**Huntington**
TESTING & TECHNOLOGY INC

October 9, 2003

United States Nuclear Regulatory Commission
Washington, DC 20555

Attention: Document Control Desk

RE: Written Report per Event Number 40148

To Whom It May Concern:,

In compliance with 10 CFR Part 30.50, a twenty-four hour notification was made of an event that had occurred at a permanent facility in Shreveport, LA. The event was as follows:

On 9/10/2003 at approximately 11:45AM, the lock slide on an AEA Technology 660B projector containing 40 curies of Ir-192, became stuck in the red or operate position. The radiographer and his assistant had been using the equipment earlier without incident, and had no explanation as to what had caused this to occur. The radiographer applied positive and negative pressure using the crank assembly hoping to move the lock slide back into its original position without success. The radiographer followed emergency procedures, took surveys of the area and contacted his RSO. After discussing the preliminary survey readings it was decided to take additional readings and determined that the source was in the shielded position of the projector. At this point the radiographer was instructed to disconnect the guide tube and attach the shipping plug to prevent any possible escape of the source from the radiography device. Once the shipping plug was secure, the radiographer was instructed to disconnect the "live" side of the control housing where it attached to the safety connector. After loosening the nut and relieving any stress placed on the posi-lock system the lock slide snapped into its original position without assistance. The source was disconnected and placed in storage without any exposure to the radiographer or assistant.

Once the source was secured the radiographer explained that he had taken three (3) prior exposures without incident and after retracting the forth exposure is when this event occurred. The radiographer was instructed to take the equipment, (controls and camera), out of service until it could be determined what had caused the malfunction. The controls were sent to our home office in Huntington, WV for evaluation with a replacement set of controls purchased from AEA Technology, Baton Rouge.

The following morning, without any new information the event was reported.

Upon receipt it was discovered that the controls were not operating properly. After disassembly and inspection, the problem was found to be a crimp in the housing that prohibited the drive cable from proper movement.

After subsequent interviews with the radiographer and assistant, it was revealed that between the third and forth exposure, a piece of equipment needed to be repositioned in order to properly perform the inspection. At this time several items were moved and positioned inside the exposure room. Once the radiographic set-up had been achieved, the radiographer slide the lock slide over for the exposure. It was at this point the radiographer realized the problem.

The cause of the event has been determined to be an unknown external force or blow to the control housing causing a dent or crimp to restrict the movement of the control cable.

Since the time of event, emphasis has been placed on housekeeping in the vault area as well as being more observant to possible risk situations with respect of the placement of equipment.

Should you have any questions or require any additional information, please give me a call at (800) 747-0441.

Sincerely,

Paul Yeoman
Radiation Safety Officer

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