NRC FORM 366 (12-81) 10 CFR 50

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB 3150-0011

LICENSEE EVENT REPORT

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

Line	Field	Entry
0 1	LICENSEE CODE (2)	A L J M F 1
	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
	LICENSE TYPE (4)	4 1 1 1 1
	CAT (5)	
CON'T 0 1	REPORT SOURCE (6)	L
	DOCKET NUMBER (7)	0 5 0 0 0 3 4 8
	EVENT DATE (8)	1 2 1 5 8 3
	REPORT DATE (9)	0 1 1 3 8 4

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 At 0800 on 12/15/83, radiation monitor R-11 (Containment Atmosphere Particulate
0 3 Activity) was declared inoperable due to an improper valve lineup. Tech. Specs.
0 4 3.3.3.1 and 3.4.7.1, in part, require this monitor to be operable. Tech. Spec.
0 5 action statement requirements were met. Health/safety of the public was not
0 6 affected.
0 7
0 8

SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
C I	A	D	V A L V E X	F	X

LER/RO REPORT NUMBER (17)

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 3	—	0 8 9	/	0 3	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
H	Z	Z	Z	0 0 0 0	Y	N	N	W 1 2 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 This event was caused by personnel error. At approximately 1620 on 12/14/83,
1 1 a health physics technician shifted radiation monitor R-11 from the outboard pump
1 2 to the inboard pump to allow troubleshooting by electrical maintenance. Upon
1 3 completion of a motor current check, the same technician attempted to shift R-11
1 4 back to the outboard pump. The technician used an incorrect (SEE ATTACHED)

Line	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
1 5	E	1 0 0	NA	A	Operational Event

Line	ACTIVITY RELEASED (33)	CONTENT OF RELEASE (34)	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z	Z	NA	NA

PERSONNEL EXPOSURES

Line	NUMBER (37)	TYPE (38)	DESCRIPTION (39)
1 7	0 0 0	Z	NA

PERSONNEL INJURIES

Line	NUMBER (40)	DESCRIPTION (41)
1 8	0 0 0	NA

LOSS OF OR DAMAGE TO FACILITY

Line	TYPE (42)	DESCRIPTION (43)
1 9	Z	NA

8401240267 840113
PDR ADOCK 05000348
S PDR

PUBLICITY

Line	ISSUED (44)	DESCRIPTION (45)
2 0	N	NA

NRC USE ONLY

NAME OF PREPARER W. G. Hairston, III PHONE (205) 899-5156

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (Continued)

section of the approved procedure which caused him to misposition the pump inlet and bypass valves. Operations personnel noticed an abnormally low indication on radiation monitor R-11 and checks were made by health physics personnel on both the evening and night shifts. These checks verified proper pump operation but failed to verify inlet and bypass valve position. Upon discovery on day shift, the valve lineup was corrected and radiation monitor R-11 was returned to service at 0830 on 12/15/83. The personnel involved have been counseled.