January 4, 2000

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-IV-00-001

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**
State Of Washington	Notification of Unusual Event
Inspection Service Inc.	Alert
Kennewick,Washington	Site Area Emergency
License No: WN-IR064	General Emergency
	X Not Applicable

Subject: INDUSTRIAL RADIOGRAPHY DEVICE MALFUNCTION

On January 3, 2000, the State of Washington, Department of Health (WDOH), notified the NRC of the malfunction of an industrial radiography device. Inspection Service Inc., a WDOH licensee, reported that the automatic locking mechanism malfunctioned while performing radiographic operations at a temporary job site location in Pasco, Washington. The device was an Industrial Nuclear Corporation (INC) Model IR100 (serial number 4495) containing approximately 25 curies of iridium-192. The malfunction was detected during the radiographer's survey of the circumference of the camera following the completion of an exposure. During his survey, the radiographer observed a dose rate of approximately 500 millirem per hour at the exit port of the camera. Upon cranking in the source, the radiographer had observed the "plunger" drop into position indicating the source had been fully retracted and the automatic locking mechanism engaged. Upon reaching the camera the radiographer key-locked the device while initiating the required circumference survey. Once locked, the key could not be moved to unlock the camera. The radiographer discovered that the source was not fully shielded and was not locked in place. Although the source could be cranked out of the camera, it could not be unlocked to crank the source back into the device the extra one eighth turn needed to fully shield the source. The licensee contacted the manufacturer and a procedure was obtained to bypass the locking mechanism and retract the source. Using the procedure supplied by the manufacturer, the licensee was able to remove the locking assembly, free the key lock, re-set the auto-lock, re-assemble the mechanism and retract the source into its fully shielded position.

No unusual exposures were received by any personnel involved during this event. Region IV received notification of this occurrence by e-mail from the State of Washington on January 3, 2000.

Region IV has informed OSP, NMSS and OEDO.

This information has been discussed with WDOH and is current as of 10:30 a.m. (CDT) January 4, 2000.

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PDR I+E PNO-IV-00-001