Carolina Power & Light Company Brunswick Nuclear Project P. O. Box 10429 Southport, NC 28461-0429 January 4, 1990 FILE: B09-13510C 10CFR50.73 SERIAL: BSEP/90-0007 U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, DC 20555 BRUNSWICK STEAM ELECTRIC PLANT UNIT 1 DOCKET NO. 50-325 LICENSE NO. DPR-71 LICENSEE EVENT REPORT 1-89-026 Gentlemen: In accordance with Title 10 to the Code of Federal Regulations, the enclosed Licensee Event Report is submitted. This report fulfills the requirement for a written report within thirty (30) days of a reportable occurrence and is in accordance with the format set forth in NUREG-1022, September 1983. Very truly yours, Y. L. Harness, General Manager Brunswick Nuclear Project. TH/mcg Enclosure cc: Mr. S. D. Ebneter Mr. E. G. Tourigny BSEP NRC Resident Office

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At 0553 hours on 12/10/89, Units' 1 and 2 common emergency bus E3 unexpectedly deenergized when the output breaker of emergency diesel generator (DG) No. 3, which was syncronized and loaded to the bus, opened. This event occurred when the master/slave feeder breakers of the normal power source to £3 from balance of plant bus 2D were opened to remove bus 2D from service for scheduled maintenance activities. Per design DG No. 3 automatically tied on to supply E3. The loss of E3 resulted in the following: Primary Containment isolations, Standby Gas Treatment System automatic initiation, and Reactor Building Ventilation System isolations (both units), and a B logic Reactor Scram signal (Unit 2 only). At the time, Unit 1 was operating at 100% and Unit 2 was defueled while in its 1989-1990 refuel/maintenance outage. By 0605 hours, normal power to E3 from bus 2D was restored and the incurred isolations and initiations of the affected systems on both units were reset and the systems were returned to normal.

DAY

MONTH

YEAR

SUPPLEMENTAL REPORT EXFECTED (14)

X YES complete EXPECTED SUBMISSION DATE!

ABSTRACT (Limit to 1400 special is approximately fifteen single space typewritten lines) (16)

A preliminary investigation has determined this event is the result of a procedural inadequacy of the involved Plant Electric System Operating Procedure (OP)-50 and the DG Emergency Power System OP-50.1. Upon completion of the investigation, a supplement to this report will be submitted by 2/16/90 to further detail the cause(s) and corrective action to this event.