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NRC PROPOSES $13,000 FINE AGAINST CTI ALASKA, INC. FOR RADIATION WORKER EXPOSURE INCIDENT

The Nuclear Regulatory Commission has proposed a $13,000 fine against CTI Alaska, Inc., of Anchorage, for an incident in which a worker was exposed to excess radiation after a radiographic camera malfunctioned. The worker did not receive more than his allowed maximum annual dose of 5 rem.

The incident took place at Endicott Island, North Slope, during the night shift on December 23-24, 1995. After using a radiographic camera, workers did not realize that the radiation source failed to fully retract into its shielded container when a safety latch inside the locking mechanism prematurely engaged. A radiographic camera is used in industrial applications, much like an X-ray machine is used in medicine, to detect flaws in dense metal objects.

The worker, called a radiographer, is trained in the use of the camera and in proper handling of radiation sources. In this case, the radiographer did not perform an adequate radiation survey as required at the completion of the job, which would have detected the unshielded radiation source. He also failed to assure he was wearing a functioning alarm ratemeter, a safety device that would have warned him he was working in a radiation field. Both failures are violations of NRC regulations.

When the radiographer made a second check of his radiation survey instrument and looked at his pocket dosimeter, a second personal radiation monitoring device he is required to carry, he realized he had been working in a high radiation field. However, he then failed to contact his supervisor immediately. When contacted, the supervisor failed to immediately contact the company's radiation safety officer, and the company did not promptly process the radiographer's film badge, a third personal radiation monitoring device that would indicate the exact dose he received. These actions are required by NRC-mandated safety procedures and represent violations.

NRC Regional Administrator Joe Callan said, in a letter to CTI president George E. Haugen, "[The first two violations] are significant because they represent two breached safety barriers

that are designed to prevent overexposures to radiographers and the public. [The third and fourth violations] are also significant because they resulted in a delay in CTI's notifications and response to the incident. . . Therefore, these violations are classified in the aggregate . . . as a Severity Level II problem." The NRC rates incidents on a four-level scale, with Level I being the most severe.

Mr. Callan noted in the letter that CTI has taken extensive corrective actions which include disciplining the radiographers involved, improved emphasis on reporting of incidents, posting safety memos regarding the incident, increased frequency of safety audits, additional training on proper use of the radiography camera, and assignment of a new safety coordinator.

CTI must respond to the Notice of Violation in writing within 30 days. The response must document specific actions taken to prevent recurrence of the incident. During this time the Company may pay the fine or file a protest.

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