PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-IV-97-001

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
H & G Inspection Company, Inc.	Notification of Unusual Event
H & G Inspection Company, Inc.	Alert
P.O. BOX 721856	Site Area Emergency
Houston,Texas 77272	General Emergency

Dockets: 03006811 License No: 42-26838-01 X Not Applicable

Subject: INDUSTRIAL RADIOGRAPHY OVEREXPOSURE

On January 2, 1997, Region-IV received written notification from the licensee of an accumulated whole-body exposure to a radiographer's assistant (RA) which exceeded the annual limit of 5,000 millirem during calendar year 1996. The licensee reported that the radiation exposure report received from the licensee's dosimetry vendor (ICN Dosimetry Service) indicates that the individual received 2,160 millirem deep dose equivalent during the September 10 - October 10, 1996, monitoring period. The dosimetry report was received by the licensee on December 9, 1996. When added to his previous exposure during 1996, the RA's accumulated radiation exposure for the year equaled 5,440 millirem. The licensee's report indicates that the vendor did not provide the licensee with immediate notification of the RA's exposure, although a notification threshold of 500 millirem had been established with the vendor. The licensee has not yet received exposure reports for the October and November monitoring periods.

Upon receipt of the exposure report, the licensee immediately placed the RA on leave of absence from work involving radioactive materials until the beginning of the 1997 monitoring period (January 10, 1997). Subsequent to receiving the dosimetry report, the licensee performed an investigation of the cause(s) of the elevated exposure reading for the September 1996 monitoring period. The licensee's internal investigation of the over-exposure was unable to determine the cause(s) of the exposure. The RA was interviewed and stated that at no time did his pocket dosimeter discharge beyond its range (200 millirem), nor did he remember misplacing his thermoluminescent device or leaving it near a radiographic exposure device. All associated safety equipment that the RA utilized during the monitoring period was inspected, and no problems were identified.

Based upon the licensee's internal investigation, the licensee is disputing the validity of the vendor's exposure report. The licensee believes that an accumulated exposure of 260 millirem is more indicative of the RA's true exposure during the September monitoring period. This dose is based upon the records of the daily readings from the RA's pocket dosimeter during this time period.

Region IV received notification of this occurrence via a written report submitted by the licensee, pursuant to 10 CFR 20.2203, and received by

NRC on January 2, 1997. The licensee's radiation safety officer was subsequently contacted by telephone by Region IV staff on January 3, 1997.

Region IV has informed NMSS and EDO.

The state of Wyoming has been informed.

Region IV intends to dispatch an inspector to review this incident during the week of January 13, 1997.

This information herein has been discussed with the licensee and is current as of 4 p.m. on January 3, 1997.

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