



**GPU Nuclear**

P.O. Box 388  
Forked River, New Jersey 08731  
609-693-6000  
Writer's Direct Dial Number:

December 8, 1982

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

Dear Mr. Haynes:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report  
Reportable Occurrence No. 50-219/82-56/01T

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/82-56/01T in compliance with paragraph 6.9.2.a.2 of the Technical Specifications.

Very truly yours,

Peter B. Fiedler  
Vice President and Director  
Oyster Creek

PBF:lse  
Enclosures

cc: Director (40 copies)  
Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

Director (3)  
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

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OYSTER CREEK NUCLEAR GENERATING STATION  
Forked River, New Jersey 08731

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

Report Date

December 8, 1982

Preliminary 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.

In addition, the operability requirement specified in Technical Specification 3.7.A.1.f was not met when 24V DC power panel A was in a degraded voltage condition for approximately thirty minutes. This related event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.b.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 Friday, November 19, 1982 between 1000 and 1100 hours, the A2 -24V DC battery was placed in the equalize charge mode. At approximately 1110 hours, a "24V system off normal" alarm was received in the control room. Since the control room operators had been informed to expect an alarm when the A2 battery was placed on equalize charge and since the voltage and operation of the nuclear instrumentation being fed from the 24V DC system were normal, no additional operator action was taken.

On Saturday, November 20, 1982 at approximately 1509 hours, control room operators noticed certain Source Range Monitor (SRM) and Intermediate Range Monitor (IRM) indications beginning to fluctuate. A short time later, both stack gas monitor indications were observed falling downscale. Instrument and Electrical Department personnel were notified to investigate the problem. At approximately 1525 hours, an electrician found the output breaker of the A2 battery charger in the tripped position. This condition had caused nuclear instrumentation, and process radiation monitors for the stack gas and service water systems, on instrument panels 1R and 3R, to operate on battery power only. Since the annunciator was already in an alarm mode and since there is only a common annunciator for the 24V DC system, the subsequent DC low voltage condition would not cause another alarm in the control room. This prevented the control room operators from recognizing the condition immediately upon occurrence. The electrician checked, reset and closed the breaker. Within a few minutes, the condition indication and alarm for the system returned to normal.

A reactor shutdown was initiated at approximately 1510 hours in compliance with Technical Specifications 3.6.A.3 and 3.7.B, after Operations personnel noticed the stack gas indication for A and B monitors falling downscale. The shutdown procedure was then terminated at approximately 1535 hours after the affected systems were returned to normal with the reset of the A2 battery charger breaker.

#### Apparent Cause of Occurrence

The apparent cause of occurrence was due to drift of the setpoint for the overvoltage alarm relay. In addition, personnel error involving miscommunication and interpretation of the alarm was contributory. When the equalizing charge was initially placed on the A2 battery, the equalizing voltage apparently increased past the overvoltage setpoint which caused the output breaker of the A2 battery charger to trip and an alarm to annunciate in the control room. The alarm was interpreted by the operators to be caused by the placement of the battery on equalize charge. Therefore, no additional action was taken at that time.

#### Analysis of Occurrence

The "A" 24V DC system provides power to liquid and gaseous process radiation monitors on instrument panel 1R, area radiation monitors on panel 2R and neutron (SRM and IRM) monitoring on panel 3R. Loss of the -24V DC power supply prevented continuous monitoring of the stack gas system. However, since the stack gas monitoring system was inoperable for approximately thirty (30) minutes, during which time the offgas and reactor building ventilation monitoring systems remained in service and showed normal indications, the safety significance of this occurrence is considered minimal. The rod block trip function associated with SRM and IRM neutron monitoring is not required when in the RUN mode.

Corrective Action

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

An evaluation will be initiated to investigate and determine any corrective actions necessary to improve the system.

Control controls will be enhanced to require checking of alarm conditions whenever an equalizing charge is initiated/completed.

A copy of this Licensee Event Report will be sent to the Operating Experience Assessment and Implementation Committee (O.E.A.I.C.) for proper distribution to all operations and instrument/electrical maintenance personnel for required reading. It also will be routed to the Training Department for "Lessons Learned" in the training program.

Failure Data

General Electric  
Model No. GRW984BN25WG2356  
24V DC Battery Charger