TENNESSEE VALLEY AUTHORITY

CHATTANOOGA, TENNESSEE 37401
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March 19, 1985

U.S. Nuclear Regulatory Commission
Region II
Attn: Dr. J. Nelson Grace, Regional Administrator
101 Marietta Street, NW, Suite 2900
Atlanta, Georgia 30323

Dear Dr. Grace:

BELLEFONTE NUCLEAR PLANT UNITS 1 AND 2 - RESPONSE TO VIOLATION 50-438/85-01-01, 50-439/85-01-01 - DEVELOPMENT OF VALVE MAINTENANCE REQUIREMENTS

This is in response to R. D. Walker's letter dated February 13, 1985, report numbers 50-438/85-01, 50-439/85-01 concerning activities at the Bellefonte Nuclear Plant which appeared to have been in violation of NRC regulations. Enclosed is our response to the citation.

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

To the best of my knowledge, I declare the statements contained herein are complete and true.

Very truly yours,

TENNESSEE VALLEY AUTHORITY

J. A. Domer
Nuclear Engineer

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

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

ENCLOSURE

BELLEFONTE NUCLEAR PLANT UNITS 1 AND 2
RESPONSE TO SEVERITY LEVEL IV VIOLATION
50-438/85-01-01 AND 50-439/85-01-01
DEVELOPMENT OF VALVE MAINTENANCE REQUIREMENTS

Description of Deficiency

10 CFR 50, Appendix B, Criterion XVI, as implemented by TVA Topical Report TVA-TR75-1A, Section 17.1.16, requires the licensee to establish measures which assure that deficiencies are promptly corrected.

Contrary to the above, the licensee's measures did not assure prompt correction of a deficiency identified in their preventive maintenance program for safety-related valves with Limitorque operators, in that:

1. On 8/9/84, over 17 months after original identification of the deficiency on nonconforming condition report (NCR) 2279 (dated 2/24/83), corrective action had not been fully implemented. This corrective action consisted of specific preventive maintenance requirements which the engineering design organization directed for immediate implementation. Examples of valves for which the specified preventive maintenance had not been implemented were as follows:

Valve Size	Valve No.	System
14-inch	1ND-IFCV-85A	Decay heat removal
3-inch	1NS-IFCV-89B	Reactor building spray
6-inch	1NS-IFCV-105A	Reactor building spray

2. As of the 8/9/84 date, over 12 months had passed since the engineering design organization had responded to the deficiency with preventive maintenance requirements for the subject valves (reference TVA memorandum dated 7/21/83).

3. As of the 8/9/84 date, almost three months had passed since the engineering design organization had modified the earlier instructions and specified that the new instructions be implemented immediately (reference TVA memorandum dated 5/17/84.

TVA Response

Admission or Denial of the Alleged Violation

TVA denies the alleged violation as stated.

TVA's Bellefonte Nuclear Plant (BLN) site personnel initiated NCR 2279 on February 24, 1983, to document the absence of certain valve operators from the maintenance program and to establish a position regarding the implementation of certain vendor recommendations for maintenance of

Limitorque-operated valves; specifically, that every valve in every system does not require incorporation into the preventive maintenance program. The NCR was submitted to the design organization for concurrence with the position. Concurrence was received by the site and the NCR was closed on July 25, 1983, with no corrective action specified.

The stand alone quality information memorandums identified in this violation were not provided in response to NCR 2279. Those memorandums were not considered to be corrective action in response to an identified deficiency.

While TVA admits that delays were encountered during the implementation of maintenance requirements associated with a stand alone quality memorandum, these delays do not violate 10 CFR 50, Appendix B, Criterion XVI nor the TVA quality assurance program. TVA policy supports the timely implementation of specified requirements. However, certain circumstances may prevent the immediate completion of actions to satisfy the requirements.

During an NRC inspection in August 1984, certain Limitorque-operated valves were identified by the NRC inspector which still had not been included in the site preventive maintenance program. Site personnel performed an investigation and confirmed the situation described by the NRC inspector. NCR 3416 was initiated to document the absence of the Limitorque-operated valves in the maintenance program. The cause of this problem was an oversight by certain responsible personnel to implement the requirements as directed by site management. Corrective action consisted of a review of all maintenance requirement sheets for class 1E Limitorque-operators and revision to those sheets which were deficient. Responsible unit supervisors and personnel were cautioned to be more thorough in future reviews. NCR 3416 was closed on October 9, 1984.