PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-IV-98-056

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region IV staff in Arlington, Texas on this date.

Facility
Anvil Corporation
Conoco Refinery
1675 Bakerview Road
Bellingham,Washington 98226
Dockets: 03032816 License No: 46-23236-03

Licensee Emergency Classification
Notification of Unusual Event
Alert
Site Area Emergency
General Emergency
X Not Applicable

Subject: INDUSTRIAL RADIOGRAPHY OVEREXPOSURE

On November 23, 1998, a representative of Anvil Corporation notified the NRC Operations Center of an incident that occurred at a temporary job-site located in Billings, Montana. At approximately 1500 PST on 11/23/98, Anvil Corp. received film badge results for two workers involved in an incident which occurred at a Conoco Refinery located in Billings, Montana, on 11/20/98. The film badge results indicated that one of the individuals received a deep dose of 3.954 R, a lens dose of 4.034 R, and a shallow dose of 4.214 R. Film badge results indicated that the other individual received a deep dose of 11.863 R, a lens dose of 11.863 R, and a shallow dose of 11.287 R. The annual dose limit is 5.000 R.

On 11/20/98, two individuals were performing industrial radiography with an Amersham-660B device which contained a 72-Curie Iridium-192 source. The first shot was performed with no problems. However, while setting up for the second shot, it was noticed that the slider on the Amersham-660B device had not engaged properly (i.e., not locked back) leaving the source unshielded. The individuals were able to turn the crank handle another one half turn, and it went into the locked position. It was noted that the individuals' dosimeters were off scale. The individuals involved estimated that the slider was not locked back for a duration of approximately 3 minutes. However, subsequent calculations based on film badge results indicated the duration of the event was approximately 6 minutes. The licensee has removed both individuals from activities involving radioactive materials.

The licensee does not consider this event to be the result of an equipment malfunction because the device locked when the crank handle was turned another one half turn. The licensee believes that this event may have resulted from a failure to follow procedures in that the source may not have been verified to be locked in the shielded position.

The Radiation Safety Officer stated that the radiographer's alarm ratemeter did not alarm and the assistant radiographer's ratemeter was not turned on.

Region IV will dispatch an inspector to review the incident the week of November 30, 1998.

The states of Montana and Washington have been informed.

This information has been discussed with the licensee and is current as of 1:00 p.m. on November 24, 1998.

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