

**NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL  
(TEMPORARY FORM)**

CONTROL NO: 5725

FILE: INCIDENT REPORT FILE

FROM: Wisconsin Public Service Green Bay, Wisconsin 54305 E. W. James			DATE OF DOC 5-23-75	DATE REC'D 5-27-75	LTR XX	TWX	RPT	OTHER
TO: Mr. B. Rusche			ORIG 1 signed	CC 1	OTHER	SENT AEC PDR <u>XXXX</u> SENT LOCAL PDR <u>XXXX</u>		
CLASS	UNCLASS XXXX	PROP INFO	INPUT	NO CYS REC'D 1		DOCKET NO: 50-305		

DESCRIPTION: Ltr trans the following:  <p align="center"><b>ACKNOWLEDGED DO NOT REMOVE</b></p> PLANT NAME: <b>KEWAUNEE</b>	ENCLOSURES: Abnormal Occurrence Report No. AO 75-10 on 5-16-75, Valve SI-2B tripped on overcurrent upon closing following completion of operational verification test...
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**FOR ACTION/INFORMATION wtm 5-30-75**

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**INTERNAL DISTRIBUTION**

<u>REG FILE</u> NRC PDR OGC, ROOM P-506A GOSSICK/STAFF CASE GIAMBUSSO BOYD MOORE (L) DEYOUNG (L) SKOVHOLT (L) GOLLER (L) (Ltr) P. COLLINS DENISE REG OPR FILE & REGION (2) MPC/PE (3) STEELE	<u>TECH REVIEW</u> SCHROEDER MACCARY KNIGHT PAWLICKI SHAO **STELLO **HOUSTON **NOVAK ROSS IPPOLITO TEDESCO LONG LAINAS BENAROYA VOLLMER	<u>DENTON</u> **GRIMES GAMMILL KASTNER BALLARD SPANGLER  <u>ENVIRO</u> MULLER DICKER KNIGHTON YOUNGBLOOD REGAN PROJECT LDR HARLESS	<u>LIC ASST</u> R. DIGGS (L) H. GEARIN (L) E. GOULBOURNE (L) P. KREUTZER (E) J. LEE (L) M. MAIGRET (L) S. REED (E) M. SERVICE (L) S. SHEPPARD (L) M. SLATER (E) H. SMITH (L) S. TEETS (L) G. WILLIAMS (E) V. WILSON (L) R. INGRAM (L)	<u>A/T IND.</u> BRAITMAN SALTZMAN MELTZ  <u>PLANS</u> MCDONALD CHAPMAN DUBE (Ltr) E. COUPE PETERSON HARTFIELD (2) KLECKER EISENHUT WIGGINTON F. WILLIAMS HANAUER
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**EXTERNAL DISTRIBUTION**

1 - LOCAL PDR <u>KEWAUNEE, WI.</u> 1 - TIC (ABERNATHY) (1)(2)(10) 1 - NSIC (BUCHANAN) 1 - ASLB 1 - Newton Anderson 1 - ACRS SENT TO LIC ASST ** SEND ONLY TEN DAY REPORTS	1 - NATIONAL LABS 1 - W. PENNINGTON, Rm E-201 GT 1 - CONSULTANTS NEWMARK/BLUME/AGBABIAN	1 - PDR-SAN/LA/NY 1 - BROOKHAVEN NAT LAB 1 - G. ULRIKSON, ORNL 1 - AGMED (RUTH GUSSMAN) Rm B-127 GT 1 - J. D. RUNKLES, Rm E-201 GT
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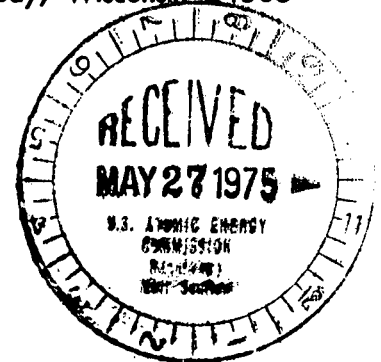
## WISCONSIN PUBLIC SERVICE CORPORATION



P.O. Box 1200, Green Bay, Wisconsin 54305

May 23, 1975

Mr. Benard Rusche, Director  
Office of Nuclear Reactor Regulation  
U. S. Nuclear Regulatory Commission  
Washington, D. C. 20555



Dear Mr. Rusche:

Subject: Docket 50-305  
Operating License DPR-43  
Abnormal Occurrence Report AO 75-10

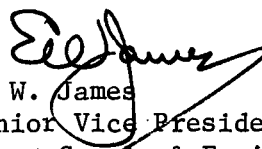
In accordance with the requirements of Technical Specifications, paragraph 6.6.2, the attached Licensee Event Report form is submitted.

As stated in the Licensee Event Report form, this occurrence is similar to the events previously reported by Abnormal Occurrence Reports AO 74-20, AO 75-6 and AO 75-8. The monitoring equipment installed to assist in diagnosis of these failures provided sufficient information to verify that the current overload breakers tripped upon valve closure and torquing until a motor locked rotor condition was attained. During this valve's torquing, the torque switch position was observed by personnel. Proper worm shaft movement and torque switch shaft rotation was not immediately noted prior to the over-current trip. The torque switch was thereby inoperative and the cause appears to be mechanical.

The valve operator manufacturer has been contacted and is scheduled to be on site for resolution of this problem on May 27, 1975. Additional information as to the resolution will be transmitted when available.

It should be noted that these valve operator failures have been after the valve has completed its required accident related operation.

Very truly yours,

  
E. W. James  
Senior Vice President  
Power Supply & Engineering

EWJ:sna

Enc.

cc - Mr. J. G. Keppler  
Mr. Dwane Boyd



5725

# SENSEE EVENT REPORT

CONTROL BLOCK:   

[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME <span style="border: 1px solid black; padding: 2px;">01</span> W I K N P I	LICENSE NUMBER <span style="border: 1px solid black; padding: 2px;">00-000000-00</span>	LICENSE TYPE <span style="border: 1px solid black; padding: 2px;">41111</span>	EVENT TYPE <span style="border: 1px solid black; padding: 2px;">01</span>
CATEGORY <span style="border: 1px solid black; padding: 2px;">01</span> CON'T	REPORT TYPE <span style="border: 1px solid black; padding: 2px;">P</span>	REPORT SOURCE <span style="border: 1px solid black; padding: 2px;">L</span>	DOCKET NUMBER <span style="border: 1px solid black; padding: 2px;">050-0305</span>
EVENT DATE <span style="border: 1px solid black; padding: 2px;">051675</span>	REPORT DATE <span style="border: 1px solid black; padding: 2px;">052375</span>		

EVENT DESCRIPTION

02 Valve SI-2B tripped on overcurrent upon closing following completion of operational

03 verification test. The valve prior to tripping had completed all safety related

04 operations as would be required by the safety injection actuation sequence. The

05 redundant valve operated properly. The failure is similar to A0 75-6, A0 75-8,

06 and A0 74-20. This event is A0 75-10.

SYSTEM CODE <span style="border: 1px solid black; padding: 2px;">S</span> <span style="border: 1px solid black; padding: 2px;">F</span>	CAUSE CODE <span style="border: 1px solid black; padding: 2px;">E</span>	COMPONENT CODE <span style="border: 1px solid black; padding: 2px;">V A L V O P</span>	PRIME COMPONENT SUPPLIER <span style="border: 1px solid black; padding: 2px;">N</span>	COMPONENT MANUFACTURER <span style="border: 1px solid black; padding: 2px;">L 2 0 0</span>	VIOLATION <span style="border: 1px solid black; padding: 2px;">N</span>
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CAUSE DESCRIPTION

08 Monitoring equipment installed prior to the test verified that the cause was not

09 electrical. The Belleville spring assemble is suspected as the cause since the

10 worm shaft has limited movement during valve torquing.

FACILITY STATUS <span style="border: 1px solid black; padding: 2px;">E</span>	% POWER <span style="border: 1px solid black; padding: 2px;">090</span>	OTHER STATUS <span style="border: 1px solid black; padding: 2px;">NA</span>	METHOD OF DISCOVERY <span style="border: 1px solid black; padding: 2px;">C</span>	DISCOVERY DESCRIPTION <span style="border: 1px solid black; padding: 2px;">Special Test</span>
FORM OF ACTIVITY RELEASED <span style="border: 1px solid black; padding: 2px;">Z</span>	CONTENT OF RELEASE <span style="border: 1px solid black; padding: 2px;">Z</span>	AMOUNT OF ACTIVITY <span style="border: 1px solid black; padding: 2px;">NA</span>	LOCATION OF RELEASE <span style="border: 1px solid black; padding: 2px;">NA</span>	

PERSONNEL EXPOSURES

NUMBER <span style="border: 1px solid black; padding: 2px;">000</span>	TYPE <span style="border: 1px solid black; padding: 2px;">Z</span>	DESCRIPTION <span style="border: 1px solid black; padding: 2px;">NA</span>
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PERSONNEL INJURIES

NUMBER <span style="border: 1px solid black; padding: 2px;">000</span>	DESCRIPTION <span style="border: 1px solid black; padding: 2px;">NA</span>
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OFFSITE CONSEQUENCES

15 No danger to public health and safety

LOSS OR DAMAGE TO FACILITY

TYPE <span style="border: 1px solid black; padding: 2px;">Z</span>	DESCRIPTION <span style="border: 1px solid black; padding: 2px;">NA</span>
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PUBLICITY

17 NA

ADDITIONAL FACTORS

18 Addition report will be transmitted upon cause verification

19

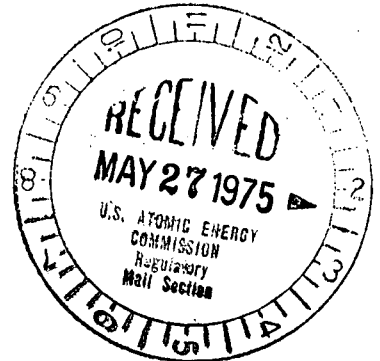
NAME: M. E. Stern

PHONE: 414/432-3311

TELEGRAM

5/23/75  
# 5725  
May 17, 1975

Mr. Duane Boyd  
Resident Inspector - US Nuclear Regulatory Commission  
Directorate of Regulatory Operations - Region III  
Two Rivers Municipal Hospital  
Two Rivers, Wisconsin 54241



SUBJECT: Docket 50-305  
OPERATING LICENSE: DPR-43  
ABNORMAL OCCURRENCE REPORT

In accordance with the requirements of Technical Specifications, Paragraph 6.6.2.a and 1.0.a.1.(d), we submit the following:

Report Number: 50-305/75-10

Occurrence Date: May 16, 1975

Facility: Kewaunee Nuclear Plant  
Kewaunee, Wisconsin 54216

Identification of Occurrence:

TRIPPING OF THERMAL OVERLOAD FOR SI-2B  
AFTER CLOSURE OF VALVE

Condition Prior to Occurrence:

Reactor Critical - 90% Power o  
Normal Operating Temperature - 556 F Tavg  
Normal Operating Pressure - 2235 psig

Description of Occurrence:

Surveillance Procedure 098 was being performed on the Safety Injection System. Valve SI-2B upon receiving signal went fully open and closed at conclusion of test. When valve closed, the motor was not de-energized and remained in a locked rotor condition until the thermal overloads tripped. Cam assembly was adjusted and valve is in operable condition.

C. R. Luoma