



USIR

February 24, 2006

Director Office of Nuclear Material Safety and Safeguards
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555-0001
ATTN: Document Control Desk

RE: Thirty day notification report in accordance with 10 CFR 30.50(2)

Dear Sir or Madam,

On January 11, 2006 at an event occurred involving an improper source location indication on a Sabia XC 5000 online coal analyzer at our Cypress Creek Mine located near Boonville, Indiana.

Description and account of this event is as follows:

Overview – On January 11, 2006 approximately 3:00 PM during a routine NRC inspection it was discovered that the location of the source handle in relation to the open and closed position of the sources was not accurate. Preliminary indications showed that the source handle that opens and closes two sources of California 252 isotopes, five mill curies each, was 180 degrees off. Also, the labeling showing the on and off position of the sources in relation to the source handle also added to the confusion. It was decided to post warnings and inform all personnel that would be in the area of the problem and to stay clear of the area until a representative from Sabia could inspect and make any necessary adjustments to eliminate the confusion or make repairs to correct the problem. On Saturday, January 14th, 2006 Dan Popovich from Sabia visited the Cypress Creek Mine site for the purpose of investigating a potential problem with the source shutter location on the Sabia XC-5000 coal analyzer. He first met with me and I explained that an NRC inspection had been scheduled and that another company had come in and performed a wipe test prior to the inspection on January 11th. During the inspection, the NRC inspector noticed that if the lockout holes in the source shutter lever and the lever mounting - indicator plate were lined up (as they would be when the shutter was locked out), the source still appeared to be in the open position. Mr. Popovich then began his inspection of the source mechanism that opens and closes the sources to determine the cause of the problem.

Findings – Dan Popovich was on site at the Cypress Creek Mine on Saturday, January 14th from approximately 7:30 AM to 11:00 AM. Upon examining the shutter, the NRC findings were verified, when locked out, the source was in the open position. It was noted that the shutter lever appeared to be 180 degrees out of phase. The rotation had the handle end pointing upwards, not downwards as is usual. The source pulley cover was then removed to determine if any damage had occurred with the source shutter mechanism. On removing the cover, everything was found to be in good working order, the cables were on the pulleys, neither pulley was loose, the source sleds were moving freely, and there was no indication that the sources had been tampered with or disturbed in any way. It should be noted, that although the lever mounting indicator plate was

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marked with an arrow and as on or off, these markings were vague when the lever was rotated through the upper 180 degrees of movement.

Repairs – The unit was repaired by removing the handle and replacing it in the proper position.

Radiation Safety – The analyzer is located on a conveyor belt far from the areas where anyone might be working. It does not appear that anyone would have received any significant radiation exposure due to this problem. The company does not perform any work on the analyzer itself but calls in trained personnel when repairs or checks are necessary.

Corrective Actions - This is the first time with all of the installed SABIA analyzers that this has occurred, and the possibility had not been anticipated. However, it did happen.

SABIA is reviewing the information gathered and is determining what can be done to eliminate the problem that has occurred. Their findings and corrective actions will be stated in their report.

The potential danger of the handle being in the wrong position would be that workmen would service conveyor parts inside the analyzer shell believing that the sources were retracted. The actual position could always be determined by observing the analyzer screen, but a workman could be confused by the handle being in the wrong position. In this instance, because the NRC inspector arrived soon after the lever position had been changed, no maintenance was done on the conveyor inside the analyzer while the indication was wrong and no one received any radiation dose resulting from this problem.

If additional information is needed or you have any questions I can be contacted at my office. My direct phone number is 812-759-8457.

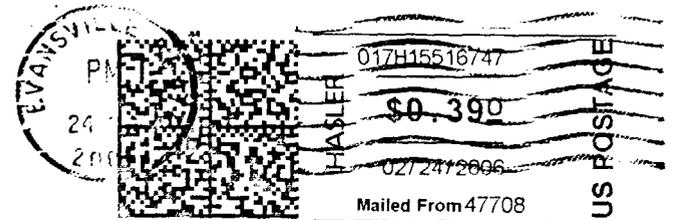
Regards,



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