

NRC FORM 366  
(12-81)  
10 CFR 50

U.S. NUCLEAR REGULATORY COMMISSION  
LICENSEE EVENT REPORT

APPROVED BY OMB  
3150-0011

CONTROL BLOCK: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[01] [A][L][B][R][F][3] [2] [0][0]-[0][0][0][0][0]-[0][0] [3] [4][1][1][1][1] [4] [ ] [5]  
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 37 CAT 58

CONT  
[01] REPORT SOURCE [L] [6] [0][5][0][0][0][2][9][6] [7] [0][8][2][5][8][0] [8] [0][5][3][0][8][4] [9]  
7 8 40 41 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[02] During normal operation while performing RCIC steam line space high temperature  
[03] SI 4.2.B-32, lead wires were accidentally pulled out of the RCIC speed feedback  
[04] magnetic pickup connector. Reference T.S. 3.5.F.2. HPCI was available. There  
[05] were no significant resulting events. There was no danger to health or safety  
[06] of public. Previous event BFRO-50-296/79008.

[07] \_\_\_\_\_  
[08] \_\_\_\_\_

[09] SYSTEM CODE [C][E] (11) CAUSE CODE [X] (12) CAUSE SUBCODE [Z] (13) COMPONENT CODE [Z][Z][Z][Z][Z][Z] (14) COMP. SUBCODE [Z] (15) VALVE SUBCODE [Z] (16)  
7 8 9 10 11 12 13 14 15 16 17 18 19 20  
[17] LER/RO REPORT NUMBER [8][0] (21) [ ] (22) [0][3][2] (23) [ ] (24) [ ] (25) [ ] (26) [ ] (27) [ ] (28) [ ] (29) [ ] (30) [ ] (31) [ ] (32) REVISION NO.  
ACTION TAKEN [B] (18) FUTURE ACTION [F] (19) EFFECT ON PLANT [Z] (20) SHUTDOWN METHOD [Z] (21) HOURS [0][0][0][0] (22) ATTACHMENT SUBMITTED [Y] (23) NRPD-4 FORM SUB. [N] (24) PRIME COMP. SUPPLIER [Z] (25) COMPONENT MANUFACTURER [Z][9][9][9] (26)  
33 34 35 36 37 38 39 40 41 42 43 44 45

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[10] Personnel performing SI accidentally stepped on the lead wires to the connector.  
[11] Wiring to connector was repaired and operability SI was completed. Flex  
[12] conduit was wrapped with a bright colored tape. There have been no similar  
[13] events since the tape was installed. No further recurrence control is planned.  
[14] \_\_\_\_\_

[15] FACILITY STATUS [E] (28) % POWER [0][9][9] (29) OTHER STATUS [NA] (30) METHOD OF DISCOVERY [ ] (31) DISCOVERY DESCRIPTION [Personnel observed] (32)  
7 8 9 10 11 12 13 14 15 16 17 18 19 20

[16] ACTIVITY RELEASED OF RELEASE [Z] (33) CONTENT OF RELEASE [Z] (34) AMOUNT OF ACTIVITY [NA] (35) LOCATION OF RELEASE [NA] (36)  
7 8 9 10 11 12 13 14 15 16 17 18 19 20

[17] PERSONNEL EXPOSURES NUMBER [0][0][0] (37) TYPE [Z] (38) DESCRIPTION [NA] (39)  
7 8 9 10 11 12 13 14 15 16 17 18 19 20

[18] PERSONNEL INJURIES NUMBER [0][0][0] (40) DESCRIPTION [NA] (41)  
7 8 9 10 11 12 13 14 15 16 17 18 19 20

[19] LOSS OF OR DAMAGE TO FACILITY TYPE [Z] (42) DESCRIPTION [NA] (43)  
7 8 9 10 11 12 13 14 15 16 17 18 19 20

[20] PUBLICITY ISSUED DESCRIPTION [N] (44) DESCRIPTION [NA] (45)  
7 8 9 10 11 12 13 14 15 16 17 18 19 20

NAME OF PREPARER Stanley D. Carter PHONE (205) 729-0889

JE22 1/1

NRC USE ONLY

LER SUPPLEMENTAL INFORMATION

BFRO-50- 296/ 80032R1 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.

Condition 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 with a bright colored tape for visibility. Installation of protective covers was considered but was determined to be impractical. There have been no similar events since the bright colored tape was installed almost four years ago. Therefore. no further recurrence control is planned.

Failure Data:

BFRO-50-296/700008 and 296/76011

Retention: Period - Lifetime; Responsibility - Administrative Supervisor

TENNESSEE VALLEY AUTHORITY  
Browns Ferry Nuclear Plant  
P. O. Box 2000  
Decatur, Alabama 35602

May 30, 1984

84 JUN 5 P12:22

Mr. James P. O'Reilly, Regional Administrator  
U. S. Nuclear Regulatory Commission  
Region II  
101 Marietta Street, Suite 3100  
Atlanta, Georgia 30303

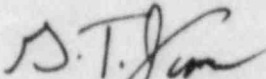
Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 3 - DOCKET  
NO. 50-296 - FACILITY OPERATING LICENSE DPR-68 - REPORTABLE OCCURRENCE  
REPORT BFRO-50-296/80032 R1

The enclosed report provides followup information concerning lead wires  
accidentally pulled out of RCIC speed feedback magnetic pickup connector.  
This report is submitted in accordance with Browns Ferry Unit 3 Technical  
Specification 6.7.2.b.(2).

Very truly yours,

TENNESSEE VALLEY AUTHORITY



G. T. Jones  
Power Plant Superintendent  
Browns Ferry Nuclear Plant

Enclosure

cc (Enclosure):  
U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington D.C. 20555

NRC Inspector, Browns Ferry Nuclear Plant

OFFICIAL COPY

1022

11