

CONTROL BLOCK: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)01 PASES1 200-000000-00 341111 45  
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 605000387 7071783 8081683 9  
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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 The 'Emergency Outside Air Intake High Radiation' alarm was received in the main  
03 control room. No auto. system initiations are associated with this alarm. Prelim-  
04 inary investigation showed that the detector in one channel had drifted high. At a  
05 higher radiation level the detector provides a signal to the circuitry which init-  
06 iates the Control Room Emergency Outside Air Supply System. The affected channel  
07 was declared inoperable and placed in the downscale tripped condition. Redundant  
08 instrumentation was available. There were no adverse effects to public health.

09 SYSTEM CODE BB 11 CAUSE CODE E 12 CAUSE SUBCODE F 13 COMPONENT CODE INSTRU 14 COMP. SUBCODE E 15 VALVE SUBCODE Z 16  
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

17 LER/RO REPORT NUMBER 83 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

18 ACTION TAKEN C 19 FUTURE ACTION Z 20 EFFECT ON PLANT Z 21 SHUTDOWN METHOD Z 22 HOURS 00000 23 ATTACHMENT SUBMITTED N 24 NPRD-4 FORM SUB. Y 25 PRIME COMP. SUPPLIER N 26 COMPONENT MANUFACTURER G080

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The investigation into why the detector drifted high showed that the GM tube had  
11 failed. It was replaced, calibrated, successfully retested and the channel re-  
12 turned to service. No future actions are planned.  
13  
14

15 FACILITY STATUS E 28 % POWER 060 29 OTHER STATUS NA 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Operator Observation 32  
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

16 ACTIVITY CONTENT RELEASED OF RELEASE Z 33 AMOUNT OF ACTIVITY NA 34 LOCATION OF RELEASE NA 35  
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

17 PERSONNEL EXPOSURES NUMBER 000 37 TYPE 38 DESCRIPTION NA 39  
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

18 PERSONNEL INJURIES NUMBER 000 40 DESCRIPTION NA 41  
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

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 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

20 PUBLICITY ISSUED DESCRIPTION N 44  
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

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PDR ADQCK 05000387  
S PDR

NRC USE ONLY

NAME OF PREPARER L.A. Kuczynski

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August 16, 1983

Dr. Thomas E. Murley  
Regional Administrator, Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

SUSQUEHANNA STEAM ELECTRIC STATION  
LICENSEE EVENT REPORT 83-104/03L-0  
ER 100450 FILE 841-23  
PLA-1794

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Dear Dr. Murley:

Attached is Licensee Event Report No. 83-104/03L-0. This event was determined to be reportable per Technical Specification 6.9.1.9(b), in that a Main Control Room Outside Air Intake Radiation Detector was inoperable. The action statement for Technical Specification Table 3.3.7.1-1 was complied with. Redundant instrumentation was available and the inoperable channel returned to service within two days.

H.W. Keiser  
Superintendent of Plant-Susquehanna

LAK/pjg

cc: G.G. Rhoads  
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