

October 10, 2000

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-00-021B

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region IV staff on this date.

Facility

Transalta Centralia Mining LLC
Centralia, Washington
License No.: WN-I0241-1
Washington Licensee

Licensee Emergency Classification

Notification of Unusual Event
 Alert
 Site Area Emergency
 General Emergency
 Not Applicable

SUBJECT: UPDATE ON THE MECHANICAL FAILURE OF A RONAN GAUGING DEVICE

DESCRIPTION:

This is the second update on an event that the Washington Department of Health initially reported (WDOH) on September 15, 2000, (PNO-IV-00-021 and PNO-IV-00-021A) regarding an additional mechanical failure of the same Ronan Engineering Company Model SA-4 gauging device.

The device is specifically licensed for density process measurements and uses a cesium-137 sealed source, Amersham Model CDC.711M not to exceed 74 gigabecquerels (2 curies). In this model version, the source rod consists of two screw-together extensions (approximately 2-1/2 feet each) that screw into the same diameter source holder (approximately 1/2-foot long). When operating, the rod with source is lowered from the shielded position into the integral and enclosed dry well tube. When not in operation, the rod with source is raised to place the source into a safe position inside the storage shield.

On September 13, 2000, the top screw connection came unscrewed apparently due to prolonged mechanical vibration. At the same time, the lower screw connection was partially unscrewed. Both connections were opened, cleaned, coated with 'Lok-tite' and tightened. WDOH reported that the disconnect was repaired and the gauge returned to operation on September 18, 2000.

The licensee notified WDOH that the source rod snapped off at the lower screw connection on the same gauging device on October 5, 2000, during a routine end-of-shift return of the source to the shielded position. The licensee stated that the operator was able to quickly grab the end of the source rod while in the shielded position and prevent the source from falling to the bottom of the dry well. WDOH staff measured an exposure rate of 0.03 millisieverts per hour (3 mR/hr) at the surface of the storage shield (approximately where the operator grabbed the source rod). The licensee successfully locked the source in the shielded storage position. Examination of the source rod indicates that the male screw connector sheared off at its juncture with the main body of the rod section. WDOH is investigating the cause of this additional failure. The manufacturer is working on a retrofit for all four gauges of this type at this licensee's facility. WDOH staff plan to be present during the retrofit.

Region IV received notification of this occurrence by email from WDOH at 6:30 p.m. on October 6, 2000. Region IV has informed OEDO, NMSS, and OSTP.

This information has been discussed with the State and is current as of 2:30 p.m. on October 10, 2000.

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