

**LICENSEE EVENT REPORT**

3150-0011

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 8 | \_\_\_\_\_

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

8 9 10 80

PUBLICITY  
ISSUED DESCRIPTION (45)

2 0 Y (44) Television, Radio, Newspaper release - 3/22/83

7 8 9 10 88 89 90

NRC USE ONLY

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Attachment

Licensee Event Report 83-043/01T-0

While the reactor was in Hot Shutdown, a pre-startup surveillance on the SCRAM Discharge Volume was in progress. Upon completion of the surveillance, the reactor mode switch was turned from the "startup" position to the "shutdown" position. Instead a full SCRAM coming in, only a one-half SCRAM was received. Immediately all control rods were checked and determined to be full in. The I&C group was called to investigate the problem and identified the mode switch as the source. The reactor was then manually scrammed by the pushbuttons and a full Reactor Protection System actuation was indicated.

The mode switch was tried several more times and operated intermittently. The switch was removed and the NSSS supplier (General Electric) was contacted to send a replacement. A replacement was shipped to the site and bench tested. As the switch was tested (contact continuity) it was also determined to be unacceptable. The switch was returned to the NSSS supplier and PP&L has been informed that they are performing a failure analysis (the ownership of the switch was never transferred from General Electric to PP&L). The NSSS supplier shipped four more mode switches to the site and they successfully passed a bench test.

The mode switch was replaced with one of the acceptable switches. The operating procedure has been revised to require the operator to push the manual scram pushbuttons in conjunction with turning the mode switch to the shutdown position. The original, replaced mode switch is to be sent out for failure analysis. In the interim, the electrical work group is being notified by Operation's each time the mode switch position is changed and they are verifying proper contact alignment. This verification is required prior to pulling rods, increasing recirculation pump flow or increasing power.

PP&L feels that the results of the switch failure analysis are required before a 10 CFR 21 report decision can be made. An investigation is in progress to determine 10 CFR 50.55e reporting requirements for Unit 2.

This LER will be updated.