February 20, 2001

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-II-01-009

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 II staff (Atlanta, Georgia) on this date.

Facility	**Licensee Emergency Classification**
Quality Inspection Services, Inc.	Notification of Unusual Event
(An Agreement State Licensee)	Alert
Jacksonville, FL	Site Area Emergency
Dockets/License: 3043-1	General Emergency
	X Not Applicable

Subject: RADIOGRAPHER OVEREXPOSURES

On Monday, February 19, 2001, the Florida Bureau of Radiation Control notified the NRC of a reported overexposure to an industrial radiographer and the assistant radiographer that had occurred on Friday, February 16, 2001. One of the radiographers received a reported whole body exposure of 39.2 rems (0.4 sievert), and the other radiographer received a reported 2.9 rems (.03 sievert) to their personnel monitoring badges. Both individuals were wearing pocket dosimeters which were reported to be off-scale. One radiographer's alarming rate meter was turned off, and the other radiographer's alarming rate meter had a low battery and would not give an audible alarm. The radiographers were using an AEA, model 660B, radiographic exposure device containing 58 curies (2 terabecquerels) of iridium-192. The radiographers failed to perform an adequate survey of the device and the source was thought to be in the shielded position. The radiographers then proceeded to set up another radiograph which took approximately 5 minutes, before discovering that the source was not fully shielded.

The licensee is having the radiographer with the highest exposure to undergo blood testing for radiation exposure. In addition, the licensee conducted a reenactment of the event. The Bureau of Radiation Control has discussed the event with the licensee and has suggested the use of cytogenetic testing for evaluating the radiographers exposure. The Bureau is conducting an on-site investigation to verify the circumstances of the event, the cause for the event, and the actions taken by the licensee.

Region II received initial notification of this occurrence by facsimile from the NRC Headquarters Operations Officer. The information presented herein has been discussed with the State of Florida, Bureau of Radiation Control and is current as of 9:30 a.m., February 20, 2001.

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