TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401
400 Chestnut Street Tower II

April 4, 1983

BLRD-50-438/82-60

U.S. Nuclear Regulatory Commission
Region II
Attn: Mr. James P. O'Reilly, Regional Administrator
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

BELLEFONTE NUCLEAR PLANT UNIT 1 - WESTINGHOUSE LOW VOLTAGE SWITCHGEAR - BLRD-50-438/82-60 - SECOND INTERIM REPORT

The subject deficiency was initially reported to NRC-OIE Inspector Don Quick on August 23, 1982 in accordance with 10 CFR 50.55(e) as NCR 1948. This was followed by our first interim report dated September 21, 1982. Enclosed is our second interim report. We expect to submit our next report by August 4, 1983.

If you have any questions concerning this matter, please get in touch with R. H. Shell at FTS 858-2688.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

L. M. Mills, Manager
Nuclear Licensing

Enclosure
cc: Mr. Richard C. DeYoung, Director (Enclosure)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Records Center (Enclosure)
Institute of Nuclear Power Operations
1100 Circle 75 Parkway, Suite 1500
Atlanta, Georgia 30339

IE 27

ENCLOSURE

BELLEFONTE NUCLEAR PLANT UNIT 1
WESTINGHOUSE LOW VOLTAGE SWITCHGEAR
NCR 1948
BLRD-50-438/82-60
10 CFR 50.55(e)
SECOND INTERIM REPORT

Description of Deficiency

The affected low-voltage switchgear was supplied by Westinghouse, Pittsburgh, Pennsylvania. During a test of the HVAC chilled water pump, the 1EX2-A switchgear failed to trip when power was lost inadvertently. Upon restoration of power, the pump motor was activated without benefit of component cooling water or lubricant because the low-voltage switchgear associated with these systems did trip thereby preventing unintentional reenergization. Consequently, the HVAC chilled water pump was burned out.

A preliminary investigation revealed that the probable cause of the deficiency was the insertion of a DC fuse block incorrectly in the low-voltage switchgear. The incorrect configuration resulted in an open circuit which, in turn, prevented the switchgear from tripping.

Interim Progress

TVA has determined that the DC fuse blocks will be marked with paint to indicate the correct position for each fuse block. This will significantly reduce the possibility of operator error when the fuse blocks are re-inserted.

TVA is evaluating this deficiency to determine the root cause of the nonconformance and the actions required to prevent recurrence. TVA will provide a final report upon completion of this evaluation.