

LICENSEE EVENT REPORT EVALUATION FORM

EVENT CLASS: EQP - EQUIPMENT PROBLEMS

LICENSEE / REPORTING PARTY INFORMATION:

Licensee/Reporting party name:	Global X-Ray & Testing Corporation		
License number :	17-29308-01		
Docket number :	030-37816		
Licensee's City of record :	Morgan City		
Licensees State of record :	Louisiana		
NRC regulated?	Yes	If so, what Region?	IV
Working under reciprocity?	No		

EVENT INFORMATION:

In what City and State did the event occur?	Gulf of Mexico
Event date :	06/24/2010
Discovery date :	06/24/2010
Report date :	07/20/2010
Agreement State reportable?	No
NRC reportable?	Yes
Reporting regulation :	34.101(a)
NMED Item Number :	100365

ADDITIONAL PARTIES INVOLVED:

Name :	Helix Energy Solutions Group
License number :	
City :	Houston
State :	Texas

LICENSEE EVENT REPORT EVALUATION FORM

EVENT CLASS: EQP - EQUIPMENT PROBLEMS

CONSULTANT INFORMATION (if any):

Consultant name :	
Company :	
Who hired consultant?	

DEVICE INFORMATION:

Manufacturer :	SPEC
Model number :	
Serial number :	860

RADIATION SOURCE INFORMATION:

Isotope :	Ir-191	
Activity :	58 Ci	
Manufacturer :	SPEC	
Model number :	G60	
Serial number :	RC1106	

LICENSEE EVENT REPORT EVALUATION FORM

EVENT CLASS: EQP - EQUIPMENT PROBLEMS

NARRATIVE EVENT DESCRIPTION:

The licensee was conducting industrial radiography in the Gulf of Mexico, when the source failed to retract into the shielded position of the Spec 150 camera being used at the off-shore platform location. The radiography staff followed the licensee's operating & emergency procedures, which included attempting to crank the source back by normal operating procedures, immediately establishing new 2mR barricades, maintaining direct surveillance & immediately notifying the Radiation Safety Officer (RSO). The licensee, authorized to perform source retrieval, sent the RSO & the Assistant RSO (ARSO) to the location, who successfully returned the source to the shielded position by following the licensee's Source Retrieval Procedure. The licensee's preliminary investigation of the equipment showed that the source was disconnected in the source tube, that the pigtail connector appeared flared or spread open a bit and apparently the drive cable became disconnected from the pigtail inside the source tube because of the flared pigtail connector. The licensee reported that no members of the public were in the entire vessel area during the duration of the job commencement & the event. The licensee reported that all radiography crew were wearing the required personnel dosimetry.

CORRECTIVE ACTIONS:

- 1). The licensee's radiography personnel followed the licensee's operating & emergency procedures by securing the area, maintaining constant surveillance & immediately notifying the RSO.
- 2). The licensee's RSO & ARSO immediately responded to the event by traveling to the off-shore platform vessel & followed the licensee's approved Source Retrieval Procedure to successfully return the source to the shielded position.
- 3). The licensee immediately sent the camera to the manufacturer for evaluation & maintenance.
- 4). The licensee immediately sent all personnel monitoring to be processed; no overexposures were noted in the processor's report back to the licensee.
- 5). The manufacturer repaired the camera and noted that the source connector showed evidence of significant wear, the source pigtail had a sharp bend behind the source capsule & the control adapter was bent. The manufacturer reported that this was possibly due to the source assembly being stuck, which resulted in excessive force being applied to the drive cable while trying to return the source into the exposure device. The manufacturer straightened the pigtail and put on a new source connector assembly. They then performed a functional & pull test, with the test results showing the source was met tests requirements. The camera was returned to the licensee.
- 6). The licensee reported that they maintained control of the area throughout the entire operation to ensure that no members of the public were in the area to receive any possible radiation exposure.
- 7). The licensee verbally notified the agency on 07/20/10 & submitted the 30-day written report in accordance with 10 CFR 34.101(a) on 7/20/10.
- 8). The licensee immediately held a meeting with staff to discuss the event & to review the licensee's operating & emergency procedures.

RECOMMENDED FOLLOWUP:

Was a reactive inspection conducted?	No	If so, inspection report number :	
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><i>Patricia Johnson</i></u> Date: <u><i>2/15/11</i></u>	Name: <u><i>[Signature]</i></u> Date: <u><i>2/16/2010</i></u>