



Description of Event

On May 3, 1980, during a periodic test to verify proper valve line-up of the auxiliary feedwater system, it was discovered that the position of auxiliary feedwater control valve MOV-FW100B, as written in the procedure, was incorrect. The procedure required the valve to be closed instead of open.

Probable Consequences of Occurrence

With the test procedure requiring valve MOV-FW100B to be closed, no operable flow path would be available from the auxiliary feedwater pumps to "B" steam generator in the event of a total power failure. Because the valve was never placed in the incorrect position due to the operator discovering and correcting the error the first time the faulty procedure revision was used, the health and safety of the general public were not affected. There are no generic implications associated with this event.

Cause of Event

The test procedure indicated an incorrect position for valve MOV-FW100B due to a clerical error when the procedure was last revised. Procedures are normally stored on word processing unit cassettes, but this procedure was mistakenly erased which required a complete retyping resulting in the error.

Immediate Corrective Action

A procedure deviation to change the valve position of MOV-FW100B from "Closed" to "Open" was submitted when the test was performed. A revision was then made to reflect this as a permanent change to the procedure.

Scheduled Corrective Action

No scheduled corrective action is required.

Actions Taken to Prevent Recurrence

Administrative procedures will be revised to require Station Records to advise the cognizant supervisor which portions of the procedure have been retyped so a more detailed proofreading may be accomplished.