

CONTROL BLOCK:

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 (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONT

0	1
7	8

REPORT SOURCE

L	6	0	5	0	0	0	2	9	6	7	0	8	2	5	8	0	8	0	9	1	8	8	0	9
60	61									68	69						74	75						80
ROCKET NUMBER										EVENT DATE										REPORT DATE				

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE C E		CAUSE CODE X		CAUSE SUBCODE Z		COMPONENT CODE Z Z Z Z Z				COMP SUBCODE Z		VALVE SUBCODE Z	
EVENT YEAR 8 0		SEQUENTIAL REPORT NO. 0 3 2		OCCURRENCE CODE 0 3		REPORT TYPE L				REVISION NO. 0			
ACTION TAKEN B	FUTURE ACTION F	EFFECT ON PLANT Z	SHUTDOWN METHOD Z	HOURS 0 0 0 0	ATTACHMENT SUBMITTED Y	NPRD-4 FORM SUB. N	PRIME COMP. SUPPLIER Z	COMPONENT MANUFACTURER Z 9 9 9					

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

FAMILY STATUS (8) POWER (9) OTHER STATUS (10)

1 6 E 78 0 9 9 29 NA

METHOD OF DISCOVERY (11) DISCOVERY DESCRIPTION (12)

B 31 Personnel observed

ACTIVITY CONTENT (13) RELEASED OF RELEASE (14) AMOUNT OF ACTIVITY (15)

1 6 Z 37 Z 38 NA

LOCATION OF RELEASE (16)

NA

LOSS OF OR DAMAGE TO FACILITY		(43)
TYPE	DESCRIPTION	
1	Z	NA

8 9 10
PUBLICITY
ISSUED DESCRIPTION (45) NA
2 0 N (44) _____
NRC USE ONLY

NAME OF PREPARED

PHONE:

8009230879

LER SUPPLEMENTAL INFORMATION

BFRO-50- 296 / 80 32 Technical Specification Involved 3.5.F.2

Reported Under Technical Specification 6.7.2.b(2)

Date of Occurrence 8/25/80 Time of Occurrence 1155 Unit 3

Identification and Description of Occurrence

While performing RCIC steam line space high temperature SI 4.2.B-32, lead wires were accidentally pulled out of the RCIC speed feedback magnetic pickup connector.

Conditions Prior to Occurrence:

Unit 1 @ 99%

Unit 2 @ 93%

Unit 3 @ 99%

Action specified in the Technical Specification Surveillance Requirements met due to inoperable equipment. Describe.

HPCI verified operable.

Apparent Cause of Occurrence:

Personnel performing the SI accidentally stepped on the lead wires to the connector.

Analysis of Occurrence:

There was no damage to plant equipment. There was no activity release, no personnel exposure or injury and no danger to the health or safety of the public.

Corrective Action:

Wiring to the connector was repaired. The flex conduit to the connector was wrapped in bright yellow tape for visibility. DCK 2039 has been submitted to install protective cage over magnetic pickup and to change flex conduit to rigid.

Failure Data:

BFRO-50-296/700008 and 296/76011

*Retention: Period - Lifetime; Responsibility - Administrative Supervisor

*Revision:

