## **EVENT RATING FORM (ERF)**

THE INTERNATIONAL NUCLEAR EVENT SCALE (INES)															
EVENT TITLE       Potential Shallow Dose Overexposure       EVENT DATE         2005.03.18       2005.03.18															
RATING	NG RATING OUT OF		DEVIATION	INCIDENT			ACCIDENT				FACILITY TYPE				
PROVISIONAL		DATE	SCALE	0	1	2	3	4	5	6	7	Power Reactor		Research [ Reactor	
FINAL		2005.18.03										Radwaste Facility		Radiation Sour	ce 🔳
COUNTRY				F	-AC	ILIT	Y NA	ME				Irradiation		Transportation	
USA				Carson, CA Fuel Fa								Fuel Fabrication		Fuel  Reprocessing	
LOCATION				1								Research Facility		Mining/Milling	
	Carson, CA Enrichment Facility										Other				
OFF-SITE IMPACT											YES	NO			
	RELEASE BEYOND AUTHORIZED LIMITS														
OVEREXPOSURE OF MEMBERS OF PUBLIC															
ON-SITE IMPACT															
CONTAMINATION SPREAD															
WORKER OVEREXPOSURE															
DAMAGE TO RADIOLOGICAL BARRIERS															
	DEGRADATION OF DEFENSE IN-DEPTH														
PERSON INJURED PHYSICALLY OR CASUALTY															
IS THERE A CONTINUING PROBLEM															
	PRESS RELEASE ISSUED (IF YES, PLEASE ATTACH)														

## EVENT DESCRIPTION

On March 11, 2005, a California industrial radiography licensee notified the state that two of its employees may have incurred an occupational overexposure. The licensee reported that two radiographers were conducting radiographic operations at a refinery located in Carson, CA using an Industrial Nuclear Corporation Model IR 100 exposure device. The device contained an iridium-192 sealed source with an activity of approximately 3.3 terabecquerels (90 Curies).

The licensee reported that subsequent to performing several radiographic exposures (approximately 10), the radiographer approached the camera without any survey instrumentation and disconnected the guide tube. After disconnecting the guide tube, it became apparent to the radiographer and his assistant that there was a problem because their survey instruments were reading off-scale. Additionally, the radiography crew checked their pocket reading dosimeters and observed they were reading off-scale. The radiographer used pliers to successfully retract the source into the shielded position.

On March 17, 2005, the State of California provided the Nuclear Regulatory Commission (NRC) with updated dosimetry results that revealed that the radiographer and his assistant received a

whole body dose of 16 millisievert (1.6 rem) and 27 millisievert (2.7 rem) respectively. Additionally, dose reconstruction results indicated that the radiographer may have received a shallow dose equivalent of 550 millisievert (55 rem) to the hands, a dose in excess of the NRC's applicable limit of 500 millisievert (50 rem). There were no reported physical abnormalities related to the exposure.

The radiographic device will be sent to the manufacturer for evaluation and repair.

The State of California will be conducting an investigation of the event.

RATING JUSTIFICATION AND DIFFICULTIES ENCOUNTERED

The provisional rating for this event is Level 2.

A Level 2 is warranted for exposure to an individual worker in excess of the statutory limits. See Section 5.2.1, "Draft Additional Guidance for the INES National Officers for Pilot Use and Feedback," Revision 26, May 2004.

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