### April 30, 1996

## NRC INFORMATION NOTICE 96-25: TRAVERSING IN-CORE PROBE OVERWITHDRAWN AT LASALLE COUNTY STATION, UNIT 1

## <u>Addressees</u>

All holders of operating licenses or construction permits for nuclear power reactors.

#### Purpose

The U.S. Nuclear Regulatory Commission (NRC) is issuing this information notice to alert addressees to a traversing in-core probe (TIP) that was overwithdrawn at LaSalle County Station, Unit 1. It is expected that recipients will review the information for applicability to their facilities and consider actions, as appropriate, to avoid similar problems. However, suggestions contained in this information notice are not NRC requirements; therefore, no specific action or written response is required.

### Description of Circumstances

On October 31, 1995, while LaSalle Unit 1 was operating at 96-percent power, a failure occurred on the 1B traversing in-core probe machine. The licensee was running a test for nuclear instrument calibrations. During the insertion of the 1B TIP detector, the operator received indications that the detector was withdrawing. An attempt by the operator to stop the TIP was unsuccessful. The TIP withdrew past its shielded storage location to the drive unit itself. A reactor building area radiation monitor (next to the drive units) pegged upscale (1 rem/hour) and alarmed in the control room. At the surface of the platform supporting the TIP drive machines, radiation surveys showed 7 Rem/hr. Licensee calculations showed potential dose rates of 250 Rem/hr one foot away from the unshielded detector. The operators entered emergency operating procedures for secondary containment control (because of high radiation levels at the 740-foot elevation level of the reactor building). Personnel were warned to stay clear of the area and an ALERT was declared based on the high radiation levels. The operational support center and the technical support center were activated. The licensee subsequently established high radiation and contamination boundaries for restricting access controls in the reactor building. With the plant condition stabilized and the radiological boundaries established, the licensee terminated the ALERT. There was no impact on the operation of Unit 1 or Unit 2, and they remained at full power. The event involved no radiological releases and no exposures of personnel.

Licensee personnel performed an inspection of the 1B TIP on November 7, 1995. The inspection revealed that the drive chain between the drive motor and the feed and takeup reel had separated at the master link. This separation caused

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the takeup reel to recoil due to a tensioner spring on the reel and to pull the TIP detector all the way out onto the reel, an unshielded area. The root cause investigation as to why the master link separated is ongoing.

#### **Discussion**

The NRC staff discussed this event and the general design of the TIP with a General Electric representative. Because of the design of the TIP, when the drive chain between the drive motor and the feed and take-up reel separates at the master link, the fail-to condition is to recoil the take up reel and pull the TIP detector all the way out onto the reel, which is usually unshielded. The kind of event could occur again because of the way the TIP is designed. The design has been modified to eliminate this type of event at newer designed BWR plants.

Irradiated components, such as BWR TIP and attached drive cables can create substantial radiation fields in accessible RB areas. Without timely worker and control room actions in response to local and remote reactor building area radiation alarms, the local radiation fields outside shielded rooms resulting from an inadvertent activated TIP withdrawal has the potential for inadvertent worker exposures in excess of regulatory limits.

#### Related Generic Communications and Correspondence

The following generic communications and correspondence discuss previous related events:

Information Notice 88-63, "High Radiation Hazards From Irradiated Incore Detectors and Cable," dated August 15, 1988.

IN 88-63, Supplement 1, dated October 5, 1990.

IN 88-63, Supplement 2, dated June 25, 1991.

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This information notice requires no specific action or written response. If you have any questions about the information in this notice, please contact the technical contacts listed below or the appropriate Office of Nuclear Reactor Regulation (NRR) project manager.

Brian K. Grimes, Acting Director. Division of Reactor Program Management Office of Nuclear Reactor Regulation

Technical contacts: Egan Y. Wang, NRR (301) 415-1076 Internet:eyw@nrc.gov

> James E. Wigginton, NRR (301) 415-1059 Internet:jew2@nrc.gov

Attachment: List of Recently Issued NRC Information Notices Affachment Filed in Tacket

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# LIST OF RECENTLY ISSUED NRC INFORMATION NOTICES

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| Information<br>Notice No. | Subject  | Date of<br>Issuance | Issued to   |
|---------------------------|--|---------------------|---|
| 96-24                     | Preconditioning of Molded-<br>Case Circuit Breakers<br>Before Surveillance Testing   | 04/25/96            | All holders of OLs or CPs<br>for nuclear power reactors   |
| 96–23                     | Fires in Emergency Diesel<br>Generator Exciters During<br>Operation Following Unde-<br>tected Fuse Blowing   | 04/22/96            | All holders of OLs or CPs<br>for nuclear power reactors   |
| 96-22                     | Improper Equipment Set-<br>tings Due to the Use of<br>Nontemperature-Compensated<br>Test Equipment   | 04/11/96            | All holders of OLs or CPs<br>for nuclear power reactors   |
| 96-21                     | Safety Concerns Related<br>to the Design of the Door<br>Interlock Circuit on<br>Nucletron High-Dose Rate<br>and Pulsed Dose Rate<br>Remote Afterloading<br>Brachytherapy Devices | 04/10/96            | All U.S. NRC Medical to the<br>Licensees authorized to use<br>brachytherapy sources in<br>high- and pulsed-dose-rate<br>remote afterloaders |
| 96-20                     | Demonstration of Associ-<br>ated Equipment Compliance<br>with 10 CFR 34.20   | 04/04/96            | All industrial radiography<br>licensees and radiography<br>equipment manufacturers  |
| 96-19                     | Failure of Tone Alert<br>Radios to Activate When<br>Receiving a Shortened<br>Activation Signal   | 04/02/96            | All holders of OLs or CPs<br>for nuclear power reactors   |
| 96-18                     | Compliance with 10 CFR<br>Part 20 for Airborne<br>Thorium  | 03/25/96            | All material licensees<br>authorized to possess and<br>use thorium in unsealed<br>form  |
| 95-03<br>Supp. 1          | Loss of Reactor Coolant<br>Inventory and Potential<br>Loss of Emergency Mitiga-<br>tion Functions While in a<br>Shutdown Condition   | 03/25/96            | All holders of OLs or CPs<br>for PWR power plants   |

OL = Operating License CP = Construction Permit

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## Original signed by Brian K. Grimes

Brian K. Grimes, Acting Director Division of Reactor Program Management Office of Nuclear Reactor Regulation

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Tech Editor reviewed 02/27/96 \*See previous concurrence DOCUMENT NAME: 96-25.IN

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| DATE   | 03/11/96<br>03/11/96  | 04/17/96  | 04/26/96    |      |

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> Dennis M. Crutchfield, Director Division of Reactor Program Management Office of Nuclear Reactor Regulation

| Technical contacts: | Egan Y. Wang, NRR<br>(301) 415-1076<br>Internet:eyw@nrc.gov | James E. Wigginton, NRR<br>(301)-415-1059<br>Internet:jew2@nrc.gov |
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