

Update Report - Previous Report Dated 7/8/79  
LICENSEE EVENT REPORT

U.S. NUCLEAR REGULATORY COMMISSION

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

01 P A B V S 1 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CONT  
01 REPORT SOURCE L 6 0 5 0 0 0 3 3 4 7 0 6 0 8 7 9 8 0 1 2 8 8 1 9  
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## EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 In June, 1979, two power cables originating at the 1B Low Head Safety Injection Pump  
03 Header Isolation Valve and the pump suction valve were found incorrectly routed  
04 through two non-color-coded cable trays. As a result of these findings, a cable  
05 sampling program was initiated where an additional 26 cables were inspected. No  
06 routing violations were discovered. During the 1980 refueling outage, 10 additional  
07 cable routing problems were found during design work changes.

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## CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The original two cables were rerouted in 1979. The 10 cable routing problems  
11 discovered in 1980 have been rerouted and verified as correct under Design Change  
12 Package (DCP) 253. Because of these deficiencies, the station has initiated DCP 393  
13 which calls for a second cable verification program. The Onsite Engineering Group  
14 is currently setting up this program.

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Attachment To LER 79-16/03L-2  
Beaver Valley Power Station  
Duquesne Light Company  
Docket No. 50-334

In June, 1979, a shorted power cable on the 1B Low Head Safety Injection Pump Header Isolation Valve was replaced. At this time, it was discovered that the cable was not installed according to its original cable pull ticket. The color-coded cable had been incorrectly routed through two non-color-coded cable trays. A further investigation revealed that one other cable, originating at the 1B Low Head Safety Injection Pump Suction Valve from the containment sump, was also incorrectly routed through the same two cable trays. These cables were then rerouted and verified as correct in August, 1979.

The Onsite Engineering Group was contacted. A plan was formulated to make a statistical sampling of all the Category I cables which shared the same common denominator with the above incidents. This denominator was found to be that, in both cases, the same two individuals were involved. A record search revealed that a total of 456 Category I cables had been installed and inspected by these individuals. From this total, 26 randomly-selected cables were inspected. Minor deficiencies were found, but no routing violations were discovered. The minor deficiencies were corrected.

During the 1980 refueling outage, 10 additional cable routing problems were discovered. These cables were rerouted and verified as correct under Design Change Package 256. This package was closed in November, 1980. These deficiencies have been noted in a Station Modification Request which recommends setting up a new cable sampling program based on the routing discrepancies found during the outage. The Onsite Engineering Group is currently setting up such a program. This program will be set up to include a routing verification of all Category I cables presently within the station.