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

May 28, 1973

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

Dear Mr. O'Leary:

DOCKET NOS. 50-266 AND 50-301
POINT BEACH NUCLEAR PLANT
UNSCHEDULED RELEASE OF RADIOACTIVITY

6/5/73 JD LH JK FN JS FJR

This is to report the details of an abnormal occurrence at Point Beach Nuclear Plant as defined by Section 15.1.a.C of the Technical Specifications. This written report, in accordance with Section 15.6.6.A.2 of the Technical Specifications, follows a telephone report made on the incident to Mr. K. Baker of Region III Regulatory Operations on May 23, 1973, as required by Section 15.6.6.A.1 of the Technical Specifications.

On Saturday, May 12, 1973, the new radwaste system waste evaporator at Point Beach was shut down for modification and adjustment following a test run. To expedite the shutdown and draining of the evaporator, operating personnel chose to break vacuum in the evaporator by manually lifting one of two evaporator safety valves. To free himself for other work during the vacuum breaking operation, the operator then placed a wrench to prop up the safety valve lifting arm; thus keeping the valve disc lifted approximately 7/8 inch off its seat.

Following the shutdown of the evaporator, the safety valve remained in the raised condition. No written or verbal report of the valve's disposition was passed to the succeeding shift operators.

The waste evaporator was restarted on May 22, 1973, for further testing. Difficulty was experienced in raising evaporator steam pressure to the required 35 psig and a subsequent investigation determined that a safety valve was in a propped open condition, permitting slightly radioactive steam to exit via the unmonitored discharge pipe. The wrench prop was removed and the safety valve was reseated tightly, stopping the leakage.

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An examination of water inventory following the event indicated that approximately 90 gallons of slightly tritiated water had discharged via the safety valve during the two hour operation of the evaporator. An estimated 50 gallons of this total condensed on the walls of the discharge pipe and drained, as per design, to the Unit 2 facade drain well. After routine sampling, this liquid was pumped to the plant retention pond following the issuance of a standard discharge permit by the Chemistry and Health Physics Group.

By deduction, the remaining 40 gallons of water was discharged as steam to the atmosphere via the unmonitored stack. The sampling of the air in the immediate area of the safety valve and condensate from the steam vapor indicated that it contained no detectable levels of beta-gamma, gamma, air particulate, airborne iodine, or gaseous activity. Tritium was detected and the following table is drawn up to indicate its significance:

	Calculated Concentration at Site Boundary (μCi/cc)	Permissible MPC At Site Boundary (μCi/cc)	Actual Discharge (μCi)
^{3}H	1.7×10^{-12}	2×10^{-7}	8.18×10^{3} (over two hour period)

The table shows that the discharge was well below permitted levels and did not constitute a hazard to the health and safety of the public.

To prevent a recurrence of this incident, the existing Administrative Procedure PBNP 4.17 "Lifted Wires, Jumpers and Bypasses", which requires personnel to complete a log sheet when actions described in its title are to be implemented, will be expanded to require documentation of any unusual disposition of plant equipment not covered by standard operating or maintenance proceedures.

Very truly yours,

Sol Burstein

Sol Burstein Senior Vice President

cc: Mr. Boyce H. Grier, Regional Director
Directorate of Regulatory Operations, Region III