



Carolina Power & Light Company

Brunswick Steam Electric Plant
P. O. Box 10429
Southport, NC 28461-0429
November 30, 1984

FILE: B09-13510C
SERIAL: BSEP/84-2628

Mr. James P. O'Reilly, Administrator
U.S. Nuclear Regulatory Commission
Suite 2900
101 Marietta Street NW
Atlanta, GA 30323

BRUNSWICK STEAM ELECTRIC PLANT UNITS 1 AND 2
DOCKET NOS. 50-325 AND 50-324
LICENSE NOS. DPR-71 AND DPR-62
RESPONSE TO INFRACTIONS OF NRC REQUIREMENTS

Dear Mr. O'Reilly:

The Brunswick Steam Electric Plant (BSEP) has received I&E Inspection Report 50-325/84-30 and 50-324/84-30 and finds that it does not contain information of a proprietary nature.

This report identified two items that appeared to be in noncompliance with NRC requirements. Enclosed please find Carolina Power & Light Company's response to the two violations.

Very truly yours,

C. R. Dietz, General Manager
Brunswick Steam Electric Plant

RMP/smp/LETSMP

Enclosure

cc: Mr. R. C. DeYoung
NRC Document Control Desk

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VIOLATION 1

Section 4 of the technical specifications identifies specific checks, tests, and calibrations that must be performed at specific intervals to demonstrate operability of systems and components required by Section 3. Technical Specification 6.8.1.a, requires the licensee to establish implementing procedures recommended in Appendix A of Regulatory Guide 1.33, November 1972. Item H.2 of the guide, specifies that procedures are required for each surveillance test, inspection and calibration listed in the technical specifications.

Contrary to the above, the licensee did not establish adequate procedures for Technical Specification Surveillance 4.5.3.2.c, in that testing procedure (PT-08.1.2) did not verify that both reactor coolant recirculation pump discharge and discharge bypass valves (B32-F031A and B and B32-F032A and B), would actuate to their correct positions during the LPCI System functional tests. These valves are required to automatically close on a LOCA signal combined with a reactor low pressure of 310 psi.

This is a Severity Level IV violation (Supplement I).

Response

1. Admission or denial of the alleged violation:

CP&L concurs that the violation occurred as stated.

2. Reasons for the violation:

This violation apparently resulted from a literal interpretation of the technical specification wording "in the flow path." The authors of the original periodic tests apparently concluded that there was no need to functionally test valves which prevented divergence of flow. Only those valves which were required to function to permit flow in the flow path were tested.

3. Corrective actions which have been taken:

- a. A review of the HPCI, LPCI, RCIC, and Core Spray Systems was conducted to identify automatic valves, which if mispositioned, could affect the system emergency flow path. Plant procedures were then reviewed to determine if these valves were adequately tested. Testing deficiencies were identified for some LPCI valves.
- b. Special procedures were written to test the LPCI valves identified in Item 3.a.
- c. A plant position was established which more clearly delineates components which must be tested during system functional tests.
- d. The existing periodic test was revised to test the LPCI valves identified in Item 3.a. This ensures the valves are tested periodically as required by technical specifications.

VIOLATION 1 (Cont'd)

4. Corrective actions to be completed:

- a. Implementation of the testing philosophy developed in Item 3.c will occur during the maintenance surveillance test development project.
- b. Determine other systems which are required to have a system logic functional test. The tests of these systems are to be reviewed to determine compliance with the position developed in Item 3.c.

5. Date for full compliance:

Full compliance has been achieved relative to the specific identified violation.

VIOLATION 2

Technical Specification 6.8.1.a requires written procedures be implemented covering procedures recommended in Appendix A of Regulatory Guide 1.33, November 1972. Item D.5 of Appendix A requires procedures for draining the shutdown cooling system.

Contrary to the above, the licensee failed to implement procedure OP-17, Residual Heat Removal System Operating Procedure, in that the system, on September 24, 1984, was not aligned as required per Step 8.7.A.3, prior to opening drain valves to radwaste. This resulted in a loss of 12 inches of vessel water level while shut down instead of a reduction in suppression pool level.

This is a Severity Level IV violation (Supplement I).

Response

1. Admission or denial of the alleged violation:

CP&L agrees the violation occurred as stated.

2. Reasons for violation:

This violation occurred as the result of a personal error by the Control Operator involved.

The Control Operator involved had been working on Unit 1 which had been operating at power for most of the year. During power operation, the RHR System is normally used for torus cooling. In contrast, Unit 2 was shut down and had RHR aligned for shutdown cooling of the reactor vessel.

During the shift turnover, the Control Operator involved received an adequate briefing on plant status for Unit 2 which included being in shutdown cooling on the RHR loops. Approximately six hours later, during depressurization from the integrated leak rate test, the involved Control Operator noticed a rapid rise in torus level and felt an urgency existed to reduce the torus level prior to its exceeding the technical specification high limit. (On an operating unit, torus level must be controlled expeditiously, since in mode 1 the torus level specifications have a high and low limit. However, in the shutdown condition, only the minimum level specification applies.) At this point the operator took actions to reduce the torus level based on the system being in torus cooling alignment. Since the RHR loops were in shutdown cooling alignment, his actions resulted in draining the reactor vessel to the torus. An additional contributing factor, the reactor vessel low level alarm was already sealed in as a result of having to maintain a static water inventory for the ILRT. Therefore, the first alarm received was the low level reactor vessel scram.

VIOLATION 2 (Cont'd)

3. Corrective actions taken:

- a. Upon receiving the reactor scram alarm, the involved Control Operator recognized his error, secured the draining evolution, and reestablished reactor vessel inventory.
- b. Training was conducted with appropriate shift personnel describing the event and stressing the need for attention to detail, strict procedural compliance, and awareness of unit status at all times.
- c. Appropriate disciplinary action was taken against the involved Control Operator.

4. Actions to be taken:

None

5. Date for full compliance:

Full compliance relative to this event has been achieved.

NOTE: LER 2-84-011 provides additional details involving this event.