Wisconsin Electric POWER COMPANY
231 WEST MICHICAN, MILWAUKEE, WISCONSIN 53201

April 11, 1974

Mr. John F. O'Leary, Director
Directorate of Licensing
U. S. Atomic Energy Commission
Washington, D. C. 20545

Dear Mr. O'Leary:

DOCKET No. 50-266
FAILURE OF SAMPLE LINE VALVE TO CLOSE
POINT BEACH NUCLEAR PLANT

This letter is to report the details of an abnormal occurrence at Point Beach Nuclear Plant, Facility Operating License No. DPR-24, as defined by Section 15.1.a.D of the Technical Specifications. This written report, filed in accordance with Section 15.6.6.A.2 of the Technical Specifications, follows a telephone report made on the incident to Mr. K. R. Baker of Region III, Directorate of Regulatory Operations, on April 4, 1974, as required by Section 15.6.6.A.1 of the Technical Specifications.

On April 4, 1974, the Operations Refueling Tests, ORT #51 and ORT #52, to leak test the 3/8 inch diameter steam generator sample line isolation valves 1AOV-2084 and 1AOV-2083, were completed satisfactorily. At 2:30 P.M., following completion of the tests, the sample line isolation valves of both the "A" and "B" steam generators were placed in their normally open position.

At 2:47 P.M., both the isolation valves closed automatically on a signal from the R-19 process monitor, indicating that liquid with radioactivity levels above normal background levels had passed down the sample lines.

The source of the radioactivity was quickly traced to the test arrangement used to pressurize the lines with air for conduct of the valve leak tests; the contamination in question having been carried over from a valve test of the pressurizer steam space isolation valve.

The decision was made to flush the sample lines to clear the contamination; the valves being manually opened at 2:55 P.M. At the completion of the flush, the manual open sig-

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nal was removed but the flushing operation was found not to have cleaned the probes. The radiation signal again called for the sample line isolation valves to close. 1AOV-2084 closed; 1AOV-2083 did not. A visual inspection of the valve verified its open position.

At 3:05 P.M., air was manually failed to 1AOV-2083 and the valve closed immediately, indicating that the operating problem lay in the solenoid valve controlling the air supply to the valve. The solenoid valve was replaced and the radiation monitor probes were cleaned. The valve then tested satisfactorily.

The faulty solenoid valve has since been disassembled and inspected but no immediately obvious reason for its failure to function correctly has been discerned to date. If the malfunction was caused by some particle of foreign matter lodging under a valve seat, this particle was lost during the removal and disassembly of the solenoid.

In examining the safety aspects of this malfunction, it should be noted that while the steam generator sample line isolation valve 1AOV-2083 is a normally open valve, the manual valve at the sample sink is normally closed and is only opened by qualified personnel for the purpose of drawing a sample, following which it is immediately closed again. In addition, a second manual valve, upstream of 1AOV-2083 but outside of the containment, can be utilized in emergencies to isolate the sample line should 1AOV-1083 fail to function. Therefore, it is not considered that this event created any hazard to the health and safety of the public.

Considering the possibility that the lodging of a foreign particle was not the cause of the valve's malfunction, it is our intention to continue our investigation of this and similar solenoid valves in the plant. Should this investigation disclose a specific problem, generic or otherwise, we will submit a further report on the matter.

Very truly yours,

Sol Burstein

Executive Vice President

cc: Mr. K. R. Baker
Directorate of Regulatory Operations, Region III