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On August 22, 1988, accumulator low pressure alarms for three hydraulic control units were present for greater than one hour in violation of plant procedures. At the time, the reactor was in the RUN mode at full power. The apparent cause of the occurrence is operator error in failing to recharge accumulators in accordance with the low pressure alarm response procedure. The safety significance of this event is minimal at full power conditions because reactor pressure assists control rod scram insertion. It would have safety significance, however, at low reactor pressure conditions. Corrective action was taken to recharge all three accumulators. Recharging requirements have been reinforced with operating shift personnel. This report will also be made required reading for operating shift personnel.

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LICENSEE EVENT	REPORT (LER) TEXT CONTINU	JATION	APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85					
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DATE OF OCCURRENCE

The event occurred on August 22, 1988, at approximately 1900 hours.

IDENTIFICATION OF OCCURRENCE

Accumulator low pressure alarms for three hydraulic control units were present for greater than one hour in violation of plant procedures. This is a voluntary report.

CONDITIONS PRIOR TO OCCURRENCE

The reactor was in the RUN mode at full power.

DESCRIPTION OF OCCURRENCE

On August 22, 1988 at 1543 hours a Control Rod Drive Hydraulic Control Unit (HCU) Scram Accumulator Low Pressure Alarm was received. This alarm actuates at a pressure of 955 pounds per square inch (psi) in the scram accumulator, which is normally charged to 1000-1150 psi. A control room operator directed an equipment operator to recharge the affected accumulator in order to clear the alarm. At 1701 hours a second low pressure alarm was received, as indicated by a rod block alarm. Some time later a third accumulator low pressure alarm was received. The time at which the third alarm was received cannot be identified because no unique alarm is associated with a third accumulator having low pressure.

When the equipment operator attempted to charge the first accumulator, he found the hose, which connects the nitrogen regulator to the nitrogen charging manifold at the North HCU bank, broken. He contacted the control room operator for assistance, who in turn contacted maintenance personnel to repair or replace the hose. No suitable replacement hose could be found. All accumulators having low pressure were located on the North HCU bank. The second and third alarms were received some time during the attempt to repair or replace the hose. The South HCU bank charging hose was moved to the North HCU bank, and accumulators were recharged. Since no unique alarm was associated with the third accumulator having low pressure, the time at which the first of the three accumulators was recharged cannot be determined. The second accumulator was recharged at 2044 hours, clearing the rod block condition. The last accumulator was recharged at 2055 hours, clearing the HCU low pressure alarm.

19-43) LICENSEE EVI	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION								APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85			
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APPARENT CAUSE OF OCCURRENCE

The apparent cause of the occurrence was personnel error. A control room operator failed to give recharging of the accumulators the appropriate priority in accordance with plant procedures. The alarm response procedure for HCU accumulator low pressure allows eight hours for restoration of accumulator pressure if one accumulator has a low pressure condition. If more than one alarm is received, indicated by a control rod block condition, then the affected accumulators are to be considered inoperable and immediate corrective action is to be taken to restore the accumulators to operable status. The procedure then states that if accumulator inoperability for more than one accumulator last longer than one hour, operators are to proceed in accordance with Technical Specification 3.0.A, which would require that the plant be placed in the cold shutdown condition within the following 30 hours. The control room operator was aware of these requirements, but lost track of the time the low pressure alarms were present.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The control rod system is designed to bring the reactor subcritical from a scram signal at a rate fast enough to prevent fuel damage. A control rod is not considered capable of fulfilling its scram function if its accumulator pressure is less than 940 psi, since the rod would not necessarily insert within the time required by Technical Specifications. However, at higher reactor pressures, the accumulator is assisted in rod insertion by reactor pressure reaching the drive through a ball check valve. As water is drawn from the accumulator, the accumulator discharge pressure falls below reactor pressure. This causes the check valve to shift its position to admit reactor pressure under the drive piston. Thus, reactor pressure furnishes the force needed to complete the scram stroke at higher reactor pressures. The accumulator is needed to accommodate low pressure scrams. Therefore, the safety significance of this event under conditions of full power operation is minimal. This event could have had some safety impact had reactor pressure fallen below 940 psi, in that the affected control rods may not have met their required scram insertion times.

LICENSEE EV	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED ONE NO. 31 KEYPIRES 8/31/85								
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CORRECTIVE ACTIONS

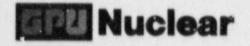
When the Group Shift Supervisor realized that three accumulator low pressure alarms had been in for some time, immediate action was taken to recharge the accumulators. The South HCU bank charging hose was moved to the North bank and the alarms were cleared.

The requirement to keep the hydraulic control units recharged was reinforced with all shift personnel who were on shift at the time of the event. The Group Shift Supervisor discussed this event with all personnel on shift and ensured that they are aware of the alarm response procedure and the importance of maintaining awareness of alarm status. This event will be discussed, emphasizing procedural compliance, with all operating shift personnel during the weekly plant status update meetings.

This report will be made required reading for all operations shift personnel.

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GPU Nuclear Corporation

Post Office Box 388 Route 9 South Forked River, New Jersey 08731-0388 609 971-4000 Writer's Direct Dial Number: September 23, 1988

Director of Nuclear Reactor Regulation U.S. Nuclear Regulatory Commission Mail Station P1-137 Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station Docket No. 50-219

Licensee Event Report

This letter forwards one (1) copy of Licensee Event Report (LER) No. 88-017.

Very truly yours,

E. E. Fitzpatrick

Vice President & Director

Oyster Creek

EEF:G8:smz(0546A) Enclosures

cc: Mr. William T. Russell, Administrator Region I U.S. Nuclear Regulatory Commission 475 Allendale Road King of Prussia, PA 19406

> Mr. Alexander W. Dromerick U.S. Nuclear Regulatory Commission Washington, DC 20555

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

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