

Connecticut Department of Energy and Environmental Protection





Harborview Training and Research Facility Cs-137 Release Incident

October 27, 2021 Mike Firsick Fall Meeting of the NEHLRWTTF



Connecticut Department of Energy and Environmental Protection

Disclaimer





Harborview Incident

Why Discuss This Incident Here?

What's the Applicability to the HLRWTTF?

Who Was Involved?



Applicability To NTSF

- Transportation of Radioactive Material
- US DOT
- DOE
- NRC
- State
- City/Town
- Government Contractors



The Incident

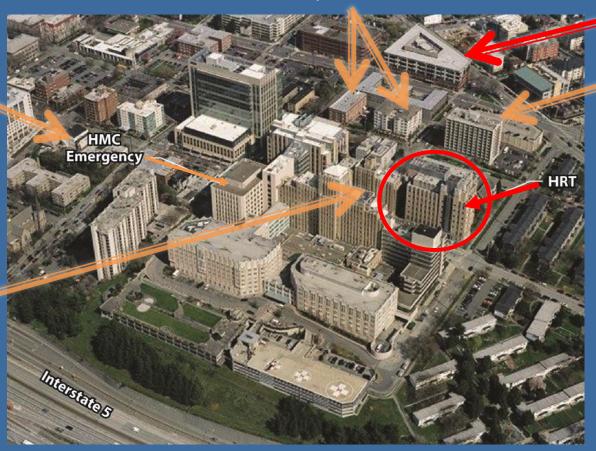
- May 2, 2019
- Part of NNSA's Off-Site Source Recovery Program (OSRP)
- Remove 2900 Curies of Cs-137 from the Harborview Research and Training Facility in Seattle, Wa.
- Required Removal of Source from Source Holder



Residential Apartments and Condos

Children's Facility

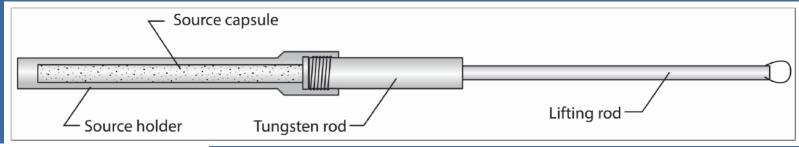
Hospital
Operating
Rooms

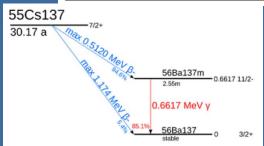


ICP

Hilltop Retirement Home

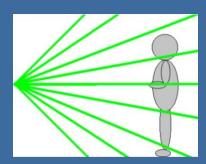






Cesium-137 decay chain





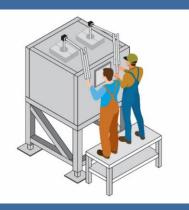
1,000 R/hr @ 1 m from an unshielded 2900 Ci source

- Exceed occupational 5 rem limit in 20 s
- Exceed Emerg 25 rem limit in 1 minute
- Onset of Radiation Sickness (100 rem) in 6 minutes

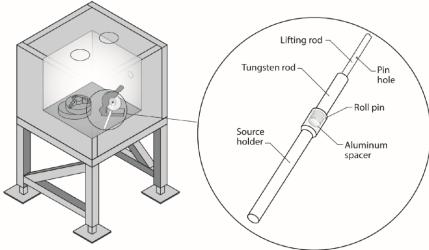
@ 1 ft onset of radiation sickness in ½ minute



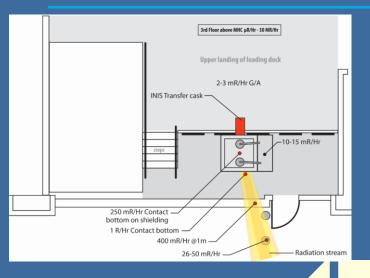














2100 Changing Roles

DOH and FBI leave

- RCT goes to buy batteries
- Rigger taking dose rates

2127 "Source may have been breached"

- Frisker pegged >500,000 cpm
- RSO notified
- NRC HOO called 2200

1900 Start cutting

- No swipe surveys
- No air samples
- No rad barriers
- Doors not closed

1600 Source moved from basement to loading dock

- Irradiator to MHC misaligned
- No donut shield
- Source holder modified with hacksaw (not in procedure)

1830 Prejob Brief

- 3 untrained techs getting OJT Observers from DOH and FBI not
- present and no dosimetry
- No rad access restrictions
- Higher than expected radiation

source

- Camera bright sparks



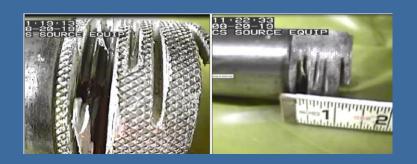


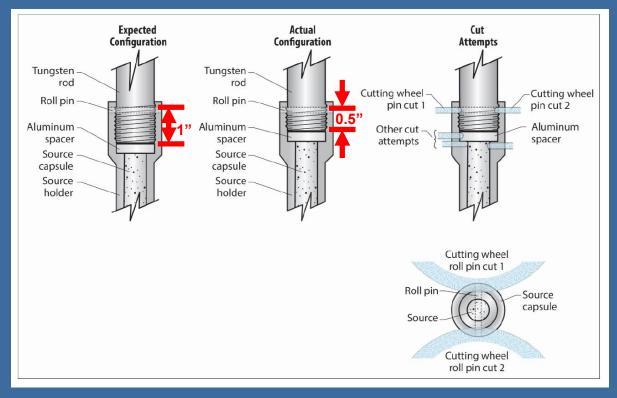
- Fewer sparks
- Source most likely breached





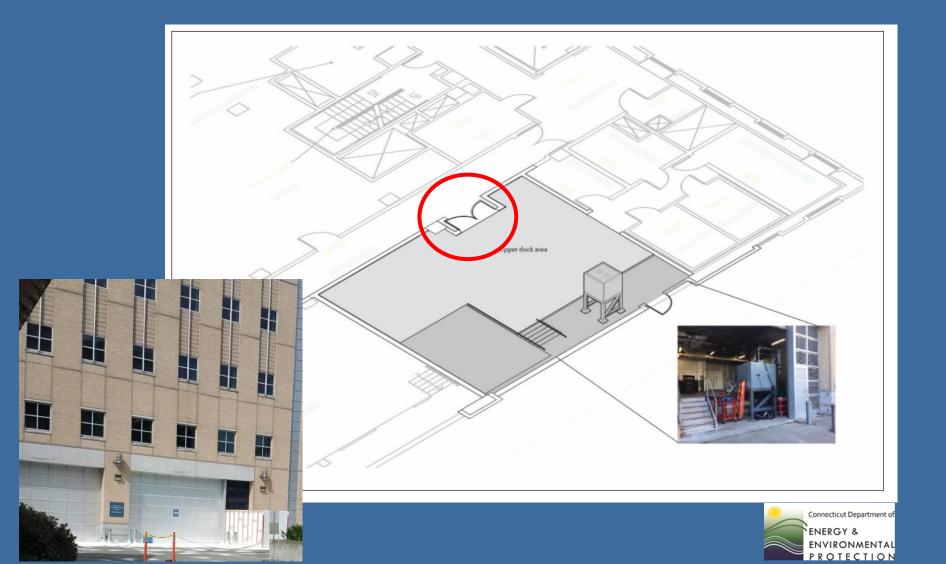
27 Cuts Later...













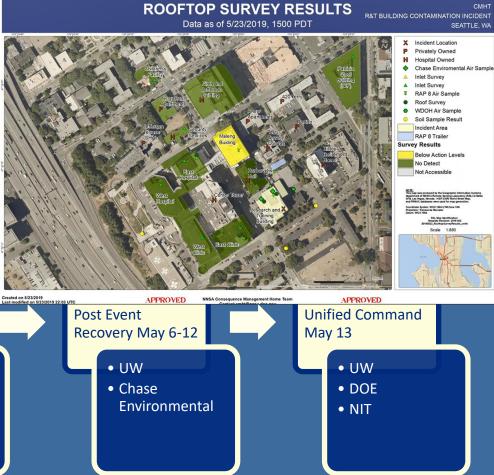
• SFD HAZMAT

• WA DOH

UWCSTREAC/TS

- UW
- DOE RAP



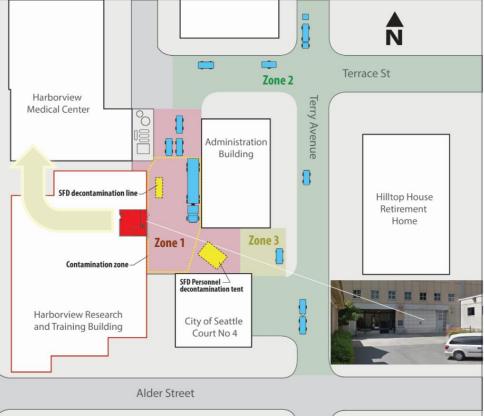




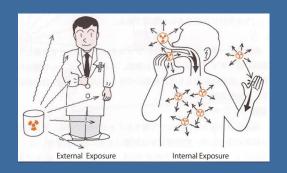












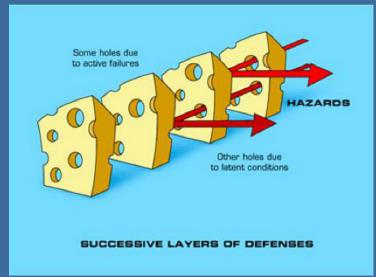




The spill of a radioactive substance at a loading dock of a University of Washington Medicine research building on First Hill left 13 people exposed to



- Failure to perform a radiological risk assessment or develop an adequate plan with contingencies
 - Removing a source from a sealed source holder with high speed cutting tools without positive contamination controls should never have been performed
 - Multiple missed Stop Work opportunities
 - First time evolution with trainees
- Overreliance on Appeal to Authority
 - Unclear roles and responsibilities





Stop the release

- No JHA or contingency plan
- Encapsulation without oversight

Warn Others

- SFD not aware of the evolution
- Believe your meters

Isolate the Area

- Ventilation not shutdown or understood
- Doors remained open
- No radiation or contamination postings
- Observers had unencumbered access

Minimize the spread of contamination

- MHC did not provide positive confinement
- No contingency plan
- People allowed in contaminated areas
- No swipe or air samples
- Techs remained in contaminated area after breach

Survey and Cleanup

- Need for Radiological expertise in response and recovery ROSS
- Underestimated spread
- Prompt assessment of internal contamination













Connecticut Department of Energy and Environmental Protection













Questions?

Mike Firsick
Supervising Radiation Control Physicist
Michael.Firsick@ct.gov
860-424-3517

