

Documentation of an irradiator event, 1/4/07
Salem, NJ

On January 4, 2007 at 17:36 hours, a fault alarm sounded for the cell and the source motion alarm sounded. The system shut down and the operator notified the facility RSO, John LaNovara, that the PLC alarm log reported an E-stop was activated. The three E-stops outside the cell located at the control room, load station and unload station, were all checked and all appeared to be normal. We attempted to determine if the alarm was the result of an electrical problem with the input / output for the E-stop stations, but no problems were not indicated. At that point we assumed that the E-stop in the cell, which is the personnel safety pull cord, had been activated by product falling against the wall and tripping it. Even though all indicators showed that the sources had lowered into their shielded positions and normal background radiation levels were displayed on the RMS II, the PLC would not allow the fault to be cleared to allow cell entry without the E-stop fault being cleared by manually resetting it.

Approximately 15 minutes after the system shut down, the facility RSO, who had already been onsite, placed calls to the corporate RSO, Mark Smith, for approval to bypass the cell safety system in order to gain access to the cell to reset the activated E-Stop. Initially, no contact was made with the corporate RSO and messages were left. Meanwhile, the facility General Manager, Thomas Dalfonso, was called and notified of the situation and upon his suggestion, the Vice President of Operations, John Schlecht, was contacted as an alternate route. Mr. Schlecht made attempts to get consensus on how to proceed with the help of corporate EH&S personnel while awaiting a call back from corporate RSO. While this was occurring, Mark Smith, corporate RSO called in to the facility at approximately 19:30 and, after being updated on the situation, gave permission to access the cell by violating a light screen and entering through the product door.

As extra precautions prior to entering the cell, both source hoist lockouts were applied, then the facility RSO, John LaNovara, entered the cell at approximately 19:40 using two Ludlum model 3 meters while keeping in verbal contact with the shift leader who was stationed at the entry door.

Upon entering the cell and confirming the sources were properly shielded, it was clearly evident that product had fallen against the wall from lane 4 position 2 and fell against the pull cord, which activated the E-stop. The E-Stop was reset and the material that fell over was reconfigured on the pallet. The safety system was then reset and routine production resumed at 19:46. The total duration of the event was 2 hours and 10 minutes.

The product that caused the event consists of very light foam planting trays that had shifted off the pallet. The remainder of the 30-pallet run was strapped to the pallet to prevent further recurrence. A specification change that will print directly on the work order was issued to ensure future runs of this product would be fully stretched wrapped and then strapped to the pallet to prevent recurrence.



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J. B. LaNovara 1-5-07

Report Completed by:
John B. LaNovara, RSO, Sterigenics, Salem, NJ

Thomas Dalfonso 1/5/07

Reviewed by:
Thomas Dalfonso, General Manager, Sterigenics, Salem, NJ

Attached

Reviewed by
Mark Smith, CHP, Sterigenics Corporate RSO

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Report Completed by:
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Mark A. Smith 01/08/07

Reviewed by
Mark Smith, CHP, Sterigenics Corporate RSO