May 1, 2002

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-III-02-019

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 III staff on this date.

Facility	**Licensee Emergency Classification**
	___Notification of Unusual Event
Longview Inspection	___ Alert
Brookfield, WI	___ Site Area Emergency
(Agreement State Licensee)	___ General Emergency
License No. IL-01899-01	__X__ Not Applicable

SUBJECT: POSSIBLE RADIATION INJURY TO RADIOGRAPHER

DESCRIPTION:

On April 30, 2002, the Illinois Department of Nuclear Safety (IDNS) reported a wound on a licensee radiographer's leg for which they could not definitively eliminate the possibility that the injury was received during radiography operations. The initiating incident apparently occurred in June 2000, involving an 81.2 curie Iridium-192 source on a temporary radiography jobsite near Channahon, Illinois. The radiographer reported to IDNS that, after believing he secured the source, after an exposure, approached the guide tube area and knelt down without looking at his survey instrument. He changed the radiography film for the next shot and unhooked the guide tube. When he did so, he noticed the source drive cable was still in the guide tube. He then saw that his survey instrument showed an off-scale high reading and his alarming rate meter was inoperable because of a low battery. He immediately cranked the source back into a shielded position. His self-reading pocket dosimeter was off-scale. Neither the radiographer, nor the second radiographer on the team, informed the licensee of the incident.

Approximately two weeks after the incident, the radiographer noticed skin redness in an approximate two centimeter-sized area of his left calf. Over the next year, the wound became ulcerated and would not heal. A physician examined the individual and concluded that the condition could have been caused by radiation. In January 2002, the Longview Inspection Radiation Safety Officer became aware of the medical condition and reported it to IDNS.

IDNS recommended that the licensee seek assistance from Oak Ridge Radiation Emergency Assistance Center, which concluded that the medical condition could be attributed to the event in June 2000.

IDNS performed interviews and extensive time-motion studies and on April 29, 2002 concluded that the incident could have occurred as described by the radiographer. A Notice of Violation was issued to the licensee. IDNS is reviewing the incident to determine any possible enforcement action against the individual under his industrial radiography certification with the State.

The State notified the NRC Operations Center of the incident, and will prepare an abnormal occurrence report.

Region III informed the Office of the Executive Director for Operations, Office of Nuclear Material Safety and Safeguards and the Office of State and Tribal Programs.

This incident was reported to the NRC Operations Center at 3:05 p.m. EDT on April 30, 2002.

This information is current as of 10:00 a.m. CDT on May 1, 2002.

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