 battery charger caused an eventual low voltage condition to occur. Subsequently, loss of source range and intermediate range nuclear instrumentation in one reactor protection system and the loss of process radiation monitoring for the stack gas and service water system occurred. Further investigation will complete the analysis of the occurrence.

Corrective Action

Immediate corrective action was to check, reset and close the output breaker of battery charger A2 to establish the required 24V DC system voltage. Affected nuclear instrumentation and process radiation monitoring was returned to normal. The over-voltage relay trip setpoint was checked and reset to the proper value which is higher than the equalizing voltage.

Failure Data

To be provided in final report.