

LICENSEE EVENT REPORT EVALUATION FORM

EVENT CLASS: EQP - EQUIPMENT PROBLEMS

LICENSEE / REPORTING PARTY INFORMATION:

Licensee/Reporting party name:	Mid-Pacific Testing & Inspection		
License number :	53-29044-01		
Docket number :	030-32809		
Licensee's City of record :	Waipahu		
Licensees State of record :	Hawaii		
NRC regulated?	Yes	If so, what Region?	IV
Working under reciprocity?	No		

EVENT INFORMATION:

In what City and State did the event occur?	Kauai, Hawaii
Event date :	July 15, 2010
Discovery date :	July 15, 2010
Report date :	July 15, 2010
Agreement State reportable?	N/A
NRC reportable?	Yes
Reporting regulation :	30.50(b)(2)
NMED Item Number :	100359

ADDITIONAL PARTIES INVOLVED:

Name :	N/A
License number :	N/A
City :	N/A
State :	N/A

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CONSULTANT INFORMATION (if any):

Consultant name :	N/A
Company :	N/A
Who hired consultant?	N/A

DEVICE INFORMATION:

Manufacturer :	Campbell Pacific Nuclear
Model number :	MC-3
Serial number :	M38098467

RADIATION SOURCE INFORMATION:

Isotope :	Am-241/Be	Cs-137
Activity :	0.05 Ci	0.01 Ci
Manufacturer :	Instrotek	Instrotek
Model number :	ANMV997	CDC805
Serial number :	9434NE	2695GC

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NARRATIVE EVENT DESCRIPTION:

A CPN Portable density gauge Model MC-3 was run over by a water truck. The gauge was sitting next to an air compressor where the technician placed it between tests to discuss fill control. The water truck operator was backing up using the compressor as his guide and accidentally ran over the gauge. This event occurred at ~ 3:10pm on JULY 15, 2010 on the Kaunualii Hwy just adjacent to the construction office entry road.

CORRECTIVE ACTIONS:

The technician immediately taped off the area and called the office. The RSO immediately contacted the NRC Headquarters Operations Center. The RSO instructed the technician to determine if the source probe would retract back into the lead casing and conducted a survey to determine exposure rates. Exposure rates were minimal indicating that the source was back into the shielded position.

The gauge was wrapped in lead sheets and properly packaged and shipped to the manufacturer for disposal.

This incident did not create exposure levels above what is normally expected during the proper usage of an undamaged nuclear density gauge.

RECOMMENDED FOLLOWUP:

Was a reactive inspection conducted?	NO	If so, inspection report number :	N/A
Is LER recommended for closure?	YES		
Is this NMED Item Number recommended to reflect "complete"?	YES		

LER Evaluator:	Branch Chief or Designee Review:
Name: <u>[Signature]</u> Date: <u>12/17/10</u>	Name: <u>[Signature]</u> Date: <u>12/17/2010</u>



November 10, 2010
US Nuclear Regulatory Commission, Region IV
Material Radiation Protection Section
611 Ryan Plaza Drive, Suite 400
Arlington, Texas 76011-4005

10 CFR 30.50 (c) (2)

Follow up report by Mid Pacific Testing & Inspection Services, Inc. (NRC license # 53-29044-01)

1. CPN Portable density gauge model MC-3 was run over by the water truck operated by Kiewit Pacific Co. The gauge was sitting next to an air compressor where the technician placed it between tests to discuss the fill control. The water truck operator was backing up using the compressor as his guide (trying to get as close to compressor as he could to slip by it) and ran over the gauge.
2. This event occurred on the Kaunualii Hwy just adjacent to the construction office entry road (Hwy heading north that runs out of Lihue, Kauai).
3. Source numbers Am-241/Be : 9434NE (encap. 8/12/88) and Cs-137: 2695GC (encap. 9/6/88)
4. Incident occurred at 3:10 pm July 15, 2010.
5. The technician immediately taped off the area and called the office (3:37). I then immediately contacted the NRC emergency line (301-816-5100) and spoke with John Knoke (3:37). He advised we determine if the source could be retracted back into the casing and to perform a survey to determine what the exposure levels were. The technician called back (3:41) and determined the source probe would retract back into the lead casing and that in doing this the exposure levels were very minimal (at or near what they are with an undamaged gauge). I called NRC back and made an official report No. 46099 (4:07). The technician then placed the gauge back in the transportation box and locked it up in the designated storage area. July 16, 2010 I flew to Kauai first thing, met with the technician, performed another survey for source levels, contacted NRC and determined that the exposure levels were well within the acceptable limits. As a precaution, we wrapped the entire case with lead sheets, boxed up the gauge in the proper transportation case and sent the gauge to Instrotek for disposal. (Called Instrotek and explained the situation to them). Instrotek officially disposed of the gauge.
6. This incident did not create exposure to radiation levels above what is normally expected during the proper usage of an undamaged nuclear density gauge.

This report was emailed to RidsRgn4MailCenter@nrc.gov and Michelle.Hammond@nrc.gov.

Please contact us should you have questions or require additional information.

James Merriman, RSO

360-771-3693