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Carolina Power & Light Company

FEB 09 1984

SERIAL: NLS-84-058

Mr. Richard C. DeYoung, Director
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, DC 20555

BRUNSWICK STEAM ELECTRIC PLANT, UNIT NOS. 1 AND 2
DOCKET NOS. 50-325 & 50-324/LICENSE NOS. DPR-71 & DPR-62
RESPONSE TO NOTICE OF VIOLATION

Dear Mr. DeYoung:

Carolina Power & Light Company (CP&L) has received the letter from Mr. James P. O'Reilly dated January 10, 1984 transmitting a Notice of Violation and Proposed Imposition of Civil Penalty (EA 83-83). Carolina Power & Light Company has also received Inspection Reports 50-324/83-11 and 50-325/83-11 for the Brunswick Steam Electric Plant, Unit Nos. 1 and 2. The above referenced Inspection Reports do not contain any information of a proprietary nature.

Pursuant to 10 CFR 2.205, CP&L hereby encloses its check in the amount of forty-thousand dollars (\$40,000) payable to the Treasurer of the United States, in payment of the proposed civil penalty. As required by 10 CFR 2.201, CP&L's response to the Notice of Violation issued with the Proposed Imposition of Civil Penalty is enclosed.

Should you need any additional information, please contact our Licensing Staff.

Yours very truly,

M. A. McDuffie
Senior Vice President
Nuclear Generation

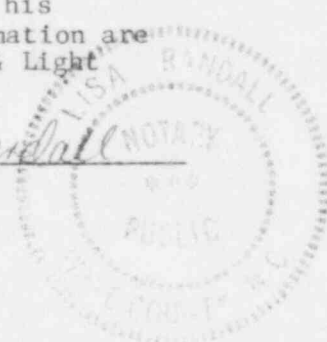
WRM/ccc (9453WRM)
Enclosures

cc: Mr. M. Grotenhuis (NRC)
Mr. J. P. O'Reilly (NRC-RIL)
Mr. D. B. Vassallo (NRC)

M. A. McDuffie, having been first duly sworn, did depose and say that the information contained herein is true and correct to the best of his information, knowledge and belief; and the sources of his information are officers, employees, contractors, and agents of Carolina Power & Light Company.

My commission expires: 5/18/88

Notary (Seal)



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ENCLOSURE 1

BRUNSWICK STEAM ELECTRIC PLANT, UNIT NOS. 1 AND 2
INSPECTION REPORTS 50-324/83-11 AND 50-325/83-11
RESPONSE TO NOTICE OF VIOLATION

Inspection Reports 50-324/83-11 and 50-325/83-11 and the January 10, 1984 Notice of Violation (EA 83-88) identified six items that were in non-compliance with NRC requirements. These items and Carolina Power & Light Company's response to each are addressed in the following text:

VIOLATION A (SEVERITY LEVEL III):

In a response dated May 24, 1982, describing corrective action taken with respect to a Notice of Violation dated April 2, 1982, the licensee stated that Tables I and IA of Volume XI of the licensee's Plant Operating Manual had been revised to assure that all Q-list equipment was correctly identified on both tables. These tables are used by licensee personnel as a reference to determine if a plant instrument is a Q-item (i.e., safety-related).

Contrary to the above, on May 24, 1982, and as of November 1982, numerous discrepancies existed between Tables I and IA of Volume XI of the licensee's Plant Operating Manual, and consequently the tables did not correctly identify all Q-list equipment. For example, Table IA did not identify pressure switches as Q-list equipment while Table I did. Thus, the licensee's response to the NRC of May 24, 1982, contained a material false statement within the meaning of Section 186 of the Atomic Energy Act of 1954, as amended. The licensee's statement was false in that Tables I and IA did not correctly identify all Q-list equipment. The statement is material for the NRC would have taken further regulatory action to correct the tables had it known they were incorrect.

CAROLINA POWER & LIGHT COMPANY'S RESPONSE:

1. Admission or Denial of Violation

Carolina Power & Light Company acknowledges that the identification of corrective actions set forth in CP&L's response to IE Inspection Report 50-324(325)/82-10, Violation D, was not accurate, due to an unintentional error, in that Tables I and IA of the Plant Operating Manual, Volume XI (Q-list), were not consistent.

2. Reason for Violation

This event occurred due to the lack of clear definition of the scope of the Q-list upgrade project and to inadequate direction to all site subunits responsible for input.

3. Corrective Steps Taken and Results Achieved

- a. The Q-list has been thoroughly reviewed for inconsistencies and corrected where applicable.

- b. The Q-list has been reformatted to minimize the potential for inconsistencies.
- c. The Q-list has been made unit specific to prevent errors due to the differences in equipment.
- d. Enhanced procedural controls have been implemented to maintain the list up-to-date.
- e. A Project Engineer has been assigned to the Q-list to oversee future improvements.
- f. Plant procedures have been developed which provide more rigid controls for accuracy of data submitted to the NRC. These controls include statement verifications and additional management reviews prior to submittal.

4. Corrective Steps to be Taken

No additional corrective actions are planned for this event.

5. Date Full Compliance will be Achieved

Full compliance for this event has been achieved.

VIOLATION B (SEVERITY LEVEL IV):

Technical Specification 3.7.8 for Brunswick, Unit Nos. 1 and 2, requires that all fire barrier penetrations, fire doors, and dampers, in fire zone boundaries protecting safety-related areas shall be functional. Technical Specification 3.7.8 Action Statement "a" requires that, with one or more of the fire barrier penetrations non-functional, within one hour a continuous fire watch must be established on at least one side of the affected penetration or verify the operability of fire detectors on at least one side of the non-functional fire barrier and establish an hourly fire watch patrol.

Contrary to the above, during the period of February 13 to April 5, 1983, fire barrier penetrations protecting safety-related areas in Unit Nos. 1 and 2 were nonfunctional and the associated fire detectors were inoperable without continuous fire watch.

CAROLINA POWER & LIGHT COMPANY'S RESPONSE:

1. Admission or Denial of Violation

Carolina Power & Light Company acknowledges that it failed to establish continuous fire watches as noted in the violation. The violation was identified by CP&L during an internal review of the Fire Protection Program.

2. Reasons for the Violation

The Operations Shift Foreman made an erroneous determination that hourly versus continuous fire watches were to be maintained in the AOG Building when the area fire detectors were declared inoperable by considering only Technical Specification 3.3.5.7, which addresses detector operability. Hourly fire watches had previously been established in accordance with Technical Specification 3.7.8 due to inoperable fire barriers in the AOG Building. When the fire detectors became inoperable, the Shift Foreman failed to realize that Technical Specification 3.7.8 required continuous versus hourly fire watches since Technical Specification 3.3.5.7 did not provide any reference to other restrictions involving the operability of fire detectors.

3. Corrective Steps Taken and Results Achieved

- a. The use of hourly fire watches has currently been discontinued and replaced by the establishment of a continuous roving fire watch in cases where fire detector or fire barrier operability is concerned. This fire watch, when required, is maintained in the affected area.
- b. Training modules for the Fire Support group have been implemented and completed, emphasizing an increased understanding of Fire Protection systems. Additional training has been conducted on the interrelations of systems within Technical Specifications.

4. Corrective Steps to be Taken

No additional corrective action for this event is planned or anticipated. Corrective measures already implemented have resulted in satisfactory procedural controls for handling Fire Protection related LCOs to avoid future occurrences of this nature.

5. Date Full Compliance will be Achieved

Full compliance for this event has been achieved.

VIOLATION C (SEVERITY LEVEL IV):

Technical Specification 6.8.1.f for Unit Nos. 1 and 2 requires that written procedures shall be established, implemented, and maintained covering Fire Protection Program implementation.

Contrary to the above, procedures covering the Fire Protection Program for Unit Nos. 1 and 2 were not adequately implemented as demonstrated by the following examples:

- a. Fire Protection Surveillance Procedure, PT-35.7, was inadequately implemented on February 12, 20, 26, and March 7, 1983, in that the position of valve WW-V207 was not properly identified. The valve was shut. The position was recorded as being locked open.

- b. Fire Protection Surveillance Procedure, PT-35.1, was inadequately implemented on February 14, 21, 28, and March 7, 1983, in that valve WW-V207 was not properly verified as locked open.
- c. Fire Protection procedures PT-35.16 and PT-35.18 were not being adequately implemented in those surveillances to ensure the functional status of fire barrier penetrations were not being performed in accordance with the acceptance criteria specified in these tests.

CAROLINA POWER & LIGHT COMPANY'S RESPONSE:

1. Admission or Denial of Violation

Carolina Power & Light Company acknowledges that it failed to adequately implement procedures covering the Fire Protection Program as stated in the violation. Two of the three examples were identified by CP&L during its investigation of the event.

2. Reasons for the Violation

- a. PT-35.7, which contains a step to check the position of valve WW-V207, did not require a hands-on verification of the valve position. In addition, the subject valve is remotely located in a dimly lighted pipe chase below floor level which led to an inaccurate determination of its position by visual verification alone. This example was reported by CP&L.
- b. PT-35.1 includes a prerequisite to verify that the Fire Protection System is lined up per OP-41. Valve WW-V207 is contained in the OP-41 valve lineup procedure and was not in its required open position when PT-35.1 was conducted. No method existed for tracking exceptions to valve lineups, resulting in the failure to recognize that valve WW-V207 was out of position and under clearance.
- c. PT-35.16 and PT-35.18 were improperly implemented as a result of insufficient training of the Fire Protection personnel assigned to perform the PTs. The determination of fire barrier seal operability was incorrectly based on visual inspection and experience rather than on the acceptance criteria specified in the PT. This example was reported by CP&L.

3. Corrective Steps Taken and Results Achieved

- a. PT-35.7 was revised on April 2, 1983, to require a hands-on-check of the associated fire protection valves. Fire Protection personnel who perform periodic testing have also been trained in the proper method to check valve position as specified in OI-13, Valve and Electrical Lineup Verification. As an interim measure until this training was completed, Fire Protection personnel who were assigned evolutions requiring valve position verification were required to be accompanied by Auxiliary Operators.

- b. A method for tracking exceptions to valve lineups has been incorporated into OI-13, requiring the use of a valve lineup exception form as documentation for the reason that a valve is not in its specified lineup position.
- c. Fire Protection personnel have received training and were required to pass a written exam on Fire Protection related Technical Specifications. In addition, they have received training on Fire Protection training modules. Real time training is conducted on a continuing basis to maintain their degree of understanding and knowledge pertaining to current plant Fire Protection concerns. Verbatim compliance with approved procedures has also been emphasized as a direct result of this event.

4. Corrective Steps to be Taken

No additional corrective action for these events is planned or anticipated. Satisfactory controls have been established to avoid future occurrences of this nature.

5. Date Full Compliance will be Achieved

Full compliance for these events has been achieved.

VIOLATION D (SEVERITY LEVEL IV):

Technical Specification 6.9.1.8 for Unit No. 1 requires the reporting within 24 hours by telephone and confirmation by telegraph, mailgram, or facsimile transmission to the Director of the Regional Office or his designee no later than the first working day following operation of the unit or affected system when any parameter or operation subject to an LCO is less conservative than the least conservative aspect of the LCO established in the Technical Specification.

Contrary to the above, the LCO violation described in the proposed civil penalty was a reportable event which was not reported to the NRC Region II within 24 hours.

CAROLINA POWER & LIGHT COMPANY'S RESPONSE:

1. Admission or Denial of Violation

Carolina Power & Light Company acknowledges that it failed to make the required prompt report when valve WW-V207 was found shut. This event was identified by CP&L on March 18, 1983.

2. Reasons for the Violation

The Shift Foreman and Shift Operating Supervisor that were involved in identifying the need for an LCO due to the WW-V207 valve being found closed failed to recognize that the conditions of the LCO had been exceeded, thus requiring a 24 hour report to be made in accordance with Technical Specification 6.9.1.8.b. No investigative action was initiated at that time. A review of the LCO form by the Regulatory Compliance group

later in the day also failed to reveal the need for a prompt notification based on the information provided on the LCO form. Five days later the full scope of the occurrence was recognized and a prompt report was made.

3. Corrective Steps Taken and Results Achieved

- a. A prompt report was made to the NRC Region II office on March 18, 1983.
- b. Formal documented "live time" training was initiated on March 29, 1983, for appropriate operating shift personnel covering details of this event, including event description, investigation results, corrective actions, safety considerations, and reportability evaluation.

4. Corrective Steps to be Taken

No additional corrective action for this event is planned or anticipated.

5. Date Full Compliance will be Achieved

Full compliance for this event has been achieved.

VIOLATION E (SEVERITY LEVEL IV):

Technical Specification 6.9.2 for Unit No. 1 requires a special report to be issued within 30 days after a fire barrier penetration has been inoperable for seven days.

Contrary to the above, in four instances, once on January 26, twice on February 19, and once on March 12, 1983, fire barrier penetrations were inoperable for more than seven days and the required special reports were not submitted.

CAROLINA POWER & LIGHT COMPANY'S RESPONSE:

1. Admission or Denial of Violation

Carolina Power & Light Company acknowledges that it failed to make required special reports as required by Technical Specifications. This event was identified by CP&L during its review of the Fire Protection Program.

2. Reasons for the Violation

- a. At the time, there was no established system for the daily tracking of fire barrier seal LCOs. Consequently, whenever an LCO time frame was exceeded, there was no mechanism by which to notify plant Regulatory Compliance personnel that a 30 day special report was required in accordance with Technical Specification 6.9.2.

- b. Plant procedures did not provide a mechanism for notifying the Regulatory Compliance group that a protection system had exceeded the allowable technical specification time and that a special report was required.

3. Corrective Steps Taken and Results Achieved

- a. Plant Operating Instruction OI-04, which deals with the handling, tracking, and disposition of plant LCOs, was revised on April 8, 1983 to establish a positive tracking system for Fire Protection LCOs. In addition, it is now specifically outlined in the procedure which plant group is responsible for notifying Regulatory Compliance of an exceeded LCO time frame and how to accomplish the notification.
- b. Special training was given to members of the plant Fire Protection group to upgrade their knowledge of the LCO tracking and handling system with respect to Fire Protection LCOs as reflected in the recently revised OI-04.
- c. The Senior Fire Protection System Specialist now maintains a daily running account of all active fire barrier seal LCOs. This ensures that those LCOs which have exceeded their specified time frames are reported to Regulatory Compliance so that timely reporting to the Commission may be accomplished.
- d. Plant management also reviews, on each working day, the status of active plant and Fire Protection System LCOs. This will help to ensure expeditious processing, correction, and cancellation of these LCOs.

4. Corrective Steps to be Taken to Avoid Further Violations

No additional corrective actions for this event are planned or anticipated. Corrective measures already implemented have resulted in a satisfactory awareness of Operations and Fire Protection personnel to avoid future occurrences of this nature.

5. Date Full Compliance will be Achieved

Full compliance has been achieved.

VIOLATION (SEVERITY LEVEL III; CIVIL PENALTY \$40,000):

Technical Specification 3.7.7.2 for Brunswick, Unit No. 1, requires that the Deluge System for the Standby Gas Treatment System (SBGTS) Trains 1A and 1B, be operable whenever the SBGTS System is required to be operable. Action Statement "a" of Technical Specification 3.7.7.2 requires that, with the Deluge System inoperable, a continuous fire watch with backup suppression equipment be established within one hour.

Contrary to the above, the Unit No. 1 Deluge System for the SBGTS Trains 1A and 1B was rendered inoperable when valve WW-V207 was shut during the period of February 11 to March 13, 1983, and a continuous fire watch was not established. During this time, the plant was in a condition which required the SBGTS to be operable.

CAROLINA POWER & LIGHT COMPANY'S RESPONSE:

1. Admission or Denial of the Alleged Violation

Carolina Power & Light Company acknowledges that a continuous fire watch was not established when valve WW-V207 was isolated as required by Technical Specifications. This event was reported in LER 1-83-15 on April 1, 1983.

2. Reasons for the Violation

Affected Deluge Systems were unknowingly isolated by closing valve WW-V207 while attempting to isolate Service Water System vital header inleakage. Since it was not recognized that the Deluge Systems were isolated, no LCO was initiated.

The following items were identified as contributing factors:

- a. The plant Shift Operating Supervisor (SOS) did not provide appropriate independent review and oversight and was too involved in the details of the actions being taken in association with generating the clearance.
- b. The plant drawing aperture card, utilized when attempting to isolate the Service Water System vital header inleakage, was not easily interpretable.
- c. Plant equipment clearance procedures did not provide for an overall plant systems impact consideration when additional clearance tags were placed on already existing equipment clearances.

3. Corrective Steps Taken and Results Achieved

- a. An appropriate LCO and fire watch were established when the event was identified and maintained until valve WW-V207 was reopened on March 15, 1983.
- b. A complete internal operations audit of existing plant equipment clearances was conducted to ensure compliance with applicable LCOs. This audit verified no LCOs were being violated.
- c. The involved SOS was extensively counseled concerning this event and further disciplinary action was taken.
- d. Informal on-shift counseling was conducted by the Manager - Plant Operations for shift supervisory personnel concerning this event. This informal counseling was begun immediately following the determination of the event.

- e. Formal, documented "live time" training was begun on March 29, 1983, for appropriate operating shift personnel covering details of this event, including event description, investigation results, corrective actions, safety considerations, and reportability evaluations.
- f. The clearance procedure has been revised to require a complete review of the entire clearance when extending the boundary of an existing clearance.
- g. Appropriate in-line valve handwheels in the Fire Protection System have been painted red for immediate identification as a Fire Protection valve.
- h. Plant drawing aperture cards have been upgraded to allow easier interpretation of actual system layouts. This upgrade is continuing as an ongoing process.

The results of the immediate corrective actions taken corrected the violation and ensured that no similar conditions existed. Follow-up corrective actions have improved operating practices and operational administrative controls such that the possibility of reoccurrence has been greatly reduced.

4. Corrective Steps Taken to Avoid Further Violations

No additional corrective actions for this event are planned or anticipated.

5. Date Full Compliance will be Achieved

Full compliance for this event has been achieved.

ADDITIONAL INFORMATION

While Carolina Power & Light Company acknowledges that the Deluge Systems to the Unit No. 1 SBT Systems 1A and 1B were made inoperable from February 11 to March 13, 1983, we would like to present several items which we believe reduce the safety significance of this event:

- 1. Although a fire watch was not specifically assigned to monitor the unprotected area, a radiation checkpoint station located between the SBTs was continuously manned during this period.
- 2. A review of Shift Foremen's log and LCOs indicate that the standpipe system and the fire detection system in the area of the SBTs were operable from February 11, 1983 to March 13, 1983 except for approximately one hour on March 10, 1983. The standpipe system was isolated from 10:45 a.m. to 11:40 a.m. to allow work on the system.
- 3. During the time of this event, Unit No. 1 was in Operational Condition 5 (Refuel) and the only equipment in the area required to be operable were the SBTs. Having been in cold shutdown for two-to-three months prior to and during this event, the anticipated fission product heat loading would

be greatly reduced from that of the design TID-14844 release. In any case, as a fire would make the SGBTs inoperable - so would activation of the Deluge System.

BRUNSWICK IMPROVEMENT PROGRAM

The notice of the proposed imposition of Civil Penalty also requested that CP&L include the changes we made, or plan to make, in the Brunswick Improvement Program (BIP) which address the programmatic problems in the Fire Protection Program. CP&L does not plan to initiate changes to the BIP to separately address the Fire Protection Program. Since this event occurred (approximately one year ago), many changes have been effected concerning Fire Protection - as addressed in the corrective actions to the enclosed violations. In addition, a Principal Engineer - Operations position has been staffed with specific management responsibility for the Fire Protection Program. The filling of this position has been instrumental in providing the managerial guidance needed in this area. Following assumption of the Principle Engineering position, an assessment of the Fire Protection Program was performed in which several additional areas were identified which require improvement. Based on the results of this assessment, and any future assessments, appropriate programmatic upgrades will be incorporated.