

8005120418

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

7 8 9 80

### CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

7 8 9 80

[illegible]

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SUPPLEMENTAL INFORMATION  
FOR  
LICENSEE EVENT REPORT 80-08

1. Cause Description and Analysis:

During normal operation on April 6, 1980, at 0944 hours, pressure transmitter 495 (PT-495), which is one of three monitoring steam generator "C", failed to full output. This type of failure mode blocks this input to the Safety Injection initiation logic for High Steam Line Differential Pressure. The event is contrary to the minimum degree of redundancy as stated in Table 3.5-3 of Technical Specifications and is reportable under Section 6.9.2.b.1. Another function of this instrument is to provide pressure compensation to one channel of steam flow for feedwater control on "C" Steam Generator. This failure caused a high flow rate on this control until the control operator placed the control in manual and switched to the other channel of steam flow which was operating normally. This resulted in a slight increase in "C" Steam Generator level but created no problems. The operator manually operated the trip bistables in the failed loop to restore the required degree of redundancy as per Table 3.5-3 of Technical Specifications.

2. Corrective Action:

The operator immediately put the "C" feedwater control on manual and switched to the channel of steam flow which was not affected. Then as quickly as practical, the Operating Work Procedures for this loop was implemented and the bistable switches for the failed pressure channel were placed in the trip position. The instrument resumed normal operation prior to any repair being made. Bistables were reset after Instrument and Control personnel tested the instrument at 1540 on April 7, 1980.

3. Corrective Action To Prevent Further Occurrence:

The cause of the upscale failure of PT-495 has not been determined due to the instrument resuming normal operation before Instrument and Control personnel could investigate. Although the instrument has been tested and monitored closely, the failure has not been duplicated nor has any condition been discovered which would have contributed to its failure.

This failure is very similar to the failure of PT-496 (LER-79-031). The instrument manufacturer investigated that failure without success. They have been contacted on this current failure and are in the process of furnishing a replacement instrument for PT-495 so they can test it thoroughly under laboratory conditions. If this continuing investigation reveals the cause, a revision to this LER will be filed.