THIS EVENT IS NOT FOR PUBLIC DISCLOSURE PER AGREEMENT STATE REQUEST UNTIL 8/1/2003

July 30, 2003

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE -- PNO-IV-03-037

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 the Region IV staff on this date.

Facility
H&G Inspection
93 Summerbell Road
Houston, TX
License No.: L02181
Texas Agreement State Licensee

Licensee Emergency Classification

___ Notification of Unusual Event
___ Alert
___ Site Area Emergency
___ General Emergency
_X_ Not Applicable

SUBJECT: OCCUPATIONAL DOSE IN EXCESS OF LIMIT

DESCRIPTION:

On July 29, 2003, the Texas Department of Health, Bureau of Radiation Control (the Bureau) notified NRC's Operations Center that a radiographer and a radiographer trainee received whole body doses of 17.978 rem and 2.65 rem, respectively, during industrial radiographic operations. H&G Inspection, the Texas licensee reported the event to the Bureau on July 28, 2003.

The licensee reported that the event occurred on July 25, 2003, at the Amoco Refinery in Texas City. The licensee reported that after a second exposure of the night, a radiographer failed to return a radiography source into its fully shielded position. The source remained 6-8 inches outside the shielded position. The radiographers were up on scaffolding in an 8 foot space for about 15 minutes with the source exposed. When the radiographer started to make a third exposure, he noticed that the source was out. It took about 1-1.5 cranks to retract the source. (The crank cables are about 35 feet long and guide tubes were used.) The radiography camera, (SPEC 300, Serial Number 009) contained a 3.7 gigabequerel (99 curie) Cobalt 60 source (SPEC Model Number G70, Serial Number C60-02).

The licensee reported that the radiographer did not do a survey and his ratemeter did not work. The trainee did not hear his ratemeter due to the excessive noise at the site and the use of earplugs. Both pocket dosimeters were off scale. The whole body dosimeters were sent to the badge company for emergency processing on July 25, 2003, and the badge results were received on July 28, 2003. On July 29, 2003, the Bureau sent an inspector to the licensee's facility to investigate the event.

Region IV received notification of this occurrence from NRC's Operations Center on July 29, 2003. Region IV has informed NMSS, OEDO, STP, and Region IV's PAO and SLO.

This information has been discussed with the State and is current as of 11:00 a.m. (CDT) on JULY 30, 2003.

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