



**GPU Nuclear Corporation**  
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Writer's Direct Dial Number:

April 26, 1996  
6730-96-2152

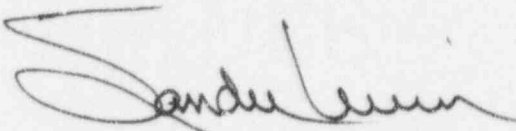
U. S. Nuclear Regulatory Commission  
Attn.: Document Control Desk  
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report 96-002

Enclosed is Licensee Event Report 96-002. This event did not impact the health and safety of the public.

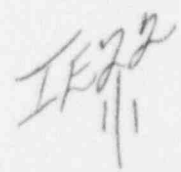
If any additional information or assistance is required, please contact Mr. John Rogers of my staff at 609.971.4893.

  
for Michael B. Roche  
Vice President and Director  
Oyster Creek

MBR/JJR  
Enclosure

cc: Oyster Creek NRC Project Manager  
Administrator, Region I  
Senior Resident Inspector

9605030081 960426  
PDR ADOCK 05000219  
S PDR



LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (IT-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Oyster Creek Unit 1		DOCKET NUMBER (2) 05000 - 219	PAGE (3) 1 of 3
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TITLE (4)  
Low Voltage Alarm Relay Improperly Set due to Improper Work Practice

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION	MONTH	DAY	YEAR	FACILITY NAME:	DOCKET NUMBER
3	29	96	96	002	00					05000
									FACILITY NAME:	DOCKET NUMBER
										05000

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)									
	20.2201(b)		20.2203(a)(2)(v)	<input checked="" type="checkbox"/>	50.73(a)(2)(i)		50.73(a)(2)(viii)			
POWER LEVEL (10) 100	20.2203(a)(1)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)			
	20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71			
	20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER			
	20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A			
	20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)					

LICENSEE CONTACT FOR THIS LER (12)

NAME Ashok Agrawal	TELEPHONE NUMBER (Include Area Code) 609.971.4560
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION			MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/>	NO							

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

During a recent review of the battery charger test and calibration procedure it was discovered that the procedural low voltage alarm setpoint (120 ± 1 vdc) was outside the Technical Specification requirement (115 ± 1 vdc). The root cause of this occurrence has been determined to be an improper work practice in that the new test and calibration procedure had been written without an adequate review of Technical Specification requirements. The safety significance has been determined to be minimal as the incorrect setpoint was more conservative than the required setpoint and would have alarmed sooner than required by design.

Upon discovery, the battery charger test and calibration procedure was immediately revised and the relay set point was adjusted to comply with the Technical Specifications requirements. To prevent a similar occurrence, the Technical Specifications related to this occurrence will be reviewed to determine if they can be clarified by an amendment. Additionally, personnel involved with the review and approval of procedures will be informed of this event and advised to ensure that Technical Specification limits are considered even when the proposed change increases the margin of safety.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Oyster Creek, Unit 1	05000	YEAR	SEQUENTIAL NUMBER	REV	2 of 3
	-219	96	-- 02	-- 00	

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

**DATE OF DISCOVERY**

The condition was discovered on March 29, 1996, at 1056 hours

**IDENTIFICATION OF OCCURRENCE**

Technical Specification 4.7.B.4.d specifies that the station battery (EIS Code: CFI(BTRY)) low voltage alarm setpoint shall be  $115 \pm 1$  vdc. During a review of the new station Battery 'C' charger (EIS Code: FI (BYC)) test and calibration procedure, it was discovered that the low voltage alarm setpoint had been changed to a value beyond the Technical Specification limit. This has been determined to be reportable under 10 CFR 50.73(a)(2)(i).

**CONDITIONS PRIOR TO DISCOVERY**

At the time of discovery, the reactor was operating at normal temperatures and pressures for full power operation. However, the reactor plant had been operated in all modes since the setpoint was changed.

**DESCRIPTION OF OCCURRENCE**

The battery charger low voltage alarm set point was designed to be used to meet the Technical Specifications requirement for the battery low voltage alarm setpoint of  $115 \pm 1$  vdc. On March 29, 1996, while reviewing the low voltage setpoint for the battery chargers, it was discovered that the new charger test and calibration procedure had been improperly changed to specify the low voltage alarm setpoint to  $120 \pm 1$  vdc in August 1994.

**APPARENT CAUSE OF OCCURRENCE**

The root cause of this occurrence has been determined to be an improper work practice in that the new test and calibration procedure had been written without an adequate review of Technical Specification requirements. The Technical Specification setpoint was originally determined based on the minimum initial battery voltage necessary to ensure the proper operation of the safety related DC equipments during a loss of AC voltage accident. As this is a low voltage alarm, the Technical Specification setpoint should have been specified as  $\geq 114$  vdc.

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**APPARENT CAUSE OF OCCURRENCE (Cont.)**

However, the sensor accuracy ( $\pm 1$  vdc) was placed into the Technical Specifications.

During a review of the startup and testing data, it was discovered that the vendor recommended setpoint for the battery charger was 120 vdc. Therefore, the test and calibration procedure was written with an alarm setpoint of  $120 \pm 1$  vdc without adequately reviewing the written Technical Specification limits.

**ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT**

The significance of this occurrence has been determined to be minimal. Although the battery charger alarm setting was placed outside the Technical Specification allowed limits, it was placed in the conservative direction and would have alarmed sooner that required by design.

**CORRECTIVE ACTION**

IMMEDIATE

Upon discovery, the battery charger surveillance procedure was revised and the low voltage sensing relays were immediately adjusted to the Technical Specification value.

LONG TERM

The Technical Specifications related to this occurrence will be reviewed to determine if they can be clarified by an amendment. This review will be completed by September 1, 1996. Additionally, personnel involved with the review and approval of procedures will be informed of this event and advised to ensure that Technical Specification limits are considered even when the proposed change increases the margin of safety.

**SIMILAR EVENTS**

None.