PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-IV-96-053

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	Licensee Emergency Classification
Barnett Industrial X-Ray, Inc.	Notification of Unusual Event
Barnett Industrial X-Ray, Inc.	Alert
P.O. Box 1991	Site Area Emergency
Stillwater,Oklahoma 74076	General Emergency

Dockets: 03030691 License No: 3526953-01 X Not Applicable

Subject: INDUSTRIAL RADIOGRAPHY INCIDENT

At 11:45 a.m. (CT) the radiation safety officer (RSO) for Barnett Industrial X-Ray, Inc. (licensee) notified Region IV staff of an incident that occurred at approximately 9:00 a.m. at a refinery in Ponca City, Oklahoma. The RSO reported that he was notified that radiography personnel working at the refinery attempted to disconnect a source guide tube following an exposure and discovered that the source had not been fully retracted into the exposure device. Upon receiving this notification, the RSO traveled to the site to begin an investigation of the incident.

The RSO indicated that a radiographer and assistant were assigned to complete two radiographs on a weld located approximately 30 feet above ground. The exposure device was placed on a scaffold, with the drive cable controls located on the ground. The radiographer was operating the drive controls and at the completion of the second radiograph, he instructed the assistant to remove the film and return the exposure device to ground level. The assistant radiographer collected the film and attempted to disassemble the equipment; however, when he attempted to remove the source guide tube and insert the safety plug, he noted the source was exposed and that nearly the full length of the source pigtail was visible. The assistant promptly returned to the ground and the radiographer returned the source to a fully shielded position without problem. The RSO stated that there was no obstruction in the s-tube or the device and was unable to explain why the radiographer had not fully retracted the source on the first attempt.

The RSO also reported that neither the radiographer nor the assistant were wearing film badges, pocket dosimeters, or alarm ratemeters. Further, although the assistant radiographer carried a survey instrument with him as he approached the exposure device, he had not observed the meter reading. The RSO completed a re-enactment of the assistant

radiographer's actions during the time that the source was exposed and reported initial dose estimates of 2 to 5 Rem for a whole body dose. The RSO was still evaluating the extremity dose received by the assistant radiographer as he attempted to remove the source guide tube. The RSO stated that no problems were known to exist with the equipment used at this temporary jobsite.

At the time of the initial telephonic report, the RSO was returning to the company office with the equipment and radiography personnel. The RSO plans to complete additional interviews and dose assessments. Region IV plans to dispatch inspectors to review this incident on October 4, 1996.

The state of Oklahoma has been informed.

Region IV received notification of this occurrence by telephone from the licensee's RSO at 11:45 a.m. on October 3, 1996. Region IV has informed NMSS.

This information herein has been discussed with the licensee and is current as of 3 p.m., October 3, 1996.

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