



Wisconsin Electric POWER COMPANY

231 WEST MICHIGAN, MILWAUKEE, WISCONSIN 53201

November 22, 1974

Mr. Edson G. Case, Acting Director
Directorate of Licensing
U. S. Atomic Energy Commission
Washington, D. C. 20545

Dear Mr. Case:

DOCKET NO. 50-266
UNIT 1 - POINT BEACH NUCLEAR PLANT
ABNORMAL OCCURRENCE

This letter is to report the details of an abnormal occurrence at the Point Beach Nuclear Plant Unit No. 1, Facility Operating License No. DPR-24, as defined by Sections 15.1.a.B and 15.1.1.C of the Technical Specifications. This written report, filed in accordance with Section 15.6.6.A.2 of the Technical Specifications, follows a verbal notification of the event to Mr. Dwane Boyd, Region III, Directorate of Regulatory Operations, on October 10, 1974, per Section 15.6.A.1 of the Point Beach Nuclear Plant Technical Specifications.

At approximately 2:00 P.M. on October 9, 1974, while personnel were exiting Unit 1 containment via the 66' level personnel airlock, air was heard to be escaping to atmosphere following the closing of the inner door of the airlock. Investigations disclosed that a 3/8 inch valve was open on a pressure gauge instrument line. This permitted air to flow from the slightly pressurized airlock (less than one psig) to the atmosphere. It was realized that, if the inner door of the airlock was opened, containment integrity would be violated via the open inner door, the open 3/8 inch valve and the 3/8 inch tubing exiting to atmosphere through the outer wall of the airlock.

In an investigation of the recent history of Unit 1 containment entries and exits, it was firmly established that the boundaries of the airlock were intact at 10:55 A.M. on October 6, 1974, when the plant manager entered the containment and particularly noted that the de-pressurizing of the airlock to the outside atmosphere, when entering, took rather longer than normal. To check on this, he personally called control room personnel at that time and requested information on containment internal pressure and asked control room personnel to commence venting the greater than one psig containment atmosphere to a lower pressure per the standard venting procedure.

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Between the time of the above event and 11:07 A.M., October 9, 1974, when the open valve was discovered, eight groups of people entered and left Unit 1 containment. Seven of these groups noted no abnormality in airlock pressure during their transit. None of the persons involved can establish when the valve was opened.

The standard procedure when entering containment when the reactor is above the cold shutdown condition gives preference to maintenance or inspecting personnel leaving the inner door of the airlock in the open position while they are in containment. In the event of a containment evacuation being required for any reason, these persons would immediately retire to the sanctuary of the personnel airlock and close the inner door. The procedure of leaving the inner door open allows occasions of closing of the door should a second group wish to pass through the airlock while the first group is still in containment, or leaving the inner door closed if frequent entrances and exits are taking place.

Personnel, upon entering and leaving the containment, punch a time clock. This provides an accurate account of their "stay time" in containment.

By taking the most conservative assumption that the inner door of the airlock was open whenever personnel were in containment over the period of this event, calculations indicate that containment integrity was violated via the open 3/8 inch valve for a total period of three hours and one minute.

The containment pressure is normally slightly above atmospheric pressure; therefore with the inner door open and the 3/8 inch valve open, air flow through the valve is to atmosphere. This constitutes an unmonitored radioactive release. The following table describes this release:

Total period of release	181 minutes
Total gaseous activity for the release	$3.78 \times 10^4 \mu\text{Ci}$
Total particulate activity for the release	$0.113 \mu\text{Ci}$
Release rate as % of total permitted annual release rate	<0.002%
Release rate as % of the maximum permitted 15 minute release rate	<0.0002%

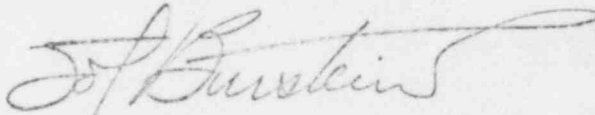
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In view of the above, it is not considered that the release constituted a hazard to the health and safety of the public.

Considering the aspect of health and safety of the public, if a rupture or leak accident occurred during the period of personnel being in containment, and with the outer door 3/8 inch valve open, action by those in containment to move to the airlock sanctuary and close the inner door would have established the accident condition integrity.

The investigation following this event failed to reveal any useful purpose for the valve in question and it was removed. Unit 2 airlock was checked but a similar valve was found not to be installed in that unit. It was not determined how the valve was opened but it is presumed to have been accidentally opened as a means of venting the airlock during exit of one of the groups. Removal of the valve prevents a recurrence of this event. We trust the delay in the written confirmation of this event has caused you no inconvenience.

Very truly yours,



Executive Vice President

Sol Burstein

cc: Mr. James G. Keppler, Regional Director
Directorate of Regulatory Operations, Region III