PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-III-95-056

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 Region III staff (Lisle, Illinois) on this date.

Facility
Commonwealth Edison Co.
La Salle 1
Marseilles, Illinois
Dockets: 50-373

Licensee Emergency Classification
Notification of Unusual Event
X Alert
Site Area Emergency
General Emergency
Not Applicable

Subject: INCORE PROBE IN UNSHIELDED POSITION

At 10:15 a.m. (CST) on October 31, 1995, a traveling incore probe (TIP) was being withdrawn from the reactor core and moved through its guide tube into its shielded storage location. Because of an apparent failure of an interlock system, the TIP was withdrawn through the storage area and into the drive mechanism. This is an unshielded location. The affected TIP is one of five used to measure power levels in the reactor core. The other four TIPs remain operational.

The problem was identified through an area radiation monitor alarm showing a higher than normal radiation level. As a precaution, the licensee evacuated all personnel from both the Unit 1 and Unit 2 reactor buildings. An alert was declared under the licensee's emergency plan. Appropriate NRC, state, and local government notifications were made. The licensee staffed its Technical Support Center.

Both units remain in operation, and this situation has had no effect on their operation. No releases of radioactivity from the plant and no abnormal radiation exposures associated with the event have been reported.

Initial radiation surveys showed a radiation level of 7 rad per hour at the surface of the platform supporting the TIP drive mechanisms. An adjacent corridor had radiation measurements of 0.5 to 1.0 rad per hour. Some minor radioactive contamination of shoes of workers in the area was reported following the incident. The contamination was successfully removed.

The licensee is developing plans for evaluating the interlock failure and for returning the TIP to its shielded location. The senior NRC resident inspector was in the control room at the time of the event. The resident inspectors remain onsite and will continue to monitor the licensee's activities. Region III (Chicago) entered the monitoring mode in its incident response center to follow the event.

The licensee has issued a news announcement. The State of Illinois has been notified. Information in this preliminary notification has been reviewed with licensee management.

Region III received notification of this event from the resident

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inspector about 10:45 a.m. on October 31, 1995. This information is current as of 1 p.m. on October 31, 1995.

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