THIS EVENT IS NOT FOR PUBLIC DISCLOSURE PER AGREEMENT STATE REQUEST UNTIL 7/9/2003

July 7, 2003

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-03-032

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 IV staff on this date.

Facility
H&G Inspection
93 Summerbell Road
Houston, TX
License No.: L02181
Texas Agreement State Licensee

Licensee Emergency Classification

___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

SUBJECT: OCCUPATIONAL DOSE IN EXCESS OF LIMIT

DESCRIPTION:

On July 3, 2003, the Texas Department of Health, Bureau of Radiation Control (the Bureau) notified NRC's Operations Center that a radiographer received a whole body dose of 6043 millirem during industrial radiographic operations.

The event occurred on May 20, 2003, between the hours of 2:00 - 2:30 a.m. (CDT), at the Amoco Refinery in Texas City. The Texas licensee, H&G Inspection, notified the Bureau's regional office on May 21, 2003. The licensee reported that one of their radiographers failed to return a radiography source into its fully shielded position which resulted in an overexposure. The licensee reported that after the last exposure of the night, the radiographer proceeded to retrieve the film and took it to the darkroom for development. The radiographer stated that he thought he had fully retracted the source before he retrieved the film. It was determined that the survey meter was not turned on for the required survey of the guide tube. In addition, although his ratemeter was alarming, the radiographer did not hear it initially because of the noise level in the refinery. After hearing the faint ringing of the alarm ratemeter, the radiographer re-surveyed the guide tube with the meter on, and the survey meter went off scale. The radiographer checked his pocket dosimeter which was also off scale. The radiographer then retracted the source into the fully shielded position and notified his management. On May 21, the radiographer's personnel monitoring badge was sent to the dosimetry company for emergency processing. The radiographer estimated the time he was exposed to the source was one minute. The radiography camera contained a 3.7 gigabequerel (100 curie) Cobalt 60 source.

Region IV received notification of this occurrence from NRC's Operations Center on July 3, 2003. Region IV has informed NMSS, OEDO, STP, and Region IV's PAO and SLO.

This information has been discussed with the State and is current as of 2:15 p.m. (CDT) on July 7, 2003.

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