THIS EVENT IS NOT FOR PUBLIC DISCLOSURE PER AGREEMENT STATE REQUEST UNTIL 1/11/03

January 9, 2003

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-II-02-038A

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 II staff (Atlanta, Georgia) on this date.

Facility	**Licensee Emergency Classification**
Huntington Testing & Technology Inc.	Notification of Unusual Event
(An Agreement State Licensee)	Alert
Ghent, KY	Site Area Emergency
License: 201-551–05	General Emergency
	X Not Applicable

Subject: RADIOGRAPHER EXPOSURE UPDATE

On November 12, 2002, the licensee reported to the Kentucky Radiation Health & Toxic Agents Branch (the Branch) that a radiographer's whole body dosimeter had recorded a dose of 48.6 millisieverts (4.86 rems) for the month of October 2002. The radiographer's total yearly dose for 2002 was reported to be 62.6 millisieverts (6.26 rems), exceeding the 50 millisieverts (5 rems) annual limit. The radiographer was removed from occupational exposure for the remainder of the year. The exposure occurred on October 8, 2002, at a temporary job site, when the source was not fully retracted following a radiograph. The radiographic camera was an Amersham Model 660-B, containing 3.81 terabecquerels (103 curies) of iridium-192.

The Commonwealth of Kentucky conducted an on-site investigation and requested the licensee to reevaluate the exposure to the radiographer. On December 29, 2002, the licensee, assisted by the Radiation Safety Officer from AEA Technologies, completed their reevaluation of the event, and determined that the radiographer received a whole body dose of 300 millisieverts (30 rems) during the event.

The Commonwealth of Kentucky concurred on this dose assessment, and identified the causes of the event. The Commonwealth of Kentucky also found that the radiographer's whole body dosimeter and the ratemeter were being worn in a pocket, an area of the body that did not receive the highest whole body dose. Kentucky officials are monitoring the licensee's corrective actions.

Region II received this updated information from the Branch by electronic mail on Tuesday, January 7, 2003. This information has been discussed with the Branch and is current as of 9:00 a.m., Thursday, January 9, 2003.

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