

TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401  
400 Chestnut Street Tower II

June 27, 1984

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BLRD-50-439/83-56

U.S. Nuclear Regulatory Commission  
Region II  
Attn: Mr. James P. O'Reilly, Regional Administrator  
101 Marietta Street, NW, Suite 2900  
Atlanta, Georgia 30323

Dear Mr. O'Reilly:

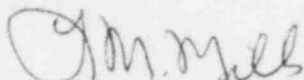
BELLEFONTE NUCLEAR PLANT UNIT 2 - VALVE FLOODED IN REACTOR BUILDING NORMAL SUMP  
- UNIT 2 - BLRD-50-439/83-56 - FINAL REPORT

The subject deficiency was initially reported to NRC-OIE Inspector P. E. Fredrickson on December 1, 1983 in accordance with 10 CFR 50.55(e) as NCR 2549. This was followed by our interim reports dated December 27, 1983 and March 23, 1984. Enclosed is our final report.

If you have any questions, 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

ENCLOSURE

BELLEFONTE NUCLEAR PLANT UNIT 2  
VALVE FLOODED IN REACTOR BUILDING NORMAL SUMP - UNIT 2  
BLRD-50-439/83-56  
10 CFR 50.55(e)  
NCR 2549  
FINAL REPORT

Description of Deficiency

The motor-operator of valve (2WL-IFCV-068-B) in the liquid waste system was damaged by flooding of the Reactor Building normal sump tank room. An investigation was made into the apparent cause of this deficiency by Bellefonte's Division of Construction and has revealed that the flooding was a result of a washdown of the unit 2 steam generators. During this washdown, the waste disposal system drain to the sump tank room was inadvertently left open and this resulted in the flooding of the tank room.

Safety Implications

If this condition had remained uncorrected for a period of time, the valve motor operator would probably rust, preventing the proper functioning of the valve to isolate containment during a loss of coolant accident. Should the valve fail to isolate the Reactor Building normal sump tank from the Auxiliary Building, highly radioactive water would be released into the Auxiliary Building. Thus, the maximum onsite dose in the Auxiliary Building might be exceeded, and the release of radioactivity to the environment could exceed 10 CFR 100 limits.

Corrective Action

Limitorque (the supplier for the motor operator in question) will provide shipping instructions to TVA in order that the motor operator can be returned for rework. When the reworked motor operator is returned from the vendor, it will be stored and maintained in the controlled environment of the warehouse until it is required to support motor operation. Based on the unit 2 schedule, the reinstallation of the motor operator is expected to be complete by March 16, 1987. TVA considers this deficiency an isolated occurrence; therefore, no further action is required to prevent recurrence.