

NUREG-0940  
Vol. 14, Nos. 3 & 4, Part 3  
**Material Licensees**

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# Enforcement Actions: Significant Actions Resolved Material Licensees

Semiannual Progress Report  
July – December 1995

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**Office of Enforcement  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555-0001**



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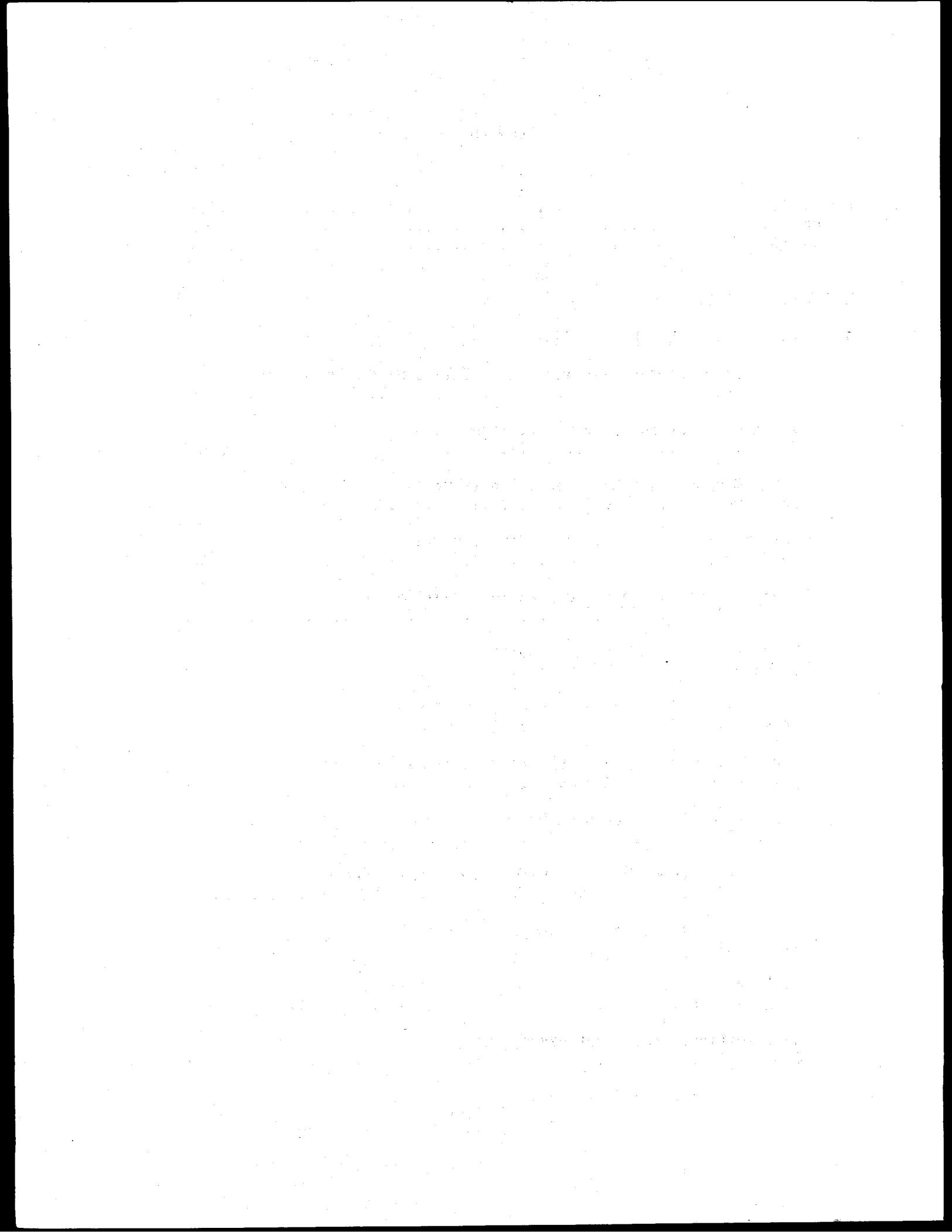


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## ABSTRACT

This compilation summarizes significant enforcement actions that have been resolved during the period (July - December 1995) and includes copies of letters, Notices, and Orders sent by the Nuclear Regulatory Commission to material licensees with respect to these enforcement actions. It is anticipated that the information in this publication will be widely disseminated to managers and employees engaged in activities licensed by the NRC, so that actions can be taken to improve safety by avoiding future violations similar to those described in this publication.



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ENFORCEMENT ACTIONS: SIGNIFICANT ACTIONS RESOLVED  
MATERIAL LICENSEES

July - December 1995

INTRODUCTION

This issue and Part of NUREG-0940 is being published to inform Nuclear Regulatory Commission (NRC) material licensees about significant enforcement actions and their resolution for the second half of 1995. Enforcement actions are issued in accordance with the NRC's Enforcement Policy, published as NUREG-1600, "General Statement of Policy and Procedure for NRC Enforcement Actions." Enforcement actions are issued by the Deputy Executive Director for Nuclear Materials Safety, Safeguards, and Operations (DEDS), and the Regional Administrators. The Director, Office of Enforcement, may act for the DEDS in the absence of the DEDS or as directed. The NRC defines significant enforcement actions or escalated enforcement actions as civil penalties, orders, and Notices of Violation for violations categorized at Severity Level I, II, and III (where violations are categorized on a scale of I to IV, with I being the most significant).

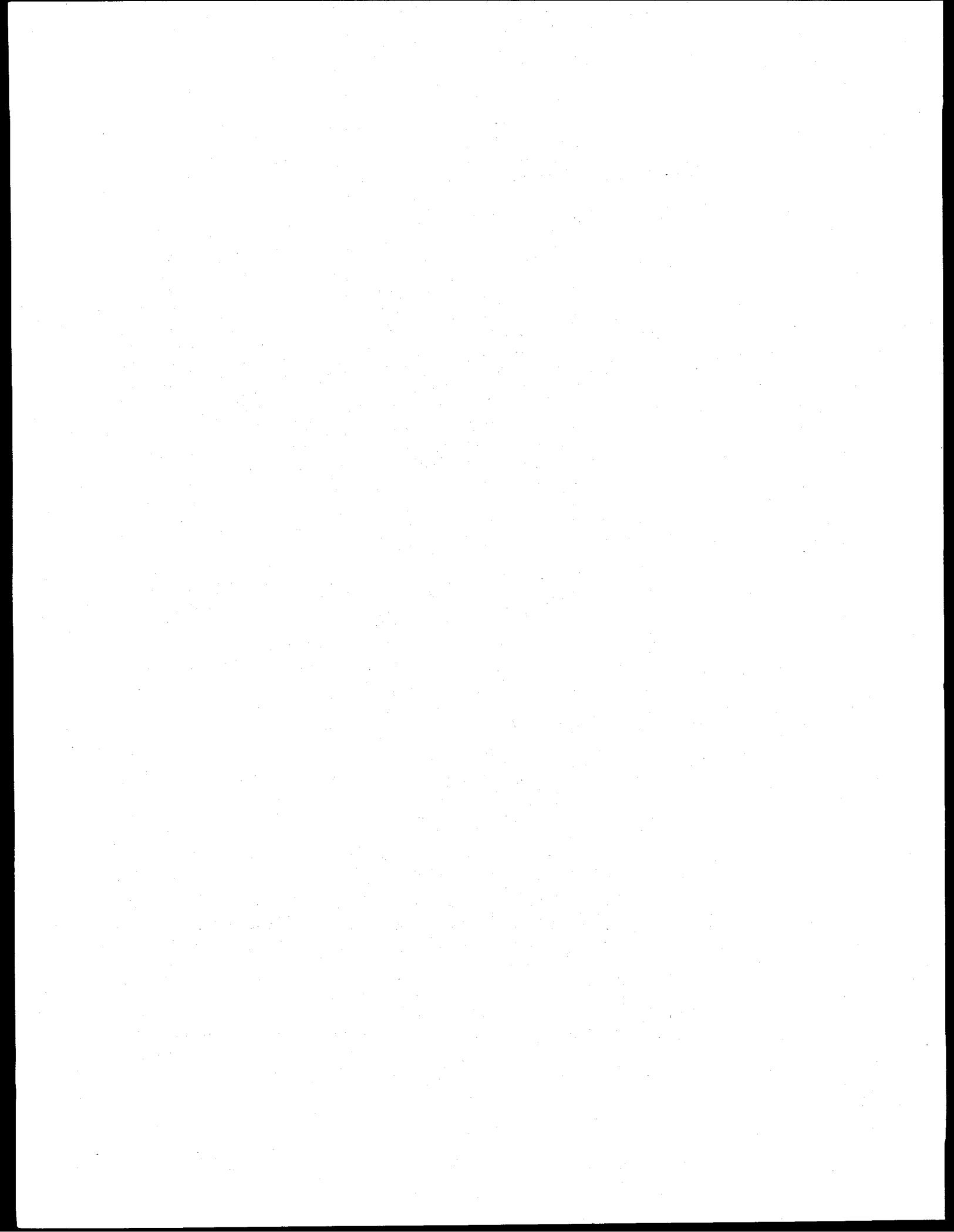
The purpose of the NRC Enforcement Program is to support the agency's safety mission in protecting the public and the environment. Consistent with that purpose, the NRC makes this NUREG available to all materials licensees in the interest of avoiding similar significant noncompliance issues. Therefore, it is anticipated that the information in this publication will be widely disseminated to managers and employees engaged in activities licensed by NRC.

A brief summary of each significant enforcement action that has been resolved in the second half of 1995 can be found in the section of this report entitled "Summaries." Each summary provides the enforcement action (EA) number to identify the case for reference purposes. The supplement number refers to the activity area in which the violations are classified in accordance with the Enforcement Policy.

Supplement I	- Reactor Operations
Supplement II	- Facility Construction
Supplement III	- Safeguards
Supplement IV	- Health Physics
Supplement V	- Transportation
Supplement VI	- Fuel Cycle and Materials Operations
Supplement VII	- Miscellaneous Matters
Supplement VIII	- Emergency Preparedness

Section A of this report consists of copies of completed civil penalty or Order actions involving materials licensees, arranged alphabetically. Section B includes copies of Notices of Violation that were issued to materials licensees for a Severity Level I, II, or III violation, but for which no civil penalties were assessed.

The NRC publishes significant enforcement actions taken against individuals and involving reactor licensees as Parts I and II of NUREG-0940, respectively.



## SUMMARIES

### CIVIL PENALTIES AND ORDERS

Advacare Management Services, Inc., Bala Cynwyd, Pennsylvania  
Supplements IV and VI, EA 94-089

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$2,500 was issued August 30, 1995 to emphasize: (1) the importance of aggressive management oversight of the radiation safety program, so as to ensure that licensed activities are conducted safely and in accordance with requirements, and violations, when they exist, are identified and corrected promptly, and (2) the need for ensuring that the licensee's corrective actions are long-lasting. The action was based on violations of NRC requirements applicable to use of radioactive material in medical practice. The licensee responded in two letters and requested mitigation of the civil penalty. After consideration of the licensee's responses, an Order imposing the civil penalty was issued November 28, 1995. The licensee paid the civil penalty on December 4, 1995.

Atlas Corporation, Denver, Colorado  
Supplement VI, EA 94-117

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$5,000 was issued June 15, 1995 to emphasize the importance of controlling contaminated material and the activities of the licensee's contractors. The action was based on a violation involving release for unrestricted use of scrap material from a dismantled uranium mill in Utah in excess of NRC limits for contamination. The licensee responded and paid the civil penalty on July 13, 1995.

Cabot Corporation, Boyertown, Pennsylvania  
Supplement IV, EA 95-086

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$5,000 was issued August 9, 1995 to emphasize the importance of conducting activities in accordance with NRC requirements, and promptly correcting violations when they exist. The action was based on the licensee's failure to make adequate surveys to ensure compliance with occupational dose limits and effluent release limits, and failure to establish controls to assure that exposures to workers and members of the public are maintained as low as reasonably achievable. The licensee responded and paid the civil penalty on September 21, 1995.

Carlisle Hospital, Carlisle, Pennsylvania  
Supplements VI and VII, EA 95-021

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$5,000 was issued June 6, 1995 to emphasize the importance of licensed activities being performed in accordance with NRC requirements. The action was based on a violation for deliberately allowing physicians who were not named on the NRC license to perform teletherapy treatments between December 1992 and April 1993 without supervision by an

authorized user. The licensee responded in a letter dated July 5, 1995 and admitted the violation, but requested mitigation of the civil penalty. After consideration of the licensee's response, the staff concluded that the violation occurred as stated and an Order imposing the civil penalty was issued August 7, 1995. The licensee paid the civil penalty on August 17, 1995.

**Champion International Corporation, Hamilton, Ohio  
Supplement VI, EA 95-184**

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$2,500 was issued November 22, 1995 to emphasize the need to strictly control licensed material. The action was based on a violation involving the loss of a gauge containing byproduct material. The licensee responded and paid the civil penalty on December 20, 1995.

**Dyna Jet, Inc., Gillette, Wyoming  
Supplement VI, EA 95-047**

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$500 was issued April 25, 1995 to emphasize the need for the licensee to ensure compliance with all requirements and to maintain cognizance of changing requirements. The action was based on a problem involving violations of NRC requirements applicable to well logging and transportation of radioactive material packages. The licensee responded on May 19, 1995 requesting mitigation of the civil penalty. After considering the licensee's response, the staff issued a letter July 11, 1995 withdrawing the civil penalty.

**Energy Technologies, Inc., Knoxville, Tennessee  
Supplements VI and VII, EA 95-187**

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$2,500 was issued October 24, 1995 to emphasize the significance of willful violations, as well as the importance of compliance with NRC reciprocity requirements. The action was based on a violation involving four instances where the licensee failed to obtain a specific NRC license or file for reciprocity prior to conducting licensed activities in West Virginia, a non-Agreement State. The licensee responded and paid the civil penalty on December 3, 1995.

**Maria Hollingsworth, dba Blackhawk Engineering, Inc., Tulsa, Oklahoma  
EA 95-018**

An Order to Cease and Desist Use and Possession of Regulated Byproduct Material was issued February 14, 1995. The action was based on the possession and use of byproduct material in a portable measuring gauge without a valid NRC license and providing inaccurate information to NRC.

Hospital Center at Orange, Orange, New Jersey  
Supplement VII, EA 95-130

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$2,500 was issued September 28, 1995 to emphasize the significance and the importance of continuously ensuring a work environment that is free of any harassment, intimidation, or discrimination against those who raise safety concerns. The action was based on a violation involving discrimination against a technician for engaging in a protected activity. The licensee responded and paid the civil penalty on November 9, 1995.

J&L Testing Company, Inc., Canonsburg, Pennsylvania  
EA 95-183

An Order Suspending License was issued September 27, 1995 based on willful violations of NRC requirements by J&L Testing and J&L Engineering, the previous licensee who possessed the licensed material (and whose license was revoked for non-payment of annual fees), for providing inaccurate information to the NRC. Specifically, the presidents of both companies stated that the company had not used the licensed material, when in fact the licensee used and possessed licensed material without a valid NRC license. In addition, the licensee (1) failed to perform required leak tests of the licensed material, (2) failed to have an approved Radiation Safety Officer, and (3) failed to perform periodic inventories of the licensed material.

Logan General Hospital, Logan, West Virginia  
Supplements V, VI, and VII, EA 94-008

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$8,000 was issued July 27, 1995 to emphasize the importance of effective management and oversight of radiation safety programs, of providing complete and accurate information to the NRC, of prompt identification of violations, and of taking comprehensive corrective action. The action was based on (1) the pervasive falsification of documentation and patient dose records, (2) the routine, unauthorized administration of radiopharmaceuticals to patients in excess of that prescribed by the authorized user, and (3) ten examples of failure of the licensee, through its former Radiation Safety Officer, to ensure that the radiation safety program was conducted in accordance with NRC requirements. The licensee responded and paid the civil penalty on August 1, 1995.

Quality Inspection Services, Inc., Buffalo, New York  
Supplements VI and VII, EA 95-046

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$13,000 was issued June 28, 1995 to emphasize that activities requiring NRC authorizations must be conducted safely and in accordance with requirements. The action was based on (1) the willful failure of QIS, an Agreement State Licensee, to file for reciprocity while working in a non-Agreement State, (2) the submittal of inaccurate information to an inspector, and (3) a failure by two radiographers to wear the required alarm ratemeters during the performance of radiography. The

licensee responded on July 14, 1995 admitting the violations, but requesting that it be allowed to pay in four equal installments. The agreement was signed July 24, 1995 and the last payment was received October 25, 1995.

Soil Testing, Inc., Fort Wayne, Indiana  
Supplement VI, EA 95-092

A Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$250.00 was issued June 15, 1995 to emphasize the need for strict control of NRC-licensed materials. The action was based on the licensee's failure to maintain surveillance of, or secure from unauthorized removal, soil moisture/density gauges in an unrestricted area. The licensee responded and paid the civil penalty on July 13, 1995.

Western Industrial X-Ray Inspection Company, Inc., Evanston, Wyoming  
EAs 93-238 and 94-131

An Order Suspending License (Effective Immediately) and Demand for Information was issued June 16, 1994. The action was based on the results of inspections and OI investigations which revealed a pattern of willful and repetitive noncompliance. The violations included the failure to perform an evaluation of a radiographer assistant's radiation exposure following an incident, the failure to perform a radiation survey of a radiography device following each radiographic exposure, the failure to supervise assistant radiographers performing radiographic operations, the failure to provide the NRC a report of an individual's radiation exposure following the individual's termination of employment, and the failure to ensure that alarm ratemeters worn by radiography personnel were calibrated at the required frequencies. An Order to Transfer Material (Effective Immediately) and Order Revoking License was issued September 27, 1995. A hearing request was filed by the licensee on July 1 and October 14, 1995. A settlement was entered November 16, 1995 stipulating that the licensee shall be allowed to resume its conduct of NRC-licensed activities with modifications of the license.

NOTICE OF VIOLATIONS, NO CIVIL PENALTY

Amersham Corporation, Burlington, Massachusetts  
Supplement IV, EA 95-058

A Notice of Violation was issued July 5, 1995 based on violations involving the failure to make adequate surveys that could assess the radiological conditions leading to, and the worker doses resulting from, exposures to hot particles; and the failure to control the occupational dose to the skin or to any extremity of individual adult workers to an annual limit of 50 rems shallow-dose equivalent. In accordance with the Enforcement Policy, a civil penalty was not proposed because the licensee had not been subject to escalated actions within the last two inspections and the licensee took prompt and comprehensive corrective actions.

Bethlehem Steel Corporation, Bethlehem, Pennsylvania  
Supplements IV and VI, EA 95-134

A Notice of Violation was issued August 17, 1995 based on violations involving failure to implement controls at each entrance or access point of a high radiation area as required by 10 CFR 20.1601, failure to post a high radiation area, and the failure to provide training to personnel in the licensee's emergency and operating procedures. In accordance with the Enforcement Policy, a civil penalty was not proposed because the licensee had not been subject to escalated enforcement for the last two inspections, comprehensive corrective actions were taken, and the licensee identified the violations.

CTI and Associates, Inc., Brighton, Michigan  
Supplement IV, EA 95-150

A Notice of Violation was issued September 28, 1995 based on a violation concerning the failure to control licensed material which resulted in physical damage to a Troxler soil moisture/density gauge. In accordance with the Enforcement Policy, a civil penalty was not proposed because the licensee had not been subject to escalated enforcement for the last two inspections, comprehensive corrective actions were taken, and the licensee identified the violation.

Department of Veterans Affairs Medical Center, Long Beach, California  
Supplement IV, EA 95-149

A Notice of Violation was issued August 21, 1995 based on a violation involving the unauthorized disposal of licensed material by release to the normal trash. In accordance with the Enforcement Policy, a civil penalty was not proposed because the licensee had not been subject to escalated enforcement for the last two inspections and the licensee took corrective actions including extensive efforts to recover the source including additional controls for receipt of radioactive materials.

GCME, Inc., DePere, Wisconsin  
Supplement VI, EA 95-154

A Notice of Violation was issued November 16, 1995 based on violations involving the failure of the RSO to ensure that personnel monitoring devices were distributed and used by the licensee's authorized nuclear gauge users from October 1990 to July 1993. In accordance with the Enforcement Policy, a civil penalty was not issued because the licensee identified the violation and took comprehensive corrective actions.

HNU Systems, Inc., Newton Highlands, Massachusetts  
Supplements IV and VI, EA 95-116

A Notice of Violation was issued July 27, 1995 based on a breakdown in control of licensed activities involving the failures to (1) have an RSO at the facility for approximately two years, (2) maintain records, (3) provide training to workers, (4) perform required inventories, (5) perform required leak tests, (6) conduct required surveys, (7) perform annual audits, (8) assess radiation doses to workers, (9) file quarterly

reports of transfers under 10 CFR 32.51, and (10) calibrate instruments. In accordance with the Enforcement Policy, a civil penalty was not proposed because the licensee had not been subject to prior escalated enforcement and the licensee took prompt comprehensive corrective actions.

Mid American Inspection Services, Inc., Gaylord, Michigan  
Supplement VI, EA 94-256

A Notice of Violation was issued August 7, 1995 based on an investigation that was initiated after the licensee reported the violation. The investigation found that for the period from October 1992 to April 1993, two radiographers assigned to the Kalkaska project deliberately failed to supervise radiographer's assistants while the assistants conducted radiographic operations. A civil penalty was not proposed to encourage prompt identification and reporting of any deliberate violations and because the licensee also took strong corrective action.

Nekoosa Papers, Inc., Nekoosa, Wisconsin  
Supplements IV and VI, EA 95-221

A Notice of Violation was issued December 29, 1995 based on violations involving unauthorized licensee contractor employees removing from service and relocating a gauge containing NRC-licensed material, and for a period of three and one-half months, on at least a weekly basis, individuals entered a vessel where the shutter mechanism was not locked in the closed position and the individuals were subject to the direct radiation beam. A civil penalty was not proposed because the licensee had not been the subject of escalated actions within the last two inspections and credit was warranted for corrective actions which included (1) revising the vessel entry procedure with more specific steps to lock the gauge, (2) providing additional training to the individuals charged with locking gauges, (3) posting signs on the nuclear gauges that they should not be moved without contacting the RSO, and (4) training supervisors, employees and contractors on the subject of radiation safety.

North Star Steel Ohio, Youngstown, Ohio  
Supplements IV and VI, EA 95-208

A Notice of Violation was issued December 8, 1995 based on a breakdown in the control of licensed activities involving a number of violations related to an incident in which molten steel damaged a gauge containing cesium-137. In accordance with the Enforcement Policy, a civil penalty was not proposed because the licensee had not had a previous civil penalty and took comprehensive corrective actions.

Professional Inspection and Testing Services, Inc., Chambersburg, Pennsylvania  
Supplement IV, EA 95-127

A Notice of Violation was issued July 6, 1995 based on a violation involving failure to maintain constant surveillance over a portable moisture density gauge containing NRC licensed material. The gauge was damaged by a construction vehicle. In accordance with the Enforcement Policy, a civil penalty was not proposed because the licensee identified and promptly informed the NRC of the violation, took prompt and comprehensive corrective action, and had no violations identified during prior NRC inspections.

**A. CIVIL PENALTIES AND ORDERS**



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

August 30, 1995

EA No. 94-089

Ms. Sandy Young  
Operations Manager  
Advacare Management Service, Inc.  
Bala Point, Suite 109  
111 Presidential Boulevard  
Bala Cynwyd, Pennsylvania 19004

**SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL  
PENALTY - \$2,500  
(NRC Inspection 030-30947/94-001 and NRC Office of Investigations  
Report 1-94-026)**

Dear Ms. Young:

This letter refers to the NRC inspection conducted on April 26-28, 1994, at Scranton, Bala Cynwyd, and Yardley, Pennsylvania, of activities authorized by NRC License No. 37-28331-01. The inspection report was sent to you on May 31, 1994. During the inspection, numerous violations of NRC requirements were identified, one of which was repetitive to a violation identified during a previous NRC inspection at your facility in March 1991. On June 8, 1994, an open enforcement conference was conducted in the Region I office with you and other members of the management and staff of Advacare Management Service, Inc., as well as your General Counsel and consulting Radiation Physicist, to discuss the apparent violations, their causes, and your corrective actions. A copy of the enforcement conference report was forwarded to you on June 17, 1994.

This letter also refers to the subsequent investigation by the NRC Office of Investigations (OI). During the OI investigation, the NRC found that your June 7, 1994 letter to the NRC, which stated that a specific Nuclear Medicine Technician (NMT) always wore monitor devices, and the attached written statement from the NMT in which the NMT claimed that she wore a spare ring badge at all times, and in particular, during July 1993 when she returned to her job as an NMT, was inaccurate. When interviewed initially by the inspector, the NMT said that she did not wear the badge at all times. In addition, a review of the dosimetry records indicated that the NMT was not wearing a ring badge in July 1993. Further, the NMT, in an interview with OI on October 28, 1994, stated that after careful consideration, she recalled that she never wore a ring badge from approximately July 1993 to early August 1993. Based on that evidence, the NRC concludes that the NMT's written statement constitutes inaccurate information, which is a violation of NRC requirements. A copy of the synopsis of the OI report is enclosed.

The violations identified during the inspection are described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice). Given the nature and number of the violations, the NRC is concerned that there existed a significant lack of attention to, and control of, licensed activities at your facilities. For example, required training was not provided to staff; radiation exposure evaluations were not performed; required surveys were not done; instrument calibrations and tests were not completed; required inventories of radioactive materials were not performed; certain required records were not maintained; and audits of licensed activities were not performed. The NRC also is concerned that one of the violations, involving the failure to perform required inventories of radioactive material, was identified during the prior routine inspection in 1991. However, adequate corrective actions were not taken to correct the violation and prevent recurrence. In addition, your Radiation Safety Officer (RSO) failed to identify the violations, even though some of them were longstanding and/or repetitive. Furthermore, some of the violations were identified by an audit report in January 1994 but were not corrected promptly and still existed at the time of the NRC inspection.

The NRC license issued to Advacare Management Services, Inc. entrusts responsibility for radiation safety to the RSO and licensee management; therefore, the NRC expects effective oversight of its licensed programs. Incumbent upon each NRC licensee is the responsibility of management in general, and the RSO in particular, to protect the public health and safety by ensuring that all requirements of the NRC license are met and any potential violations of NRC requirements are identified and corrected expeditiously. Given the lack of management attention towards licensed responsibilities, these violations are classified in the aggregate as a Severity Level III problem in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 FR 34381; June 30, 1995). The violations are set forth in Section I of the enclosed Notice.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 is considered for a Severity Level III problem. Because your facility has not been the subject of a previous escalated enforcement action, the NRC considered whether credit was warranted for Corrective Action in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. Your corrective actions, which were described at the enforcement conference, included: (1) an increase in the scope of services of your consultant physicist to include a monthly audit of your Scranton, Bala Cynwyd, and Lancaster facilities and bi-monthly audits of all other facilities; (2) plans to have your RSO work closely with your Nuclear Group Manager and your facilities NMT to provide professional and management oversight to ensure all violations reported in the audits are corrected and documented promptly; (3) plans to have your consulting health physicist and RSO continue to provide bi-annual in-service refresher programs on safety and training to each NMT at each facility; and (4) plans to have your Nuclear Group Manager responsible for compliance coordination and management oversight for each facility. These actions, although acceptable, were not considered prompt and comprehensive because many of the corrective actions for the individual violations had not been completed at the time of the enforcement conference, nor had you reviewed the applicability of the violations to other of your facilities that were not inspected during this inspection.

Moreover, violations identified by audit reports were not corrected promptly. While some of these violations normally would be considered minor violations under the Enforcement Policy, the fact that they were not corrected promptly increases the regulatory concern. Therefore, credit was not provided for your corrective actions.

To emphasize: (1) the importance of aggressive management oversight of the radiation safety program, so as to ensure that licensed activities are conducted safely and in accordance with requirements, and violations, when they exist, are identified and corrected promptly, and (2) the need for ensuring that your corrective actions are long-lasting, I have been authorized, after consultation with the Director, Office of Enforcement, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the base amount of \$2,500 for the Severity Level III problem.

In addition to the above, another violation also is being cited for the inaccurate/misleading information provided to the NRC by the NMT. This violation is described in Section II of the enclosed Notice. The submittal of any inaccurate information to the NRC, whether done orally, or in writing, is a significant regulatory concern that can result in civil and/or criminal action against the licensee, as well as responsible individuals. Therefore, you should emphasize to your staff the importance of providing complete and accurate information to the NRC. You also should inform them that the failure to do so could result in action against them. NRC is communicating with the NMT concerning this matter and is forwarding a copy of this letter and the enclosed Notice to her. A copy of that communication will be sent to you under separate cover.

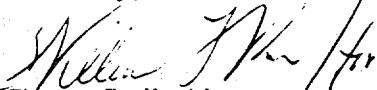
You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions you have taken and any additional actions you plan to take to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure(s), and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

Advacare Management Service, Inc. 4

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket No. 030-30947

License No. 37-28331-01

Enclosures:

1. Notice of Violation and Proposed Imposition of Civil Penalty
2. OI Synopsis

cc w/encls:

Commonwealth of Pennsylvania

State of New Jersey

Ms. Antonia Kist

ENCLOSURE 1

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Advacare Management Services, Inc.  
Bala Cynwyd, Pennsylvania 19004

Docket No. 030-30947  
License No. 37-28331-01  
EA No. 94-089

During an NRC inspection conducted between April 26 and 28, 1994, as well as a subsequent investigation by the NRC Office of Investigations, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG 1600 (60 FR 34381; June 30, 1995), the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

I. Violations Assessed a Civil Penalty

A. 10 CFR 19.12 requires, in part, that all individuals working in or frequenting any portion of a restricted area be instructed in the applicable provisions of Commission regulations and licenses.

Contrary to the above, as of April 28, 1994, nuclear medicine technologists working in restricted areas at the Scranton, Bala Cynwyd, and Yardley offices, were not instructed in the applicable provisions of Commission regulations and the Advacare license. (01013)

B. 10 CFR 35.21(a) requires that the licensee, through the Radiation Safety Officer, ensure that radiation safety activities are being performed in accordance with approved procedures and regulatory requirements in the daily operation of the licensee's byproduct material program. At the time of the inspection, the licensee's approved procedures for the safe use of radioactive material were those described in Section 10.h of the license application dated December 27, 1988 and were approved by License Condition No. 14; and the licensee's approved procedures for calibrating the dose calibrator were those described in Section 10.d of the application dated December 27, 1988, and were approved by License Condition No. 14.

1. Item 8 of Section 10.h of the safe use procedures required that a finger exposure monitor be worn during the preparation, assay, and injection of radiopharmaceuticals, and when holding patients during procedures.

Contrary to the above, the licensee through its Radiation Safety Officer failed to ensure that radiation safety activities were being performed in accordance with the above procedures. Specifically: (1) for approximately 3 weeks in July 1993, a nuclear medicine technologist employed at the Bala Cynwyd office did not wear a finger exposure monitor during the preparation, assay, and injection of radiopharmaceuticals; and (2) according to the technologist, from August 1, 1993 to April 27, 1994, she occasionally forgot to wear a finger exposure monitor during the preparation, assay, and injection of radiopharmaceuticals. (01023)

2. Section 10.d of the application dated December 27, 1988, states that the dose calibrator will be calibrated in accordance with ANSI Standard N422.1986 entitled "Calibration and Usage of Dose Calibrator Ionization Chambers for the Assay of Radionuclides". Item 4.5.1 of the ANSI Standard states that calibration checks of the dose calibrator using a long-lived reference source shall be performed and logged on each work shift during which the instrument is used and that a determination be made that the assay reading is within 10% of the anticipated assay.

Contrary to the above, from January 1, 1994 to April 28, 1994, the licensee through its Radiation Safety Officer, failed to ensure that radiation safety activities were being performed in accordance with the above procedures. Specifically, calibration checks of the dose calibrator at the Bala Cynwyd office using a long lived reference source were performed and logged on each work shift the instrument was used, but a determination was not made that the assay reading was within 10% of the anticipated reading. (01033)

- C. 10 CFR 20.1501(a) requires that each licensee make or cause to be made surveys that may be necessary for the licensee to comply with the regulations in Part 20 and that are reasonable under the circumstances to evaluate the extent of radiation levels, concentrations or quantities of radioactive materials, and the potential radiological hazards that could be present. Pursuant to 10 CFR 20.1003, survey means an evaluation of the radiological conditions and potential hazards incident to the production, use, transfer, release, disposal, or presence of radioactive material or other sources of radiation.

Contrary to the above, as of April 1994, the licensee did not make surveys to assure compliance with that part of 10 CFR 20.1201 which limits the occupational radiation exposure to workers. Specifically, exposure records were not reviewed nor was a personnel monitor issued by the licensee to a contractor nuclear medicine technologist employed at the Bala Cynwyd facility from November 1, 1993 to April 28, 1994, to assure that the occupational radiation exposure to the nuclear medicine technologist was below the limits specified in 10 CFR 20.1201. In addition, no evaluation was performed to estimate the dose which may have been received, in order to assign an occupational radiation exposure to the technologist. (01043)

D. 10 CFR 35.51(c) requires, in part, that a licensee check each survey instrument for proper operation with the dedicated check source each day of use.

Contrary to the above, each survey instrument was not checked for proper operation with a dedicated check source on certain days when the instrument was used. Specifically, from July 1, 1993 to April 27, 1994, survey instruments at the Bala Cynwyd office were not checked for proper operation with a dedicated check source each day of use. In addition, survey instruments at the Scranton office were not checked for proper operation with a dedicated check source from November 29, 1993 to January 30, 1994. (01053)

E. 10 CFR 35.70(a) requires that a licensee survey with a radiation detection survey instrument at the end of each day of use all areas where radiopharmaceuticals are routinely prepared for use or administration.

Contrary to the above, from July 1, 1993 to April 27, 1994, the licensee did not survey with a radiation detection survey instrument at the end of the day areas where radiopharmaceuticals were routinely prepared for use. Specifically, surveys were conducted at the beginning of each day of use, rather than at the end of each day's use, at the Bala Cynwyd facility. (01063)

F. 10 CFR 35.50(b)(3) requires, in part, that a licensee test each dose calibrator for linearity upon installation and at least quarterly thereafter.

Contrary to the above, linearity tests of the dose calibrator were not conducted during the third and fourth quarter of 1993 at the Bala Cynwyd office. Specifically, although data were gathered to perform linearity tests in August 1993 and November 1993 at the Bala Cynwyd office, the data were either not analyzed to determine linearity or were analyzed several months later, after the calendar quarter was completed. (01073)

G. 10 CFR 35.59(g) requires, in part, that a licensee in possession of a sealed source or brachytherapy source conduct a quarterly physical inventory of all such sources in its possession.

Contrary to the above, the licensee did not conduct a quarterly physical inventory of all sealed sources in the possession of the licensee. Specifically, a cesium-137 dose calibrator source was not inventoried at the Bala Cynwyd office between December 1993, and April 27, 1994, a period in excess of one calendar quarter. (01083)

This is a repeat violation.

H. 10 CFR 20.2106(a) requires, in part, that each licensee maintain records of doses received by all individuals for whom personnel monitoring was required pursuant to 10 CFR 20.1502 until the Commission terminates each pertinent license requiring the record.

Contrary to the above, as of April 27, 1994, the licensee did not maintain records of doses received by Scranton facility personnel for whom monitoring was required pursuant to 10 CFR 20.1502. Specifically, film badge records for the period January 5 through March 5, 1994, for the Scranton facility, were not maintained. (01093)

I. 10 CFR 30.51(a) requires, in part, that each licensee retain records of receipt of byproduct material for as long as the material is possessed and that records of transfer of byproduct material be maintained for three years after each transfer.

Contrary to the above, as of April 28, 1994, records of receipt of byproduct material were not maintained for as long as the material was possessed. Specifically, a record of receipt of a cesium-137 dose calibrator source in November 1993, was not maintained at the Scranton office, and a record of receipt of a cesium-137 dose calibrator source sometime prior to July 1993 to the Bala Cynwyd office was not maintained. (01103)

J. 10 CFR 35.70(h) requires, in part, that records of (weekly contamination) surveys contain the removable contamination in each area expressed in disintegrations per minute per 100 square centimeters.

Contrary to the above, as of April 28, 1994, records of weekly contamination surveys at the Scranton office expressed the removable contamination in each area in terms of counts per minute instead of disintegrations per minute per 100 square centimeters. (01113)

K. 10 CFR 35.59(d) & (g) respectively require that records of leak tests and inventories of sealed sources include the signature of the radiation safety officer.

Contrary to the above, records of leak tests and inventories of sealed sources performed in 1992 and 1993 at the Bala Cynwyd facility, did not include the signature of the radiation safety officer. (01123)

L. 10 CFR 35.20(a) requires that each licensee develop and implement a written radiation protection program that includes the provisions for keeping doses ALARA. The licensee's approved ALARA program is described in Section 10.b of the license application dated December 27, 1988, and approved by License Condition 14. Item 1.b. of the licensee's ALARA program states that a formal annual review of the radiation safety program will be performed, including reviews of operating procedures and past dose records, inspections, and consultations with the radiation safety staff or outside consultants.

Contrary to the above, the formal annual review of the radiation safety program performed for 1992 and 1993 did not include a review of operating procedures. (01133)

M. 10 CFR 35.25(a)(3) requires that a licensee that permits the receipt, possession, use, or transfer of byproduct material by an individual under the supervision of an authorized user periodically review the supervised individual's preparation of byproduct material for medical use and the records kept to reflect that work.

Contrary to the above, as of April 1994, the licensee permitted the receipt, possession, use, or transfer of radioactive material by an individual under the supervision of an authorized user and did not periodically review the supervised individual's preparation of byproduct material for medical use and the records kept to reflect that work. Specifically, the licensee did not periodically review the use of radioactive material by a physician at the Bala Cynwyd office who was not listed as an authorized user on the license and who performed cardiac studies using technetium-99m in April 1994 under the supervision of an authorized user. (01143)

N. 10 CFR 19.11 requires, in part, that each licensee post current copies of the regulations in 10 CFR Part 20, the license, license conditions, or documents incorporated into a license by reference, license amendments and operating procedures applicable to licensed activities or the licensee may post a notice that describes the document and states where it may be examined, in a sufficient number of places to permit individuals engaged in licensed activities to observe them.

Contrary to the above, as of April 28, 1994, current copies of the regulations in 10 CFR Part 20, the license, license conditions, or documents incorporated into a license by reference, and amendments thereto, and the operating procedures applicable to licensed activities or a notice that describes the document and states where it may be examined, were not posted at the Bala Cynwyd, Scranton, and Yardley, facilities to permit individuals engaged in licensed activities to review them. (01153)

These violations collectively represent a Severity Level III problem (Supplements IV and VI).

Civil Penalty - \$2,500

II. Violation Not Assessed a Civil Penalty

10 CFR 30.9(a) requires, in part, that information provided to the Commission by a licensee, or information required by the Commission's regulations to be maintained by the licensee, shall be complete and accurate in all material respects.

Contrary to the above, in an attachment to a letter, dated June 7, 1994 from the licensee's General Counsel, a Nuclear Medicine Technician (NMT) submitted a statement which stated, "When I began work in July 1993. . . I wore current batch body and ring badges labeled 'spare.' There was no time period that I worked with radioactive materials without personnel monitoring devices." This statement was inaccurate in that (1) a review of dosimetry records determined that the NMT was not wearing a ring badge during July 1993; (2) the NMT, in an interview with the NRC Office of Investigations on October 28, 1994, stated that after careful consideration, she recalled that she never wore a ring badge from approximately July 1993 to early August 1993, and the NMT worked with radioactive material during this period. The statement attached to the June 7, 1994 letter to the NRC was material because it had the capability to influence the NRC as to whether a violation of the personnel monitoring requirements occurred.

This is a Severity Level IV Violation (Supplement VII).

Pursuant to the provisions of 10 CFR 2.201, Advacare Management Services, Inc. (Licensee) is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved.

If an adequate reply is not received within the time specified in this Notice, an Order or a Demand for Information may be issued as why the license should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or the cumulative amount of the civil penalties if more than one civil penalty is proposed, or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violations listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of the Enforcement Policy should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The response noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region I, 475 Allendale Road, King of Prussia, PA 19406.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, Pennsylvania  
this 30th day of August 1995

SYNOPSIS

This investigation was initiated by the Office of Investigations (OI) on June 14, 1994, to determine whether personnel at Advacare Management Services Inc. (Advacare), deliberately submitted false and/or misleading statements to the NRC before and during an Enforcement Conference (EC). Specifically, the investigation was initiated to determine whether a letter, with appended suspected false declarations, was submitted with the intention of deceiving the NRC.

A cover letter, dated June 7, 1994, with appended letters and statements, was submitted to the NRC by Advacare prior to the EC. The letter challenged portions of the NRC inspection report. One section of the cover letter, signed by the Advacare General Counsel, refers to another letter, dated June 2, 1994, from the Radiation Safety Officer (RSO). The June 2, 1994, letter states that the RSO overread studies (scan interpretations) of another physician, when, in fact, the RSO overread only one study. Although the June 2, 1994, letter was submitted both prior to and during the EC, the RSO corrected the contents of the letter at the EC. The evidence developed during the OI investigation did not substantiate that the RSO deliberately submitted the false and/or misleading letter in an attempt to deceive the NRC.

In addition, the June 7th cover letter also refers to a signed statement from a nuclear medical technician (NMT). The NMT claimed that she wore a spare ring badge, at all times, and in particular during July 1993 when she returned to her job as an NMT. When interviewed originally by the NRC inspector, the NMT said that she did not wear her dosimetry badge at all times. Later, she submitted a signed statement claiming she wore both body and ring dosimetry badges. A review of dosimetry records determined that the NMT was not wearing a ring badge during July 1993. The OI investigation found sufficient evidence to conclude the NMT knowingly made false and/or misleading statements regarding that issue.



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001

November 28, 1995

EA 94-089

Ms. Sandy Young, Operations Manager  
Advacare Management Services, Inc.  
Bala Point, Suite 109  
111 Presidential Boulevard  
Bala Cynwyd, Pennsylvania 19004

SUBJECT: ORDER IMPOSING CIVIL MONETARY PENALTY - \$2,500

Dear Ms. Young:

This refers to your letters, dated September 21, 1995, in response to the Notice of Violation and Proposed Imposition of Civil Penalty (Notice) sent to you by our letter dated August 30, 1995. Our letter and Notice describe numerous violations identified during an NRC inspection and investigation of your licensed program. To emphasize the importance of aggressive management oversight of the radiation safety program, so as to ensure that licensed activities are conducted safely and in accordance with requirements, and violations, when they exist, are identified and corrected promptly, and the need for ensuring that your corrective actions are long-lasting, a civil penalty of \$2,500 was proposed.

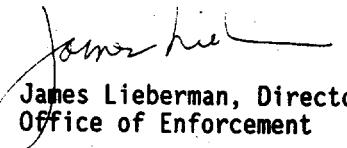
In your responses, although you admit the violations as stated in the Notice, you request mitigation of the civil penalty for the reasons summarized in the enclosed Appendix. After consideration of your responses, we have concluded for the reasons given in the Appendix attached to the enclosed Order Imposing Civil Monetary Penalty that mitigation of the civil penalty is not warranted in this case. Accordingly, we hereby serve the enclosed Order on Advacare Management Services, Inc., imposing a civil monetary penalty in the amount of \$2,500. As provided in Section IV of the enclosed Order, payment should be made within 30 days of the date of this Order, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555. We will review the effectiveness of your corrective actions during a subsequent inspection.

Advacare Management  
Services, Inc.

- 2 -

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice", a copy of this letter and the enclosures will be placed in the NRC's Public Document Room.

Sincerely,

  
James Lieberman, Director  
Office of Enforcement

Docket No. 030-30947  
License No. 37-28331-01

Enclosure: As Stated

cc w/encl:  
James G. Datz, Regional Administrator, Image America

UNITED STATES  
NUCLEAR REGULATORY COMMISSION

In the Matter of

ADVACARE MANAGEMENT SERVICES, INC.  
Bala Cynwyd, Pennsylvania

)  
Docket No. 030-30947  
License No. 37-28331-01  
EA 94-089

ORDER IMPOSING CIVIL MONETARY PENALTY

I

Advacare Management Services, Inc. (Licensee) is the holder of Materials License No. 37-28331-01 issued by the Nuclear Regulatory Commission (NRC or Commission), issued April 4, 1989, renewed most recently on May 9, 1994. The license authorizes the Licensee to possess and use byproduct material for diagnostic nuclear medicine studies in accordance with the conditions specified therein.

II

An inspection of the Licensee's activities was conducted on April 26-28, 1994. Subsequently, an investigation was conducted by the NRC Office of Investigations. The results of the inspection and investigation indicated that the Licensee had not conducted its activities in full compliance with NRC requirements. A written Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was served upon the Licensee by letter dated August 30, 1995. The Notice states the nature of the violations, the provisions of the NRC's requirements that the Licensee had violated, and the amount of the civil penalty proposed for the violations.

The Licensee responded to the Notice in two letters, dated September 21, 1995. In its responses, the Licensee admits the violations as stated in the Notice, but requests mitigation of the civil penalty.

III

After consideration of the Licensee's response and the statements of fact, explanation, and argument for mitigation contained therein, the NRC staff has determined, as set forth in the Appendix to this Order, that the violations occurred as stated and that the penalty proposed for the violations designated in the Notice should be imposed.

IV

In view of the foregoing and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205, IT IS HEREBY ORDERED THAT:

The Licensee pay a civil penalty in the amount of \$2,500 within 30 days of the date of this Order, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555.

The Licensee may request a hearing within 30 days of the date of this Order. A request for a hearing should be clearly marked as a "Request for an Enforcement Hearing" and shall be addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission Washington, D.C. 20555, with a copy to the Commission's Document Control Desk, Washington, D.C. 20555. Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address and to the Regional Administrator, NRC Region I, 475 Allendale Road, King of Prussia, Pennsylvania 19406.

If a hearing is requested, the Commission will issue an Order designating the time and place of the hearing. If the Licensee fails to request a hearing within 30 days of the date of this Order, the provisions of this Order shall be effective without further proceedings. If payment has not been made by that time, the matter may be referred to the Attorney General for collection.

In the event the Licensee requests a hearing as provided above, the issues to be considered at such hearing shall be:

- 4 -

Whether on the basis of the violations admitted by the Licensee, this Order should be sustained.

FOR THE NUCLEAR REGULATORY COMMISSION

*James Lieberman*  
James Lieberman, Director

Office of Enforcement

Dated at Rockville, Maryland  
this 28th day of November 1995

APPENDIX  
EVALUATIONS AND CONCLUSION

On August 30, 1995 a Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was issued for violations identified during an NRC inspection and subsequent investigation by the NRC Office of Investigations. Advacare Management Services, Inc. (Licensee) responded to the Notice on September 21, 1995. The Licensee admitted the Violations, but requested mitigation of the civil penalty. The NRC's evaluation and conclusion regarding the licensee's requests are as follows:

**1. Summary of Licensee's Request for Mitigation**

In its responses, the Licensee contends that mitigating circumstances were not fully considered by the NRC. In support of its contention, the Licensee noted the following:

- a. A prior inspection at the Bala Cynwyd facility identified few items of non-compliance and thus provided a level of managerial assurance that the radiation protection/compliance program was acceptable.
- b. The term "promptly", as used on page 3 of Mr. Martin's letter dated August 30, 1995, is clearly a subjective word. The Licensee stated that its audit reports were received in January 1994 and the NRC inspection was on April 26-28, 1994. The Licensee stated that it was in the process of correcting the multiple minor areas of non-compliance identified in the audits and although some of the corrections were not completed by April 1, 1994, the majority were corrected by the enforcement conference and by subsequent spot check inspections by Region I inspectors between the June 1994 enforcement conference and the time of the Licensee's responses. The Licensee contends that its response was, in fact, reasonably prompt.

Therefore, the licensee requests that the combination of these factors should result in a modification of the proposed civil penalty from \$2,500 to \$1,250.

The Licensee further noted that it recognized and self-identified material weaknesses in its radiation safety program and contracted a consultant medical radiation physicist to assist the RSO in correcting those weaknesses and that the correction process was in place at the time of the inspection.

**2. NRC Evaluation of Licensee's Request for Mitigation**

The fact that an inspection was conducted at the Bala Cynwyd facility, one of several Licensee facilities, and in which only a few items of noncompliance were noted, three years prior to the inspection conducted on April 26-28, 1994, does not alleviate the need for aggressive managerial oversight of the radiation safety program. In order to

assure continued acceptable performance in the area of radiation safety, the Licensee is required to not only perform periodic audits of its radiation safety program in accordance with its commitments under the ALARA program, but in accordance with 10 CFR 35.23, through its Radiation Safety Officer (RSO) identify radiation safety problems, as well as initiate corrective actions and verify the implementation of those corrective actions.

Although the Licensee had corrected some of the individual violations identified by the NRC, it had not corrected the majority of them by the Enforcement Conference. The day prior to that Conference, the Licensee submitted a lengthy letter addressing the violations and the status of corrective actions. The information in this letter was not completely accurate and at the Conference several corrections were requested. These corrections were later submitted by the Licensee. In addition, the NRC staff had questioned the RSO's ability to meet his responsibilities for the numerous facilities and Licensee management had indicated that it intended to request a separate license for a New Jersey facility in order to relieve the RSO of some responsibilities, but it had not yet done so. In addition, the Licensee did not consider the need to apply similar corrective actions at the other facilities covered by the license.

Although the Licensee had recognized that it had weaknesses in its program and had engaged a consultant to assist the RSO, and these actions led to eventual good comprehensive corrective action, they were not sufficiently prompt and comprehensive as of the time of the Enforcement Conference to provide a basis for mitigating the civil penalty.

3. NRC Conclusion

The NRC has concluded that the violations occurred as stated and an adequate basis for mitigation of the civil penalty was not provided by the licensee. Consequently, the proposed civil penalty in the amount of \$2,500 should be imposed.



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064

June 15, 1995

EA 94-117

Atlas Corporation  
ATTN: Richard E. Blubaugh, Vice President  
Environmental and Governmental Affairs  
Republic Plaza  
370 Seventeenth Street, Suite 3150  
Denver, Colorado 80202

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY -  
\$5,000 (NRC INSPECTION REPORT NOS. 040-3453/93-02 AND 95-01 AND  
NRC INVESTIGATION REPORT NO. 4-93-047R)

This is in reference to NRC Inspection Report Nos. 040-3453/93-02 and 95-01 and NRC Investigation Case No. 4-93-047R. The referenced inspection reports were issued on April 20, 1995, and identified two apparent violations that were being considered for escalated enforcement action. The referenced investigation, which was conducted by the NRC's Office of Investigations (OI), concluded that deliberate misconduct on the part of Atlas' radiation control coordinator and a former subcontractor had resulted in one of the apparent violations. These matters were discussed with you and other Atlas Corporation (Atlas) representatives at an enforcement conference in the NRC's Arlington, Texas office on May 16, 1995. A list of conference participants is enclosed.

The NRC has reviewed the information developed during its inspection and investigation, as well as the information obtained from the enforcement conference, and has concluded that the violations described in the inspection reports did occur. These violations involved: 1) a failure to assure that scrap material and components released from Atlas' Moab Mill met NRC release limits for radioactive contamination; and 2) a subsequent failure to conduct one of a series of required audits of Atlas' enhanced contamination survey program for materials being released from the mill.

The first violation, which is the one of most concern to the NRC, was discovered after a former Atlas subcontractor publicly alleged in October 1993 that material had been released from the mill that exceeded the NRC's contamination limits. The former subcontractor alleged that he had knowingly removed contaminated material from the mill site by taking advantage of a poorly implemented survey program.

The former subcontractor's allegations were confirmed by the NRC and various state radiation control agencies which conducted surveys of material that had been shipped from the Moab Mill to other locations, e.g., ball mills that had been shipped to Spokane, Washington. Furthermore, when the NRC conducted an inspection at the mill site beginning on November 30, 1993, approximately one month after the subcontractor's allegations were made public, NRC inspectors surveyed scrap steel and other material that had been released from the mill for unrestricted use and found a number of items that exceeded the

contamination limits. This finding indicates that Atlas' actions in response to the allegations were not effective in promptly identifying the extent of the problem.

The NRC gave careful consideration to whether Atlas' radiation control coordinator's actions constituted deliberate violations of NRC requirements. As indicated in the letter transmitting the inspection reports, the NRC's OI investigation found that the radiation control coordinator had deliberately failed to conduct complete and accurate surveys and to obtain wipe test results before releasing material from the site. During the enforcement conference, the radiation control coordinator stated that he had never knowingly permitted material that was contaminated in excess of the limits to be released. He also defended his survey practices and the manner in which he conducted wipe tests. Specifically, he stated that wipe surveys for removable contamination were required only if instrument surveys indicated that there was a potential for removable contamination to be present and that he had conducted reasonable surveys which complied with Atlas' procedures as he understood them. This appears to be consistent with Atlas' survey procedures, which stated that "Each peice [sic] is monitored for total Alpha and Beta gamma and wipe tests are done on the higher peices [sic] where the total alpha and beta gamma showed the highest." The NRC has concluded that the radiation control coordinator's actions were not indicative of an intent to violate NRC requirements. Therefore, no enforcement action against the radiation control coordinator is being considered.

In retrospect, the contamination surveys performed by Atlas' radiation control coordinator were insufficient to assure that the contamination limits were met in all cases. Another important factor in this case was Atlas' failure to exercise adequate control over potentially contaminated material and its subcontractor's activities, creating the opportunity for the subcontractor to remove material from the mill that had not been adequately cleaned and surveyed. It is apparent that the subcontractor, exploited weaknesses in Atlas' control of this material and survey program in order to get more salvageable material off-site.

The NRC acknowledges the corrective actions that Atlas has taken since the first violation was discovered, including the hiring of a consultant to assist in developing comprehensive revisions to its survey program. The NRC's inspections in early 1994 and 1995 confirmed that the revised survey program was being effectively implemented and identified no additional instances of contaminated material being inappropriately released from the mill site.

Notwithstanding these corrective actions, Atlas' failure to adequately control potentially contaminated material, as well as its failure to adequately control the activities of its subcontractor, are matters of significant regulatory concern because they resulted in sending contaminated material to buyers who in most cases had no reason to believe that the material they purchased was radioactively contaminated. The fact that this material posed virtually no health or safety hazard is not determinative of the significance of this violation because it was not an isolated failure. This violation reflected programmatic weaknesses in Atlas' system for assuring that the

contamination limits for release of material were met and that contaminated material was properly controlled. Therefore, this violation has been classified at Severity Level III in accordance with Supplement IV of the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C.

To emphasize the importance of controlling contaminated material and the activities of your contractors, I have been authorized after consultation with the Director, Office of Enforcement, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the amount of \$5,000 for the Severity Level III violation. The base value of a civil penalty for a Severity III violation is \$5,000. The civil penalty adjustment factors in Section VI.B.2 of the Enforcement Policy were considered as follows: 1) the penalty was escalated 50% under the *Identification* factor because the violation was identified after third-party allegations were made and because material that exceeded the release limits was identified by NRC inspectors outside the restricted area; 2) your subsequent prompt and extensive corrective action, including the enhancements you made in your survey program, resulted in a 50% decrease under the *Corrective Action* factor; and 3) your generally good performance as a licensee of the NRC was considered but did not result in any mitigation under the *Licensee Performance* factor because the activity involved in this violation, the dismantling of the mill, was substantially different from the past activity of maintaining an idle mill. The other adjustment factors were considered, but no further adjustments to the base civil penalty were considered appropriate. Thus, on balance, no adjustment to the base civil penalty has been deemed appropriate.

The second violation involved the failure to perform a quarterly audit required under the revised Quality Assurance procedure. This violation is not being cited because the criteria in paragraph VII.B.2 of Appendix C to 10 CFR Part 2 of the NRC's "Rules of Practice," were satisfied. This violation was identified by your consultant and resulted in prompt and effective corrective actions to correct the problem.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

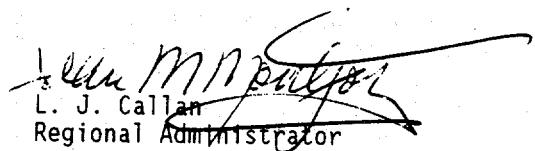
In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Atlas Corporation

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The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,

  
L. J. Callan  
Regional Administrator

Docket No. 040-3453  
License No. SUA-917

Enclosures:

- 1) Notice of Violation and Proposed Imposition of Civil Penalty
- 2) List of Enforcement Conference Participants

cc w/Enclosures: State of Utah  
Dale Edwards, Atlas Corporation

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Atlas Corporation  
Denver, Colorado

Docket No. 040-3453  
License No. SUA-917  
EA 94-117

During NRC inspections conducted on November 30 to December 2, 1993, and February 9, 1995, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violation and associated civil penalty are set forth below:

Condition 18 of License No. SUA-917 requires that released equipment or packages from the restricted area be in accordance with the document entitled "Guidelines for Decontamination of Facilities and Equipment Prior to Release for Unrestricted Use or Termination of License for Byproduct or Source Materials," dated September, 1984. The Guidelines specify the radionuclides and radiation exposure rate limits to be used in decontamination and survey of equipment prior to release for unrestricted use. For natural uranium the specified limits are for alpha contamination not to exceed 15,000 disintegrations per minute per 100 square centimeters (dpm/100 cm<sup>2</sup>) maximum and 5,000 dpm/100 cm<sup>2</sup> average, with removable contamination not to exceed 1,000 dpm/100 cm<sup>2</sup>.

Contrary to the above, equipment and materials were released from the licensee's restricted area during 1993 which exceeded the limits specified in the Guidelines. For example, during an NRC inspection conducted November 30 to December 2, 1993, scrap materials released for unrestricted use and contained within a staging area outside of the restricted area were found with an average alpha contamination level in excess of 20,000 dpm/100 cm<sup>2</sup>. Also during 1993, two ball mills with contamination in excess of 15,000 dpm/100 cm<sup>2</sup> were released for unrestricted use and shipped to a scrap dealer in Spokane, Washington.

This is a Severity Level III Violation (Supplement VI).  
Civil Penalty - \$5,000

Pursuant to the provisions of 10 CFR 2.201, Atlas Corporation is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved.

If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license

should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or the cumulative amount of the civil penalties if more than one civil penalty is proposed, or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violation listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of 10 CFR Part 2, Appendix C, should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The responses noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011.

Dated at Arlington, Texas  
this 15th day of June 1995

Enclosure 2

Enforcement Conference participants

May 16, 1995  
NRC Region IV office, Arlington, Texas

Atlas Corporation representatives

Richard Blubaugh, Vice President, Environmental & Governmental Affairs  
Dale Edwards, Radiation Control Coordinator  
Anthony J. Thompson, Counsel to Atlas; Shaw, Pittman, Potts & Trowbridge

U.S. Nuclear Regulatory Commission, Region IV representatives

Sam Collins, Director, Division of Radiation Safety & Safeguards  
Chuck Cain, Chief, Fuel Cycle and Decommissioning Branch  
Linda McLean, Senior Health Physicist, Fuel Cycle and Decommissioning Branch  
J. Vincent Everett, Health Physicist, Fuel Cycle and Decommissioning Branch  
William Brown, Regional Counsel  
Gary Sanborn, Enforcement Officer

U.S. Nuclear Regulatory Commission, Headquarters representatives

Susan Chidakel, Senior Attorney, Office of the General Counsel  
Geoffrey Cant, Enforcement Specialist, Office of Enforcement



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

August 9, 1995

EA No. 95-086

Mr. John S. Lindell  
Director of Operations  
Cabot Corporation  
County Line Road  
Boyertown, Pennsylvania 19512

Subject: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL  
PENALTY - \$5,000 (NRC Inspection No. 040-06940/95-001)

Dear Mr. Lindell:

This letter refers to the NRC inspection conducted on February 1-7, 1995, at your facility located in Boyertown, Pennsylvania of activities authorized by NRC License No. SMB-920. During the inspection, apparent violations of NRC requirements were identified, and were described in the NRC letter sent to you on May 17, 1995. On May 25, 1995, an enforcement conference was conducted with you and other members of your staff to discuss the violations, their causes, and your corrective actions. At the conference, the NRC also discussed the status of commitments you made to the NRC, as stated in Confirmatory Action Letter (CAL) No. 1-95-002 sent to you on February 9, 1995, to correct the violations and preclude recurrence. A copy of the enforcement conference report was sent to you on June 14, 1995.

The violations are described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice). The three most significant violations involved: (1) failure to make suitable and timely surveys to assure compliance with occupational dose equivalent limits, such as surveys of the concentrations of radioactive materials in the air in the work place; quantities of radionuclides in the body; quantities of radionuclides excreted from the body; or a combination thereof; (2) failure to make suitable and timely surveys to assess the dose to members of the public from radioactive materials in effluents released to unrestricted areas; and (3) failure to establish appropriate procedural and engineering controls to ensure occupational doses and doses to members of the public were as low as is reasonably achievable (ALARA).

The weaknesses in your engineering and procedural controls, such as holes in ventilation systems, are of concern as they may have caused significant leakage of thorium materials, leaks in the process piping and equipment, and dust concentrations in work areas. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety by ensuring that all requirements of the NRC license are met and any potential violations of NRC requirements are identified and corrected expeditiously. In this case, adequate attention has not been provided to assuring that your program is conducted in accordance with requirements. For example, in 1993, a consultant of yours indicated to you that 10 CFR Part 20 requirements were going to change and that you may not be in compliance with the new requirements. In addition, the NRC, Fuel Cycle and Licensing Branch conducted site visits as well as numerous conversations with you

with regard to compliance with the revised 10 CFR Part 20. Given these opportunities and the violations identified during the February 1995 inspection, the failure to take prompt and comprehensive corrective actions is not an acceptable performance by the Cabot Corporation.

Since the above requirements exist to ensure that individuals, both workers and members of the public, are not exposed unnecessarily to radioactive material, your failures to adhere to these requirements constitute a significant regulatory concern. Therefore, in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) (60 FR 34381, June 30, 1995), the violations have been classified in the aggregate at Severity Level III. The violations are described in Section I of the enclosed Notice.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$5,000 is considered for a Severity Level III problem. Because your facility has not been the subject of past escalated enforcement action, the NRC considered whether credit was warranted for *Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. No credit was warranted because your corrective actions were neither prompt nor comprehensive. Specifically, although you committed to complete a number of corrective actions, as described in the CAL, several commitments had not been completed as of the date of the enforcement conference<sup>1</sup>. For example, bioassays were not performed to determine whether or not workers had received significant exposure or exceeded the regulatory limits, even though you committed to do so by March 31, 1995. Furthermore, while you committed to commence appropriate and representative sampling of worker's breathing zones, as well as effluent air and water sampling by April 3, 1995, you failed to implement these corrective measures in a timely fashion.

Therefore, to emphasize the importance of conducting activities in accordance with NRC requirements, and promptly correcting violations when they exist, to ensure that activities are conducted safely, and exposures to workers and members of the public are monitored and are within NRC limits, I have been authorized to issue the enclosed Notice in the amount of \$5,000 for the Severity Level III problem set forth in Section I of the enclosed Notice.

An additional violation identified during the inspection involved the failure of the ALARA Review Committee to meet at least annually, and to include in its membership the radiological consultant. This violation is described in Section II of the enclosed Notice. Although this violation has been classified at Severity Level IV and has not been assessed a civil penalty, the NRC emphasizes that any similar violations in the future could result in escalated enforcement action.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you

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<sup>1</sup> At the enforcement conference, you agreed to provide a schedule for completion of the commitments specified in the CAL. That schedule was provided to the NRC in a letter dated June 2, 1995.

Cabot Corporation

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plan to prevent recurrence. In this regard, please address how you plan to maintain enhanced oversight to ensure compliance with NRC requirements. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information, so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket No. 040-06940  
License No. SMB-920

Enclosure: Notice of Violation and Proposed Imposition  
of Civil Penalty

cc w/encl:  
Commonwealth of Pennsylvania

ENCLOSURE

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Cabot Corporation  
Boyertown, Pennsylvania

Docket No. 040-06940  
License No. SMB-920  
EA 95-086

During an NRC inspection conducted on February 1-7, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381, June 30, 1995), the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

I. Violations Assessed a Civil Penalty

A. 10 CFR 20.1501 requires that each licensee make or cause to be made surveys that may be necessary for the licensee to comply with the regulations in Part 20 and that are reasonable under the circumstances to evaluate the extent of radiation levels, concentrations or quantities of radioactive material, and the potential radiological hazards that could be present. Pursuant to 10 CFR 20.1003, survey means an evaluation of the radiological conditions and potential hazards incident to the production, use, transfer, release, disposal, or presence of radioactive material or other sources of radiation.

10 CFR 20.1204(a) requires that for the purposes of assessing dose used to determine compliance with occupational dose equivalent limits, the licensee shall, when required under 10 CFR 20.1502, take suitable and timely measurements of (1) concentrations of radioactive materials in air in work areas; or (2) quantities of radionuclides in the body; or (3) quantities of radionuclides excreted from the body; or (4) combinations of the these measurements.

10 CFR 20.1502(b)(1) requires, in part, that each licensee shall monitor the occupational intake of radioactive material by, and assess the committed effective dose equivalent to, adults likely to receive, in 1 year, an intake in excess of 10 percent of the applicable Annual Limit on Intake (ALI) in Table 1, Columns 1 and 2 of Appendix B to 10 CFR 20.1001-20.2401.

Contrary to the above, as of February 7, 1995, the licensee did not make or cause to be made surveys that may be necessary for the licensee to comply with the regulations in Part 20 and that are reasonable under the circumstances to evaluate the extent of radiation levels, concentrations or quantities of radioactive materials, and the potential radiological hazards that could be

present. These surveys were necessary to comply with 10 CFR 20.1204(a), for purposes of assessing dose used to determine compliance with occupational dose equivalent limits. The licensee, as required by 20.1502, did not take suitable and timely measurements of (1) concentrations of radioactive materials in air in work areas; or (2) quantities of radionuclides in the body; or (3) quantities of radionuclides excreted from the body; or (4) combinations of these measurements. The licensee was required to monitor the occupational intake of radioactive material by and assess the committed effective dose equivalent to adults because they were likely to receive, in one year, an intake in excess of 10 percent of the applicable Annual Limit on Intake (ALI) in Table 1, Columns 1 and 2 of Appendix B to 20.1001-20.2401, as evidenced by the following examples.

1. As of February 7, 1995, several workers routinely performed various tasks in areas where ores containing thorium and uranium are stored routinely (such as opening and emptying barrels and/or bags of dust or powder; changing and/or recovering dust from dust collector filters; and broom sweeping the facility and equipment in Building 73), and the licensee did not make or cause to be made adequate surveys during these operations to evaluate the extent of concentration of radioactive materials that could be present. These individuals who worked with thorium and uranium in the form of powder or dust likely were to receive in one year, an intake in excess of 10 percent of the ALI, because the licensee's air samples and NRC's confirmatory air samples of the general work area, exceeded 10 percent of the derived air concentration (DAC) for thorium. However, the licensee did not monitor the occupational intake of radioactive material and assess the committed effective dose equivalent potentially received by workers in the thorium airborne areas. In addition, the licensee did not take suitable and timely measurements of (1) concentrations of radioactive materials in air in work areas; or (2) quantities of radionuclides in the body; or (3) quantities of radionuclides excreted from the body; or (4) combination of these measurements.
2. As of February 7, 1995, approximately 15 individuals routinely worked with ores containing thorium and uranium and the surveys that were performed during these processing operations were inadequate to evaluate the extent of concentration of radioactive materials that could be present. The individuals who routinely worked with thorium likely were to receive, in one year, an intake in excess of 10 percent of the ALI, because the licensee's air samples and NRC's confirmatory air samples of the general work area exceeded 10 percent of the derived air concentration (DAC) for thorium. However, the licensee did not monitor the occupational intake of radioactive materials and assess the committed effective dose equivalent. In addition, the licensee did not take suitable

and timely measurements of (1) concentrations of radioactive materials in air in work areas; or (2) quantities of radionuclides in the body; or (3) quantities of radionuclides excreted from the body; or (4) combination of these measurements. Specifically,

- a. air samples taken to assess thorium and uranium in air were not representative of the workers' breathing zone in that air samples were only taken of the general work area and not of worker specific tasks; and
- b. no measurements were made to quantify radionuclides in the body, or excreted from the body, or combinations thereof.

B. 10 CFR 20.1302(a) requires, in part, that each licensee make or cause to be made, as appropriate, surveys of radioactive materials in effluents released to unrestricted areas to demonstrate compliance with the dose limits for individual members of the public in 10 CFR 20.1301.

10 CFR 20.1302 (b)(2)(i) requires, in part, that annual average concentrations of radioactive material released in gaseous and liquid effluents at the boundary of the unrestricted area do not exceed the values specified in Table 2, appendix B of 10 CFR 20.1001-20.1401.

Contrary to the above, as of February 7, 1995, the licensee did not make or cause to be made, as appropriate, surveys of radioactive materials in effluents released to unrestricted areas to demonstrate compliance with the dose limits for individual members of the public in 10 CFR 20.1301. Specifically, air effluent releases from Building 73 were not monitored. In addition, the surveys (analyses) that were made of the water effluent samples were not sensitive enough to demonstrate compliance with the effluent release limits in 10 CFR Part 20, Appendix B, nor to demonstrate compliance with the dose limits for individual members of the public in 10 CFR 20.1301 in that the lower limit of detection of the instrumentation used to measure water effluent samples exceeded the limits as stated in 10 CFR Part 20, Appendix B.

C. 10 CFR 20.1101(b) requires that the licensee use, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA).

Contrary to the above, as of February 7, 1995, the licensee did not use, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA). Specifically, the

procedural and engineering controls were inadequate in that the licensee's containment and ventilation systems had holes and leaks that allowed licensed radioactive material to be released into workers' breathing zones and to the environment.

D. License Condition No. 10 of License No. SMB-920 requires that licensed material be possessed and used in accordance with statements, representations and procedures contained in an application dated September 15, 1977, and letters dated, June 18, 1982, January 20 and May 29, 1984, July 26, 1985, January 23 and June 24, 1986, and March 4 and May 13, 1987.

The letter dated June 24, 1986 requires, in part, that the licensee monitor air continuously with a low volume environmental air sampler.

Contrary to the above, as of February 7, 1995, the licensee did not monitor air continuously with a low volume environmental air sampler. Specifically, the licensee's environmental air sampler was inoperable during the months of November and December of 1994 and January of 1995.

These violations represent a Severity Level III problem (Supplement IV). Civil Penalty - \$5,000.

II. Violation Not Assessed a Civil Penalty

Condition 11 of License No. SMB-920 requires, in part, that the licensee's ALARA review committee meet at least annually and that membership include the radiological consultant.

Contrary to the above, the licensee's ALARA Review Committee did not meet in 1991 or in 1994. In addition, the membership of the ALARA Review Committee did not include the radiological consultant.

This is Severity Level IV violation (Supplement VI).

Pursuant to the provisions of 10 CFR 2.201, Cabot Corporation (Licensee) is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved.

If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time

for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or the cumulative amount of the civil penalties if more than one civil penalty is proposed, or may protest imposition of the civil penalty, in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violations listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty, in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of the Enforcement Policy should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234(c) of the Act, 42 U.S.C. 2282c.

The response noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region I, 475 Allendale Road, King of Prussia, Pennsylvania 19406.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, Pennsylvania  
this 9th day of August 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

June 6, 1995

EA 95-021

Mr. Michael Halstead  
Interim Chief Executive Officer  
Carlisle Hospital  
224 Parker Street  
Carlisle, Pennsylvania 17013

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL  
PENALTY - \$5,000  
(NRC Inspection Report 030-03018/94-001 and NRC Office of  
Investigations (OI) Report 1-94-005R)

Dear Mr. Halstead:

This letter refers to the NRC inspection conducted on February 2 and 3, 1994, as well as the subsequent investigation by the NRC Office of Investigations (OI). The inspection report was sent to you on February 28, 1994. A copy of the synopsis of the OI investigation was sent to you on March 23, 1995. On April 25, 1995, an enforcement conference was conducted with you and members of your staff, including the three individuals that were the subject of the OI findings, to discuss several violations, their causes, and your corrective actions. Based on the inspection and OI investigation, as well as the enforcement conference, the NRC finds that you continued to use two doctors, who were not named as authorized users on your NRC license, to perform teletherapy activities between December 1992 and April 1993 without those doctors being supervised by the authorized users listed on your license. This violation continued even though you were issued a Notice of Violation on December 23, 1992 for this same issue. In addition, the Vice President, General Services, provided inaccurate information to the NRC when questioned about this activity during a telephone conversation in February 1993.

The circumstances related to these two violations are as follows: On December 2, 1992, the NRC identified a violation at your facility involving two doctors working as authorized users under the teletherapy license without being listed on the license as authorized users, as required. Although the license would allow the doctors to perform these activities under the supervision of either of the two individuals who were listed on the license as authorized users, no such supervision was provided. As a result, Region I issued a Notice of Violation to the hospital on December 23, 1992. After being apprised of the violation during the December 1992 inspection, your Vice President, General Services, committed to ensure that if the two doctors continued to perform teletherapy, they would do so under the supervision of the authorized users until such time as they were listed as authorized users on your NRC license.

Further, the Vice President, General Services, stated, in a telephone conversation with Region I staff on February 5, 1993, that the authorized users listed on the license had been, and would remain involved in the program until such time as the license renewal was issued approving the two doctors as authorized users. However, during a subsequent NRC inspection conducted in February 1994, the NRC learned that the two doctors continued to perform teletherapy after the December 1992 inspection without being under the supervision of one of the two authorized users (one of whom was the Radiation Safety Officer (RSO), and the other of whom was the Radioisotope Committee (RIC) Chairman). Although the two authorized users were informed, following the December 1992 inspection, that the two doctors could perform teletherapy only if the authorized users provided supervision, they did not provide such supervision, even though they knew the unauthorized doctors continued to perform teletherapy.

Since the RIC Chairman and RSO were aware, as admitted by them at the enforcement conference, that the doctors were performing teletherapy activities without being listed as authorized users on the license; and neither the RIC Chairman nor the RSO took adequate action to: (1) supervise the activities or (2) prevent the doctors from performing the activities until they were named on the NRC license as authorized users, this constitutes a deliberate violation of NRC requirements. In addition, the Vice President, General Services, at a minimum, should have known that the two doctors continued to perform the activities without supervision after the December 1992 inspection, and he failed to ensure that supervision was provided even though he committed to correct this violation when it initially was identified during the December 1992 inspection. Given the willful nature of the violation, and the fact that three senior individuals had an opportunity to prevent the violation, the violation is classified at Severity Level III in accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, (Enforcement Policy). Notwithstanding the fact that the physicians were qualified and were eventually named on your NRC license, this violation is considered to be of significant regulatory concern, because the NRC's regulatory process depends on licensees and their employees acting with integrity in the conduct of licensed activities.

In addition to this enforcement action, Notices of Violation are being issued to the RIC Chairman and the RSO, and a letter is being sent to the Vice President, General Services. You will receive copies of these communications under separate cover.

The NRC recognizes that at the time of the enforcement conference, timely and comprehensive actions had been taken to correct the violation and prevent recurrence, including (1) replacement of the RSO with another individual who has taken an RSO training course; (2) changing your policy such that only individuals listed on the license may perform licensed activities; and (3) adding the Vice President, General Services, to the Radiation Safety Committee.

However, notwithstanding your corrective actions, a significant NRC action is warranted, given the senior levels of hospital personnel involved in this case, so as to emphasize the importance of licensed activities being performed in accordance with NRC requirements. Accordingly, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Materials Safety, Safeguards, and Operational Support, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the amount of \$5,000 for the Severity Level III violation set forth in Section I of the Notice.

The base civil penalty amount for a Severity Level III violation is \$2,500. Application of the escalation and mitigation factors in Section VI.B.2 of the Enforcement Policy was considered, and on balance, 100% escalation of the penalty is warranted. A basis exists for 50% escalation since the violation was identified by the NRC. A basis exists for 50% mitigation based on your prompt and comprehensive corrective actions. No adjustment is warranted based on your past performance prior to the February 1994 inspection, given the willful and repetitive nature of the violation. Further, a basis exists for 100% escalation based on the prior opportunity you had to prevent the violation from recurring, given the issuance of the Notice of Violation on December 23, 1992, as well as the telephone inquiry by the NRC in February 1993. The other escalation/mitigation factors were considered, and no further adjustment was warranted.

In addition to the violation for which a civil penalty is being issued, another violation also was identified. Specifically, when questioned by NRC staff during the telephone conversation in February 1993 regarding this matter, the Vice President, General Services provided inaccurate information to the NRC in that he stated that the authorized users remained involved in the teletherapy program, when, in fact, they had not. Although the Vice President, General Services, denied, at the enforcement conference, that he was aware at that time that supervision was not being provided, he clearly should have been aware given his commitment in December 1992 to ensure that the violation was corrected. This violation is described in Section II of the enclosed Notice. Had accurate information been provided, the NRC staff could have focused its review on the physicians' qualifications and issued a separate license amendment on an expedited basis to ensure that regulatory compliance was maintained while patient teletherapy services continued.

You are required to respond to this letter and the enclosed Notice and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

Carlisle Hospital

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy or proprietary information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket No. 030-00472  
License No. 37-02385-01

Enclosure: Notice of Violation and Proposed  
Imposition of Civil Penalty

ENCLOSURE

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Carlisle Hospital  
Carlisle, Pennsylvania

Docket No. 030-00472  
License No. 37-02385-01  
EA 95-021

As a result of an NRC inspection at the facility on February 2 and 3, 1994, as well as a subsequent investigation by the NRC Office of Investigations, the report synopsis of which was sent to the licensee on March 23, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

I. Violation Assessed a Civil Penalty

10 CFR 35.21(a) requires that the licensee, through the Radiation Safety Officer, ensure that radiation safety activities are being performed in accordance with regulatory requirements.

License Condition 11 of Amendment No. 19 of NRC License No. 37-02385-01, which expired on February 29, 1992, but which remained in effect (until Amendment No. 20 was issued on April 7, 1993) pursuant to a timely renewal application made on October 7, 1991, states that licensed material shall be used by, or under the supervision of, Charles K. Loh, M.D., or Robert F. Hall, M.D.

10 CFR 35.13(b), in effect at the time the violation occurred, provided that a licensee shall apply for and must receive a license amendment before it permits anyone, except a visiting authorized user described in 10 CFR 35.27, to work as an authorized user under the license.

10 CFR 35.11(b) provides that an individual may use byproduct material in accordance with the regulations in this chapter under the supervision of an authorized user as provided in 10 CFR 35.25, unless prohibited by license condition.

10 CFR 35.25(a)(3) requires, in part, that a licensee that permits the use of byproduct material by an individual under the supervision of an authorized user, shall periodically review the supervised individuals' use of byproduct material and the records to reflect this use.

Contrary to the above, from December 3, 1992 to April 7, 1993, the licensee, through its Radiation Safety Officer, failed to ensure that radiation safety activities were being performed in accordance with the above requirements. Specifically, during this period, byproduct material was used by two individuals (other than Dr. Loh or Dr. Hall) to perform teletherapy; and the two individuals were not listed as authorized users on the license and did not qualify as visiting authorized users pursuant to 10 CFR 35.27, and the individuals' use of byproduct material was not under the supervision of Dr. Loh or Dr. Hall (in that neither Dr. Loh nor Dr. Hall reviewed the individuals' use of the byproduct material, and the related records reflecting such use).

This is a Severity Level III Violation (Supplements VI and VII).  
Civil Penalty - \$5,000

**II. Violation Not Assessed a Civil Penalty**

10 CFR 30.9(a) requires, in part, that information provided to the Commission by a licensee, shall be complete and accurate in all material respects.

Contrary to the above, during a telephone conversation on February 5, 1993, in response to NRC questions regarding supervision of two physicians who used the licensee's cobalt-60 teletherapy unit for patient treatments, inaccurate information was provided to the NRC by the licensee's Vice President, General Services. Specifically, the Vice President, General Services, stated that the two authorized users listed on the license had remained involved in the teletherapy program and would remain involved until such time as a license renewal was issued approving additional authorized users at the facility. This statement was inaccurate because the two authorized users listed on the license had not remained involved in the program by providing supervision of the unauthorized individuals who were performing teletherapy. This statement was material because it concealed a continuing violation of an NRC license condition.

This is a Severity level IV Violation (Supplement VII)

Pursuant to the provisions of 10 CFR 2.201, Carlisle Hospital (Licensee) is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved. If an adequate reply is not received within the time specified in this Notice, an Order or a Demand For Information may be issued as to why the license should not be modified, suspended, or revoked or why such other action as may be proper

Enclosure

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should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violation listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section V.B of 10 CFR Part 2, Appendix C (1992), should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234(c) of the Act, 42 U.S.C. 2282(c).

The response noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region I, 475 Allendale Road, King of Prussia, Pennsylvania 19406.

Dated at King of Prussia, Pennsylvania  
this 6th day of June 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20585-0001

August 7, 1995

EA 95-021

Mr. Michael Halstead  
President and Chief Executive Officer  
Carlisle Hospital  
246 Parker Street  
Post Office Box 310  
Carlisle, Pennsylvania 17013-0310

SUBJECT: ORDER IMPOSING CIVIL MONETARY PENALTY - \$5000

Dear Mr. Halstead:

This refers to your letter, dated July 5, 1995, in response to the Notice of Violation and Proposed Imposition of Civil Penalty (Notice) sent to you by our letter dated June 6, 1995. Our letter and Notice described two violations of NRC requirements, including a violation that was classified at Severity Level III. A civil penalty in the amount of \$5000 was proposed for the Severity Level III violation that involved the failure of your Radiation Safety Officer to ensure that radiation safety activities were being performed in accordance with NRC requirements. Specifically, byproduct material was used by two individuals (physicians) who were not listed as authorized users on your license and did not qualify as visiting authorized users, and the individuals' use of byproduct material was not supervised by the authorized users listed on your license. The penalty was issued to emphasize the importance of performing licensed activities in accordance with NRC requirements.

In your response, you admit the violation assessed a penalty (Violation I) and request abatement or mitigation of the penalty for the reasons summarized in the enclosed Appendix. You also admitted the violation that was not assessed a civil penalty (Violation II).

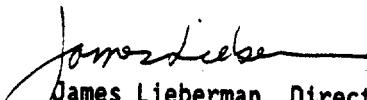
After consideration of your responses, we have concluded for the reasons given in the Appendix attached to the enclosed Order Imposing a Civil Monetary Penalty, that an adequate basis was not provided for abatement or mitigation of the civil penalty. Accordingly, we hereby serve the enclosed Order on Carlisle Hospital imposing a civil monetary penalty in the amount of \$5000. As provided in Section IV of the enclosed Order, payment should be made within 30 days of the date of this Order, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852-2738. We will review the effectiveness of your corrective actions during a subsequent inspection.

Carlisle Hospital

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice", a copy of this letter and its enclosures will be placed in the NRC's Public Document Room.

Sincerely,

  
James Lieberman, Director  
Office of Enforcement

Docket No. 030-00472  
License No. 37-02385-01

Enclosures:  
As Stated

cc w/encls:  
Commonwealth of Pennsylvania

UNITED STATES  
NUCLEAR REGULATORY COMMISSION

In the Matter of )  
Carlisle Hospital ) Docket No. 030-00472  
Carlisle, Pennsylvania ) License No. 37-02385-01  
 ) EA No. 95-021

ORDER IMPOSING A CIVIL MONETARY PENALTY

I

Carlisle Hospital (Licensee) is the holder of Byproduct Materials License No. 37-02385-01 (License) issued by the Nuclear Regulatory Commission (NRC or Commission) on March 12, 1985. The License was most recently renewed by the Commission on April 7, 1993. The License authorizes the Licensee to possess and use certain byproduct materials in accordance with the conditions specified therein at the Licensee's facility in Carlisle, Pennsylvania.

II

An inspection of the Licensee's activities was conducted on February 2 and 3, 1994, at the Licensee's facility located in Carlisle, Pennsylvania. In addition, an investigation was conducted subsequently by the NRC Office of Investigations. The results of this inspection and investigation indicated that the Licensee had not conducted its activities in full compliance with NRC requirements. A written Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was served upon the Licensee by letter dated June 6, 1995. The Notice states the nature of the violations, the provisions of the NRC's requirements that the Licensee had violated, and the amount of the civil penalty proposed for one of the violations.

The Licensee responded to the Notice in a letter dated July 5, 1995. In its response, the Licensee admits the violation assessed a civil penalty (Violation I), and requests abatement or mitigation of the penalty.

III

After consideration of the Licensee's response and the statements of fact, explanation, and argument contained therein, the NRC staff has determined, as set forth in the Appendix to this Order, that an adequate basis was not provided for abatement or mitigation of the penalty and that a penalty of \$5000 should be imposed.

IV

In view of the foregoing and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205, IT IS HEREBY ORDERED THAT:

The Licensee pay a civil penalty in the amount of \$5000 within 30 days of the date of this Order, by check, draft, money order, or electronic transfer, payable to the Treasurer of the United States and mailed to James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852-2738.

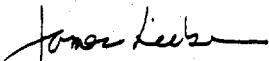
The Licensee may request a hearing within 30 days of the date of this Order.

A request for a hearing should be clearly marked as a "Request for an Enforcement Hearing" and shall be addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, with a copy to the Commission's Document Control Desk, Washington, D.C. 20555. Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address and to the Regional Administrator, NRC Region I, 475 Allendale Road, King of Prussia, PA 19406.

If a hearing is requested, the Commission will issue an Order designating the time and place of the hearing. If the Licensee fails to request a hearing within 30 days of the date of this Order, the provisions of this Order shall be effective without further proceedings. If payment has not been made by that time, the matter may be referred to the Attorney General for collection.

In the event the Licensee requests a hearing as provided above, the issues to be considered at such hearing shall be whether, on the basis of the violation admitted by the Licensee as set forth in Section I of the Notice referenced in Section II above, this Order should be sustained.

FOR THE NUCLEAR REGULATORY COMMISSION

  
James Lieberman, Director  
Office of Enforcement

Dated at Rockville, Maryland  
this 7<sup>th</sup> day of August 1995

APPENDIX  
EVALUATIONS AND CONCLUSION

On June 6, 1995, a Notice of Violation and Proposed Imposition of Civil Penalty (Notice) was issued for violations identified during an NRC inspection conducted at the Licensee's facility located in Carlisle, Pennsylvania. The penalty was issued for one violation. The Licensee responded to the Notice in a letter, dated July 5, 1995. In its responses, the Licensee admits the violation assessed a penalty (Violation I), and requests abatement or mitigation of the civil penalty. The NRC's evaluation and conclusion regarding the Licensee's requests are as follows:

Restatement of Violation Assessed a Civil Penalty

10 CFR 35.21(a) requires that the licensee, through the Radiation Safety Officer, ensure that radiation safety activities are being performed in accordance with regulatory requirements.

License Condition 11 of Amendment No. 19 of NRC License No. 37-02385-01, which expired on February 29, 1992, but which remained in effect (until Amendment No. 20 was issued on April 7, 1993) pursuant to a timely renewal application made on October 7, 1991, states that licensed material shall be used by, or under the supervision of, Charles K. Loh, M.D., or Robert F. Hall, M.D.

10 CFR 35.13(b), in effect at the time the violation occurred, provided that a licensee shall apply for and must receive a license amendment before it permits anyone, except a visiting authorized user described in 10 CFR 35.27, to work as an authorized user under the license.

10 CFR 35.11(b) provides that an individual may use byproduct material in accordance with the regulations in this chapter under the supervision of an authorized user as provided in 10 CFR 35.25, unless prohibited by license condition.

10 CFR 35.25(a)(3) requires, in part, that a licensee that permits the use of byproduct material by an individual under the supervision of an authorized user, shall periodically review the supervised individual's use of byproduct material and the records to reflect this use.

Contrary to the above, from December 3, 1992 to April 7, 1993, the licensee, through its Radiation Safety Officer, failed to ensure that radiation safety activities were being performed in accordance with the above requirements. Specifically, during this period, byproduct material was used by two individuals (other than Dr. Loh or Dr. Hall) to perform teletherapy; and the two individuals were not listed as authorized users on the license and did not qualify as visiting authorized users pursuant to 10 CFR 35.27, and the individuals' use of byproduct material was not under the supervision of Dr. Loh or Dr. Hall (in that neither Dr. Loh nor Dr. Hall reviewed the individuals' use of the byproduct material, and the related records reflecting such use).

This is a Severity Level III violation (Supplements VI and VII).

Summary of Licensee's Request for Mitigation

The Licensee maintains that it is committed to full regulatory compliance as illustrated by its past record. The Licensee stated that it has only been issued one other Notice of Violation and admitted that it involved a similar matter of concern as addressed by the present Notice. The Licensee stated that it was of the belief that this matter had been addressed adequately by having the authorized users supervise the unauthorized users. The Licensee further stated that its otherwise stellar record of compliance evidences its commitment to compliance with regulatory requirements of the NRC.

The Licensee also stated that, although the previously issued Notice involved unauthorized use similar to that described in the present Notice, it should not be the basis for escalation of the proposed penalty because the Licensee believed that the issue of unauthorized use had been adequately addressed. The Licensee contends that the underlying cause of the present violation stems primarily from poor channels of communication and that these causes were not apparent and not an issue, at the time of the previous Notice. The Licensee stated that it did not previously have the opportunity to address these communication issues.

The Licensee further stated that upon being apprised of the violations, it took effective and comprehensive actions to correct the violations and brought the Licensee into immediate compliance. The Licensee further stated that the violation upon which the civil penalty is based did not cause injury to patients, employees, or staff nor did it create a substantial risk. The Licensee also stated that the unauthorized physicians were well qualified, albeit unauthorized, and subsequently were listed on the license by the NRC, upon approval of the Licensee's amendment.

In addition, the Licensee contends that the violation would not have occurred if the license amendment was timely processed. The Licensee stated that it filed a license amendment with the NRC on October 7, 1991. The Licensee further stated that the two unauthorized physicians were to be added as authorized users. The Licensee notes that while it did not request that the amendment be expedited, the need to make such a request was not foreseen, because it believed that proper supervision was being provided.

For these reasons, the Licensee requests that the proposed civil penalty be wholly abated or, in the alternative, mitigated so as to preclude the 100% escalation of the proposed civil penalty.

NRC Evaluation of Licensee's Request for Mitigation

The NRC letter, dated June 6, 1995, transmitting the proposed civil penalty, notes that the base civil penalty amount of \$2500 in this case was increased by 50% because the violation was identified by the NRC; increased by 100% because the Licensee had prior opportunity to prevent the violation from recurring given the issuance of the Notice of Violation on December 23, 1992, as well as the telephone inquiry by NRC in February 1993; and decreased 50% based on the Licensee's prompt and comprehensive corrective actions. As a result, a penalty of \$5000 was proposed.

The Licensee's enforcement history includes one violation identified during an NRC inspection conducted in 1991, and one violation identified during an NRC inspection conducted in 1992 that involved the failure to apply for an amendment before permitting physicians to work as authorized users. The latter violation was identified again during the most recent inspection conducted in February 1994.

The Licensee was given prior notice regarding this violation based on the Notice of Violation dated December 23, 1992. It is the Licensee's responsibility to assure that the violation does not recur. The underlying cause of the violation identified during the 1994 inspection may in fact be different from the cause of the similar violation in 1992; however, under the NRC Enforcement Policy, the Licensee is expected to implement lasting corrective action that will not only prevent recurrence of the violation at issue but will be appropriately comprehensive to prevent the occurrence of similar violations in the future. The Licensee committed to providing supervision of the unauthorized users, and it is the Licensee's responsibility to assure that the supervision was provided. The supervision did not occur, even though a Licensee Vice President informed the NRC during a February 1993 telephone conversation that it was occurring.

The Licensee requests that credit be given for its prompt and comprehensive corrective action for the violations identified during the 1994 inspection. The NRC notes that the base civil penalty amount was mitigated 50% based on the Licensee's prompt and comprehensive corrective actions, as provided by the NRC Enforcement Policy. Therefore, no further adjustment of the base civil penalty is warranted based on this factor.

While the Licensee also contends that the violation did not cause injury, the NRC notes that classification of a violation at Severity Level III is based on its safety and regulatory significance, and is not premised on an injury to an individual. If a violation were to contribute directly to an injury to an individual, a higher Severity Level could be assigned and a higher civil penalty could be issued.

The NRC recognizes that the Licensee filed a request for renewal of its NRC license on October 7, 1991, and the processing of that renewal by the NRC was not completed until April 7, 1993. However, during the exit interview following the 1992 inspection, the Licensee informed the NRC inspector that the unauthorized users would be supervised by physicians named on the NRC license. Then, during a February 1993 telephone call to the Licensee's Vice President, General Services, the Licensee again informed the NRC that such supervision was being provided. Had the Licensee provided accurate information to the NRC as required by 10 CFR 30.9, the NRC staff could have focused its review on the qualifications of the unauthorized physicians and issued a separate license amendment on an expedited basis to ensure that regulatory compliance was maintained while patient teletherapy services continued. Under these circumstances, the NRC staff believes that the timeliness of the processing of the license renewal should not be a mitigating factor in assessing the civil penalty amount.

Appendix

- 4 -

Accordingly, based on the Enforcement Policy in effect at the time, a \$5,000 civil penalty was appropriate.

The NRC notes that its Enforcement Policy was revised on June 30, 1995 (60 FR 34381). In applying the revised NRC Enforcement Policy, the same civil penalty of \$5,000 would be warranted given the willful nature of the violation; the fact that it was identified by the NRC; consideration of the Licensee's good corrective actions; and the exercise of discretion as warranted under the circumstances, including the facts that the violation represents a recurrence (i.e., directly repetitive) of an earlier violation and the Licensee missed a number of opportunities to correct it. Therefore, application of the new policy results in the same civil penalty being assessed.

NRC Conclusion

The NRC has concluded that the Licensee did not provide an adequate basis for abatement or mitigation of the civil penalty. Accordingly, the proposed civil penalty in the amount of \$5000 should be imposed.



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION III  
801 WARRENVILLE ROAD  
LISLE, ILLINOIS 60532-4351

November 22, 1995

EA 95-184

Champion International Corporation  
ATTN: Daniel J. Maheu, Vice President/  
Operations Manager  
601 North B Street  
Hamilton, OH 45013

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL  
PENALTY - \$2,500  
(NRC INSPECTION REPORT NO. 99990003/95017(DRSS))

Dear Mr. Maheu:

This refers to the inspection conducted on August 14-15, 1995, at the Champion Hamilton Mill facility in Hamilton, Ohio. The purpose of the inspection was to review the circumstances surrounding the inadvertent disposal of a generally licensed gauge containing krypton-85. We notified you of the event on July 31, 1995, and you submitted a written report dated August 4, 1995. The report documenting our inspection was sent to you by letter dated September 18, 1995.

Based on the information developed during the inspection, and the information that you provided in your October 16, 1995 response to the inspection report, the NRC has determined that a violation of NRC requirements occurred. The violation involves the failure to properly dispose of generally licensed material in accordance with 10 CFR 31.5(c)(8). The violation is cited in Section A of the enclosed Notice of Violation and Proposed Imposition of Civil Penalty and the circumstances surrounding the violation are described in detail in the inspection report.

On July 31, 1995, the NRC notified you that a Taylor Betamike gauge containing krypton-85 was found in a truck of scrap metal located at Hamilton Scrap. The gauge was traced to Champion through the manufacturer's records, which indicated that a shutter test had been performed on the gauge on September 28, 1983. You determined that the gauge had apparently been removed from its installed location and stored in a remote storage area for a number of years. On or about July 17, 1995, in an effort to clean-up the location, the gauge was inadvertently placed in a shipment of scrap metal. The root cause of the violation appeared to be a lack of a centralized group or individual responsible for the oversight of the nuclear gauge program prior to December 1993.

Fortunately, the actual safety consequence was minimal in this case. The gauge was found with a maximum radiation level of 3 mrem/hr, the shutter was closed, and the source holder was intact. The gauge was located in a truck full of scrap and was most likely previously stored at Hamilton Mill with unused metal in areas not normally occupied by plant employees. Therefore, it

Champion International Corporation - 2 -

was unlikely that any individual received a radiation exposure in excess of regulatory limits. However, this violation is of significant regulatory concern because uncontrolled licensed materials entered the public domain. The NRC entrusts responsibility for radiation safety to the management of Champion International Corporation. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety by ensuring that all licensed materials are controlled at all times. Therefore, this violation has been categorized in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 FR 34381; June 30, 1995) at Severity Level III.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 is considered for a Severity Level III violation. Although the NRC recognizes that application of the civil penalty assessment process would not result in a civil penalty in this case, the NRC is exercising discretion in accordance with Section VII.A.1(g) of the Enforcement Policy and is proposing a civil penalty of \$2,500. Discretion is being exercised because the loss of the gauge (which was not identified and reported by your staff) put uncontrolled radioactive material in the public domain.

Therefore, to emphasize the need to strictly control licensed material, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Materials Safety, Safeguards, and Operations Support, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the base amount of \$2,500 for the Severity Level III violation.

One violation, not assessed a civil penalty, is cited in Section B of the Notice. The violation involves the unauthorized removal of the installed krypton-85 gauge prior to its disposal. This violation is of concern because your staff was unaware of the proper procedures for handling licensed material.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

Champion International Corporation - 3 -

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Hubert J. Miller  
Regional Administrator

Docket No. 99990003  
General License

Enclosure: Notice of Violation and  
Proposed Imposition of Civil Penalty

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Champion International Corporation  
Hamilton, Ohio

Docket No. 99990003  
General Licensee  
EA 95-184

During an NRC inspection conducted on August 14-15, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600 (60 FR 34381; June 30, 1995), the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

**A. Violation Assessed a Civil Penalty**

10 CFR 31.5(c)(8) requires, in part, that any person who acquires, receives, possesses, uses or transfers byproduct material in a device pursuant to a general license shall, except as provided in 10 CFR 31.5(c)(9), transfer or dispose of the device containing byproduct material only by transfer to persons holding a specific license pursuant to 10 CFR Parts 30 and 32 or from an Agreement State to receive the device.

Contrary to the above, on or about July 17, 1995, the licensee disposed of a Taylor krypton-85 gauge containing a nominal activity of 190 millicuries of krypton-85 (42.5 millicuries as of July 1995) and this disposal was not made to a person holding a specific license pursuant to 10 CFR Parts 30 and 32 or from an Agreement State to receive the device (the exceptions in 10 CFR 31.5(c)(9) did not apply). Specifically, the device was disposed of in a shipment of scrap metal to Hamilton Scrap, an unlicensed company. (01013)

This is a Severity Level III violation (Supplement VI).  
Civil Penalty - \$2,500.

**B. Violation Not Assessed a Civil Penalty**

10 CFR 31.5(c)(3) requires, in part, that any person who acquires, receives, possesses, uses or transfers byproduct material in a device pursuant to a general license shall assure that removal from installation involving the radioactive material, its shielding or containment, are performed: (1) in accordance with the instructions provided by the labels; or (2) by a person holding a specific license pursuant to 10 CFR Parts 30 and 32 or from an Agreement State to perform such activities.

The label affixed to the licensee's Taylor krypton-85 gauge states, in part, that relocation involving shielding or containment of the radioactive material shall be performed by persons specifically licensed by the NRC or an Agreement State.

Contrary to the above, at an indeterminate time between September 28, 1983, and July 17, 1995, removal of the licensee's Taylor krypton-85 gauge containing a nominal activity of 190 millicuries of krypton-85 was not performed in accordance with the instructions provided by the labels or by a person holding a specific license pursuant to 10 CFR Parts 30 and 32 or from an Agreement State to perform such activities. Specifically, the licensee removed and relocated the gauge, including its shielding and containment, and does not hold a specific license pursuant to 10 CFR Parts 30 and 32 or from an Agreement State to perform such activities. (02014)

This is a Severity Level IV violation (Supplement VI).

Pursuant to the provisions of 10 CFR 2.201, Champion International Corporation (Licensee) is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved. This reply may incorporate information previously submitted to the NRC to avoid repetition, but such incorporation must specifically reference, by citing page and paragraph numbers of, the previously submitted documents.

If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as why the license should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violations listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil

penalty in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of the Enforcement Policy should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The response noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region III, 801 Warrenville Road, Lisle, IL 60532-4351.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at Lisle, Illinois  
this 22nd day of November 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064

April 25, 1995

EA 95-047

Dyna Jet, Inc.  
ATTN: Les Desavedo, President  
P.O. Box 2444  
Gillette, Wyoming 82716

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY -  
\$500 (NRC Inspection Report No. 030-13233/95-01)

This refers to the NRC inspection of Dyna Jet, Inc. (Dyna Jet) conducted in Gillette, Wyoming on February 14 and 15, 1995, and discussed during telephonic exit interviews on March 7 and 16, 1995. The results of this inspection were documented in a report issued on March 31, 1995, and were again discussed with you and Mr. Fink, your logging supervisor, during a telephonic enforcement conference on April 6, 1995. A list of enforcement conference participants is enclosed.

During the enforcement conference, you were given an opportunity to respond to the 18 apparent violations identified in the inspection report and to describe Dyna Jet's corrective actions. As a result of the information you provided during the conference, two of the apparent violations are not being cited. These involved blocking and bracing of radioactive material packages during transport and annual inspections of logging supervisors. In both cases, the information you provided indicated that Dyna Jet had been meeting the intent of these requirements by adequately blocking and bracing radioactive material packages and by conducting periodic checks at jobsites where the logging supervisor was conducting licensed activities.

As indicated in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice), the NRC has found Dyna Jet in violation of 16 requirements applicable to the use and transport of NRC-licensed radioactive materials. These violations are described in the Notice. As we have acknowledged, the violations do not appear to have led to any significant safety consequences. Nonetheless, the NRC finds the violations significant when considered collectively because they indicate insufficient knowledge of, and attention to, the requirements of your license and NRC regulations. The violations indicate a substantial need for Dyna Jet to re-familiarize itself with the commitments made in its license application and with the requirements found in 10 CFR Parts 20 and 39 and the applicable regulations in 49 CFR.

Therefore, in the aggregate, these violations have been classified at Severity Level III in accordance with Section IV.A of the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C. A copy of the Enforcement Policy was provided to you with the inspection report.

You made a point during the enforcement conference that Dyna Jet was conducting activities in essentially the same manner in 1991 when the NRC performed an inspection of its radiation safety program and found no violations. You also stated that had the NRC done a better inspection in 1991, that Dyna Jet wouldn't be in this situation today. I must disagree with your premise that it is the NRC's job to identify noncompliance. To the contrary, the infrequency of NRC's inspections makes it essential that licensees accept the responsibility for assuring that they are aware of all applicable regulations and are following them in the conduct of licensed activities.

During the enforcement conference, you described actions Dyna Jet was taking in response to each of the violations. It is apparent to the NRC that you devoted considerable effort to remedy the problems, although some actions were still being developed as of the date of the conference. You also indicated that Dyna Jet was considering naming a new radiation safety officer (RSO) since you, as the current RSO, are not routinely involved in nuclear logging activities or tracer studies. We encourage you to pursue this issue to assure that your RSO has sufficient involvement and knowledge to assure compliance in the daily performance of licensed activities.

Notwithstanding these corrective actions, to emphasize the need for Dyna Jet to assure compliance with all requirements and to maintain cognizance of changing requirements, I have been authorized to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the amount of \$500 for the Severity Level III problem discussed above and in the Notice.

The base value of a civil penalty for a Severity III violation is \$500. The civil penalty adjustment factors in Section VI.B.2 of the Enforcement Policy were considered and resulted in the following adjustments: 1) the NRC's identification of the violations warranted 50% escalation; and 2) your actions to correct each of the violations and to assure future compliance warranted 50% mitigation. Your generally good performance as a licensee of the NRC was considered but did not result in any mitigation because of the substantial decline in performance as indicated by the violations identified during this inspection. The other adjustment factors were considered, but no further adjustments to the base civil penalty were considered appropriate. Thus, on balance, no net adjustment to the base civil penalty value was made.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. We request that you specifically address how you plan to assure, on a continuing basis, improved oversight of NRC-licensed activities. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96.511.

Sincerely,



L. V. Callan  
Regional Administrator

Docket No. 030-13233  
License No. 49-17724-01

Enclosures:

- 1) Notice of Violation and Proposed Imposition of Civil Penalty
- 2) List of Enforcement Conference Participants

cc w/Enclosures: State of Wyoming

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Dyna Jet, Inc.  
Gillette, Wyoming

Docket No. 030-13233  
License No. 49-17724-01  
EA 95-047

During an NRC inspection conducted February 14-15, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

A. Condition 9A of License No. 49-17724-01 authorizes sealed sources of americium-241 to be used in oil and gas well logging.

Contrary to the above, on May 24, 1986, and October 5, 1994, the licensee used an americium-241 sealed source to log cased water wells, a use not specified in the license.

B. Condition 10 of License No. 49-17724-01 specifies that licensed material be used at 1807½ Echeta Road, Gillette, Wyoming, and at temporary job sites of the licensee anywhere in the United States where the U.S. Nuclear Regulatory Commission maintains jurisdiction for regulating the use of licensed material.

Contrary to the above, from January 1, 1993, to February 15, 1995, the licensee had stored a 5 curie americium-241 sealed source at a storage facility located approximately 5 miles north of 1807½ Echeta Road, Gillette, WY, a location not specified in the license.

C. Condition 12 of License No. 49-17724-01 specifies, by name, three individuals authorized to act as logging supervisors, and that no individuals are authorized to act as logging assistants as that term is defined in 10 CFR 39.2.

Contrary to the above, from 1992 to 1994, the licensee permitted two individuals to act as logging assistants.

D. Condition 16 of license No. 49-17724-01 specifies that the licensee shall conduct its program in accordance with the statements, representations, and procedures contained in the application dated September 30, 1987, and letter dated June 30, 1988.

Item 2 of the letter dated June 30, 1988, specifies that the licensee's radiation safety officer will conduct annual safety reviews and that items to be covered are as follows: (1) review of radiation safety principles, (2) current regulations, (3) operating and emergency procedures, (4) company policies with respect to radiation safety,

(5) results of the annual radiation safety inspection, and (6) new regulations or requirements.

Contrary to the above, from October 1991 to February 15, 1995, the licensee had not conducted annual safety reviews that covered the above noted items.

E. 10 CFR 39.15(a) requires, in part, that a licensee perform well logging with a sealed source only after the licensee has a written agreement with the well owner or operator. This written agreement must identify who will meet the requirements specified in 10 CFR 39.15(a)(1) through 10 CFR 39.15(a)(5).

Contrary to the above, from October 1991 to February 15, 1995, the licensee had routinely conducted well logging operations with a sealed source prior to obtaining a written agreement with the well owner or operator.

F. 10 CFR 39.39(a) requires, in part, that a licensee maintain records for each use of licensed material showing: (1) the make, model number, serial number or a description of each sealed source used; (2) the identity of the logging supervisor who is responsible for the licensed material and the identity of logging assistants present; and (3) the location and date of use of the licensed material.

Contrary to the above, from January 1992 to February 1995, the licensee had not maintained records for each use of an americium-241 sealed source indicating: (1) the make, model number, serial number or a description of the sealed source; (2) the identity of the logging supervisor who was responsible for the licensed material and the identity of logging assistants present; and (3) the location and date of use of licensed material.

G. 10 CFR 39.43 (b) requires, in part, that a licensee have a program for semiannual visual inspection and maintenance of source holders, logging tools, injection tools, source handling tools, and storage and transport containers to ensure that the required labeling is legible and that no physical damage is visible.

Contrary to the above, the licensee had not conducted semiannual visual inspection and maintenance of source holders, logging tools, injection tools, source handling tools, and storage and transport containers during the calendar years 1992-1994.

H. 10 CFR 39.67 requires, in part, that a licensee make radiation surveys of each area where licensed materials are used and stored, including vehicle surveys prior to transporting licensed materials and surveys confirming that the logging tool is free of contamination if the sealed source assembly is removed from the logging tool before departure from the temporary jobsite. The results of the surveys must be recorded and retained for a period of 3 years.

Contrary to the above, from January 1992 through February 1995, the licensee had not maintained records of: 1) storage area surveys for two areas used to store sealed sources; and 2) surveys of vehicles performed prior to transporting licensed materials. In addition, the licensee had not made radiation surveys confirming that logging tools were free of contamination in instances where the sealed source assembly was removed from the logging tool before departure from the temporary jobsite.

I. 10 CFR 39.73 requires, in part, that a licensee maintain copies of 10 CFR Parts 19, 20, and 39 and the licensee's operating and emergency procedures required by 10 CFR 39.63 at each field station.

Contrary to the above, between October 1991 and February 15, 1995, the licensee had not maintained copies of 10 CFR Parts 19, 20, and 39 and the licensee's current operating and emergency procedures.

J. 10 CFR 20.1501 requires that each licensee make or cause to be made surveys that may be necessary for the licensee to comply with the regulations in Part 20 and that are reasonable under the circumstances to evaluate the extent of radiation levels, concentrations or quantities of radioactive materials, and the potential radiological hazards that could be present.

Pursuant to 10 CFR 20.1003, *survey* means an evaluation of the radiological conditions and potential hazards incident to the production, use, transfer, release, disposal, or presence of radioactive material or other sources of radiation.

10 CFR 20.1502(b) requires that each licensee monitor the occupational intake of radioactive material by and assess the committed effective dose equivalent to adults likely to receive, in 1 year, an intake in excess of 10 percent of the applicable ALI(s) in Table 1, Columns 1 and 2, of Appendix B.

Contrary to the above, from January 1994 to February 15, 1995, the licensee had not performed an evaluation to show compliance with 10 CFR 20.1502(b). Specifically, the licensee had not performed an evaluation of the occupational intake of radioactive materials or assessed the committed effective dose equivalent for adults to determine whether they were likely to receive, in 1 year, an intake in excess of the applicable limits requiring monitoring for internal dose assessment.

K. 10 CFR 20.1906(b) and (c) require, in part, that each licensee monitor the external surfaces of a package labeled with a Radioactive White I, Yellow II, or Yellow III label for radioactive contamination, unless the package contains only radioactive material in the form of a gas or in special form as defined in 10 CFR 71.4. This monitoring shall be performed as soon as practicable, but not later than 3 hours after receipt of the package during the licensee's normal working hours, or not later than 3 hours from the beginning of the next working day if it is received after working hours.

Contrary to the above, from March 1994 through January 1995, the licensee received six packages labeled with Radioactive Yellow II or Yellow III labels during working hours, the packages were not exempt from the monitoring requirement for radioactive contamination, and the licensee did not perform the required monitoring. The packages received by the licensee contained 15-45 millicuries of iodine-131 tracer material in liquid form.

L. 10 CFR 71.5(a) requires that a licensee who transports licensed material outside of the confines of its plant or other place of use, or who delivers licensed material to a carrier for transport, comply with the applicable requirements of the regulations appropriate to the mode of transport of the Department of Transportation (DOT) in 49 CFR Parts 170-189.

1. 49 CFR 177.817(a) requires that a carrier not transport a hazardous material unless it is accompanied by a shipping paper prepared in accordance with 49 CFR 172.200-203.

49 CFR 172.202(a) and (b) require in part, with exceptions not applicable here, that the shipping description of a hazardous material on the shipping paper include, in the following sequence: (1) the proper shipping name prescribed for the material in 172.101 or 172.102, (2) the hazard class, (3) the identification number, and (4) the total quantity by weight or volume. Pursuant to 49 CFR 172.101, radioactive material is classified as hazardous material.

Contrary to the above, from January 1992 to February 15, 1995, the licensee had routinely transported outside the confines of its plant iodine-131 tracer material and an americium-241 sealed source, and the shipping description on the shipping papers that accompanied the shipments had not included: (1) the proper shipping name prescribed for the material in 172.101 or 172.102, (2) the hazard class, (3) the identification number, and (4) the total quantity of material by weight or volume.

2. 49 CFR 172.203(c) requires that the letters "RQ" be entered on the shipping paper either before or after the basic description required for each hazardous substance. Pursuant to 49 CFR 172.101, radioactive material is classified as hazardous material.

Contrary to the above, from January 1992 to February 15, 1995, the licensee transported licensed material outside the confines of its plant and the letters "RQ" were not entered either before or after the hazardous material description on the shipping paper that accompanied the shipments.

3. 49 CFR 172.403 requires, in part, with exceptions not applicable here, that each package of radioactive material be labeled, as

appropriate, with two RADIOACTIVE WHITE-I, RADIOACTIVE YELLOW-II, or RADIOACTIVE YELLOW-III labels on opposite sides of the package. The contents, activity, and transport index must be entered in the blank spaces on the label.

Contrary to the above, on five occasions between from January 1992 and February 1995, the licensee transported a package containing an americium-241 sealed source outside the confines of its plant and the package was not labeled with the required RADIOACTIVE YELLOW-III labels.

4. 49 CFR 172.604 (a) and (b) require that a person who offers a hazardous material for transportation must provide a 24-hour emergency response telephone number for use in the event of an emergency involving the hazardous material. The telephone number must be: (1) monitored at all times the hazardous material is in transportation, including storage incidental to transportation, (2) the number of a person who is either knowledgeable of the hazardous material being shipped and has comprehensive emergency response and incident mitigation information for that material, or has immediate access to a person who possesses such knowledge, and (3) entered on the shipping paper.

Contrary to the above, from January 1992 to February 15, 1995, the licensee routinely transported packages containing iodine-131 and americium-241, and the emergency response telephone number on the shipping paper that accompanied the shipment was not the number of a person who was knowledgeable of the hazardous material being shipped or a person who had comprehensive emergency response and incident mitigation information for the material.

5. 49 CFR 172.702(a) and (c) require, in part, that a hazmat employer ensure that each of its hazmat employees are trained in accordance with the requirements prescribed in Subpart H, 49 CFR Part 172.700-704, and that training for a hazmat employee employed on or before July 2, 1993, be completed prior to October 1, 1993. Pursuant to 49 CFR 172.101, radioactive material is classified as hazardous material.

Contrary to the above, as of February 15, 1995, hazmat employees employed prior to July 2, 1993, had not completed the required hazmat training, and the employees had transported radioactive materials during the above noted period.

These violations represent a Severity Level III problem (Supplement VI).  
Civil Penalty - \$500

Pursuant to the provisions of 10 CFR 2.201, Dyna Jet, Inc. is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice).

Notice of Violation

- 6 -

This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved.

If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or the cumulative amount of the civil penalties if more than one civil penalty is proposed, or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violation listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of 10 CFR Part 2, Appendix C, should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The responses noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to:

Notice of Violation

- 7 -

Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White  
Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738, with a copy to  
the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 611  
Ryan Plaza Drive, Suite 400, Arlington, Texas 76011.

Dated at Arlington, Texas  
this 25th day of April 1995

Enclosure 2

Enforcement Conference participants

April 6, 1995

Telephonic enforcement conference

Dyna Jet, Inc.

Les Desavedo, President/Radiation Safety Officer  
Todd Fink, Logging Supervisor

U.S. Nuclear Regulatory Commission, Region IV

Ross Scarano, Deputy Director, Division of Radiation Safety & Safeguards

Linda Howell, Chief, Nuclear Materials Inspection Branch

Richard Leonardi, Radiation Specialist, NMIB

William Brown, Regional Counsel

Gary Sanborn, Enforcement Officer



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20585-0001

July 11, 1995

EA 95-047

Dyna Jet, Inc.  
ATTN: Les Desavedo, President  
P.O. Box 2444  
Gillette, Wyoming 82716

SUBJECT: WITHDRAWAL OF PROPOSED CIVIL PENALTY - \$500  
(NRC Inspection Report No. 030-13233/95-01)

This is in reference to your May 1, 1995 letter and May 19, 1995 reply to a Notice of Violation and Proposed Imposition of Civil Penalty issued by the NRC on April 25, 1995. Our correspondence to you identified 16 violations of NRC requirements applicable to the use and transport of NRC-licensed radioactive materials and stated that the violations indicated a substantial need for Dyna Jet to re-familiarize itself with the commitments made in its license application, with the requirements found in 10 CFR Parts 20 and 39, and with the applicable regulations in 49 CFR. A civil penalty of \$500 was proposed for the violations.

In your May 19, 1995 reply, you admitted all but one of the violations and described the corrective actions you had taken in response to all of the violations. In your May 1, 1995 letter, you requested that the proposed \$500 fine be mitigated because no issues of health and safety had been found and because you had aggressively addressed the violations following the NRC's inspection. You also cited inconsistencies in NRC's inspection program, stating that a 1991 inspection had found no violations despite your conducting activities in essentially the same manner as you were at the time of the 1995 inspection.

We have addressed these points in previous correspondence. In both the April 25, 1995 letter transmitting the Notice of Violation and Proposed Imposition of Civil Penalty and in a May 16, 1995 letter to you, we explained our basis for considering the violations significant despite there being no significant safety consequences. We also addressed your point about inconsistencies in NRC's inspection program in our April 25, 1995 letter, noting that the NRC's regulatory system relies on licensees to assure that they are aware of all applicable regulations and are following them in the conduct of licensed activities. Licensees cannot use the NRC's not having identified problems during a brief inspection as an excuse for not complying with all requirements.

Notwithstanding that NRC considers the violations to be of significant regulatory concern, we are withdrawing the proposed civil penalty because NRC has reconsidered its civil penalty process as reflected in Section VI.B.2 of the revised Enforcement Policy (60 FR 34381, June 30, 1995). A copy of the

Dyna Jet, Inc.

- 2 -

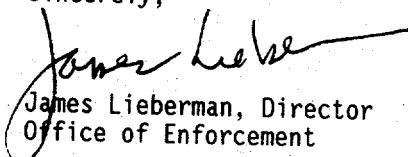
revised Enforcement Policy is enclosed. Under the terms of the revised policy, the violations identified during our inspection of Dyna Jet would not have resulted in a civil penalty because: 1) Dyna Jet had no previous escalated enforcement action in the past two inspections; and 2) Dyna Jet's corrective actions were considered prompt and comprehensive. However, NRC's concern about the violations would not be affected by the change in policy; Dyna Jet would still receive a Severity Level III problem in the aggregate. Thus, the change in policy has no effect on the Notice of Violation that was issued.

With regard to the violation that Dyna Jet denied in its May 19, 1995 reply, the NRC has reviewed your response and has concluded that the violation occurred as stated. Specifically, with respect to Violation K in the Notice of Violation, you stated that Dyna Jet had performed meter surveys of incoming packages of radioactive materials and that wipe tests would have been performed had any of the packages been leaking. As discussed with you during the April 6, 1995 enforcement conference, the revised 10 CFR Part 20 requires that licensees perform two types of surveys on incoming packages, one for external radiation levels and one for radioactive contamination on the external surface of the package. The requirement cited in this case is to monitor incoming packages for surface contamination. The NRC does not believe that the surveys conducted by Dyna Jet were adequate to detect external contamination on the package surface because the survey could not distinguish between radiation coming from the package content and any radiation detected as a result of surface contamination.

No response to this letter or to Violation K is required, since you committed in your May 19, 1995 reply to taking corrective actions to all of the violations. Should you have any questions about this matter, please contact me at 301/415-2741.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter will be placed in the NRC Public Document Room.

Sincerely,

  
James Lieberman, Director  
Office of Enforcement

Docket No. 030-13233  
License No. 49-17724-01

Enclosure: As stated  
cc w/enclosure: State of Wyoming



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA STREET, N.W., SUITE 2900  
ATLANTA, GEORGIA 30323-0199

October 24, 1995

EA 95-187

Energy Technologies, Inc.  
ATTN: Mr. David K. Swindell  
President  
P. O. Box 23860  
127 Perimeter Park Drive  
Knoxville, Tennessee 37933-1860

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY -  
\$2,500 (NRC INSPECTION REPORT NO. 150-00041/95-01)

Dear Mr. Swindell:

This refers to the inspection conducted on August 28, 1995, at your facility in Knoxville, Tennessee. During the inspection, the NRC examined the facts and circumstances surrounding Energy Technologies, Inc.'s (ETI's) use of radioactive material in the State of West Virginia, a non-Agreement State under NRC jurisdiction, without notifying the NRC as required by 10 CFR 150.20(b)(1). The results of the inspection were sent to you by letter dated September 11, 1995. A closed and transcribed predecisional enforcement conference was conducted in the Region II office on September 25, 1995, to discuss the apparent violation, the root causes, and your corrective actions to preclude recurrence. A list of conference attendees, NRC presentation materials, and a copy of the documentation you provided at the conference are enclosed.

Based on the information developed during the inspection and the information you provided during the conference, the NRC has determined that a violation of NRC requirements occurred. The violation is cited in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice). The violation involved ETI's installation of fixed nuclear gauges in areas under NRC jurisdiction without first obtaining a specific NRC license, in accordance with 10 CFR 30.3, or filing NRC Form-241, "Report of Proposed Activities in Non-Agreement States," as required pursuant to the general NRC license in 10 CFR 150.20. This violation relates to four (4) instances identified by the NRC where your company performed licensed activities in West Virginia during the period of April through August 1995 without notifying the NRC.

The NRC has determined that, in one instance, ETI demonstrated careless disregard for the requirements of 10 CFR 150.20(b). The bases for this conclusion are: (1) the August 4 and 7, 1995, telephone discussions between ETI and NRC Region II staff during which NRC reciprocity requirements were discussed; (2) the reciprocity requirements, a fee schedule, and copies of NRC Form-241 that were facsimiled to ETI on August 7, 1995; and (3) ETI's subsequent installation of a gauging device at Falcon Energy, Inc. on August 8, 1995, without first filing the appropriate documentation with the NRC, despite the communications and information provided by the NRC. During the conference, you stated that based on the August 4 and 7, 1995

discussions with NRC, you understood that ETI was required to file for reciprocity when conducting activities in non-Agreement States; however, you believed that on-going activities could proceed in parallel with the preparation and submittal of the reciprocity documents and fees. You further stated that it was not until August 22, 1995 (when ETI was again contacted by the NRC when it was discovered that ETI had installed a gauge at Select Mining on April 26, 1995, without complying with the reciprocity requirements) that you fully understood that the company had operated in violation of NRC requirements and that advance filing and notification was required. Notwithstanding these statements, as well as your admission of the violation at the conference, the NRC has determined that you were provided copies of the applicable regulations on August 7, 1995, but failed to take the steps necessary to ensure that the regulations were fully understood and implemented appropriately prior to conducting NRC-licensed activities.

This violation is of significant regulatory concern because of its willful nature (in one instance) and because it denied the NRC an opportunity to inspect ETI's activities in non-Agreement States, thereby impeding the NRC's ability to perform its statutory responsibility of verifying that licensed activities are performed in accordance with NRC requirements. The NRC relies on licensees and their employees to fully understand and comply with NRC requirements prior to performing licensed activities. In this case, however, ETI failed to assure or otherwise confirm its understanding of NRC requirements which demonstrates careless disregard for the NRC requirements. Although the NRC Enforcement Policy allows categorization of this violation at Severity level II, given your statements at the conference and the facts surrounding the occurrence of the violation, this violation has been categorized in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), (60 FR 34381; June 30, 1995/NUREG-1600) at Severity Level III.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 is considered for a Severity level III violation. The NRC considered whether credit was warranted for *Identification* and *Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. No credit was warranted for *Identification* because the NRC identified the violation through its license application review and inspection processes. At the predecisional enforcement conference, you stated that your corrective actions included: (1) Suspension of licensed activities following the August 22, 1995 discussion with NRC; (2) Submittal of reciprocity documentation to NRC Region II on August 28, 1995; (3) Evaluation of compliance with reciprocity requirements for other Agreement States; (4) Review of the event with the ETI staff; and (5) Initiation of a review of license and NRC requirements to ensure overall compliance with all regulatory requirements. Based on these facts, the NRC determined that credit was warranted for *Corrective Action*.

Therefore, to emphasize the significance of willful violations, as well as the importance of compliance with NRC reciprocity requirements, I have been authorized, after consultation with the Director, Office of Enforcement, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty in the base amount of \$2,500 for the Severity Level III violation.

Energy Technologies, Inc.

- 3 -

During the predecisional enforcement conference, several discrepancies were identified on Page 3 of the subject Inspection Report regarding the dates that ETI installed gauges. To correct the official record regarding the errors, an amended copy of the report is enclosed.

While the NRC concluded that, in one instance (i.e., August 8, 1995), you exhibited careless disregard, which is a willful violation, we have decided not to issue an enforcement action against you as an individual based on your corrective actions and your belief that on-going activities could proceed in parallel with the preparation and submittal of the reciprocity documents and fees. You should be aware, however, that NRC regulations (i.e., 10 CFR 30.10, "Deliberate Misconduct,") allow enforcement actions to be issued directly against unlicensed persons who engage in deliberate misconduct that causes a licensee to be in violation of any NRC requirement. For example, an order may be issued to prohibit an individual from engaging in licensed activities at all NRC-licensed facilities. A violation of this regulation may also lead to criminal prosecution.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether future NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,

*Jon R. Johnson*  
for Stewart D. Ebneter  
Regional Administrator

Docket No.: 150-00041  
License No.: General License

Enclosures: 1. Notice of Violation and Proposed  
                  Imposition of Civil Penalty  
2. Predecisional Enforcement Conference Attendees  
3. NRC Slides  
4. ETI Handouts  
5. Inspection Report 150-00041/95-01 (Amended)

cc w/encls: State of Tennessee

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Energy Technologies, Inc.  
Knoxville, Tennessee

Docket No. 150-00041  
General License  
EA 95-187

During an NRC inspection conducted on August 28, 1995, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381; June 30, 1995/NUREG-1600), the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violation and associated civil penalty are set forth below:

10 CFR 30.3 requires, in relevant part, that no person shall possess or use byproduct material except as authorized by a specific or general license issued by the NRC.

10 CFR 150.20(a) provides, in part, that any person who holds a specific license from an Agreement State is granted an NRC general license to conduct the same activity in non-Agreement States subject to the provisions of 10 CFR 150.20(b).

10 CFR 150.20(b)(1) requires, in part, that any person engaging in activities in non-Agreement States under the general license provided in 10 CFR 150.20(a) shall, at least 3 days before engaging in such activity, file four copies of Form-241, "Report of Proposed Activities in Non-Agreement States," and four copies of its Agreement State specific license with the Regional Administrator of the U.S. NRC Regional Office for the Region in which the Agreement State that issued the license is located.

Contrary to the above, Energy Technologies, Inc. engaged in activities in non-Agreement States without obtaining a specific license issued by the NRC and without filing any copies of Form-241 with the NRC. Specifically, Energy Technologies, Inc. installed fixed nuclear gauges containing byproduct material in West Virginia, a non-Agreement State, at the following locations on the indicated dates:

1. Catenary Coal/Samples Mine on or about April 19, 1995;
2. Select Mining on or about April 26, 1995;
3. RoxCoal/Diamond T Mine on or about May 31, 1995; and
4. Falcon Energy/Gary Mine on or about August 8, 1995 (01013)

This is a Severity Level III violation (Supplements VI and VII).  
Civil Penalty - \$2,500

Pursuant to the provisions of 10 CFR 2.201, Energy Technologies, Inc. (Licensee) is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to

Enclosure 1

Notice of Violation and Proposed - 2 -  
Imposition of Civil Penalty

a "Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved.

If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or the cumulative amount of the civil penalties if more than one civil penalty is proposed, or may protest imposition of the civil penalty, in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violation listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty, in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of the Enforcement Policy should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

Notice of Violation and Proposed - 3 -  
Imposition of Civil Penalty

The response noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738, and a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region II.

Dated at Atlanta, Georgia  
this 24 day of October 1995

Predecisional Enforcement Conference Attendees  
September 25, 1995

Licensee

David K. Swindell, President, Energy Technologies, Inc.

Nuclear Regulatory Commission

Bruce S. Mallett, Director, Division of Radiation Safety and Safeguards (DRSS), Region II (RII)

Bruno Uryc, Director, Enforcement and Investigation Coordination Staff (EICS), RII

Carolyn F. Evans, Regional Counsel, RII

Charles M. Hosey, Chief, Nuclear Materials Inspection Section, DRSS, RII

Jeffrey A. Mumper, Nuclear Materials Inspector, DRSS, RII

Anne T. Boland, Senior Enforcement Specialist, EICS, RII

Enclosure 2



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20585-0001

February 14, 1995

EA 95-018

Maria Hollingsworth  
dba Blackhawk Engineering, Inc.  
Post Office Box 434  
Tulsa, Oklahoma 74101

**SUBJECT: ORDER TO CEASE AND DESIST USE AND POSSESSION OF REGULATED BYPRODUCT MATERIAL**

The enclosed Order requires you, in part, to discontinue the use of regulated byproduct material currently in your possession, to maintain all such material in storage, and to make arrangements to transfer all such material to the manufacturer or to another authorized recipient. The terms of this Order are described in detail in Section IV. This Order is being issued because you continued to use gauges containing NRC-regulated material after agreeing not to do so and because you were not truthful in statements made to NRC personnel, including an NRC inspector who conducted an inspection on December 19, 1994. If you fail to comply with this Order you will be subject to civil penalties. Furthermore, pursuant to Section 234 of the Atomic Energy Act, as amended, the NRC is authorized to impose daily civil penalties of up to \$100,000 per violation per day. Therefore, your continued failure to transfer the byproduct material in accordance with 10 CFR 30.36 will subject you to daily civil penalties.

In addition, pursuant to section 223 of the Atomic Energy Act of 1954, as amended, any person who willfully violates, attempts to violate, or conspires to violate, any provision of this Order shall be subject to criminal prosecution as set forth in that section.

Other violations of NRC requirements were identified during the December 19, 1994, inspection. These violations remain under NRC review and will be the subject of future correspondence. In addition, the NRC has suspended processing of your application for a new license dated December 4, 1994. The NRC does not intend to consider processing this application until the matters that led to the issuance of this Order and the remaining violations discovered during the NRC's inspection are resolved.

The enclosed Order supersedes and closes the Confirmatory Action Letter issued by the NRC on November 8, 1994. You must respond to this Order as described in Section IV. Questions concerning this Order should be addressed to Ms. Patricia A. Santiago, Assistant Director for Materials, Office of Enforcement, who can be reached at (301) 504-3055.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy or proprietary information so that it can be placed in

Maria Hollingsworth

- 2 -

the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Sincerely,



Hugh L. Thompson, Jr.  
Deputy Executive Director for  
Nuclear Materials Safety, Safeguards  
and Operations Support

Docket No. 030-31252  
License No. 35-26996-01

Enclosure: As Stated

UNITED STATES  
NUCLEAR REGULATORY COMMISSION

In the Matter of

BLACKHAWK ENGINEERING, INC., and  
MARIA HOLLINGSWORTH  
(dba BLACKHAWK ENGINEERING, INC.)  
Tulsa, Oklahoma

Docket No. 030-31252  
License No. 35-26996-01  
EA 95-018

ORDER TO CEASE AND DESIST USE AND POSSESSION  
OF REGULATED BYPRODUCT MATERIAL

I

Blackhawk Engineering, Inc. (Blackhawk) was issued Byproduct Material License 35-26996-01 by the Nuclear Regulatory Commission (NRC or Commission) on August 22, 1989. The license authorized the possession and use of cesium-137 and americium-241 in gauges, in accordance with the conditions specified therein. The license expired on August 31, 1994, and the licensee did not submit a renewal application 30 days prior to the expiration date, as required by 10 CFR 30.37. Furthermore, the NRC has determined that Blackhawk Engineering, Inc., has not been recognized as a corporation in the state of Oklahoma since February 20, 1987, when the State of Oklahoma suspended Blackhawk's corporate status. Thus, although Blackhawk has been doing business as Blackhawk Engineering, Inc., it was not a legal corporation recognized by the State of Oklahoma or the NRC. The President of Blackhawk is Maria Hollingsworth.

II

On August 30, 1994, an NRC Region IV employee placed a phone call to Maria Hollingsworth, the president of Blackhawk, to discuss the August 31, 1994 license expiration. Records of that phone call indicate that Ms. Hollingsworth said she had received a renewal package from NRC and that

she planned to send a renewal application within 30 days. No renewal application was received. Ms. Hollingsworth has stated in a recent interview with an NRC investigator on January 12, 1995, that she had apparently confused payment of an NRC annual fee with license renewal at the time of the August 1994 call, and stated "I had no idea I had to submit another application."

On November 3, 1994, an NRC Region IV employee again called Ms. Hollingsworth and discussed the fact that Blackhawk's NRC license had expired and, therefore, in accordance with 10 CFR 30.36(c)(1)(i), Blackhawk was no longer authorized to use NRC-regulated gauges listed on the license, i.e., gauges containing sealed sources of radioactive material. During this call, the NRC instructed Ms. Hollingsworth to secure these gauges and maintain them in storage, and confirmed her commitment to submit a new license application. These commitments were confirmed by NRC in a November 8, 1994 Confirmatory Action Letter (CAL) to Ms. Hollingsworth. The CAL described the commitments that she had made, including her commitment to "Ensure that licensed material is not used until this matter is resolved and a specific license authorizing possession and use of byproduct material is issued from this office." Her receipt of the CAL was confirmed on November 23, 1994, during another telephone call from NRC Region IV. On December 19, 1994, NRC Region IV conducted an inspection of Blackhawk.

In January 1995, the NRC Office of Investigations began an investigation based on concerns about the accuracy of Ms. Hollingsworth's statements to NRC personnel during the December 19, 1994 inspection. Ms. Hollingsworth was interviewed by an NRC investigator and, in a signed, sworn statement on

January 12, 1995, she admitted that she understood in November 1994 that she should no longer use the gauges; admitted that she had used gauges containing byproduct material up until December 22, 1994, to complete a construction job; and admitted that she had not been truthful when she told the NRC inspector, during the December 19, 1994 inspection, that she had not used any gauges since 1992. She stated "I needed to get the job done and I thought by not telling ... the truth I could go ahead and get the job done."

III

Based on the above, Maria Hollingsworth, doing business as Blackhawk Engineering, Inc., has willfully violated NRC requirements by deliberately using NRC-regulated material in violation of 10 CFR 30.36(c)(1)(i), and by deliberately making false statements to NRC personnel in violation of 10 CFR 30.9. These deliberate violations also constitute a violation of 10 CFR 30.10, which prohibits deliberate misconduct. The NRC must be able to rely on the Licensee and its employees to comply with NRC requirements, including the requirement to provide information that is complete and accurate in all material respects. By her actions, Ms. Hollingsworth has demonstrated that she is either unwilling or unable to comply with Commission requirements and cannot be trusted to provide complete and accurate information to the Commission. Furthermore, Ms. Hollingsworth is currently in possession of NRC-regulated byproduct material without a valid NRC license.

Consequently, I lack the requisite reasonable assurance that the health and safety of the public will be protected. Therefore, the public health, safety, and interest require that Blackhawk Engineering, Inc. and Maria Hollingsworth, doing business as Blackhawk Engineering, Inc., be required to cease and desist unauthorized possession of regulated byproduct material and to provide certification to the NRC that all regulated byproduct material has been transferred to authorized recipients.

IV

Accordingly, pursuant to sections 81, 161b, 161c, 161i, and 161o of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR Parts 20 and 30, IT IS HEREBY ORDERED THAT BLACKHAWK ENGINEERING, INC. AND MARIA HOLLINGSWORTH, DOING BUSINESS AS BLACKHAWK ENGINEERING, INC., SHALL:

- A. Immediately cease and desist from any further use of byproduct material now in their possession, with the exception that sealed source(s) containing cesium-137 or americium-241 shall be tested for leakage by a person authorized to perform the test prior to the transfer of the source(s) to another person or entity if a leak test has not been performed within the last six months prior to transfer.
- B. Maintain safe control over the byproduct material, as required by 10 CFR Part 20, by keeping the material in locked storage and not allowing any person access to the material, except for purposes of assuring the

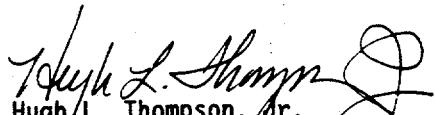
material's continued safe storage, until the material is transferred to a person authorized to receive and possess the material in accordance with the provisions of this Order and the Commission's regulations.

- C. Within 30 days of the date of this Order, transfer all byproduct material to a person authorized to receive and possess it.
- D. At least two working days prior to the transfer of the byproduct material, notify Ms. Linda Howell, Region IV, by telephone (817-860-8213) so that the NRC may, if it elects, observe the transfer of the material to the authorized recipient.
- E. Within seven days following completion of the transfer, provide to the Regional Administrator, Region IV, in writing, under oath or affirmation: (1) confirmation, on NRC Form 314, that the byproduct material has been transferred; (2) the last date that the byproduct material was used; (3) a copy of the leak test performed prior to transfer; (4) a copy of the survey performed in accordance with 10 CFR 30.36(c)(1)(v); and (5) a copy of the certification from the authorized recipient that the source has been received.

Copies of the response to this Order shall be sent to the Regional Administrator, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011, and to the Assistant General Counsel for Hearings and Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555.

After reviewing the response, the NRC will determine whether further action is necessary to ensure compliance with NRC requirements.

FOR THE NUCLEAR REGULATORY COMMISSION



Hugh L. Thompson, Jr.  
Deputy Executive Director for  
Nuclear Materials Safety, Safeguards,  
and Operations Support

Dated at Rockville, Maryland  
this 14<sup>th</sup> day of February 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

September 28, 1995

EA No. 95-130

Mr. Paul Mertz  
Senior Vice President for Operations  
Hospital Center at Orange  
188 Essex Avenue  
Orange, New Jersey 07051

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL  
PENALTY - \$2,500  
(OFFICE OF INVESTIGATIONS REPORT NO. 1-92-056R)

Dear Mr. Mertz:

This letter refers to the investigation conducted by the NRC Office of Investigations (OI) at the Hospital Center at Orange concerning a violation involving discrimination against an oncology technician after she responded to an NRC inspector's question, during an NRC inspection conducted on August 25, 1992, regarding previous violations involving individuals working adjacent to the teletherapy treatment room wall. On July 18, 1995, a predecisional enforcement conference was conducted with you and members of your staff to discuss the violation, its causes, and your corrective actions. In addition, during this conference, discussions were held with the oncology technician's supervisor who was responsible for the discriminatory actions.

Based on the NRC OI investigation (the synopsis of which was sent to you on July 3, 1995), and the results of the predecisional enforcement conference with you and the technician's supervisor, the Chairman of the Section of Radiation Oncology of the Department of Medicine (Chairman, SRODM), the NRC has determined that discrimination occurred at the Hospital Center at Orange with respect to the technician.

The specific incident began on October 2, 1992, when the supervisor issued a letter to the Chairman of Radiology stating that he was displeased with the oncology technician's performance and that the technician takes every opportunity to discredit him and to "bad mouth" the department. The supervisor expressed displeasure when the technician volunteered information to an NRC inspector during an unannounced inspection on August 25, 1992. The information involved a January 1991 violation that prompted the inspector to see a copy of the citation that neither the technician nor the physicist could produce without asking the Radiation Safety Officer's office for help. The October 2, 1992 letter was presented to the technician on October 5, 1992. At this same time, the technician also was given a poor Employee Evaluation, which was dated October 2, 1995. While he was present when the letter and evaluation were given to the technician, the Administrative Director of Radiology and Oncology, who had examined the October 2, 1992 letter, did not take action to correct or preclude the violation.

At the enforcement conference, you denied that a violation of 10 CFR 30.7 occurred. Also, you indicated that the technician's conversation with the inspector did not play a role in the technician's evaluation and that a violation of 10 CFR 30.10 did not occur in that there was no deliberate misconduct. Notwithstanding your denial, the NRC maintains that the action by the technician's supervisor (i.e., issuance of the October 2, 1995 letter) constitutes a violation of the employee protection provisions in 10 CFR 30.7, given his expressed written displeasure at the technician for her discussions with the NRC.

As an NRC licensee, your organization has the responsibility to ensure that employees feel free to discuss safety concerns with management and the NRC; all safety concerns raised by staff are addressed adequately; and discrimination of individuals involved in protected activities does not occur. The actions of the supervisor in 1992 did not adhere to these standards, and did not provide an appropriate example for others under his supervision or those with whom he interfaced. In addition, management's failure to correct the situation once it became aware of the October 2, 1992 memorandum is also of concern. While you stated, during the enforcement conference, that the Hospital Center at Orange is opposed to any kind of discrimination, it is apparent, based on the actions of the supervisor, that the hospital's policy on discrimination did not result in the condition being precluded or corrected. Therefore, the violation is classified at Severity level III in accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 FR 34381, June 30, 1995).

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 is considered for a Severity Level III violation. Because the violation was willful, the NRC considered whether credit was warranted for *Identification and Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. No credit is warranted for identification since you did not identify the discriminatory actions. Credit is warranted for your corrective actions, which were described at the enforcement conference and included: (1) reaching a settlement with the technician; (2) instructing relevant supervisors and managers that employees should be encouraged to raise safety concerns and that the hospital will not permit retaliation against employees for raising safety concerns; (3) informing staff concerning its right to engage in protected activities and assuring the staff that the hospital endorses this policy; and (4) holding a meeting with employees to review NRC Form 3 and employee rights.

Nonetheless, to emphasize the significance of this case, and the importance of continuously assuring a work environment that is free of any harassment, intimidation, or discrimination against those who raise safety concerns, I have been authorized, after consultation with the Director, Office of Enforcement, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the base amount of \$2,500 for the Severity Level III violation set forth in the Notice.

You are required to respond to this letter and the enclosed Notice and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements. In addition, a Notice of Violation is being issued on this date to the supervisor for violation of NRC requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure(s), and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket No. 030-00347  
License No. 29-03038-02

Enclosure: Notice of Violation and Proposed Imposition of Civil Penalty

cc w/encl:

Jose Barba, M.D.

John F. McKeon, Bumgardner, Hardin & Ellis

State of New Jersey

ENCLOSURE

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Hospital Center at Orange  
Orange, New Jersey

Docket No. 030-00347  
License No. 29-03038-02  
EA 95-130

During an NRC investigation at the Hospital Center at Orange by the NRC Office of Investigations, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600 (60. FR 34381; June 30, 1995), the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violation and associated civil penalty are set forth below:

10 CFR 30.7(a) prohibits discrimination by a Commission licensee against an employee for engaging in certain protected activities. Discrimination includes discharge and other actions that relate to compensation, terms, conditions, or privileges of employment. The protected activities are established in Section 211 of the Energy Reorganization Act of 1974, as amended, and in general are related to the administration or enforcement of a requirement imposed under the Atomic Energy Act or the Energy Reorganization Act. The protected activities include an employee's providing the Commission or his or her employer information about alleged violations.

Contrary to the above, on October 2, 1992, the licensee discriminated against an employee (oncology technician) for engaging in protected activities. Specifically, the employee was discriminated against in that the employee's supervisor, Chairman of the Section of Radiation Oncology of the Department of Medicine, presented her with a letter on October 5, 1992, which the supervisor had signed on October 2, 1992, and sent to the Administrative Director of Radiology and Oncology as well as the Chairman of Radiology, criticizing her for having discredited him and the department by providing information regarding an earlier violation to an NRC inspector in August 1992.

This is a Severity Level III Violation (Supplement VII).  
Civil Penalty - \$2,500.

Pursuant to the provisions of 10 CFR 2.201, Hospital Center at Orange (Licensee) is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved.

If an adequate reply is not received within the time specified in this Notice, an Order or a Demand For Information may be issued as to why the license should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violation listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of the Enforcement Policy should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The response noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555, Rockville Pike, Rockville, MD, 20852-2738, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region I, 475 Allendale Road, King of Prussia, Pennsylvania 19406.

Enclosure

3

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal, privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, Pennsylvania  
this 28th day of September 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20585-0001

September 27, 1995

EA 95-183

Ms. Lourdes T. Boschuk, President  
J&L Testing Company, Inc.  
938 South Central Avenue  
Canonsburg, Pennsylvania 15317

SUBJECT: ORDER SUSPENDING LICENSE (EFFECTIVE IMMEDIATELY)

Dear Ms. Boschuk:

The enclosed Order Suspending License (Order) is being issued because of your violations of the Commission's regulations. The Order requires that: (1) all NRC-licensed material in your possession shall be placed in locked storage; (2) you suspend all activities under your license; (3) you shall not receive any NRC-licensed material while this Order is in effect; and (4) all records related to licensed activities must be maintained in their original form and must not be removed or altered in any way.

Pursuant to Section 223 of the Atomic Energy Act of 1954, as amended, any person who willfully violates, attempts to violate, or conspires to violate, any provision of this Order shall be subject to criminal prosecution as set forth in that section. Violation of this Order may also subject you to civil sanctions.

Questions concerning this Order should be addressed to Mr. James Lieberman, Director, Office of Enforcement, who may be reached at (301) 415-2741.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and the enclosure will be placed in the NRC's Public Document Room.

Sincerely,

*Hugh L. Thompson Jr.*  
Hugh L. Thompson, Jr.  
Deputy Executive Director for  
Nuclear Materials Safety, Safeguards  
and Operations Support

Docket No. 030-33725  
License No. 37-28442-02

Enclosure: As Stated

UNITED STATES  
NUCLEAR REGULATORY COMMISSION

In the Matter of )  
J&L TESTING COMPANY, INC. ) Docket No. 30-33725  
Canonsburg, Pennsylvania ) License No. 37-28442-02  
 ) EA 95-183

ORDER SUSPENDING LICENSE  
(EFFECTIVE IMMEDIATELY)

I

J&L Testing Company, Inc., (Licensee or JLT) is the holder of Byproduct Nuclear Material License No. 37-28442-02 issued by the Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR Part 30. The license authorizes possession and use of Cesium-137 and Americium-241 in sealed sources. The license, originally issued on February 7, 1995, was amended on August 22, 1995, and is due to expire on February 29, 2000.

II

J & L Engineering, Inc., (JLE) a corporation located at the same address and using the same telephone and facsimile numbers as the Licensee, held license No. 37-28442-01 for the same three gauges for which the Licensee is now licensed. John Boschuk, the president of JLE, is the co-owner, along with Lourdes T. Boschuk, of JLT. JLE's license was revoked on August 30, 1993, for non-payment of fees and JLE was ordered, in part, to cease use of byproduct material, dispose of the byproduct material, and notify the NRC of the disposition within 30 days of that order. On October 5, 1994, a Notice of Violation (Notice) was issued to JLE for possession of licensed material without a valid NRC license, as its NRC license had been revoked. On October 11, 1994, John Boschuk responded to the Notice, stating, among other things, that the "...equipment [3-Troxler Nuclear Density gauges] has not been used

for over 2 years and has not left the storage area in our office."

On November 21, 1994, JLT submitted an application for a license. The November 21, 1994 cover letter for the application, signed by Lourdes T. Boschuk, President of JLT, stated the following:

... submitted herein is our application to restore our expired license to store and operate three (3) Troxler Nuclear Density Gages (sic). We understand our license was revoked on August 30, 1993. Since that date, these units were not removed from storage nor used in anyway (sic).

Relying on the application and the statement concerning use of the gauges after the time the JLE license was revoked, the NRC issued a new license (License No. 37-28442-02) to JLT on February 7, 1995.

On August 1 and 3, 1995, the NRC conducted a routine safety inspection of activities authorized by License No. 37-28442-02 at the Licensee's facility in Canonsburg, Pennsylvania. During the inspection, an NRC inspector determined, based on a review of utilization logs, that one of the gauges, which JLE and the Licensee separately had stated in writing to the NRC were in storage, had been used on September 1 and 2, 1994 (at a temporary jobsite at the S. Hill Village Sears project), by either JLE or JLT (when neither possessed an NRC license). The use of this gauge without a valid NRC license was in violation of 10 CFR 30.3, which prohibits use of byproduct material without a valid license from the NRC. In addition to this violation, the statements by Ms. Boschuk, in her November 21, 1994 letter to the NRC, and by Mr. Boschuk, in

his October 11, 1994 letter to the NRC, were not accurate and, therefore, constituted a violation of 10 CFR 30.9.

During the August 1995 inspection three additional violations of NRC requirements were identified. These violations involved the failure to perform leak tests of the devices (gauges) at the required 6-month intervals as required by Condition 12 of the license, the failure to have an approved Radiation Safety Officer (RSO) (the RSO listed on the license terminated employment on May 26, 1995) as required by License Condition 11A, and the failure to perform inventories of the gauges at the required 6-month intervals as required by Condition 14 of the license. By letter dated September 11, 1995, the Licensee's president stated that the facts of these violations were correct.

A predecisional enforcement conference was held with the Licensee on September 15, 1995, to discuss the five violations identified during the August 1995 inspection. At the conference JLT's president admitted all five violations but offered no explanations for why the material had been used notwithstanding the revocation of JLE's license or for the inaccurate statements made to the NRC.

In addition, based on a September 22, 1995, letter from the State of New York to JLT, it appears that JLT had not requested or obtained reciprocity for use of radioactive materials as required by regulations of the State of New York. JLT also appears to have provided false statements to the New York State Department of Labor concerning use of radioactive material in New York State.

III

Although the NRC has initiated an investigation into these violations, based on the above and on information developed to date, the NRC concludes that the Licensee violated NRC requirements by: (1) providing inaccurate information to the Commission, a violation of 10 CFR 30.9; (2) using and possessing licensed material without a valid NRC license, a violation of 10 CFR 30.3; (3) not performing leak tests of the gauges at the required 6-month intervals, a violation of License Condition 12; (4) not having an approved Radiation Safety Officer (RSO), a violation of License Condition 11A; and (5) not performing inventories of the gauges at the required 6-month intervals, a violation of License Condition 14.

The Atomic Energy Act of 1954, as amended (Act), limits possession and use of byproduct material to those who possess a valid NRC license. In this case, the Licensee's use of the gauge without a license is a significant regulatory concern, particularly in view of the inaccurate information submitted to the Commission in response to the Notice (JLE's October 11, 1994 letter) and in support of an NRC license application (JLT's November 21, 1994 letter). Such inaccurate information was material and influenced the NRC's decision to grant the Licensee an NRC license. The NRC's concern is further heightened given the potential safety significance of the other violations - failure to have an approved RSO, failure to perform required leak tests of the gauges, and failure to perform periodic inventories of the gauges.

While the investigation is ongoing, the NRC has concluded based upon the

information developed to date that the Licensee, through its co-owners, who knew that JLE's license had been revoked, knew that the NRC had requested a formal response to a Notice of Violation, and knew it was submitting information to influence the NRC to grant it a new license, provided inaccurate information in response to a Notice of Violation and in obtaining a license from the Commission. In light of the above and regulatory significance of the submittals, the staff concludes that the submittal of this false information, if not deliberate, was in careless disregard of Commission requirements. Further, based on the correspondence and co-ownership of JLE and the JLT, the NRC concludes that Mr. and Ms. Boschuk, co-owners of the JLT, are responsible for compliance with NRC requirements.

The NRC must be able to rely on the Licensee and its employees to comply with NRC requirements, including the requirement to provide information that is complete and accurate in all material respects. The Licensee, through its representatives, has demonstrated an unwillingness or inability to comply with NRC requirements. The Licensee's misrepresentations to the NRC, as well as its actions in violating other NRC requirements, have raised serious doubt as to whether it can be relied upon in the future to provide complete and accurate information to the NRC or to comply with NRC requirements.

Consequently, I lack the requisite reasonable assurance that the Licensee's current operations can be conducted under License No. 37-26442-02 in compliance with the Commission's requirements and that the health and safety of the public, including the Licensee's employees, will be protected if the Licensee is permitted to conduct licensed activities at this time. Therefore,

the public health, safety, and interest require that License No. 37-26442-02 be suspended, with the exception of certain requirements enumerated in Section IV below pending the completion of the investigation. Furthermore, pursuant to 10 CFR 2.202, I find that in light of the willfulness of the Licensee's conduct, the public health, safety, and interest require that this Order be immediately effective.

IV

Accordingly, pursuant to sections 81, 161b, 161i, 161o, 182 and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR 2.202 and 10 CFR Part 30, IT IS HEREBY ORDERED, EFFECTIVE IMMEDIATELY, THAT LICENSE NO. 37-28442-02 IS SUSPENDED AS FOLLOWS:

Pending further investigation and Order by the NRC:

- A. All NRC-licensed material in the Licensee's possession shall be placed in locked storage.
- B. The Licensee shall suspend all activities under its license to use or transfer licensed material. The Licensee shall provide prior notice to the NRC, Region I before transferring the sources. All other requirements of the license remain in effect.
- C. The Licensee shall not receive any NRC-licensed material while this Order is in effect.

D. All records related to licensed activities must be maintained in their original form and must not be removed or altered in any way.

The Regional Administrator, Region I, may, in writing, relax or rescind any of the above conditions upon demonstration by the Licensee of good cause.

V

In accordance with 10 CFR 2.202, the Licensee must, and any other person adversely affected by this Order may, submit an answer to this Order, and may request a hearing on this Order, within 20 days of the date of this Order. Where good cause is shown, consideration will be given to extending the time to request a hearing. A request for extension of time must be made in writing to the Director, Office of Enforcement, and include a statement of good cause for the extension. The answer may consent to this Order. Unless the answer consents to this Order, the answer shall, in writing and under oath or affirmation, specifically admit or deny each allegation or charge made in this Order and shall set forth the matters of fact and law on which the Licensee or other person adversely affected relies and the reasons why the Order should not have been issued. Any answer or request for hearing shall be submitted to the Secretary, U.S. Nuclear Regulatory Commission, Attn: Chief, Docketing and Service Section, Washington, DC 20555. Copies also shall be sent to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, to the Assistant General Counsel for Hearings and Enforcement at the same address, to the Regional Administrator, NRC Region I, 475 Allendale Road, King of Prussia, Pennsylvania 19406-1415, and to the

Licensee, if the answer or hearing request is by a person other than the Licensee. If a person other than the Licensee requests a hearing, that person shall set forth with particularity the manner in which his or her interest is adversely affected by this Order and shall address the criteria set forth in 10 CFR 2.714(d).

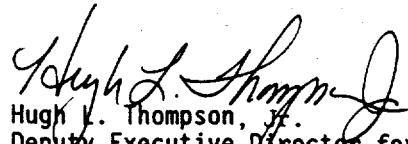
If a hearing is requested by the Licensee or a person whose interest is adversely affected, the Commission will issue an Order designating the time and place of any hearing. If a hearing is held, the issue to be considered at such hearing shall be whether this Order should be sustained.

Pursuant to 10 CFR 2.202(c)(2)(i), the Licensee, or any other person adversely affected by this Order, may, in addition to demanding a hearing, at the same time the answer is filed or sooner, move the presiding officer to set aside the immediate effectiveness of the Order on the grounds that the Order, including the need for immediate effectiveness, is not based on adequate evidence but on mere suspicion, unfounded allegations, or error.

In the absence of any request for hearing, or written approval of an extension of time in which to request a hearing, the provisions specified in Section IV above shall be final 20 days from the date of this Order without further order or proceedings. If an extension of time for requesting a hearing has been approved, the provisions specified in Part IV of this Order shall be final when the extension expires if a hearing request has not been received. AN

ANSWER OR A REQUEST FOR HEARING SHALL NOT STAY THE IMMEDIATE EFFECTIVENESS OF  
THIS ORDER.

FOR THE NUCLEAR REGULATORY COMMISSION



Hugh L. Thompson, Jr.  
Deputy Executive Director for  
Nuclear Materials Safety, Safeguards,  
and Operations Support

Dated at Rockville, Maryland  
this 27th day of September 1995



EA 94-008

UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA STREET, N.W., SUITE 2900  
ATLANTA, GEORGIA 30323-0199

July 27, 1995

Logan General Hospital  
ATTN: Mr. C. David Morrison  
President  
20 Hospital Drive  
Logan, West Virginia 25601

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY -  
\$8,000 (NRC Inspection Report No. 47-19919-01/93-01 and  
Investigation Report No. 2-93-067R)

Gentlemen:

This refers to an inspection conducted by Mr. Jerry Ennis of this office on December 7-8, 1993, and an investigation conducted by the Nuclear Regulatory Commission (NRC) Office of Investigations (OI) completed on November 23, 1994. During these reviews, the NRC examined the facts and circumstances surrounding the falsification of certain NRC-required records and the administration of diagnostic radiopharmaceuticals to patients in excess of the prescribed doses at your Logan, West Virginia, facility. Based on the results of our reviews, violations of NRC requirements were identified.

The subject inspection report and the synopsis of the OI investigation were sent to you by letters dated January 13, 1994 and June 8, 1995, respectively. The latter correspondence also provided you an opportunity to attend an enforcement conference to discuss the apparent violations, their cause, and your corrective action to preclude recurrence. In a response dated June 14, 1995, you declined to attend a conference indicating no objection to the additional apparent violations provided and your belief that NRC was fully knowledgeable of the corrective actions implemented. We have reviewed the aforementioned inspection and investigation results as well as inspections of corrective actions associated with the Confirmatory Actions Letters (CALs) issued by NRC on December 10, 1993, and February 25, 1994, and have concluded that sufficient information is available to determine the appropriate enforcement action in this matter.

The violations described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) involved: (1) the pervasive falsification of documentation and patient dose records; (2) the routine, unauthorized administration of radiopharmaceuticals to patients in excess of that prescribed by the authorized user; and (3) the failure of the licensee, through the Radiation Safety Officer (RSO)<sup>1</sup>, to ensure that the radiation safety program was conducted in accordance with regulatory requirements. This latter violation included ten examples of where you failed to comply with the

<sup>1</sup> The licensee's RSO referenced throughout this letter and its enclosure is the RSO employed by the licensee in approximately June 1991, suspended on February 18, 1994, and subsequently dismissed.

applicable requirements and involved training, security and storage of radioactive material, conduct of periodic linearity tests and surveys, shipping and transportation, and processing and evaluation of dosimetry. With the exception of a few of the examples cited in Violation C (i.e., security of licensed material, and storage of food and beverages with radioactive material), the violations resulted from the deliberate misconduct of your RSO, who willfully disregarded regulatory requirements, falsified documents to conceal the practices, and trained and directed subordinates to do the same.

As a result of the aforementioned activities, on March 10, 1994, an Order was issued prohibiting the RSO from engaging in any licensed activities, pending further action by NRC. The RSO also pled guilty to a criminal violation of the Atomic Energy Act and the Commission's regulations.

Nevertheless, you, as an NRC licensee, are responsible for the acts of your employees. It is essential that the NRC be able to maintain the highest trust in individuals working with licensed material and that licensees appropriately manage their programs to ensure that personnel fully understand the importance of complying with regulatory requirements. Apart from the willful nature of the violations, the NRC is concerned because the magnitude and duration of the violations were indicative of a substantial breakdown in the management and control of licensed activities. Your designation of the same individual as the RSO, Chairman of the Radiation Safety Committee, and Chief Technologist, coincident with the lack of additional management oversight, permitted an environment to develop and be maintained in which falsification of records and willful violations occurred without detection. Although the specific violations did not appear to adversely impact the health of patients, the violations are of very significant regulatory concern because of the potential safety significance they presented. Therefore, in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), (60 FR 34381, June 30, 1995), the violations have been categorized collectively as a Severity Level II problem.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$4,000 is considered for a Severity Level II problem. The NRC considered whether credit was warranted for *Identification* and *Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. No credit was given for identification because the NRC identified the violations through its inspection and investigation process. Your corrective actions included: (1) retraining of the nuclear medicine technologists (NMTs) in all safety activities associated with licensed materials; (2) initiation of monthly independent audits, the results of which were reported to Hospital Administration; (3) implementation of increased oversight of daily activities; and (4) designation of three different individuals for the positions of Chief Technologist, Radiation Safety Officer, and Chairman of the Radiation Safety Committee. However, credit for such actions was not warranted in view of the fact that upon initial indication of the concerns in December 1993, the hospital did not take prompt corrective

actions (i.e., you did not aggressively pursue an internal assessment of the program or activities of the RSO, given the significance of the violations). Instead, NRC involvement, as documented in the two CALs, was necessary before comprehensive corrective action was taken by the hospital.

We note that the NRC has confirmed through inspections that the committed corrective actions have been implemented. In addition, the NRC observed significant improvements in the level of knowledge and training of the NMTs and substantial improvement in the management involvement and oversight of the program. Based on these latter inspections, you subsequently were granted relief from the monthly frequency for independent audits to a quarterly frequency.

Nonetheless, to emphasize the importance of effective management and oversight of radiation safety programs, of providing complete and accurate information to the NRC, of prompt identification of violations, and of taking comprehensive corrective action, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Materials Safety, Safeguards, and Operations Support, to issue the enclosed Notice in the amount of \$8,000, twice the base amount for the Severity Level II problem.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. Your response may reference or include previously docketed correspondence, if the correspondence adequately addressed the required response. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it is necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act 1980, Pub. L. No. 96-511.

Logan General Hospital

- 4 -

If you have any questions regarding this letter, please contact Mr. Charles M. Hosey, Chief, Nuclear Materials Inspection Section at (404) 331-5614.

Sincerely,



Stewart D. Ebnetter  
Regional Administrator

Docket No. 030-19530  
License No. 47-19919-01

Enclosures: 1. Notice of Violation and  
Proposed Imposition of Civil Penalty  
2. Enforcement Policy (60 FR 34381, June 30, 1995)

cc w/encls 1 and 2:  
State of West Virginia

U.S. Department of Justice  
United States Attorney  
Southern District of West Virginia  
ATTN: Mr. Paul A. Billups  
Assistant U.S. Attorney  
Post Office Box 1239  
Huntington, West Virginia 25714

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Logan General Hospital  
Logan, West Virginia

Docket No. 030-19530  
License No. 47-19919-01  
EA 94-008

During an NRC inspection conducted on December 7 and 8, 1993, and an Office of Investigations (OI) investigation concluded on November 23, 1994, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381, June 30, 1995), the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Action of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

A. 10 CFR 30.9(a) requires, in part, that information provided to the Commission by a licensee or information required by the Commission's regulations, orders, or license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

Contrary to the above, during the December 7 and 8, 1993 NRC inspection, and subsequent OI investigation, the licensee's Radiation Safety Officer (RSO) provided information and presented records to the NRC describing and documenting the licensee's fulfillment of regulatory requirements which were not accurate in all material respects in that the information and records indicated that licensed activities conducted between September 1992 and December 1993 were being performed in accordance with applicable regulatory requirements when, in fact, they were not. Specifically, information and records involving:

- (1) radiopharmaceutical doses required by 10 CFR 35.53(c)(3) were inaccurate in that records did not contain the correct activity of the dosage at the time of measurement and instead indicated the prescribed activity;
- (2) the training of licensee personnel required by License Condition 16 and by commitments made in response to an NRC Confirmatory Action Letter, dated December 10, 1993, were inaccurate in that the documented training had not been conducted;
- (3) the conduct of daily dose calibrator constancy checks required by 10 CFR 35.50(b)(1) were inaccurate in that records did not reflect a radionuclide activity which had been measured;
- (4) surveys of radioactive material received or being prepared for shipment required by 10 CFR 20.205<sup>2</sup>, 10 CFR 71.5(a) and 49 CFR 173.475(i) were inaccurate in that records did not reflect

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<sup>2</sup> This regulatory reference is consistent with that in effect at the time the violation was identified. The current version of 10 CFR Part 20 did not become effective until January 1, 1994.

Enclosure 1

Notice of Violation and Proposed - 2 -  
Imposition of Civil Penalty

radiation and contamination levels which had been actually measured; and

(5) the performance of daily radiation surveys and weekly contamination surveys of nuclear medicine areas required by 10 CFR 35.70 were inaccurate in that records did not reflect radiation and contamination levels which had been actually measured. (01012)

B. 10 CFR 35.25(a)(2) requires, in part, that a licensee that permits the receipt, possession, use or transfer of byproduct material by an individual under the supervision of an authorized user shall require the supervised individual to follow the instructions of the supervising authorized user. The Nuclear Medicine Department's Procedures Manual provided instructions to technologists, reviewed and approved by the authorized user, regarding the dose ranges for various nuclear medicine procedures.

License Condition 16 to License Number 47-19919-01 requires, in part, that the licensee conduct its program in accordance with the statements contained in the application, dated February 26, 1992. The application states, in part, that the licensee will implement the model safety rules published in Appendix I to Regulatory Guide 10.8 (R.G. 10.8), Revision 2. The model safety rules in Appendix I to R.G. 10.8, Revision 2, provide, in part, that patient doses shall be measured in a dose calibrator before administering and shall not be used if the measured dosage differs from the authorized dosage by more than ten percent.

Contrary to the above, on numerous occasions between September 1992 and December 1993, supervised individuals did not follow the instructions of the supervising authorized user contained in the Procedures Manual in that technologists, at the direction of the RSO, measured and used patient doses of radiopharmaceuticals which exceeded the authorized dosage by substantially more than ten percent. (01022)

C. 10 CFR 35.21(a) requires, in part, that the licensee, through the RSO, shall ensure that radiation safety activities are being performed in accordance with approved procedures and regulatory requirements in the daily operation of the licensee's byproduct material program.

Contrary to the above, on numerous occasions between September 1992 and December 1993, the licensee, through the RSO, did not ensure that radiation safety activities were being performed in accordance with approved procedures and regulatory requirements in the daily operation of the licensee's byproduct material program, as evidenced by the following violations of procedures and regulatory requirements:

Notice of Violation and Proposed - 3 -  
Imposition of Civil Penalty

1. License Condition 16 to License Number 47-19919-01 requires, in part, that the licensee conduct its program in accordance with the statements contained in the application, dated February 26, 1992. The application states, in part, that the licensee will implement the model training program contained in Appendix A to Regulatory Guide 10.8, Revision 2 (R.G. 10.8).

Between at least September 1992 and December 8, 1993, the licensee did not implement the model training program contained in Appendix A to R.G. 10.8 in that technologists who worked in areas where byproduct material was used or stored were not trained in the following subjects: applicable regulations and license conditions; potential hazards associated with radioactive material in areas where the technologists worked; appropriate radiation safety procedures; the technologists' obligation to report unsafe conditions to the RSO; the appropriate response to emergencies or unsafe conditions; the technologists' right to be informed of occupational radiation exposures or bioassay results; and locations where notices, copies of pertinent regulations, and the license are posted or made available.

2. License Condition 16 to License Number 47-19919-01 requires, in part, that the licensee conduct its program in accordance with the statements contained in the application dated February 26, 1992. The application states, in part, that the licensee will implement the model safety rules published in Appendix I to R.G. 10.8, Revision 2. The model safety rules in Appendix I to R.G. 10.8, Revision 2, provide, in part, that food or drink are not to be stored in areas where radioactive material are stored.

On December 7, 1993, the licensee failed to implement the model safety rules published in Appendix I to R.G. 10.8 in that a container of juice was found stored in a refrigerator in the Nuclear Medicine Department where radioactive material was also stored. The refrigerator containing the items bore a "Caution- Radioactive Materials" sign on its door and contained a tube labeled "Cobalt-58, 8 ml, 0.016 uCi/ml."

3. 10 CFR 20.207(a) requires that licensed materials stored in an unrestricted area be secured against unauthorized removal from the place of storage. 10 CFR 20.207(b) requires that materials not in storage be under the constant surveillance and immediate control of the licensee. As defined in 10 CFR 20.3(a)(17), in part, an unrestricted area is any area access to which is not controlled by

Notice of Violation and Proposed - 4 -  
Imposition of Civil Penalty

the licensee for purposes of protection of individuals from exposure to radiation and radioactive materials.<sup>2</sup>

On December 7, 1993, licensed material consisting of one Molybdenum-99/Technetium-99m generator containing approximately 0.707 Curies of radioactive material and sealed calibration/check sources containing microcurie (uCi) amounts of Cesium-137, Barium-133, Manganese-54, Cadmium-109, and Cobalt-60 were located in an unrestricted area, were not secured against unauthorized removal, and were not under the constant surveillance and immediate control of the licensee. Specifically, the licensed materials were located in the hot laboratory in an unoccupied, unsecured Nuclear Medicine Department.

4. 10 CFR 20.201(b) requires that each licensee make such surveys as may be necessary to comply with the requirements of Part 20 and which are reasonable under the circumstances to evaluate the extent of radiation hazards that may be present. As defined in 10 CFR 20.201(a), "survey" means an evaluation of the radiation hazards incident to the production, use, release, disposal, or presence of radioactive material or other sources of radiation under a specific set of conditions.<sup>2</sup>

As of December 8, 1993, the licensee did not conduct a survey to evaluate the extent of radiation exposure received by the licensee's RSO during the month of April 1993 following a report from the licensee's film badge processor that the RSO's film badge for that period was unreadable.

5. 10 CFR 35.50(b)(3) requires, in part, that a licensee test each dose calibrator at least quarterly for linearity over the range of its use between the highest dosage that will be administered to a patient and 10 microcuries.

During the second, third, and fourth quarters of 1993, the licensee failed to adequately test the dose calibrator for linearity to 10 microcuries. This failure to test dose calibrator linearity over the required range was identified by the licensee's consultant and reported by the consultant to the RSO, but no corrective action was taken.

6. 10 CFR 71.5(a) requires that a licensee who transports licensed material outside of the confines of its plant or other place of use, or who delivers licensed material to a carrier for transport,

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<sup>2</sup> This regulatory reference is consistent with that in effect at the time the violation was identified. The current version of 10 CFR Part 20 did not become effective until January 1, 1994.

Notice of Violation and Proposed - 5 -  
Imposition of Civil Penalty

comply with the applicable requirements of the regulations appropriate to the mode of transport of the Department of Transportation (DOT) in 49 CFR Parts 170 through 189.

49 CFR 172.203(d) requires, in part, that the description for a shipment of radioactive material include: (1) the name of each radionuclide; (2) the physical and chemical form of the material; (3) the activity contained in each package of the shipment in terms of curies, millicuries, or microcuries; (4) the category of label applied to each package (e.g., RADIOACTIVE WHITE-I); and 5) the transport index assigned to each package in the shipment bearing RADIOACTIVE YELLOW-II OR -III labels.

On numerous occasions between September 1992 and December 1993, the licensee delivered licensed material to a carrier for transport and did not comply with the applicable requirements of the Department of Transportation. Specifically, the descriptions on the shipping papers that accompanied the shipments of radioactive material did not accurately reflect the activity contained in each package and the transport index assigned for each package. Failure to comply with applicable DOT requirements regarding shipping papers was identified by the licensee's consultant and reported by the consultant to the RSO, but no corrective action was taken.

7. 10 CFR 30.51(a) requires that each licensee keep records showing the receipt, transfer, export, and disposal of byproduct material.

The licensee did not keep records of the transfer of byproduct material, Molybdenum-99/Technetium-99 in a generator, shipped on or about November 30, 1993.

8. License Condition 16 to License Number 47-19919-01 requires, in part, that the licensee conduct its program in accordance with the statements contained in the application dated February 26, 1992. The application states, in part, that the licensee will implement the model procedure for area surveys published in Appendix N to R.G. 10.8, Revision 2. The model procedure for area surveys in Appendix N to R.G. 10.8, Revision 2 provides, in part, that the wipe sample assay procedure be sufficiently sensitive to detect the presence of 2000 dpm/100 cm<sup>2</sup> (2000 disintegrations per minute per 100 square centimeters).

Between at least September 1992 and December 1993, the licensee failed to adequately implement the model procedures for area surveys published in Appendix N of R.G. 10.8 in that the wipe sample assay procedure in use was not sufficiently sensitive to detect the presence of 2000 dpm/100 cm<sup>2</sup>. Specifically, observations of two technologists performing surveys determined

Notice of Violation and Proposed - 6 -  
Imposition of Civil Penalty

that their survey technique (i.e., orientation of the detection probe to the source of radiation being measured) would result in readings lower than the actual levels and would not have detected 2000 dpm/100 cm<sup>2</sup>.

9. 10 CFR 35.70(a) requires that a licensee survey with a radiation detection survey instrument at the end of each day of use all areas where radiopharmaceuticals are routinely prepared for use or administered.

On numerous occasions between at least September 1992 and December 1993, the licensee did not survey with a radiation detection survey instrument at the end of each day of use all areas where radiopharmaceuticals were routinely prepared for use or administered.

10. License Condition 16 to License Number 47-19919-01 requires, in part, that the licensee conduct its program in accordance with the statements contained in the application dated February 26, 1992. The application states, in part, that the licensee will implement the model personnel exposure monitoring program published in Appendix D of R.G. 10.8, Revision 2. The model procedure for personnel exposure monitoring devices states, in part, that personnel exposure monitoring devices (film badges) will be processed by a contract service on a monthly basis.

The licensee did not implement the model personnel exposure monitoring program published in Appendix D of R.G. 10.8 in that film badges were not processed by the licensee's contract service in the month of February 1993. (01032)

This is a Severity Level II problem (Supplements V, VI and VII).  
Civil Penalty - \$8,000

Pursuant to the provisions of 10 CFR 2.201, Logan General Hospital (Licensee) is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation; (2) the reasons for the violation if admitted, and if denied, the reasons why; (3) the corrective steps that have been taken and the results achieved; (4) the corrective steps that will be taken to avoid further violations; and (5) the date when full compliance will be achieved.

If an adequate reply is not received within the time specified in this Notice, an Order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked or why such other actions as may

Notice of Violation and Proposed - 7 -  
Imposition of Civil Penalty

be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or the cumulative amount of the civil penalties if more than one civil penalty is proposed, or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an Order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violations listed in this Notice in whole or in part; (2) demonstrate extenuating circumstances; (3) show error in this Notice; or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of the Enforcement Policy should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The response noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852-2738, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region II, 101 Marietta Street, Atlanta, GA 30323.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you

Notice of Violation and Proposed - 8 -  
Imposition of Civil Penalty

should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at Atlanta, Georgia  
this 27th day of July 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA PENNSYLVANIA 19406 1415

June 28, 1995

EA 95-046

Mr. John E. Sisson, President  
Quality Inspection Services, Inc.  
186 Warwick Avenue  
Post Office Box 732  
Buffalo, New York 14215-0732

**SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL  
PENALTIES - \$13,000; AND DEMAND FOR INFORMATION (NRC INSPECTION  
REPORT 95-001 AND NRC OFFICE OF INVESTIGATIONS REPORT 1-95-010)**

Dear Mr. Sisson:

This letter refers to the NRC inspection conducted at a radiography field office in Warren, Pennsylvania, on February 3, 1995, as well as the subsequent investigation by the NRC Office of Investigations (OI). A copy of the inspection report and the OI investigation synopsis were sent to you on March 17, 1995, and May 8, 1995, respectively. On May 18, 1995, an enforcement conference was conducted with you and members of your staff to discuss the apparent violations, their causes, and your corrective actions.

Based on the inspection and OI investigation, as well as an enforcement conference held on May 18, 1995, three violations of NRC requirements were identified. The violations, which are described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalties (Notice), involved: (1) the performance of radiography by your company (a New York State licensee) in Pennsylvania, between May 1993 and February 1995, without an NRC specific license or notifications required for work under reciprocity; (2) the submittal of inaccurate information to the NRC inspector during the inspection by your former Quality Control Field Supervisor (QCFS) when the inspector questioned the QCFS as to whether he had ever performed radiography in the Commonwealth of Pennsylvania for QIS; and (3) the failure of two radiographers to wear the required alarm ratemeters during the performance of radiography on February 3, 1995.

During the February 1995 inspection, the NRC determined that your company had been performing radiography in Warren, Pennsylvania, without authorization from the NRC, either via an NRC specific license or reciprocity. Although you did possess a New York State license authorizing you to perform radiography within the State of New York, the New York State license did not authorize you to perform radiography in Pennsylvania. Rather, an NRC specific license or a notification to the NRC to work under reciprocity was needed for performing radiography in Pennsylvania.

Based on further investigation by OI, the NRC also learned that your performance of radiography in Pennsylvania had been occurring periodically since May 1993. Although you filed an application with the NRC for an NRC license on November 17, 1994, you did not do so until approximately five months after the State of New York had sent its licensees a notification, dated June 14, 1994, emphasizing to them the need to notify the NRC under reciprocity prior to doing work in a non-Agreement state. Furthermore, you continued to perform radiography in Pennsylvania after the application was prepared (but not submitted) as well as after it was submitted to the NRC without awaiting NRC approval of the license. Also, at the time the application was submitted, you did not inform the NRC that radiography already had been, and was being, performed in Pennsylvania.

The first two violations, which are described in Section I of the Notice, are of particular concern because of their willful nature. In addition, the failure to notify NRC, through submittal of NRC Form-241, is of concern because it denies the NRC an opportunity to conduct inspections of licensed activities to ensure compliance with NRC requirements. The failure to provide accurate information to the NRC is of concern, because it interfered with the NRC's inspection and investigation, and because licensees, including their employees, are expected to be honest and forthright in their communications with the NRC. Therefore, the violations are of very significant regulatory concern and are classified in the aggregate as a Severity Level II problem in accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, (Enforcement Policy).

The violation addressed in Section II of the Notice is of significant regulatory concern because the alarm ratemeters are required by NRC regulations to ensure that radiographers are warned of the presence of radiation and to avoid unnecessary radiation exposure. Given the significance of assuring that alarm ratemeters are worn to ensure such protection, this violation is classified at Severity Level III in accordance with the Enforcement Policy.

The NRC recognizes that at the time of the enforcement conference, corrective actions had been planned or taken to correct the violations and prevent recurrence, including: (1) stopping of the work in Pennsylvania; (2) hiring a clerk to assist the Radiation Safety Officer in the performance of his duties; (3) bringing the former QCFS to the enforcement conference, even though he had been laid off by you, to send a message to all staff that the submittal of inaccurate information to the NRC will not be tolerated; (4) discussing the alarm ratemeter violation with all of your radiographers; (5) purchasing radiation videotapes from the American Society for Nondestructive Testing and incorporating them as part of your training program; and (6) plans for training and certification of all radiographers.

The NRC also recognizes that at the enforcement conference, although you did not deny the violations, you indicated that there were not any attempts to conceal your activities. However, notwithstanding your contentions and corrective actions, a significant NRC action is warranted, so as to emphasize that activities requiring NRC authorizations are conducted safely and in accordance with requirements. Accordingly, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for

Nuclear Materials Safety, Safeguards, and Operations Support, to issue the enclosed Notice in the cumulative amount of \$13,000 for the violations set forth in the Notice.

With respect to the violations in Section I of the Notice, the base civil penalty amount for a Severity Level II problem is \$8,000. Based on the circumstances of this case, the NRC is exercising discretion and is not using the escalation and mitigation factors of Section VI.B.2 of the Enforcement Policy, because the civil penalty for this problem is appropriate to reflect the level of NRC concern regarding the willful nature of the violations and to convey the appropriate message to QIS.

As to Section II of the Notice, on balance, no adjustment of the \$5,000 base civil penalty is warranted. A basis exists for 50% escalation since the violation was identified by the NRC. A basis exists for 50% mitigation based on your prompt and comprehensive corrective actions. No adjustment is warranted based on your past performance given this was the first NRC inspection of your company. The other escalation/mitigation factors were considered and no further adjustment was warranted.

In addition, pursuant to Sections 161c, 161o, 182 and 186 of the Atomic Energy Act of 1954, as amended, 10 CFR 2.204, 10 CFR 30.32, and 10 CFR 150.20, in order for the Commission to determine whether a specific NRC license should be issued (in response to your application filed on November 17, 1994), and whether your general license should be modified, suspended or revoked, you are required to submit to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, Maryland 20852-2738, within 30 days of the date of this Demand For Information, in writing and under oath or affirmation, an explanation as to why the NRC can have confidence that: (1) QIS will be fully knowledgeable of NRC requirements and will comply with NRC requirements in the future, and (2) QIS will assure that information submitted to the NRC is complete and accurate in all material respects. Copies of the response to this Demand for Information should be sent to the Assistant General Counsel for Hearings and Enforcement at the same address, and the Regional Administrator, NRC Region I, 475 Allendale Road, King of Prussia, Pennsylvania 19406-1415.

You are required to respond to this letter and the enclosed Notice and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket No. 15000031  
New York License No. 2514-3645

Enclosure: Notice of Violation and Proposed Imposition of  
Civil Penalties

ENCLOSURE

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTIES

Quality Inspection Services, Inc. (QIS)  
Buffalo, New York

Docket No. 15000031  
New York License No. 2514-3645  
EA 95-046

During an NRC inspection conducted on February 3, 1995, as well as a subsequent investigation by the NRC Office of Investigations (OI), violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the Nuclear Regulatory Commission proposes to impose civil penalties pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalties are set forth below:

I. Violations Involving Reciprocity

A. 10 CFR 150.20(b)(1) requires, in part, that any person engaging in activities in non-Agreement States under the general license granted by 10 CFR 150.20(a) shall at least three days prior to engaging in such activity, file four copies of Form-241 (revised), "Report of Proposed Activities in Non-Agreement States," and four copies of its Agreement State specific license with the Regional Administrator of the U.S. Nuclear Regulatory Commission Regional Office for the region in which the Agreement State that issued the license is located. The Regional Administrator may authorize the Agreement State licensee to begin licensed activities upon notification by telephone of the licensee's intent to conduct the proposed activity under the general license, provided that four copies of Form 241 (revised) and four copies of the Agreement State license are filed within three days after the telephone notification.

Contrary to the above, from May 1993 through February 3, 1995, QIS engaged in activities under the general license granted by 10 CFR 150.20(a) in a non-Agreement State (Pennsylvania) by utilizing a Tech/Ops Model 660 iridium-192 exposure device on a pipeline owned and operated by the National Fuel Gas Company in and around the Allegheny National Forest in northwestern Pennsylvania, without first notifying the NRC or filing any copies of NRC Form-241 with the NRC Region I office. (01012)

B. 10 CFR 150.20 provides, in part, that persons who hold a specific license from an Agreement State are granted an NRC general license to conduct the same activity in a non-Agreement State provided the general licensee complies with, *inter alia*, 10 CFR 30.9.

10 CFR 30.9(a) requires, in part, that information provided to the Commission by a licensee be complete and accurate in all material respects.

Contrary to the above, on February 3, 1995, QIS provided information to the Commission that was not complete and accurate in all material respects. Specifically, Mr. Frank Papalia, the QIS Quality Control Field Supervisor in Warren, Pennsylvania, when questioned by an NRC inspector as to whether he had ever used an iridium-192 source at the United Refineries facility in Warren, Pennsylvania, stated that he had not used such source in Pennsylvania. This statement was inaccurate, because QIS records indicate that the individual had, in fact, performed radiography at the facility on at least three occasions in April 1994, and because Mr. Papalia admitted during an enforcement conference on May 18, 1995, that he had performed radiography at the facility. This information was material, because it interfered with the NRC inspection and investigation. (01022)

This is a Severity Level II problem (Supplements VI and VII).  
Civil Penalty - \$8,000

## II. Violation Involving Alarm Ratemeter

10 CFR 150.20 provides, in part, that persons who hold a specific license from an Agreement State are granted an NRC general license to conduct the same activity in a non-Agreement State provided the general licensee complies with, *inter alia*, Subpart B of Part 34.

10 CFR 34.33(a), which is contained in Subpart B of Part 34, requires that a licensee not permit any individual to act as a radiographer or a radiographer's assistant unless, at all times during radiographic operations, each such individual wears an alarm ratemeter.

Contrary to the above, on February 3, 1995, two QIS radiographers failed to wear alarm ratemeters while performing radiographic operations at a National Fuel Gas Company's pipeline field site in and around the Allegheny National Forest in northwestern Pennsylvania. Specifically, the radiographers performed 15 radiographic exposures at the field site using a Tech/Ops Model 660 camera containing a 33 curie iridium-192 sealed source, and neither radiographer was wearing an alarm ratemeter at the time of the exposures. (01013)

This is a Severity Level III violation (Supplement VI).  
Civil Penalty - \$5,000

Pursuant to the provisions of 10 CFR 2.201, QIS is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved. If an adequate reply is not received

within the time specified in this Notice, an Order or a Demand For Information may be issued as to why the general license should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, QIS may pay the civil penalties by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalties proposed above, or may protest imposition of the civil penalties in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should QIS fail to answer within the time specified, an order imposing the civil penalties will be issued. Should QIS elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalties, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violation listed in this Notice, in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalties in whole or in part, such answer may request remission or mitigation of the penalties.

In requesting mitigation of the proposed penalties, the factors addressed in Section VI.B.2 of 10 CFR Part 2, Appendix C, should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of QIS is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing civil penalties.

Upon failure to pay any civil penalties due which subsequently have been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalties, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The response noted above (Reply to Notice of Violation, letter with payment of civil penalties, and Answer to a Notice of Violation) should be addressed to: Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, Maryland 20852-2738 with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region I, 475 Allendale Road, King of Prussia, Pennsylvania 19406.

Dated at King of Prussia, Pennsylvania  
this 28th day of June 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20585-0001

July 21, 1995

EA 95-046

Quality Inspection Services, Inc.  
ATTN: Mr. John E. Sisson, President  
186 Warwick Avenue  
Post Office Box 732  
Buffalo, New York 14215-0732

SUBJECT: CIVIL PENALTY PROPOSED IN NOTICE OF VIOLATION AND PROPOSED  
IMPOSITION OF CIVIL PENALTIES DATED JUNE 28, 1995

Dear Mr. Sisson:

Regarding the above captioned matter, enclosed is a settlement agreement which specifies the terms that have been discussed between Mr. Ralph Fierle, Vice President, Quality Inspection Services, Inc. (QIS), and Mr. Nader Mamish, Enforcement Specialist, Nuclear Regulatory Commission (NRC) on July 20, 1995. I have signed the enclosed settlement agreement.

If you agree to terms of the agreement, you should sign on behalf of QIS in the space provided and date your signature. Please return the signed original document, together with the \$3,250 initial payment, by July 28, 1995, to Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, Maryland 20852-2738. Please note that by accepting this agreement, you waive your right to a hearing to contest the civil penalty.

If you do not accept this agreement or have any questions concerning this matter, please contact myself or Mr. Nader Mamish of my staff at (301) 415-2741.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

Sincerely,

*James Lieberman*  
James Lieberman, Director  
Office of Enforcement

Docket No. 15000031  
New York License No. 2514-3645

Enclosure: As stated

UNITED STATES  
NUCLEAR REGULATORY COMMISSION

BEFORE THE OFFICE OF ENFORCEMENT

In the Matter of )

QUALITY INSPECTION SERVICES, INC. )  
Buffalo, New York )

Docket No. 15000031  
New York License No. 2514-3645  
EA 95-046

SETTLEMENT AGREEMENT

1. On June 28, 1995, the Nuclear Regulatory Commission (NRC) issued to Quality Inspection Services, Inc. (Licensee or QIS) a Notice of Violation and Proposed Imposition of Civil Penalties (Notice) in the amount of \$13,000 for violations involving: (1) the performance of radiography by QIS (a New York State Licensee) in Pennsylvania without an NRC specific license or notifications required for work under reciprocity; (2) the submittal of inaccurate information to the NRC inspector during the NRC inspection; and (3) the failure of two radiographers to wear the required alarm ratemeters during the performance of radiography on February 3, 1995.

2. In a July 14, 1995 response to the Notice, QIS admitted the above violations but stated that full payment of the \$13,000 proposed civil penalty would present financial difficulties for QIS. The Licensee requested a payment schedule that would allow QIS to remit \$3,250 on July 28, 1995, followed by payments of \$3,250 on the 28th day of August, September, and October of 1995.

3. The Licensee desires to resolve this matter without litigating it and therefore agrees to pay a civil penalty of \$13,000 with payment of the first \$3,250 on July 28, 1995, followed by payments of \$3,250 on the 28th day of August, September, and October of 1995. The NRC staff concludes that this

Settlement Agreement best serves the interests of the public and the parties and the purposes of the Atomic Energy Act and the NRC's requirements.

4. The Licensee agrees that if any payment is not made within the agreed upon time, then the Licensee shall be in default and payment of the full \$13,000 civil penalty proposed by the NRC in its June 28, 1995 Notice shall be due immediately without further notice or order.

5. The Licensee hereby waives the need for the NRC to issue an Order imposing payment of the \$13,000 civil penalty. In addition, the Licensee hereby waives the right to request a hearing on the \$13,000 civil penalty; and waives any right to contest the payment of the \$13,000 civil penalty should QIS default on the payment schedule agreed upon in Section 3.

6. The payments required by this Settlement Agreement shall be made by check, draft, money order, or electronic transfer payable to the Treasurer of the United States and addressed to Mr. James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, Maryland 20852-2738.

U. S. NUCLEAR REGULATORY COMMISSION

*James Lieberman*  
\_\_\_\_\_  
James Lieberman, Director  
Office of Enforcement

*July 21, 1995*  
\_\_\_\_\_  
Date

QUALITY INSPECTION SERVICES, INC.

*J. E. S.*  
\_\_\_\_\_  
John E. Sisson, President

*7-24-95*  
\_\_\_\_\_  
Date



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION III  
801 WARRENVILLE ROAD  
LISLE, ILLINOIS 60532-4351

June 15, 1995

EA 95-092

Soil Testing Inc.  
ATTN: Kevin Snyder  
President  
8368 Young Road  
Fort Wayne, Indiana 46835

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY - \$250  
(NRC INSPECTION REPORT NO. 030-18044/95001)

Dear Mr. Snyder:

This refers to the routine safety inspection conducted from April 25 to May 3, 1995, to review the activities authorized by NRC Byproduct Material License No. 13-20167-01. The report documenting the inspection was mailed to you by letter dated May 12, 1995. A significant violation of NRC requirements was identified during the inspection, and on May 19, 1995, an enforcement conference was held by telephone. Participating in the enforcement conference were you, Mr. James Caldwell, Deputy Director, Division of Radiation Safety and Safeguards, and other members of our respective staffs. A copy of the enforcement conference report was mailed to you on May 25, 1995.

On April 25, 1995, an NRC inspector arrived at your facility and observed two soil moisture/density gauges, each containing NRC licensed materials (nominally 10 millicuries of cesium-137 and 50 millicuries of americium-241 in sealed sources), that were in an unrestricted area and were not secured against unauthorized removal. One gauge was inside your storage shed. The shed door was not locked and that gauge was not secured inside the shed. The inspector found a second gauge in the open bed of a pick-up truck and it was not secured to the truck to prevent unauthorized removal. These conditions existed for up to 60 minutes, at which time you and the other authorized users returned to the facility.

Violation A is fully described in the enclosed Notice of Violation (Notice) and represents the failure to control access to NRC licensed materials for radiation purposes. In accordance with the "Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C, Violation A is categorized at Severity Level III.

The root cause of Violation A and the subsequent corrective actions were discussed during the May 19, 1995, enforcement conference. The root cause was attributed to inattention. Corrective actions consisted of reemphasizing to all authorized users the need to secure the gauges when not in use and conducting audits of the authorized users. Another corrective action was to post a sign on the storage shed reminding the authorized users to secure a gauge or otherwise maintain surveillance of the device. Also, a procedure was implemented requiring the authorized users to sign-out/sign-in each gauge to formalize the control of each device.

As the holder of a Byproduct Material License, the NRC entrusts responsibility for radiation safety to the management of Soil Testing, Inc.; therefore, the NRC expects effective management and oversight of its licensed programs. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety by assuring that all requirements of the NRC license are met and access to licensed materials are controlled so that materials do not inadvertently enter the public domain.

To emphasize the need for strict control of NRC-licensed materials, I have decided to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty in the amount of \$250 for the Severity Level III violation.

The base value of a civil penalty for a Severity Level III violation is \$500. The civil penalty adjustment factors in the Enforcement Policy were considered. The base civil penalty was initially escalated 50 percent because the NRC identified the violation. The base civil penalty was mitigated 50 percent for the above described corrective actions. The civil penalty was mitigated an additional 50 percent for your performance in the area of concern. Full mitigation for your performance was not warranted because your overall performance was considered average for a similarly NRC licensed program. The remaining factors in the enforcement policy were also considered and no further adjustment to the base civil penalty is considered appropriate. On balance, the base civil penalty was mitigated 50 percent.

Two violations of U. S. Department of Transportation (DOT) requirements were also identified during the inspection. One violation concerned the failure to have shipping papers readily visible or located in the required place in a licensee vehicle. The second violation pertained to a package (transport container) containing licensed material that was not properly blocked and braced to prevent movement during shipment. Each violation was categorized at Severity Level IV and is fully discussed in Section B of the enclosed Notice. A civil penalty was not assessed for either violation.

Additionally, the inspection found two other DOT violations that are categorized at Severity Level V. The NRC is exercising the enforcement discretion authorized by Section VII.B.1. of the NRC Enforcement Policy and these violations are not cited in the enclosed Notice. These violations pertained to three packages, containing licensed materials, that were shipped by Soil Testing, Inc. The letters "RQ" were not marked in association with the proper shipping name on the packages (49 CFR 172.324(b)). Also, the letters "RQ" were not marked with the description of the hazardous substance on the shipping papers that accompanied two of the packages (49 CFR 172.203(c)).

You are required to document your response to this letter and the enclosed Notice and should follow the instructions specified in the enclosed Notice when preparing your response. In addition to your specific response to the violations, please also address the actions you have implemented or plan to take to ensure timely and lasting improvement in your radiation safety program. You should also address the management of the program and any improvements needed in the procedures and practices to achieve and maintain compliance with NRC requirements and license conditions, including internal or

Soil Testing, Inc.

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external audits to assess the effectiveness of your program.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, the enclosed Notice and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not contain any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Public Law No. 96-511.

Sincerely,

  
John B. Martin  
Regional Administrator

Docket No. 030-18044  
License No. 13-20167-01

Enclosure: Notice of Violation and  
Proposed Imposition of Civil Penalty

NOTICE OF VIOLATION  
AND  
PROPOSED IMPOSITION OF CIVIL PENALTY

Soil Testing, Inc.  
Fort Wayne, Indiana

Docket No. 030-18044  
License No. 13-20167-01  
EA 95-092

During an NRC inspection conducted from April 25 to May 3, 1995, violations of NRC requirements were identified. In accordance with the "Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

**A. Violation Assessed a Civil Penalty**

10 CFR 20.1801 requires that the licensee secure from unauthorized removal or access licensed materials that are stored in unrestricted areas. 10 CFR 20.1802 requires that the licensee control and maintain constant surveillance of licensed material that is in an unrestricted area and that is not in storage. As defined in 10 CFR 20.1003, "unrestricted area" means an area, access to which is neither limited nor controlled by the licensee.

Contrary to the above, on April 25, 1995, the licensee did not secure from unauthorized removal or limit access to moisture density gauges containing licensed material (nominally 10 millicuries of cesium-137 and 50 millicuries of americium-241 in sealed sources) located in unrestricted areas, nor did the licensee control and maintain constant surveillance of this licensed material. Specifically, constant surveillance was not maintained for:

1. A gauge inside an unlocked storage shed, an unrestricted area, and the gauge was not secured inside the shed, and
2. A gauge located on the bed of an open-bed pickup truck, an unrestricted area, and the gauge was not secured to the truck.

This is a Severity Level III violation (Supplement VI).  
Civil Penalty - \$250. (01013)

**B. Violations Not Assessed a Civil Penalty**

10 CFR 71.5(a) requires that a licensee who transports licensed materials outside of the confines of its plant or other place of use, or who delivers licensed material to a carrier for transport, comply with the applicable requirements of the regulations appropriate to the mode of transport of the U. S. Department of Transportation (DOT) in 49 CFR Parts 170 through 189.

Notice of Violation

- 2 -

1. 49 CFR 177.817(e) requires, in part, that the driver of a motor vehicle containing hazardous material ensure that the shipping paper is readily available to, and recognizable by, authorities in the event of accident or inspection. Specifically, (i) when the driver is at the vehicle's controls, the shipping paper shall be either readily visible to a person entering the driver's compartment or in a holder which is mounted to the inside of the door on the driver's side of the vehicle.

Pursuant to 49 CFR 172.101, radioactive material is classified as a hazardous material.

Contrary to the above, on April 25, 1995, the licensee transported a moisture-density gauge containing a nominal 10 millicuries of cesium-137 and 50 millicuries of americium-241 outside the confines of its plant and the driver of the vehicle did not ensure that the shipping paper was readily visible to a person entering the driver's compartment, as required. Specifically, the shipping paper was inside a brief case and it was not readily visible to a person entering the driver's compartment.

This is a Severity Level IV violation (Supplement V). (02014)

2. 49 CFR 177.842 requires, in part, that packages of radioactive materials be so blocked and braced that they cannot change position during conditions normally incident to transportation.

Contrary to the above, on April 25, 1995, the licensee transported a package containing licensed material outside the confines of its plant, and the package was not blocked and braced such that it could not change position during conditions normally incident to transportation. Specifically, the licensee loosely threaded a cable through the transportation case handle and an eyelet fastened to the truck bed. This technique allowed the package to swivel during normal transport because the cable was threaded through only one handle and the cable was loose.

This is a Severity Level IV violation (Supplement V). (02024)

Pursuant to the provisions of 10 CFR 2.201, Soil Testing, Inc. (Licensee) is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this Notice of Violation and Proposed Imposition of Civil Penalty (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, and if denied, the reasons why, (3) the corrective steps that have been taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved. If an adequate reply is not received within the time specified in this Notice, an order or a demand for information may be issued as to why the license should not be modified, suspended, or revoked or why such other

Notice of Violation

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action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required under 10 CFR 2.201, the Licensee may pay the civil penalty by letter addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check, draft, money order, or electronic transfer payable to the Treasurer of the United States in the amount of the civil penalty proposed above or may protest imposition of the civil penalty in whole or in part, by a written answer addressed to the Director, Office of Enforcement, U. S. Nuclear Regulatory Commission. Should the Licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the Licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation" and may: (1) deny the violations listed in this Notice in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty in whole or in part, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section VI.B.2 of 10 CFR Part 2, Appendix C, should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the Licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The responses noted above (Reply to Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region III, 801 Warrenville Road, Lisle, Illinois 60532-4351.

Dated at Lisle, Illinois  
this 15 day of June 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20585-0001

JUN 18, 1984

Docket No. 030-32190  
License No. 49-27356-01  
EA 93-238

Western Industrial X-Ray Inspection Company, Inc.  
ATTN: Larry Wicks  
5354 Highway 89 North  
Evanston, Wyoming 82931

SUBJECT: ORDER SUSPENDING LICENSE (IMMEDIATELY EFFECTIVE) AND DEMAND FOR INFORMATION

The enclosed Order Suspending License (Immediately Effective) (Order) and Demand for Information is being issued as a result of NRC inspections and investigations that have identified numerous violations of radiation safety requirements by employees of Western Industrial X-Ray Inspection Company, Inc. (WIX).

The enclosed Order, which is effective on the date issued, requires WIX to suspend all radiography activities with the exception of taking steps to ensure that all licensed radioactive materials are stored safely. WIX is prohibited from conducting radiography activities pending further NRC order. This means that you must immediately stop using all radiography cameras in your possession and place them in safe storage.

You are required to provide an Answer to the Order and respond to the Demand for Information, which requires you to provide information to assist the NRC in determining whether the license should be revoked or whether the NRC can have confidence that future activities will be carried out in compliance with all requirements.

Failure to comply with the provisions of this Order may result in civil or criminal sanctions. The issuance of this Order does not preclude the possibility of further enforcement action against individuals who deliberately violated NRC requirements.

Questions concerning this Order should be addressed to James Lieberman, Director, Office of Enforcement, who can be reached by telephone at (301) 504-2741.

Western Industrial X-Ray  
Inspection Company, Inc.

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice", a copy of this letter and the enclosures will be placed in the NRC's Public Document Room.

Sincerely,

  
Hugh L. Thompson, Jr.  
Deputy Executive Director for  
Nuclear Materials Safety, Safeguards  
and Operations Support

Enclosure: As Stated

cc w/Enclosure:  
State of Wyoming

UNITED STATES  
NUCLEAR REGULATORY COMMISSION

In the Matter of ) Docket No. 030-32190  
Western Industrial X-Ray ) License No. 49-27356-01  
Inspection Company, Inc. ) EA 93-238  
Evanston, Wyoming )

ORDER SUSPENDING LICENSE  
(EFFECTIVE IMMEDIATELY)  
AND DEMAND FOR INFORMATION

I

Western Industrial X-Ray Inspection Company, Inc. (Licensee or WIX) is the holder of Byproduct Material License No. 49-27356-01 issued by the Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR Parts 30 and 34. The license authorizes the Licensee to possess sealed sources of iridium-192 in various radiography devices for use in performing industrial radiography activities. The license, originally issued on August 12, 1991, is due to expire on August 31, 1996.

II

In April 1993 and in January and March 1994, the NRC conducted inspections and investigations of Western Industrial X-Ray Inspection Company, Inc., at the company's offices in Evanston, Wyoming, and at temporary job sites near Granger, Wyoming. These inspections and investigations identified numerous violations of NRC's radiation safety requirements, including some violations which were found to have recurred after being found in previous inspections. These violations were described in inspection reports 030-32190/93-01 and 030-32190/94-01 issued on May 12, 1994. In addition, based on the investigations conducted by the Office of Investigations (OI), several of the violations have

been determined by the NRC to have been committed deliberately by Licensee employees.

In a March 2, 1994, letter to the Licensee, the NRC described the apparent violations that had been identified as of that date and confirmed the arrangements for the Licensee to attend an enforcement conference in the NRC's Arlington, Texas office. The enforcement conference, which was transcribed, occurred on April 1, 1994. The Licensee was represented by Mr. Larry D. Wicks, who is the president and owner of WIX as well as the company's designated radiation safety officer (RSO).

The most significant of the NRC's concerns, and many of the violations, are related to a July 31, 1993, incident involving a WIX radiographer and radiographer's assistant who were performing radiography on a pipeline near LaBarge, Wyoming. The incident involved a radiographic device containing a 37-curie, sealed iridium-192 source and resulted in a potentially significant radiation exposure to the radiographer's assistant.

This incident was reviewed during the inspection and investigation that began in January 1994. The following information regarding this incident is based on joint interviews conducted by the inspector and investigator; on signed, sworn statements taken by the investigator during these interviews; and on statements made by Mr. Wicks at the April 1 enforcement conference. With the exception of certain statements made by Mr. Wicks at the enforcement conference, which are noted below, all other statements were made to the inspector and investigator during their joint interviews of WIX personnel.

The radiographer admitted that he violated NRC requirements by not observing the assistant as she radiographed welds and moved equipment from one location to another (in a later statement, the radiographer said he was aware he was responsible for the assistant but not aware that he had to observe her performing radiographic operations 100% of the time). The assistant admitted that she violated NRC requirements by not performing a radiation survey after each radiographic exposure and by not locking the sealed radioactive source in the radiography device prior to moving equipment to another weld. The assistant stated further that after moving the equipment to another weld she noticed her survey instrument was "pegged," and that her self-reading pocket dosimeter was off-scale, both indications that the device's radioactive source had not been returned to its fully shielded position or had been jostled from its shielded position when the device was moved. The assistant stated that her alarm ratemeter, a protective device which is set to alarm in a radiation field of 500 millirem/hour, did not alarm but added that it was probably turned off. Both she and the radiographer stated that she immediately brought this incident to the radiographer's attention and that he "cranked" the source into the device and locked it, and that they stopped work for the day.

Both the assistant and the radiographer stated that they prepared incident reports for their employer, Larry Wicks, the company president and RSO, and that the incident reports were false in that they falsely stated that the radiographer and the assistant were working together at the time of the incident and falsely stated that they had surveyed the device and locked the source in the device prior to its being moved. The assistant claimed that she told Mr. Wicks at the time the reports were turned in that the incident

reports were false, but Mr. Wicks denied this claim during interviews with the inspector and investigator and at the enforcement conference, stating that he did not know the incident reports were false until brought to his attention by the NRC.

Mr. Wicks stated during the investigation and at the enforcement conference that after learning of the incident he sent the assistant's thermoluminescent dosimeter (TLD) in for immediate processing along with other TLDs worn by company personnel during the month of July 1993. Mr. Wicks also stated that all of the TLDs were sent in the same package. However, the company that processes TLDs for WIX, Landauer, Inc., stated, through its representative, to NRC personnel that while it had received TLDs from WIX for other employees for the month of July 1993, it had no record of receiving a TLD for the assistant for the month of July 1993 and no record of receiving a request from Mr. Wicks for immediate processing of any TLDs sent in for that month. Exposure records mailed by Landauer to WIX and retained by WIX contain no information regarding the assistant's exposure for the month of July 1993 (her exposure records for all other months are available). The assistant, whom Mr. Wicks placed on restricted duty pending a determination of her exposure, also told NRC personnel that she persisted in trying to obtain from Mr. Wicks her exposure record for the month of July and that Mr. Wicks eventually -- about three weeks after the incident -- told her that she had received 350 millirem.

Mr. Wicks stated during the investigation, however, that he never provided the assistant an exposure estimate based on Landauer's processing of the TLD because he did not have such a number to give her. The only explanation he

has offered for not pursuing the question of her July 1993 exposure is that he was very busy. Despite the occurrence of the following events, Mr. Wicks has stated that he was not reminded of the need to evaluate the assistant's exposure from the incident or for the month of July 1993: 1) placing the assistant on restricted duty from the date of the incident (July 31, 1993) until she left his employ in September 1993; 2) receiving Landauer reports for July 1993 which contained no exposure records for the assistant even though, according to Mr. Wicks' statement, he had sent in her TLD for immediate emergency processing; 3) preparing a summary of the assistant's radiation exposure history for her new employer, which included the period in question (July 1993); and 4) responding in the fall of 1993 to a request from the NRC for the radiation exposure reports of terminated employees. In responding to the latter request, Mr. Wicks did not provide a report for the radiographer's assistant despite having provided one for her husband, whose termination date occurred five days after hers. As of the time of the inspection and investigation in January 1994, Mr. Wicks had not performed an adequate evaluation to determine the assistant's exposure resulting from the July 31, 1993 incident. After further requests from the NRC, Mr. Wicks submitted on March 8, 1994, an estimate of 6 rems for the assistant's whole body exposure and at the enforcement conference characterized that estimate as "pure and simply a guess," noting that "I had to have something to send you."

Based on its inspection and investigation of the July 31, 1993 incident, as well as the information obtained during the enforcement conference, the NRC has concluded that the Licensee and its employees violated NRC requirements by failing to: 1) perform an evaluation of the assistant's radiation exposure to

ensure compliance with NRC limits, as required by 10 CFR 20.201, and send the assistant's TLD in for immediate processing when her pocket dosimeter had gone off-scale, as required by 10 CFR 34.33(d); 2) check the alarm function on alarm ratemeters prior to the start of each shift, as required by 10 CFR 34.33(f)(1); 3) perform a radiation survey of a radiography device following each exposure, as required by 10 CFR 34.43(b); 4) lock the sealed radioactive source in the device after each exposure, as required by 10 CFR 34.22(a); 5) ensure that radiographers supervise assistant radiographers who are performing radiographic operations, as required by 10 CFR 34.44, a repeat violation in that it occurred in July 1993, was discussed during the inspection in January 1994, and was found again in March 1994; 6) provide NRC a report of an individual's radiation exposure following the individual's termination of employment, as required by 10 CFR 20.408(b); and 7) ensure that alarm ratemeters worn by radiography personnel were calibrated at a one-year frequency, as required by 34.33(f)(4), a repeat violation in that it was found and discussed with Mr. Wicks following the inspection and investigation in April 1993, recurred in July 1993 and was found again in January 1994.

Other violations found during the NRC's inspections and investigations, but unrelated to the July 1993 incident, include the Licensee's failure to:

- 1) ensure that pocket dosimeters worn by radiography personnel were checked for correct response to radiation at 12-month intervals, as required by 10 CFR 34.33(c), a violation that occurred on January 18, 1994, 13 days after the inspector had informed the RSO that he should remove uncalibrated dosimeters from service; 2) perform and record quarterly audits of radiography personnel for all calendar quarters in 1992, as required by license condition;

3) maintain constant surveillance and immediate control of licensed material in March 1993, as required by 10 CFR 20.207; 4) submit to the NRC a quality assurance program for use of shipping containers, as required by 10 CFR 71.12(b), a repeat violation in that it was cited in 1992 and had not been corrected by January 1994; and 5) leak test sealed sources prior to removing them from storage and transferring them to the manufacturer in April 1993 and December 1993, as required by license condition.

The NRC has also concluded from its inspections and investigations that Mr. Wicks and employees of WIX violated the provisions of 10 CFR 30.10, "Deliberate Misconduct," a regulation which prohibits individuals from deliberately causing a licensee to be in noncompliance with NRC requirements and prohibits individuals from deliberately providing materially false information to the NRC or a licensee. Specifically, based on its review of the July 31, 1993 incident, its review of the OI findings, and its review of the enforcement conference transcript, the NRC has concluded that Mr. Wicks deliberately failed to perform an evaluation of the assistant's radiation exposure; that Mr. Wicks deliberately failed to send the assistant's TLD in for immediate processing; that the radiographer deliberately failed to watch an assistant perform radiography operations; and that the radiographer and assistant deliberately provided materially false information to the Licensee about the incident.

Based on its review of violations that were unrelated to the July 1993 incident, the NRC has concluded that Mr. Wicks deliberately failed to perform and record quarterly audits of radiography personnel in 1992, because Mr.

Wicks stated that he was aware of these requirements and his responsibility to comply with them but failed to do so. The NRC also has concluded that Mr. Wicks deliberately failed to ensure that alarm ratemeters used by radiography personnel in March, April and July 1993 and January 1994 were calibrated at a one-year frequency, again because Mr. Wicks stated that he was aware of these requirements and his responsibility to comply with them but repeatedly failed to do so.

III

Based on the above, it appears that Licensee employees, including the president and radiation safety officer, have engaged in deliberate misconduct by deliberately violating NRC requirements that are important to the protection of radiography personnel and the public and have failed to ensure compliance with numerous requirements that are important to the safe use of radiographic sources. Deliberate violations of the nature described above cannot and will not be tolerated by the NRC. Further, the history of numerous violations, including repetitive violations, and the failure to follow through on important safety issues, indicate that Mr. Wicks, who is the president and radiation safety officer, is either incapable or unwilling to ensure that the Licensee's radiography program is conducted in accordance with all NRC requirements.

Consequently, I lack the requisite reasonable assurance that the Licensee's current operations can be conducted under License No. 49-27356-01 in compliance with the Commission's requirements and that the health and safety

of the public, including the Licensee's employees, will be protected. Therefore, the public health, safety, and interest require that License No. 49-27356-01 be suspended. Furthermore, pursuant to 10 CFR 2.202, I find that the significance of the violations and deliberate misconduct described above are such that the public health, safety, and interest require that this Order be immediately effective.

IV

Accordingly, pursuant to sections 81, 161b, 161i, 182 and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR 2.202 and 10 CFR Parts 30 and 34, IT IS HEREBY ORDERED, EFFECTIVE IMMEDIATELY, THAT LICENSE NO. 49-27356-01 IS SUSPENDED PENDING FURTHER ORDER.

The Regional Administrator, Region IV, may, in writing, relax or rescind this order upon demonstration by the Licensee of good cause.

V

In accordance with 10 CFR 2.202, the Licensee must, and any other person adversely affected by this Order may, submit an answer to this Order, and may request a hearing on this Order, within 20 days of the date of this Order. The answer may consent to this Order. Unless the answer consents to this Order, the answer shall, in writing and under oath or affirmation, specifically admit or deny each allegation or charge made in this order and set forth the matters of fact and law on which the Licensee or other person

adversely affected relies and the reasons as to why the Order should not have been issued. Any answer or request for a hearing shall be submitted to the Secretary, U.S. Nuclear Regulatory Commission, ATTN: Chief, Docketing and Service Section, Washington, D.C. 20555. Copies of the hearing request also should be sent to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, to the Assistant General Counsel for Hearings and Enforcement at the same address, to the Regional Administrator, NRC Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011, and to the Licensee if the hearing request is by a person other than the Licensee. If a person other than the Licensee requests a hearing, that person shall set forth with particularity the manner in which his interest is adversely affected by this Order and shall address the criteria set forth in 10 CFR 2.714(d).

If a hearing is requested by the Licensee or a person whose interest is adversely affected, the Commission will issue an Order designating the time and place of any hearing. If a hearing is held, the issue to be considered at such hearing shall be whether this Order should be sustained.

Pursuant to 10 CFR 2.202(c)(2)(i), the Licensee, or any other person adversely affected by this Order, may, in addition to demanding a hearing, at the time the answer is filed or sooner, move the presiding officer to set aside the immediate effectiveness of the Order on the ground that the Order, including the need for immediate effectiveness, is not based on adequate evidence but on mere suspicion, unfounded allegations, or error.

In the absence of any request for hearing, the provisions specified in Section IV above shall be final 20 days from the date of this Order without further order or proceedings. AN ANSWER OR A REQUEST FOR HEARING SHALL NOT STAY THE IMMEDIATE EFFECTIVENESS OF THIS ORDER.

VI

In addition to issuance of this Order Suspending License No. 49-27356-01, the Commission requires further information from the Licensee in order to determine whether the Commission can have reasonable assurance that in the future the Licensee will conduct its activities in accordance with the Commission's requirements or, lacking such assurance, whether the Commission should proceed to revoke the license.

Accordingly, pursuant to sections 161c, 161o, 182 and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's requirements in 10 CFR 2.204 and 10 CFR 30.32(b), in order for the Commission to determine whether License No. 49-27356-01 should be revoked, or other enforcement action taken to ensure compliance with NRC regulatory requirements, the Licensee is required to submit to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, within 20 days of the date of this Order and Demand for Information, the following information, in writing and under oath or affirmation:

- A. State why, in light of the violations and managerial failures discussed in II and III above, NRC License No. 49-27356-01 should not be revoked.
- B. State why, in light of the facts described above, an order should not be issued to Mr. Wicks as an individual prohibiting Mr. Wicks from performing NRC-licensed activities. In addition, if an order is not issued to prohibit Mr. Wicks from performing NRC-licensed activities, then why should the NRC have confidence Mr. Wicks will comply with Commission requirements.

Copies also shall be sent to the Assistant General Counsel for Hearings and Enforcement at the same address, and to the Regional Administrator, NRC Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011-8064.

After reviewing your response, the NRC will determine whether further action is necessary to ensure compliance with regulatory requirements.

FOR THE NUCLEAR REGULATORY COMMISSION

  
Hugh L. Thompson, Jr.  
Deputy Executive Director for  
Nuclear Materials Safety, Safeguards,  
and Operations Support

Dated at Rockville, Maryland  
this 16 day of June 1994



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001

September 27, 1994

EA 94-131

Western Industrial X-Ray Inspection Company, Inc.  
ATTN: Larry Wicks  
5354 Highway 89 North  
Evanston, Wyoming 82931

**SUBJECT: ORDER TO TRANSFER MATERIAL (EFFECTIVE IMMEDIATELY) AND ORDER REVOKING LICENSE**

On June 16, 1994, the NRC issued an Order Suspending License and Demand for Information (Suspension Order) to Western Industrial X-Ray Inspection Company, Inc. (WIX). In letters dated June 17 and June 28, 1994, Mr. John C. Phillips, an attorney representing WIX, requested that the NRC relax or rescind the Suspension Order. On July 19, 1994, the NRC issued a letter to WIX denying the requests for relaxation or rescission.

On July 1, 1994, WIX requested a hearing on the Suspension Order, which is currently pending before an NRC Atomic Safety and Licensing Board. The Suspension Order provided in Section IV that License No. 49-27356-01 was suspended pending further order. WIX was required to suspend its use of NRC-licensed material and to store it safely. The Suspension Order remains in effect. In addition, enclosed is an Order to Transfer Material (Effective Immediately) and Order Revoking License (Order). Section IV.A, which is immediately effective, requires WIX to transfer all NRC-licensed material in its possession to authorized recipients within 20 days of the date of the Order, and requires WIX to certify in writing within 5 days of completing the transfer that all such material has been properly transferred. Section IV.B of the Order revokes License No. 49-27356-01 following completion of the transfer of all licensed material.

You are required to provide an Answer to the Order. Failure to comply with the provisions of this Order may result in further civil enforcement action or criminal sanctions. The issuance of this Order does not preclude the possibility of further enforcement action against individuals who have deliberately violated NRC requirements.

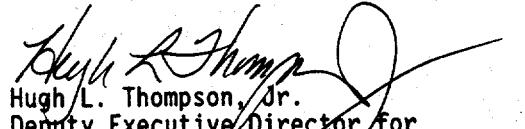
Questions concerning this Order should be addressed to Mr. James Lieberman, Director, Office of Enforcement, who can be reached by telephone at (301) 504-2741.

Western Industrial X-Ray  
Inspection Company, Inc.

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice", a copy of this letter and the enclosures will be placed in the NRC's Public Document Room.

FOR THE NUCLEAR REGULATORY COMMISSION

  
Hugh L. Thompson, Jr.  
Deputy Executive Director for  
Nuclear Materials Safety, Safeguards  
and Operations Support

Docket No. 030-32190  
License No. 49-27356-01  
EA 94-131

Enclosure: As Stated

cc w/Enclosure:  
State of Wyoming

UNITED STATES  
NUCLEAR REGULATORY COMMISSION

In the Matter of

WESTERN INDUSTRIAL X-RAY  
INSPECTION COMPANY, INC.  
Evanston, Wyoming

Docket No. 030-32190  
License No. 49-27356-01  
EA 94-131

ORDER TO TRANSFER MATERIAL (EFFECTIVE IMMEDIATELY)  
AND ORDER REVOKING LICENSE

I

Western Industrial X-Ray Inspection Company, Inc. (Licensee or WIX) is the holder of Byproduct Material License No. 49-27356-01 issued by the Nuclear Regulatory Commission (NRC or Commission) pursuant to 10 CFR Parts 30 and 34. The license authorizes the Licensee to possess sealed sources of iridium-192 in various radiography devices for use in performing industrial radiography activities. The license, originally issued on August 12, 1991, and due to expire on August 31, 1996, was suspended by NRC Order (EA 93-238) on June 16, 1994.

II

On June 16, 1994, the NRC issued an Order Suspending License (Immediately Effective) (Suspension Order) and Demand for Information to WIX. The Suspension Order was based on inspections and investigations that had identified numerous violations of NRC's radiation safety requirements, including some violations which were found to have recurred after being found in previous inspections and several which were determined to have been committed deliberately by WIX employees and by the President and Radiation Safety Officer (RSO) for WIX, Larry D. Wicks. Apparent violations were described in inspection reports 030-32190/93-01 and 030-32190/94-01 issued on May 12, 1994. The violations were also described in the June 16, 1994

Suspension Order. The Suspension Order required WIX to suspend its use of NRC-regulated material and to place it in safe storage pending further order. The Demand for Information required WIX to describe why, in light of the violations and managerial failures discussed in the Suspension Order, NRC License No. 49-27356-01 should not be revoked and also why an order should not be issued to Mr Wicks prohibiting him from performing NRC-licensed activities.

On June 17 and June 28, 1994, letters were submitted to the NRC on behalf of WIX by its attorney, John C. Phillips. These letters provided WIX's response to the violations and requested relaxation or rescission of the Suspension Order. In response to the violations, WIX admitted some of the violations, denied some of the violations, and denied that Larry D. Wicks had ever deliberately caused the Licensee to be in violation of NRC requirements or at any time provided materially false information to the NRC. In addition, the June 28, 1994 letter included a Corrective Measures Plan that described various actions taken by WIX to preclude a recurrence of the violations that led to the Suspension Order. Actions described in the responses included obtaining more alarm ratemeters, establishing a system for their issuance and ensuring the currency of their calibrations, designation of an Assistant RSO, and creation of additional records, along with statements assuring future compliance. The responses amount to assertions of being in compliance, that most of the violations were inconsequential and the public health and safety had not been jeopardized, and that future conduct will prevent violations. These responses were submitted as a basis for relaxing or rescinding the Suspension Order and did not provide an adequate or specific response to the Demand for Information which asked why the license should not be revoked. The

NRC reviewed the information in these letters to determine whether WIX had provided sufficient justification for the NRC to relax or rescind the Suspension Order. On July 19, 1994, the NRC denied WIX's requests in writing, stating, "Given the nature of the violations in this case, the NRC's concerns about the integrity of certain WIX personnel, and the licensee's failure to address adequately the fundamental problems identified in the Order, e.g., our significant concerns regarding the capability or willingness of Mr. Wicks and other WIX personnel to ensure compliance with NRC requirements, I find the mere promise in your submittals of future compliance with NRC requirements insufficient assurance at this time that WIX employees will conduct licensed activities in accordance with NRC requirements."

In its second report, OI concluded that four WIX employees, including the President, committed four deliberate violations. These violations have safety significance, such as failure to evaluate a potential overexposure, preparation of false reports concerning a potential overexposure, and failure to supervise radiography operations. The NRC remains concerned about the deliberate violations caused by WIX's President and RSO, especially as they pertain to a possible overexposure incident, and his other failures to properly direct the conduct of licensed activities in a safe manner. It is this failure to conduct licensed activities in a safe manner, coupled with questions as to the integrity of several employees, that cause the NRC to be concerned about public health and safety. In its response, WIX did not sufficiently demonstrate that the NRC could rely upon it to ensure that the public health and safety would be protected if radioactive materials were to be used in the future under License No. 49-27356-01.

III

The acts and omissions of WIX's President and RSO violated NRC requirements over an extended period of time. These violations jeopardized the public health and safety and, on that basis alone, represent a very significant regulatory concern. These violations demonstrate that the Licensee and its President are not willing or able to comply with the Commission's requirements to protect the public health and safety. As a result, I am also issuing an Order (EA 94-140) this date to the President and RSO of WIX prohibiting him from engaging in NRC-licensed activities (except as necessary to store and transfer material).

WIX's license has remained suspended since June 16, 1994. Several radiography exposure devices containing sealed radiation sources have remained in the Licensee's possession although the Licensee does not have authorization to use the material. Given the seriousness of the violations that occurred, and the NRC's order removing WIX's President and RSO, who is responsible for this material, I find that the public health, safety, and interest require the Licensee to transfer all NRC-regulated material in its possession and that License No. 49-27356-01 be revoked. Furthermore, in view of the nature of the violations and the deliberate misconduct described in both the June 16, 1994 Suspension Order (EA 93-238) and the Order Prohibiting Involvement in NRC-licensed activities (EA 94-140) issued this date to Mr. Wicks, the Commission does not have reasonable assurance that the material will be safely stored and transferred during the time that it might take to litigate this Order and the removal Order (EA 94-140). Therefore, pursuant to 10 CFR 2.202, I find that

the significance of the violations and deliberate misconduct described in the June 16, 1994 Suspension Order (EA 93-238) and the Order (EA 94-140) to Mr. Wicks of this date, are such that the public health, safety, and interest require that the Order to Transfer Material part of this Order be immediately effective.

IV

Accordingly, pursuant to sections 81, 161b, 161c, 161i, 161o, 182 and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR 2.202 and 10 CFR Parts 30 and 34:

A. IT IS HEREBY ORDERED, EFFECTIVE IMMEDIATELY, THAT:

1. The licensee shall transfer all NRC-licensed material acquired or possessed under the authority of License No. 49-27356-01 within 20 days of the date of this Order, either by returning the material to the manufacturer or transferring it to another person authorized to possess that material;
2. Any sources that have not been leak tested within six months prior to the transfer shall be leak tested by a person authorized to do so, prior to transfer of the source;
3. The Licensee shall notify Ms. Linda Kasner, NRC, Region IV, (817) 860-8213, by telephone at least two working days prior to the date(s) of

transfer of radioactive material so that the NRC, may, if it elects, observe the transfer of the material; and

4. The licensee shall, within 5 days after transfer of the material, certify in writing to the Regional Administrator, NRC Region IV, that all material has been properly transferred and provide the Regional Administrator copies of records of transfer required by 10 CFR 30.51.

5. The issuance of this Order does not otherwise alter the continued effectiveness of the Suspension Order.

**B. IT IS FURTHER ORDERED THAT:**

Following confirmation of the transfer of all NRC-licensed material currently possessed, as discussed above, License No. 49-27356-01 is revoked.

The Director, Office of Enforcement, may, in writing, at any time prior to final agency action sustaining the revocation of License No. 49-27356-01, relax or rescind this order on demonstration by the Licensee, in writing, of good cause.

V

In accordance with 10 CFR 2.202, the Licensee must, and any other person adversely affected by this Order may, submit an answer to this Order, and may request a hearing on this Order, within 20 days of the date of this Order.

The answer may consent to this Order. Unless the answer consents to this Order, the answer shall, in writing and under oath or affirmation, specifically admit or deny each allegation or charge made in this order and set forth the matters of fact and law on which the Licensee or other person adversely affected relies and the reasons as to why the Order should not have been issued. Any answer or request for a hearing shall be submitted to the Secretary, U.S. Nuclear Regulatory Commission, ATTN: Chief, Docketing and Service Section, Washington, D.C. 20555. Copies also shall be sent to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, to the Assistant General Counsel for Hearings and Enforcement at the same address, to the Regional Administrator, NRC Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011, and to the Licensee if the hearing request is by a person other than the Licensee. If a person other than the Licensee requests a hearing, that person shall set forth with particularity the manner in which his or her interest is adversely affected by this Order and shall address the criteria set forth in 10 CFR 2.714(d).

If a hearing is requested by the Licensee or a person whose interest is adversely affected, the Commission will issue an Order designating the time and place of any hearing. If a hearing is held, the issue to be considered at such hearing shall be whether this Order should be sustained.

Pursuant to 10 CFR 2.202(c)(2)(i), the Licensee, or any other person adversely affected by this Order, may, in addition to demanding a hearing, at the time the answer is filed or sooner, move the presiding officer to set aside the immediate effectiveness of Section IV.A of this Order on the ground that

portion of the Order, including the need for immediate effectiveness, is not based on adequate evidence but on mere suspicion, unfounded allegations, or error.

In the absence of any request for hearing, the provisions specified in Section IV above shall be final 20 days from the date of this Order without further order or proceedings. AN ANSWER OR A REQUEST FOR HEARING SHALL NOT STAY THE IMMEDIATE EFFECTIVENESS OF THE ORDER TO TRANSFER MATERIAL SET FORTH IN SECTION IV.A OF THIS ORDER.

FOR THE NUCLEAR REGULATORY COMMISSION



Hugh L. Thompson, Jr.  
Deputy Executive Director for  
Nuclear Materials Safety, Safeguards,  
and Operations Support

Dated at Rockville, Maryland  
this 27<sup>th</sup> day of September 1994

November 16, 1995

UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION

ATOMIC SAFETY AND LICENSING BOARD

Before Administrative Judges:

Peter B. Bloch, Chairman  
Dr. Jerry Kline  
Dr. Charles Kelber

In the Matter of

WESTERN INDUSTRIAL X-RAY  
INSPECTION CO., INC.

and

LARRY D. WICKS

Docket Nos. 30-32190-EA  
30-32190-EA-2

ASLBP Nos. 94-699-09-EA  
95-702-01-EA-2

FINAL INITIAL ORDER  
(Approval of Settlement and Dismissal)

Western Industrial X-Ray Inspection Co., Inc. (WIX), Larry D. Wicks, and the Staff of the United States Nuclear Regulatory Commission (Staff) have reached an agreement in settlement of these proceedings, the terms of which agreement are set forth in full in Attachment A, "Stipulation for Settlement of Proceedings." After studying this agreement, the Atomic Safety and Licensing Board had some questions concerning the appropriateness of the settlement. Accordingly, it held a transcribed teleconference, on November 3, 1995, which resolved the Board's questions.

In the course of the teleconference, we became satisfied:

- WIX has an adequate reason for selecting Mr. Heath as Radiation Safety Officer. Though he is not a trained RSO, he has an engineering degree and radiography background and will be required to take appropriate training. Paragraph 5 of the Settlement Agreement provides further assurance by requiring audits of operations. The Staff is satisfied with this arrangement. Tr. 17-19.
- Mr. John Phillips, who has a 1/3 financial interest in the company and is the company lawyer and a local municipal court judge, will take management responsibility. Mr. Larry Wicks will be restricted to a role in sales and business acquisition and as an advisor to Mr. Phillips about commercial practices in the industry. Mr. Wicks will not play any role in employee evaluation. Tr. 20-25, 29-30, 30-32.
- Although Mr. Wicks may be reinstated in WIX after two years upon application to the Staff, this process will not be automatic and will entail Staff discretion. Tr. 25-29, 32-33, 34.

1. ORDER

For all the foregoing reasons and upon consideration of the entire record in this matter, it is this 15th day of November, 1995, ORDERED, that:

1. The Western Industrial X-Ray Inspection Co., Inc. (WIX) motions to withdraw its requests for hearing are granted. The withdrawn requests for hearing relate to (a) the Staff's Order to WIX of June 16, 1994 ("Order Suspending License (Effective Immediately) and Demand for Information," 59 Fed. Reg. 33027 (June 27, 1994) ("Suspension Order"), dated July 1, 1994, and (b) the Staff's Orders to WIX of September 27, 1994 ("Order to Transfer Material (Effective Immediately) and Order Revoking License" 59 Fed. Reg. 50931 (October 6, 1994) ("Revocation Order"), dated October 14, 1994.

2. WIX is dismissed as a party in the proceedings pertaining to those Orders and to this proceeding.

3. The motion of Larry Wicks to withdraws his request for hearing on the Staff's Order to Mr. Wicks of September 27, 1994 ("Order Prohibiting Involvement in NRC-Licensed Activities (Effective Immediately)," 59 Fed. Reg. 50932 (October 6, 1994) ("Prohibition Order"), dated October 14, 1994, is granted.

4. Mr. Wicks is dismissed as a party in the proceeding pertaining to that Order.

-- 4 --

5. The "Stipulation for Settlement of Proceedings," contained in Attachment A to this Memorandum and Order is adopted as an Order of this Atomic Safety and Licensing Board.

THE ATOMIC SAFETY AND LICENSING BOARD

Jerry R Kline

Dr. Jerry Kline  
Administrative Judge

Charles Kelber

Dr. Charles Kelber  
Administrative Judge

Peter B. Bloch

Peter B. Bloch  
Chairman

Rockville, Maryland

11/2/95

**Attachment A<sup>1</sup>**

**STIPULATION FOR SETTLEMENT OF PROCEEDINGS<sup>2</sup>**

THIS AGREEMENT is made by and between Western Industrial X-Ray Inspection Co., Inc. ("WIX" or the Licensee"), Larry D. Wicks ("Wicks") and the Staff of the United States Nuclear Regulatory Commission ("NRC Staff" or "Staff"), to wit:

WHEREAS WIX holds Byproduct Material License No. 49-27356-01 issued by the NRC pursuant to 10 C.F.R. Parts 30 and 34, which license authorizes WIX to possess sealed sources of iridium-192 in various radiography devices for use in performing industrial radiography activities in accordance with the conditions specified therein, and is due to expire on August 31, 1996; and

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<sup>1</sup>The heading contained in the stipulation of the parties has been omitted as redundant. Page numbers have been changed for consistency with this document.

<sup>2</sup>In the course of the Teleconference of November 3, the Board admitted two exhibits. Tr. 16. On further consideration, it is not necessary that those exhibits be admitted. This Attachment is sufficient. Accordingly, the two Board exhibits shall not be admitted. This Order and its attachment may be read in conjunction with the official Transcript. No further exhibits are necessary.

WHEREAS Wicks is and has been at all times relevant hereto the principal shareholder, President, and Radiation Safety Officer ("RSO") of WIX, with responsibilities, *inter alia*, involving compliance with NRC requirements for radiation protection; and

WHEREAS on June 16, 1994, the NRC Staff issued an "Order Suspending License (Effective Immediately) and Demand for Information," 59 Fed. Reg. 33027 (June 27, 1994) ("Suspension Order"), based, *inter alia*, upon a finding that WIX had engaged in numerous violations of NRC radiation safety regulatory requirements, including several violations which were found to be of a recurring nature and/or were committed deliberately by Licensee employees, including WIX's President and RSO, in violation of 10 C.F.R. § 30.10; and

WHEREAS the Suspension Order suspended License No. 49-27356-01, pending further order, effective immediately, and also demanded information from the Licensee in order to assist the NRC in determining whether the license should be revoked and whether Wicks should be prohibited from performing NRC-licensed activities; and

WHEREAS on September 27, 1994, the NRC Staff issued (1) further Orders directed to WIX, "Order to Transfer Material (Effective Immediately) and Order Revoking License" 59 Fed. Reg. 50931 (October 6, 1994) ("Revocation Order"); and (2) an Order directed to Wicks, "Order Prohibiting Involvement in NRC-Licensed Activities (Effective Immedi-

ately)," 59 Fed. Reg. 50932 (October 6, 1994) ("Prohibition Order"), based, *inter alia*, upon a finding that the NRC lacked adequate assurance that the public health and safety would be protected if WIX retains possession of licensed material, or if licensed activities are conducted by WIX and/or its President and RSO in the future; and

WHEREAS the Revocation Order required the Licensee, *inter alia*, to transfer all NRC-regulated material in its possession to the manufacturer or other person authorized to possess the material and revoked License No. 49-27356-01, effective immediately; and

WHEREAS the Prohibition Order, *inter alia*, prohibited Wicks from engaging in NRC-licensed activities (including any supervising, training or auditing) for either an NRC licensee or Agreement State licensee performing licensed activities in areas of NRC jurisdiction in accordance with 10 C.F.R. § 150.20 for a period of five (5) years from the date of that Order; and

WHEREAS requests for hearing were filed by WIX concerning the Suspension Order and Revocation Order on July 1 and October 14, 1994, respectively, and a request for hearing was filed by Wicks concerning the Prohibition Order on October 14, 1994, in response to which adjudicatory proceedings have been convened and remain pending before an Atomic Safety and Licensing Board ("Licensing Board") at this time; and

WHEREAS the undersigned parties recognize that certain advantages and benefits may be obtained by each of them through settlement and compromise of the matters now pending in litigation between them, including, without limitation, the elimination of further litigation expenses, uncertainty and delay, and other tangible and intangible benefits, which the parties recognize and believe to be in the public interest; and

WHEREAS, pursuant to 10 C.F.R. § 2.203, the Staff, WIX and Wicks have stipulated and agreed to the following provisions for settlement of the above-captioned proceedings, subject to the approval of the Licensing Board, before the taking of any testimony or trial or adjudication of any issue of fact or law; and

WHEREAS WIX and Wicks are willing to waive their hearing and appeal rights regarding these matters, in consideration of the terms and provisions of this Stipulation and settlement agreement; and

WHEREAS the terms and provisions of this Stipulation, once approved by the Licensing Board, shall be incorporated by reference into an order, to be issued in accordance with subsections b, I and o of section 161 of the Atomic Energy Act of 1954, as amended (the "Act"), 42 U.S.C. § 2201, and into License No. 49-27356-01, issued pursuant to section 81 of the Act, 42 U.S.C. § 2111, and shall be subject to

enforcement pursuant to the Commission's regulations and Chapter 18 of the Act, 42 U.S.C. § 2271 et seq.;

NOW, THEREFORE, IT IS STIPULATED AND AGREED AS FOLLOWS:

1. Wicks agrees to refrain from engaging in, and is hereby prohibited from engaging in, any NRC-licensed activities up to and including June 15, 1999, five years from the date of the NRC "Order Suspending License (Effective Immediately)," dated June 16, 1994. For purposes of this Stipulation and Agreement, the definition of "NRC-licensed activities," as set forth above, is understood to include any and all activities that are conducted pursuant to a specific license issued by the NRC or general license conferred by NRC regulations, including, but not limited to, those activities of Agreement State licensees conducted pursuant to the authority granted by 10 C.F.R. § 150.20, but does not include marketing, other business activities or ownership of an interest in WIX.

2. For a period of five years after the above-specified five-year period of prohibition has expired, i.e., from June 16, 1999 through June 15, 2004, Wicks shall, within 20 days of his acceptance of each and any employment offer involving NRC-licensed activities or his becoming involved in NRC-licensed activities, as defined above, provide written notice to the Regional Administrator, NRC Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, TX 76011, of the name,

address, and telephone number of the employer or the entity where he is, or will be, involved in the NRC-licensed activities, and a detailed description of his duties and the activities in which he is to be involved.

3. In the first notification provided pursuant to Paragraph 2 above, Wicks shall include a statement of his commitment to compliance with NRC regulatory requirements and an explanation of the basis why the Commission should have confidence that he will comply with applicable NRC requirements.

4. Notwithstanding the above, it is understood that Wicks may request reconsideration of the Prohibition Order after WIX has conducted two (2) years of resumed NRC-licensed activities, however, it is understood that the NRC Staff shall have the sole discretion to determine whether any such reconsideration is warranted, with respect to which determination Wicks hereby waives any right to or opportunity for hearing or appeal before the NRC and/or a court of law.

5. It is hereby agreed by the parties that WIX shall be allowed to resume its conduct of NRC-licensed activities upon approval of this Stipulation and Agreement by the Licensing Board, but it is expressly understood and agreed that Wicks is prohibited from participation in the conduct of any such activities in accordance with Paragraph 1 above. In furtherance of this understanding, WIX and Wicks further agree that License No. 49-27356-01 shall be modified

to include the following requirements, prior to any resumption of NRC-licensed activities, which shall remain in effect up to and including June 15, 1999 or until such other time as may be explicitly stated herein:

- (a) WIX (1) shall retain Mr. Ray Heath, or other person approved by the NRC Staff to serve as RSO or successor RSO until at least June 15, 1999, who shall at all times be responsible for performing the duties of an RSO and shall be responsible for maintenance of all NRC-required records; (2) shall establish the minimum number of hours to be devoted to RSO duties; and (3) shall describe the responsibilities and audits to be performed by the RSO under the radiation safety program. WIX shall submit the qualifications of any person it proposes to serve as RSO, other than Mr. Heath, to the NRC Staff for prior approval; the statement of qualifications should demonstrate that the person has not previously been employed by WIX, that he/she is likely to exercise independence from Wicks, and that he/she meets the NRC's minimum criteria established for an RSO.
- (b) Prior to restart, Mr. Heath (if he is selected by WIX to serve as RSO) must successfully complete an Industrial Radiography course

of at least 40 hours duration. Within six months of restart, Mr. Heath must successfully complete a Radiography Radiation Safety Officer training course of at least three days duration. Courses selected by the licensee to satisfy this condition must receive prior approval by NRC Region IV.

(c) If Mr. Heath is selected to serve as RSO, WIX shall name an Assistant Radiation Safety Officer to the license. The designated Assistant RSO must have at least five years experience as an industrial radiographer. The assistant RSO shall be readily available to respond to incidents and emergencies and shall be on call by means of a pager, telephone, or radio at all times when radiographic operations are scheduled or in progress.

(d) If Mr. Heath is selected to serve as RSO, the RSO and Assistant RSO shall be identified by name on the license. An Assistant RSO shall be carried on the license until Mr. Heath has gained the appropriate practical radiography training and experience, or a minimum of one year.

(e) The RSO shall have full authority for radiation protection and safety, entirely inde-

pendent from any involvement or interference by Wicks, with full authority to direct all aspects of radiography operations including the authority to shut down operations that are unsafe or which violate the license or NRC requirements. The RSO shall report to the person who is retained pursuant to paragraph 5(g) below, and the RSO shall have the authority to report any concerns directly to the NRC. The RSO shall notify the NRC immediately if Wicks participates or becomes involved in any NRC-licensed activities, or interferes with the RSO's independence in any way.

(f) The RSO shall certify to the NRC Staff in advance of commencing NRC-licensed activities that he/she understands (1) the terms of this Stipulation and Agreement, the license requirements, and the Commission's regulations associated with radiography, (2) that he/she may be held personally accountable for violations of the license or Commission requirements under 10 C.F.R. § 30.10 for deliberate misconduct, (3) that he/she is responsible for making reports required by NRC regulations, and (4) that Wicks is prohibited from having any involvement in NRC-licensed activities, and that the RSO is

required to notify the NRC immediately if Wicks participates or becomes involved in any NRC-licensed activities, or interferes with the RSO's independence in any way.

(g) WIX will retain the services of a person, to be approved in advance by the NRC Staff, to be responsible for management of those aspects of the company's business that could affect the RSO or the conduct of radiation safety-related activities, including the authority (1) to hire and terminate the employment of the RSO or other employees engaged in the conduct of NRC-licensed activities, (2) to make and execute salary and other financial decisions which may affect such persons including the RSO, and/or the safe conduct of NRC-licensed activities, and (3) to have control over financial resources (e.g., through the establishment of an escrow account) sufficient to ensure the safe and proper conduct of NRC-licensed activities. This individual shall also notify the NRC immediately if he/she determines that Wicks is or has been involved in NRC-licensed activities.

(h) Neither Wicks nor any person related to, or in privity with, him shall have any direct or indirect involvement in or exercise control over

NRC-licensed activities, including management, supervision and financial control or participation in hiring and firing decisions which may affect the RSO and/or the safe and proper conduct of NRC-licensed activities. In addition, while Beverly Wicks (Wicks' wife) may continue to serve as WIX' secretary, she shall not participate in or have any involvement in NRC-licensed activities (including, without limitation, such tasks as mailing and receiving film badges or radiation exposure reports, handling or distributing dosimeters, and any other tasks related to radiation safety).

(I) WIX shall retain an outside independent auditor (and any successor auditor), who is to be approved in advance by the NRC Staff based upon a review of the auditor's qualifications. The auditor (and any approved successor) shall submit an audit plan for NRC approval that describes the items to be audited and the methodology to be employed, including the number of field inspections and the percentage of employees engaged in radiography who will be audited in the field. The auditor is to provide copies of all draft and final audit reports to the NRC Staff at the same time that such reports are

provided to WIX. WIX shall provide a written response to the audit findings within 30 days after receipt thereof, including a description of any corrective actions taken or an explanation of why such actions were not taken. The auditor shall perform audits and examinations of the radiation safety program and operations, including the performance of field audits, as follows: An independent program audit will be performed at about three months, and no later than six months, following the resumption by WIX of NRC-licensed activities, with the results of the audit submitted to NRC Region IV for review. Following the initial audit, audits will be performed every six months. One year after restart, the NRC RIV Regional Administrator may consider, at the request of the licensee, relief in the audit requirements based on good cause shown. Further, the timing and scope of such audits shall not be disclosed to WIX or Wicks in advance; and the auditor shall be informed in advance that Wicks is prohibited from participation in any NRC-licensed activities.

(j) Any notification required to be made pursuant to this Paragraph 5 shall be made in writing to the Regional Administrator, NRC Re-

gion IV, 611 Ryan Plaza Drive, Suite 400,  
Arlington, TX 76011.

(k) The Regional Administrator, NRC Region IV, may relax or rescind any of the conditions set forth in this Stipulation and Agreement upon a demonstration of good cause, however, it is understood that the Regional Administrator shall have the sole discretion to determine whether any such reconsideration is warranted, with respect to which determination WIX and Wicks hereby waive any right to or opportunity for hearing or appeal before the NRC and/or a court of law.

6. The parties agree that, as an integral part of this Stipulation and upon execution hereof, and subject to the approval of this Stipulation by the Licensing Board,

(a) WIX and Wicks will withdraw their July 1 and October 14, 1994 requests for hearing on the Suspension Order, Revocation Order and Prohibition Order, and (b) the parties will file a joint request for dismissal of the proceedings on the Suspension Order, Revocation Order and Prohibition Order, with prejudice, it being understood and agreed that this Stipulation and Agreement resolves all outstanding issues with respect to those Orders, that WIX and Wicks hereby waive their hearing and appeal rights regarding the matters which are the subject of these Orders, and that the Staff will take

no further enforcement or other action against WIX or Wicks in connection with those Orders, subject to the terms of this Stipulation and Agreement.

7. WIX and Wicks hereby agree that a failure on their part to comply with the terms of this Stipulation and Agreement will constitute a material breach of this Agreement, and that any such breach may result in the immediate revocation or suspension of the license, effective immediately, if the NRC Staff, in its sole discretion, determines such action to be appropriate, and may result in further enforcement or other action as the NRC Staff may be determine, in its sole discretion, to be appropriate.

8. It is understood and agreed that nothing contained in this Stipulation and Agreement shall relieve the Licensee from complying with all applicable NRC regulations and requirements. Further, it is understood and agreed that nothing contained in this Agreement shall be deemed to prohibit the NRC Staff from taking enforcement or other action (a) against any entity or person for violation of this Stipulation and Agreement, or (b) against persons other than WIX or Wicks in connection with or related to any of the matters addressed in the Suspension Order, Revocation Order or Prohibition Order, should the Staff determine, in its sole discretion, that it is appropriate to do so.

9. It is understood and agreed that this Stipulation and Agreement is contingent upon prior approval by the

Licensing Board and dismissal of the instant adjudicatory proceedings.

10. This Stipulation and Agreement shall be binding upon the heirs, legal representatives, successors and assigns of the parties hereto.

IN WITNESS WHEREOF, we set our hand and seal this 2nd day of November, 1995.<sup>3</sup>

FOR WESTERN INDUSTRIAL X-RAY  
INSPECTION CO., INC., and  
LARRY D. WICKS:

FOR THE NRC STAFF:

Larry D. Wicks, individually and  
as President, Western Industrial  
X-Ray Inspection Co., Inc.

Sherwin E. Turk  
Counsel for NRC Staff

John C. Phillips  
Counsel for Western Industrial  
X-Ray inspection Co., Inc.  
and Larry D. Wicks

<sup>3</sup>The signed original was filed with the Board.

UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION

In the Matter of

WESTERN INDUSTRIAL X-RAY INSPECTION  
COMPANY, INC.  
(Byproduct Material License No.  
49-27356-01 - EA 93-238)

Docket No.(s) 30-32190-EA

CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing FINAL INITIAL ORDER-LBP-95-22 have been served upon the following persons by U.S. mail, first class, except as otherwise noted and in accordance with the requirements of 10 CFR Sec. 2.712.

Office of Commission Appellate  
Adjudication  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Peter B. Bloch, Chairman  
Atomic Safety and Licensing Board  
Mail Stop T-3 F 23  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Jerry R. Kline  
Atomic Safety and Licensing Board  
Mail Stop T-3 F 23  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Charles N. Kelber  
Atomic Safety and Licensing Board  
Mail Stop T-3 F 23  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Office of the General Counsel  
Mail Stop 0-15 B 18  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

John C. Phillips, Esq.  
Phillips Law Offices  
912 Main Street  
Evanston, WY 82931

Dated at Rockville, Md. this  
16 day of November 1995

  
Office of the Secretary of the Commission

UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION

In the Matter of

WESTERN INDUSTRIAL X-RAY INSPECTION  
COMPANY, INC.

Docket No.(s) 30-32190-EA-2

CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing FINAL INITIAL ORDER-LBP-95-22 have been served upon the following persons by U.S. mail, first class, except as otherwise noted and in accordance with the requirements of 10 CFR Sec. 2.712.

Office of Commission Appellate  
Adjudication  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Peter B. Bloch, Chairman  
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Mail Stop T-3 F 23  
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Washington, DC 20555

Administrative Judge  
Jerry R. Kline  
Atomic Safety and Licensing Board  
Mail Stop T-3 F 23  
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Washington, DC 20555

Administrative Judge  
Charles N. Kelber  
Atomic Safety and Licensing Board  
Mail Stop T-3 F 23  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Office of the General Counsel  
Mail Stop 0-15 B 18  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

John C. Phillips, Esq.  
Counsel for WIX  
Phillips Law Offices  
912 Main Street  
Evanston, WY 82931

Dated at Rockville, Md. this  
16 day of November 1995

  
\_\_\_\_\_  
Office of the Secretary of the Commission

UNITED STATES OF AMERICA  
NUCLEAR REGULATORY COMMISSION

In the Matter of

LARRY D. WICKS

(EVANSTON, WYOMING)

Docket No.(s) IA-94-024

CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing FINAL INITIAL ORDER-LBP-95-22 have been served upon the following persons by U.S. mail, first class, except as otherwise noted and in accordance with the requirements of 10 CFR Sec. 2.712.

Office of Commission Appellate  
Adjudication  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Peter B. Bloch, Chairman  
Atomic Safety and Licensing Board  
Mail Stop T-3 F 23  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Jerry R. Kline  
Atomic Safety and Licensing Board  
Mail Stop T-3 F 23  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

Administrative Judge  
Charles M. Kelber  
Atomic Safety and Licensing Board  
Mail Stop T-3 F 23  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

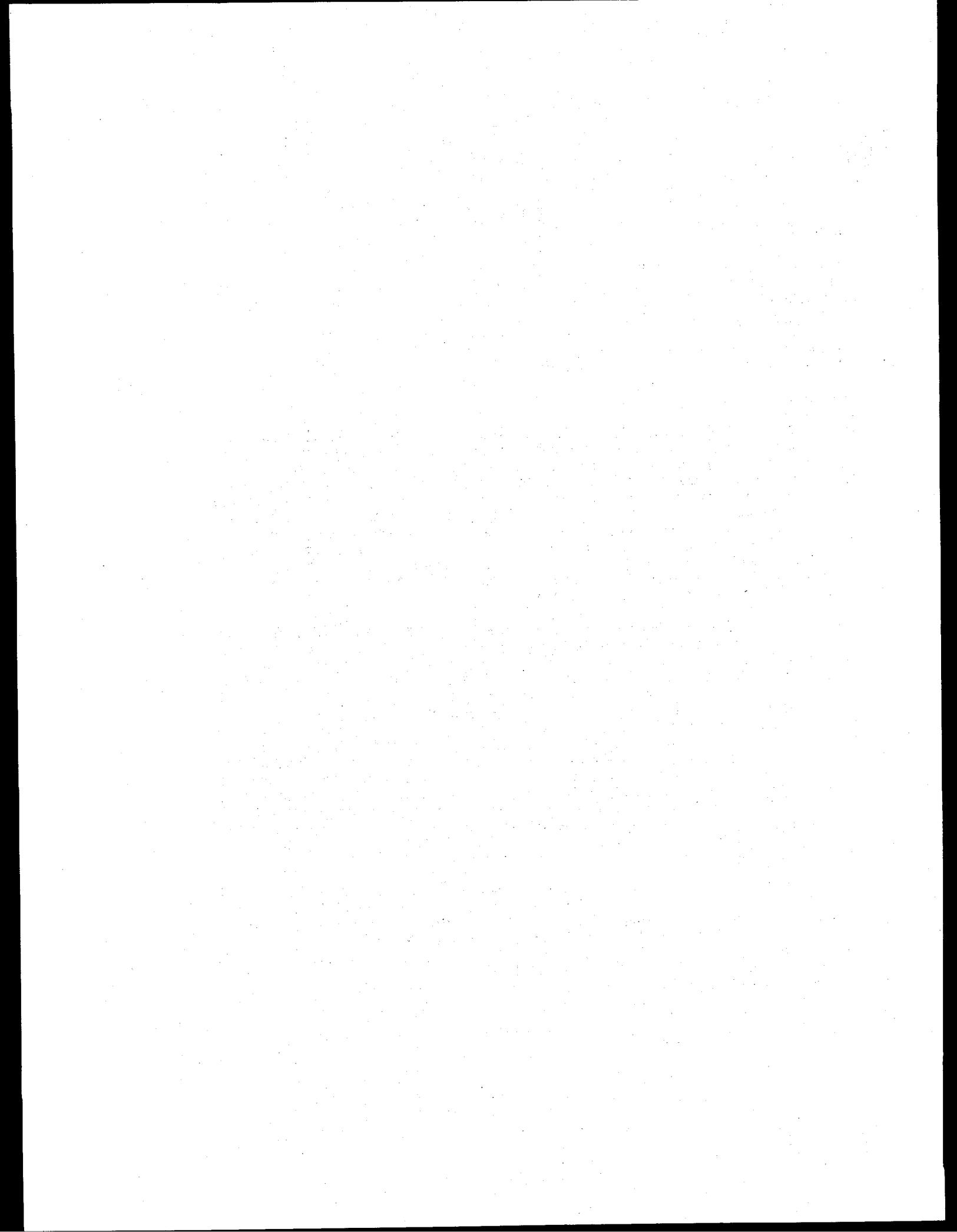
Office of the General Counsel  
Mail Stop 0-15 B 18  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

John C. Phillips, Esq.  
Counsel for Larry D. Wicks  
Phillips Law Offices  
912 Main Street  
Evanston, WY 82931

Dated at Rockville, Md. this  
16 day of November 1995

  
Office of the Secretary of the Commission

**B. NOTICE OF VIOLATIONS, NO CIVIL PENALTY**





UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

July 5, 1995

EA No. 95-058

Mr. William McDaniel, Site Manager  
Amersham Corporation  
40 North Avenue  
Burlington, MA 01803

Subject: NOTICE OF VIOLATION  
(NRC Inspection No. 030-29300/95-001)

Dear Mr. McDaniel:

This letter refers to the NRC inspection conducted on March 29, 1995, at your facility located in Burlington, Massachusetts, of activities authorized by NRC License No. 20-12836-01. The inspection report was sent to you on April 13, 1995. Based on the inspection, two violations of NRC requirements were identified. On May 15, 1995, an enforcement conference was conducted with you and other members of your staff, to discuss the violations, their causes and your corrective actions as well as to discuss the status of actions described in the April 6, 1995 Confirmatory Action Letter. A copy of the enforcement conference report was sent to you on June 6, 1995. The inspection was continued until June 16, 1995, to review additional information provided to the NRC following the enforcement conference regarding dose assessments.

The violations are described in the enclosed Notice of Violation (Notice). The first violation involves failure to make, or cause to be made, surveys that may be necessary to comply with the regulations in Part 20 and that are reasonable under the circumstances to evaluate the extent of radiation levels, concentrations or quantities of radioactive materials, and potential radiological hazards that could be present. Specifically, adequate surveys were not performed to assess the radiological conditions leading to, and the workers doses resulting from, exposures to hot particles. Failure to adhere to this regulatory requirement, represents a significant regulatory concern. The nature of the violation indicates that there has been a lack of attention toward licensed responsibilities in the area regarding control of contamination in the unloading cell. The NRC particularly is concerned that although you knew about the hot particle contamination of wafers supplied to your facility since 1991, you did not take immediate corrective actions to prevent recurrence or the spread of contamination within the unloading cell.

The second violation involves your failure to control the occupational dose to the skin or to any extremity of individual adults to an annual limit of 50 rems shallow-dose equivalent. Specifically, one adult worker received approximately 60 rems shallow-dose equivalent to the left and right hand on October 19, 1994, and another adult worker received approximately 230 rems shallow-dose equivalent to the skin of the back on March 24, 1995. This violation is of particular concern to the NRC because it resulted in exposures to members of your staff in excess of regulatory limits.

Incumbent upon each NRC licensee is the responsibility to protect the health and safety of its workers by ensuring that all requirements of the NRC license are met and any potential violations of NRC requirements are identified and corrected expeditiously. In this case, adequate attention was not provided to a very specific portion of your radiation safety program involving control of radioactive contamination. These violations demonstrate the importance of increased attention to this aspect of your program to ensure that individual workers are not exposed to radioactive material unnecessarily, and that regulatory requirements are understood, and your activities are conducted safely and in accordance with those requirements. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) (60 FR 34381, June 30, 1995) the violations are classified in the aggregate at Severity Level III.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$12,500 is considered for a Severity Level III violation. Because your facility has not been the subject of escalated enforcement within the last two inspections in 1993 and 1994, the NRC considered whether credit was merited for Corrective Action in accordance with Section VI.B.2 of the Enforcement Policy. Credit was warranted for your prompt and comprehensive Corrective Action as the NRC recognizes that after the violations were identified by the NRC, actions were taken or planned to correct the violations and effect improvements in the control and implementation of the radiation safety program. These actions that were described at the enforcement conference, as well as in a Confirmatory Action Letter (CAL) (1-95-006) issued on April 6, 1995 included: (1) implementation of procedures for two person frisking; (2) revision and implementation of procedures for frisking protective clothing; (3) conducting formal training in revised procedures; and (4) submitting an action plan for decontaminating the unloading cell.

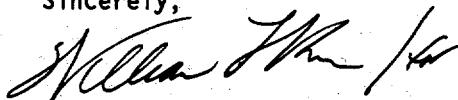
Therefore, to encourage prompt and comprehensive correction of violations, and in recognition of the absence of previous escalated enforcement action, I have been authorized not to propose a civil penalty in this case. However, any similar violations in the future could result in more significant escalated enforcement action.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific status of actions taken and any additional actions you plan to prevent recurrence. In this regard, please address how you plan to maintain enhanced oversight to ensure compliance with the requirements. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information, so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket No. 030-29300  
License No. 20-12836-01

Enclosure: Notice of Violation

cc w/encl:  
Commonwealth of Massachusetts (2)

ENCLOSURE

NOTICE OF VIOLATION

Amersham Corporation  
Burlington, Massachusetts

Docket No. 030-29300  
License No. 20-12836-01  
EA 95-058

During an NRC inspection conducted on March 29, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 60 FR 34381, June 30, 1995, the particular violations are set forth below:

A. 10 CFR 20.1501 requires that each licensee make or cause to be made surveys that may be necessary for the licensee to comply with the regulations in Part 20 and that are reasonable under the circumstances to evaluate the extent of radiation levels, concentrations or quantities of radioactive materials, and the potential radiological hazards that could be present.

Pursuant to 10 CFR 20.1003, survey means an evaluation of the radiological conditions and potential hazards incident to the production, use, transfer, release, disposal, or presence of radioactive material or other sources of radiation.

Contrary to the above, as of March 29, 1995, adequate surveys were not made to assure compliance with 10 CFR 20.1201(a)(2)(ii), which limits radiation exposure to the skin to 50 rem. Specifically,

1. the licensee's egress survey (frisking) of an individual on March 24, 1995, for iridium-192 hot particles (to assure compliance with 10 CFR 20.1201(a)(2)(ii)), did not adequately identify a hot particle (with an activity of approximately 100 microcuries) that was at a location on the individual not directly viewed by the monitoring detectors used by the licensee. (IFS Code 01023)
2. the licensee calculated the skin exposure to the left and right hand of a worker on October 19, 1994, to be approximately 21 rem from hot particles and the skin exposure to the back of a worker on March 24, 1995 to be approximately 145 rem and did not take into account the resolving time of the detector. If the resolving time of the detector had been considered, the exposures on October 19, 1994 would have been approximately 60 rem, and the exposure on March 24, 1995, would have been approximately 230 rem; and

B. 10 CFR 20.1201(a)(2)(ii) requires, with exceptions not applicable here, that the licensee control the occupational dose to the skin or to any extremity of individual adults to an annual dose limit of 50 rems shallow-dose equivalent.

Contrary to the above, on October 19, 1994, and March 24, 1995, the licensee did not control the occupational dose to the skin or any extremity of two individual adults to an annual dose limit of 50 rems shallow-dose equivalent. Specifically, one adult worker received approximately 60 rems shallow-dose equivalent to the left and right hand on October 19, 1994 and another adult worker received approximately 230 rems shallow-dose equivalent to the skin of the back on March 24, 1995. (IFS Code 01013)

This is a Severity Level III problem (Supplement IV).

Pursuant to the provisions of 10 CFR 2.201, Amersham Corporation is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region I, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Dated at King of Prussia, Pennsylvania  
this 5<sup>th</sup> day of July 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

August 17, 1995

EA No. 95-134

Mr. Gus Moffitt, Vice President  
Safety Health and Environment  
Bethlehem Steel Corporation  
8th Eaton Avenues  
1292 Martin Towers  
Bethlehem, Pennsylvania 18016-7699

Subject: NOTICE OF VIOLATION  
(NRC Inspection No. 030-06029, 030-06032/95-001)

Dear Mr. Moffitt:

This letter refers to the NRC inspection conducted on June 21 and 27, 1995, at your facilities located in Chesterton, Indiana, and Bethlehem, Pennsylvania, of activities authorized by NRC License Nos. 37-01861-01 and 37-01861-05. The inspection report was sent to you on July 14, 1995. Based on the inspection, four violations of NRC requirements were identified. On August 3, 1995, a predecisional enforcement conference was conducted with Mr. Tom Civic, of your staff, and your Corporate Radiation Safety Officer, Anthony LaMastra. Mr. George Burnet and other members of the Isotope Measuring Systems, Inc. (IMS) staff were also present, to discuss the violations, their causes, and your corrective actions. A copy of the enforcement conference report is enclosed.

The violations are described in the enclosed Notice of Violation (Notice). The first violation involves failure to implement controls at each entrance or access point of a high radiation area as required by 10 CFR 20.1601. Specifically, the door to the test enclosure located at your Indiana facility was not locked during one minute test irradiations performed on June 16, 1995. In addition, the door was not equipped with an interlock or equivalent control device that, upon entry, would cause the radiation level to be reduced below a high radiation area, nor were there positive controls maintained over the entry via continuous or electronic surveillance. Failure to adhere to these regulatory requirements represents a significant regulatory concern. As identified by Bethlehem Steel and reported to NRC on June 20, 1995, three ironworkers entered the gauge test enclosure and were exposed unnecessarily. However, the exposure received by these individuals was not in excess of regulatory limits to individual members of the public. The nature of this violation indicates a lack of attention toward licensed responsibilities in access control to a high radiation area.

The NRC is particularly concerned because, although IMS was contracted by your company to install one of their gauging devices at your facility, you failed to assume responsibility for maintaining oversight while the installation was being accomplished under the authority of your NRC broad-scope license.

The second violation involves the failure to post a high radiation area as required by 10 CFR 20.1902. Specifically, the test enclosure which the three ironworkers entered was not posted with a conspicuous sign bearing the radiation caution symbol and the words "Caution-High Radiation Area".

The third and fourth violations include failure to provide training as required by 10 CFR 19.12 and License Condition No. 18 of NRC License No. 37-01861-05. Specifically, training was not provided to personnel who entered a restricted area nor was training in your emergency and operating procedures provided to supervised personnel performing licensed activities.

Incumbent upon each NRC licensee is the responsibility to protect the health and safety of its workers by ensuring that all requirements of the NRC license are met and any potential violations of NRC requirements are identified and corrected expeditiously. In this case, adequate attention was not provided to a very specific portion of your radiation safety program involving access control of a high radiation area. These violations demonstrate the importance of increased attention to this aspect of your program to ensure that individual workers are not exposed to radioactive material unnecessarily, and that regulatory requirements are understood, and your activities are conducted safely and in accordance with those requirements.

In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG 1600 (60 Fed. Reg. 34381, June 30, 1995), the violations are classified in the aggregate at Severity Level III and are described in the enclosed Notice.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 was considered for this Severity Level III problem to emphasize the need for, and importance of, adequate attention to the radiation safety program. Because your facility has not been the subject of escalated enforcement in the past two inspections, the NRC considered whether credit was warranted for corrective action in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. Credit was warranted for your prompt and comprehensive corrective actions taken in response to the inspection findings. Your corrective actions included but were not limited to: (1) locking the door to the testing enclosure with keys controlled by test personnel, and instituting the plant's lockout procedure for access into the enclosure; (2) installing an electrical interlock on the entry door that causes the device shutter to close if the door is open, and requires resetting at the control panel; (3) conspicuously posting the door with a "Caution-High Radiation Area" and authorized entry only signs; and (4) installing red and green shutters on/off indicator lights at eye level at the entrance door. Therefore, to encourage prompt identification and comprehensive correction of violations, and in recognition of the absence of previous escalated enforcement action, I have been authorized not to propose a civil penalty in this case. However, any similar violations in the future could result in more significant escalated enforcement action, including issuance of a civil penalty.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific status of actions taken and any additional actions you plan to prevent recurrence. In this regard, please address how you plan to maintain enhanced oversight to ensure compliance with the requirements. In addition, please address in detail what actions you will take in order to ensure that appropriate oversight will be maintained when contractors perform licensed activities at your facilities whether under authorization of your NRC license or their own license. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information, so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket Nos. 030-06032, 030-06029  
License Nos. 37-01861-05, 37-01861-01

Enclosures:

1. Notice of Violation
2. Predecisional Enforcement Conference Report No. 95-002

cc w/encls:

Commonwealth of Pennsylvania  
State of Indiana

ENCLOSURE 1

NOTICE OF VIOLATION

Bethlehem Steel Corporation  
Bethlehem, Pennsylvania

Docket Nos. 030-06032

030-06029

License Nos. 37-01861-05

37-01861-01

EA 95-134

During an NRC inspection conducted on June 21 and 27, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 Fed. Reg. 34381, June 30, 1995), the violations are set forth below:

A. 10 CFR 20.1601(a) requires, with exceptions not applicable here, that the licensee ensure that each entrance to a high radiation area has one or more of the following features: (1) a control device that, upon entry into the area, causes the level of radiation to be reduced below that level at which an individual might receive a deep-dose equivalent of 0.1 rem in one hour at 30 centimeters from the radiation source or from any surface that the radiation penetrates; (2) a control device that energizes a conspicuous visible or audible alarm signal so that the individual entering the high radiation area and the supervisor of the activity are made aware of the entry; or (3) entryways that are locked, except during periods when access to the area is required, with positive control over each individual entry.

10 CFR 20.1601(b) provides that, in place of the controls required by 10 CFR 20.1601(a), for a high radiation area, a licensee may substitute continuous direct or electronic surveillance that is capable of preventing unauthorized entry.

Contrary to the above, on June 16, 1995, the entrance to a gauge test enclosure in your Chesterton, Indiana Plate Mill, a high radiation area with a radiation dose rate of approximately 50,000 millirem/hour at 60 centimeters from the source and approximately 8600 millirem/hour in accessible areas of the enclosure, was not controlled by any of the methods described in 10 CFR 20.1601(a) or (b).

B. 10 CFR 20.1902(b) requires that the licensee post each high radiation area with a conspicuous sign or signs bearing the radiation symbol and the words "CAUTION, HIGH RADIATION AREA" or "DANGER, HIGH RADIATION AREA."

Contrary to the above, on June 16, 1995, the gauge test enclosure at the licensee's Chesterton, Indiana Plate Mill facility, a high radiation area with a radiation dose rate of approximately 50,000 millirem/hour at 60 centimeters from the source and approximately 8600 millirem/hour in accessible areas, was not posted with a sign bearing the radiation symbol and the words "CAUTION (OR DANGER), HIGH RADIATION AREA."

C. 10 CFR 19.12 requires, in part, that all individuals working in a restricted area be instructed in the precautions and procedures to minimize exposure to radioactive materials, in the purpose and functions of protective devices employed, and in the applicable provisions of the Commission's regulations and licenses.

Contrary to the above, as of June 16, 1995, individuals who were working in a gauge test enclosure at the licensee's Chesterton, Indiana Plate Mill facility, a restricted area, had not been instructed in the applicable provisions of the regulations, radiation safety precautions, health protection problems associated with exposure to such radioactive materials and the conditions of the license. Specifically, three ironworkers that worked in the enclosure on June 12, 13 and 16, 1995, had not received the required instruction.

D. Condition No. 18 of License No. 37-01861-05 requires that the licensee conduct its program in accordance with the statements, representations and procedures contained in the application dated May 30, 1989.

Item 8, of the application dated May 30, 1989, requires that personnel working under the supervision of an unsupervised user or Anthony LaMastra be given a minimum of 6 hours of instruction by Mr. LaMastra in the following topics:

- Principals and methods of radiation protection
- Survey technique and instrument protection
- Biological effects
- Bethlehem Steel Corporation's policies and procedures
- Applicable regulations
- Emergency procedures

Contrary to the above, from June 12 to June 16, 1995, the licensee permitted personnel to work under the supervision of an unsupervised user and the personnel had not received all of the required instruction. Specifically, Isotope Measuring System personnel performed testing on a custom-built gauge (i.e., an IMS Model 5245-03 gauge) without having received instructions in the licensee's policies and procedures or emergency instructions.

These violations are classified in the aggregate as a Severity Level III problem (Supplement IV and VI).

Pursuant to the provisions of 10 CFR 2.201, Bethlehem Steel Corporation is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region I, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, Pennsylvania  
this 17th day of August 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION III  
801 WARRENVILLE ROAD  
LISLE, ILLINOIS 60532-4351  
September 28, 1995

EA 95-150

CTI and Associates, Inc.  
ATTN: James H. Staden, P.E.  
Principal Engineer  
12482 Emerson Drive  
Brighton, Michigan 48116

SUBJECT: NOTICE OF VIOLATION  
(NRC Inspection Report No. 030-12040/95001)

Dear Mr. Staden:

This refers to the special safety inspection conducted from July 6 to July 17, 1995, to review the circumstances concerning damage to a Troxler soil moisture/density gauge containing NRC licensed material (nominally 10 millicuries (370 megabecquerel) of cesium-137 and 40 millicuries (1480 megabecquerel) of americium-241 in sealed sources). The inspection report, including a description of an apparent violation of NRC requirements, was mailed to you on August 1, 1995. In a letter dated August 28, 1995, you responded to the apparent violation and provided a description of the corrective actions.

The event occurred on June 14, 1995, at a construction site in Green Oak Township, Michigan, after a gauge technician-in-training placed the device at the edge of an asphalt road where it was struck by a pick-up truck. Neither the technician nor the authorized user, who was conducting the training, had the gauge under constant surveillance or control when it was struck. The truck driver immediately informed the technician of the incident. The authorized user and the technician then limited access to the device and notified the radiation safety officer (RSO). The RSO went to the site, determined that the source rod was broken, and notified the NRC. Surveys and leak tests indicated that the sealed sources were not damaged.

Based on the information developed during the inspection and the information that you provided in your response to the inspection report, the NRC has determined that a violation of NRC requirements occurred. The violation is cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding it are described in detail in the inspection report. The root cause of the violation was attributed to the poor judgement of the instructor and trainee. As the holder of a Byproduct Material License, the NRC entrusts responsibility for radiation safety to the management of CTI and Associates, Inc.; therefore, the NRC expects effective management and oversight of its licensed programs. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety by assuring that all NRC requirements are met and access to licensed material is controlled so that materials do not inadvertently enter the public domain. In this case the violation is of regulatory concern because it represents a significant failure to control licensed material. Therefore, the violation is categorized at Severity

Level III in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 FR 34381; June 30, 1995).

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 is considered for a Severity Level III violation. Because your facility has not been the subject of escalated enforcement actions within the last two inspections, the NRC considered whether credit was warranted for *Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. Corrective actions consisted of: counselling both the authorized user and the trainee about their responsibility to control licensed material, establishing a policy that a gauge containing licensed material should not be more than arm's length from a technician, and establishing an annual refresher training program for all technicians. Based on these corrective actions, we have concluded that CTI and Associates should be given credit for these measures to correct the violation and prevent recurrence. Therefore to encourage prompt identification and corrective actions, I have been authorized, after consultation with the Director, Office of Enforcement, to issue the enclosed Notice without a civil penalty. However, escalated enforcement will be considered should a similar significant violation occur in the future.

The NRC has concluded that information regarding the reason for the violation, the corrective actions taken and planned to correct the violation and prevent recurrence is already adequately addressed on the docket in Inspection Report No. 030-12040/95001 and a letter from CTI and Associates, Inc., dated August 28, 1995. Therefore, you are not required to respond to this letter unless the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to provide additional information, you should follow the instructions specified in the enclosed Notice.

Sincerely,



Hubert J. Miller  
Regional Administrator

Docket No. 030-12040  
License No. 21-17007-01

Enclosure:  
Notice of Violation

NOTICE OF VIOLATION

CTI and Associates, Inc.  
12482 Emerson Drive  
Brighton, Michigan 48166

Docket No. 030-12040  
License No. 21-17007-01  
EA 95-150

During an NRC inspection conducted from July 6 through July 17, 1995, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600 (60 FR 34381; June 30, 1995), the violation is listed below:

10 CFR 20.1801 requires that the licensee secure from unauthorized removal or access licensed materials that are stored in unrestricted areas.  
10 CFR 20.1802 requires that the licensee control and maintain constant surveillance of licensed material that is in an unrestricted area and that is not in storage. As defined in 10 CFR 20.1003, *unrestricted area* means an area, access to which is neither limited nor controlled by the licensee.

Contrary to the above, on June 14, 1995, the licensee did not secure from unauthorized use or limit access to a Troxler moisture/density gauge containing licensed material (nominally 10 millicuries (370 megabecquerel) of cesium-137 and 40 millicuries (1480 megabecquerel) of americium-241) located at a construction site in Green Oak Township, Michigan, an unrestricted area, nor did the licensee control and maintain constant surveillance of this licensed material. (01013)

This is a Severity Level III violation (Supplement IV).

The NRC has concluded that information regarding the reason for the violation, the corrective actions taken and planned to correct the violation and prevent recurrence is already addressed on the docket in Inspection Report No. 030-12040/95001 and your letter dated August 28, 1995. However, you are required to respond to the provisions of 10 CFR 2.201 if the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to respond, clearly mark your response as a "Reply to a Notice of Violation," and send it to the U. S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555 with a copy to the Regional Administrator, Region III, 801 Warrenville Road, Lisle, IL 60532 within 30 days of the date of the letter transmitting this Notice of Violation (Notice).

Dated at Lisle, Illinois  
this 28 day of September 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION IV

611 RYAN PLAZA DRIVE, SUITE 400  
ARLINGTON, TEXAS 76011-8064

August 21, 1995

EA 95-149

Department of Veterans Affairs  
Medical Center

ATTN: Mr. Jerry Boyd  
Medical Center Director  
5901 East Seventh Street  
Long Beach, California 90822

SUBJECT: NOTICE OF VIOLATION  
(NRC INSPECTION REPORT 030-01215/95-01)

This refers to the routine, unannounced inspection conducted by Mr. David D. Skov of this office on April 17 through July 10, 1995. The inspector was accompanied by Mr. Eugene J. Power, Investigator, Region IV Office of Investigations (Field Office). The inspection included a review of activities authorized by Byproduct Material License 04-00689-07. At the conclusion of the inspection, the findings were discussed with members of your staff. The enclosed NRC Inspection Report 030-01215/95-01 documents this inspection.

The inspection was an examination of activities conducted under the license as they relate to radiation safety and to compliance with the Commission's rules and regulations and the conditions of the license. The inspection consisted of selective examinations of procedures and representative records, interviews of personnel, independent measurements, and observation of activities in progress. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements.

Based on the results of this inspection, the NRC has determined that violations of NRC requirements occurred. These violations are cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding them are described in detail in the subject inspection report. The violations are of concern because they represent implementation weaknesses in several areas of the radiation safety program.

In addition, one apparent violation of NRC requirements was identified for escalated enforcement action in accordance with the General Statement of Policy and Procedure for NRC Enforcement Actions (Enforcement Policy) (NUREG 1600, 60 FR 34381, June 30, 1995). The apparent violation involved the

unauthorized disposal of licensed material by release to the normal trash in violation of 10 CFR 20.2001(a).

The NRC learned of the improper disposal through a telephone call to the NRC operations center from your radiation safety officer on March 4, 1994. This was followed by a written report (dated March 30, 1994) of the incident and the corrective actions taken. It was determined that a research laboratory principal investigator had ordered 5 millicuries of iodine-125 (I-125) as sodium iodide in liquid form on February 23, 1994. The carrier's delivery report (signed by a Department of Veterans Affairs Medical Center representative) provided positive evidence that the I-125 package was received at the Medical Center the following day. However, the investigator did not receive the shipping package and after an extensive search, it was concluded that the package had been accidentally disposed to normal trash and was probably buried at a landfill disposal site.

The NRC staff considered both the safety and regulatory significance of having disposed of the I-125 in the normal trash. The NRC recognizes the relative low safety significance of the I-125 disposal provided the material remains intact within its shielded container. However, considering the relatively long half life of I-125 (approximately 60 days) and the quantity involved, a potential hazard to the general public would have existed for an extended period of time if the container had been breached, releasing its radioactive contents. Secondly, the NRC considers the regulatory significance of this event to be very high. The NRC, in licensing the use of byproduct material, requires that the licensee maintain positive control over the storage, use and disposal of the material to ensure the health and safety of the user, patients and the public.

On July 17, 1995, a telephone conversation was held between you and Mr. Skov of my staff regarding a predecisional enforcement conference. Based on this conversation it was determined that an enforcement conference was not necessary and that the apparent violation including the description of the event and associated corrective action were appropriately understood for the NRC staff to come to an enforcement decision. Therefore, in accordance with the Enforcement Policy this apparent violation has been classified at Severity Level III because of the overall significance the NRC places on the proper disposal of radioactive materials.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 is considered for a Severity Level III violation. Because your facility has not been the subject of escalated enforcement actions within the last two inspections the NRC considered whether credit was warranted for Corrective Action in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. Based on the extensive efforts to recover the source which included interviewing personnel about the missing package and a wide-spread search with a survey meter of nuclear medicine, research, and waste storage areas, and based on the additional controls that were put in place for receipt of radioactive materials, the NRC staff

determined that credit for corrective actions taken was appropriate. Therefore, to encourage prompt and comprehensive correction of violations, and in recognition of the absence of previous escalated enforcement action, I have been authorized, after consultation with the Director, Office of Enforcement, not to propose a civil penalty in this case. However, any significant violations in the future could result in a civil penalty.

The NRC has concluded that information regarding the reason for Violation A, the corrective actions taken and planned to correct the violation and prevent recurrence is already adequately addressed in the enclosed inspection report and on the docket in the licensee's letter dated March 30, 1994. Therefore, you are not required to respond to Violation A unless the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to provide additional information, you should follow the instructions specified in the enclosed Notice. You are however required to respond to Violations B-G and should follow the instructions specified in the enclosed Notice when preparing your response.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure(s), and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

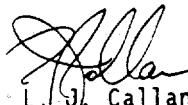
In addition to the concerns discussed above regarding violations identified during this inspection, we are concerned about the implementation of your program in the area of management control. Although management oversight and overall radiation safety program performance in preventing, identifying, and correcting violations and deficiencies has markedly improved since the last two NRC inspections, the violations identified during the current inspection indicate the need for additional management attention to this program area. For example, three of the violations involved failures to calibrate or adequately calibrate various counting instruments used for conducting area radiation surveys and bioassays of personnel. Therefore, in your reply to this letter, we request that you also describe those actions planned or taken to improve the effectiveness of the management control of your licensed operations, with particular emphasis on measures currently being taken to prevent further violations.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96.511.

Department of Veterans Affairs -4-  
Medical Center

Should you have any questions concerning this letter, please contact  
Mr. Frank A. Wenslawski at (510)975-0219.

Sincerely,



L. J. Callan  
Regional Administrator

Docket: 030-01215

License: 04-00689-07

Enclosures:

1. Notice of Violation
2. NRC Inspection Report  
030-01215/95-01
3. Copy of General Statement of Policy and Procedure for NRC Enforcement Actions (60 FR 34381, June 30, 1995)

cc w/enclosures:

California Radiation Control Program Director

Department of Veterans Affairs  
National Health Physics Program (115HP)  
ATTN: Dr. F. Herbig  
915 North Grand Boulevard  
St. Louis, MO 63106

Edwin M. Leidholdt, Jr., Ph.D.  
Radiation Safety Program Manager (134RAD)  
Department of Veterans Affairs  
Western Region  
301 Howard Street, Suite 700  
San Francisco, CA 94105-2241

ENCLOSURE 1

NOTICE OF VIOLATION

Department of Veterans Affairs  
Medical Center  
Long Beach, California 90822

Docket: 030-01215

License: 04-00689-07

During an NRC inspection conducted at the Department of Veterans Affairs Medical Center, Long Beach, California on April 17 through July 10, 1995, seven violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," 60 FR 34381, June 30, 1995, the violations are listed below:

A. 10 CFR 20.2001(a) requires that the licensee dispose of licensed material only by certain specified procedures.

Contrary to the above, on approximately February 24, 1994, the licensee disposed of 5 millicuries of iodine-125 in liquid form by release to the non-radioactive trash, a method not authorized by 10 CFR 20.2001. (01013)

This is a Severity Level III violation (Supplement IV).

B. 10 CFR 35.406(b) requires that a licensee make a record of brachytherapy source use, including: (1) the names of the individuals permitted to handle the sources; (2) the number and activity of sources removed from storage, the patient's name and room number, the time and date they were removed from storage, the number and activity of the sources in storage after the removal, and the initials of the individual who removed the sources from storage; and (3) the number and activity of sources returned to storage, the patient's name and room number, the time and date they were returned to storage, the number and activity of sources in storage after the return, and the initials of the individual who returned the sources to storage.

Contrary to the above, the licensee did not make a record of brachytherapy source usage for a 30-seed patient implant containing 95 millicuries of iridium-192 used between September 14 and 16, 1994.

This is a Severity Level IV violation (Supplement VI).

C. 10 CFR 35.51(a) requires, in part, that a licensee calibrate the survey instruments used to show compliance with 10 CFR Part 35.

10 CFR 35.51(b) states, in part, that when calibrating a survey instrument, a licensee shall consider a point as calibrated if the indicated exposure rate differs from the calculated exposure rate by not more than 20 percent.

Contrary to the above, as of April 28, 1995, the licensee was using a Technical Associates Model TBM-3 survey instrument to show compliance

with 10 CFR Part 35 and, when the instrument was last calibrated, the indicated exposure rate differed from the calculated exposure rate by more than 20 percent at various points on the scales of this instrument.

This is a Severity Level IV violation (Supplement VI).

D. 10 CFR 35.205(e) requires, in part, that a licensee check each month the operation of reusable collection systems for radioactive gases and measure each 6 months the ventilation rates available in areas of use of radioactive gas.

1. Contrary to the above, the licensee used a reusable collection system for radioactive xenon-133 gas and did not check the operation of the collection system from August 1993 to October 1994.
2. Contrary to the above, the licensee used radioactive xenon-133 gas in Room 434 and did not measure the ventilation rates at all exhaust vents therein each 6 months as required between July 1993 and April 17, 1995.

This is a Severity Level IV violation (Supplement VI).

E. 10 CFR 35.315(a)(4) requires, in part, that for each patient receiving radiopharmaceutical therapy and hospitalized for compliance with 10 CFR 35.75, after administration of the dosage, the licensee promptly measure the dose rates in contiguous restricted and unrestricted areas with a radiation measurement survey instrument to demonstrate compliance with the requirements of 10 CFR Part 20.

10 CFR 20.1301(a)(2) requires that the licensee conduct operations so that the dose in any unrestricted area from external sources does not exceed 2 millirem in any 1 hour.

Contrary to the above, on November 29, 1993, licensee operations involving the therapeutic administration of 100 millicuries of iodine-131 to a patient housed in Room 543 of Ward N-5, Building 126, resulted in a dose of 3 millirem in 1 hour in the adjacent hallway, and 4 millirem in 1 hour in the adjacent room, both unrestricted areas.

This is a Severity Level IV violation (Supplement IV).

F. 10 CFR 35.21(a) requires that the licensee, through the radiation safety officer, ensure that radiation safety activities are being performed in accordance with approved procedures. The licensee's procedures for bioassay measurements of personnel for iodine-125 and iodine-131 are described in the letters dated November 15, 1991, and December 21, 1994, and were approved by License Condition No. 19.

The letter dated November 15, 1991, states in Item No. 8 that bioassays for personnel using radioactive isotopes of iodine will be conducted in accordance with NRC Regulatory Guide 8.20, Revision 1, 1979. Section C.1.a of the guide states that a routine bioassay is necessary when an individual handles, in open form, unsealed quantities of radioactive iodine that exceed the quantities in Table 1 of the guide. Table 1 of the guide specifies a minimum quantity requiring a bioassay of 10 millicuries for operations involving the handling of radioiodine bound to a non-volatile agent in an open room or the handling of volatile or dispersible radioiodine within a fume hood of adequate design, face velocity, and performance reliability. Section C.1.b. states that when quantities handled in unsealed form are greater than 10 percent of the Table I quantity (i.e., 1 millicurie), bioassays may still be necessary under certain circumstances.

Contrary to the above, on at least eight occasions between October 21, 1994, and February 28, 1995, the licensee failed to ensure that radiation safety activities were being performed in accordance with the above procedures. Specifically, bioassay measurements to evaluate for iodine-131 and iodine-125 were not performed following the use of greater than 10 millicuries of iodine-131 in a form bound to a non-volatile agent for radiopharmaceutical therapy, and following the use of greater than 1 millicurie of iodine-125 in a volatile form for research.

This is a Severity Level IV violation (Supplement VI).

G. 10 CFR 20.1501(b) requires the licensee to ensure that instruments and equipment used for quantitative radiation measurements are calibrated periodically for the radiation measured.

Contrary to the above, an instrument (Canberra Series 10 Plus counting system) used since at least 1990 for quantitative thyroid bioassay measurements to determine the radioactive uptake of iodine-131 in radiation workers, has not been calibrated for the radiation measured.

This is a Severity Level IV violation (Supplement IV).

The NRC has concluded that information regarding the reason for Violation A, the corrective actions taken and planned to correct the violation and prevent recurrence is already adequately addressed on the docket in the enclosed inspection report and your letter dated March 30, 1994. However, The Department of Veterans Affairs Medical Center (Licensee) is required to respond to the provisions of 10 CFR 2.201 if the description therein does not accurately reflect the Licensee's corrective actions or position. In that case and for the remaining violations, pursuant to the provisions of 10 CFR 2.201. The Department of Veterans Affairs Medical Center is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555,

with a copy to the Regional Administrator, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011, and Walnut Creek Field Office, 1450 Maria Lane, Walnut Creek, California 94596, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. Where good cause is shown, consideration will be given to extending the response time.

Because the response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if it necessary to include such information, it should clearly indicate the specific information that should not to be placed in the PDR, and provide the legal basis to support the request for withholding the information from the public.

Dated at Arlington, Texas  
this 21st day of August 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION III  
801 WARRENVILLE ROAD  
LISLE, ILLINOIS 60532-4351

November 16, 1995

EA 95-154

GCME, Inc.  
ATTN: Wayne Weinfurter  
President  
3471 Packerland Drive  
DePere, WI 54115

SUBJECT: NOTICE OF VIOLATION  
(NRC INSPECTION REPORT NO. 030-31195/95001(DRSS) AND  
OFFICE OF INVESTIGATIONS REPORT NO. 3-95-004)

Dear Mr. Weinfurter:

This refers to the inspection conducted on January 10, 1995, at your facility located in DePere, Wisconsin, with continuing NRC review through August 9, 1995. This also refers to a transcribed interview conducted by the NRC Office of Investigations on March 20, 1995, of your then Radiation Safety Officer (RSO). The purpose of the inspection was to determine whether activities authorized by your NRC license were conducted safely and in accordance with NRC requirements. The report documenting this inspection was sent to you by letter dated September 10, 1995.

Based on the information developed during the inspection and interview, and the information that you provided in your October 5, 1995 response to the inspection report, the NRC has determined that violations of NRC requirements occurred. The violations are cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding them are described in detail in the subject inspection report. Violation A in the Notice involves the failure of the RSO to ensure that personnel monitoring devices (film badges) were distributed and used by your authorized nuclear gauge users from October 1990 to July 1993.

The NRC has determined that the RSO, while being personally responsible for distributing the personnel monitoring devices, exhibited careless disregard for NRC requirements in that he failed to distribute such devices from October 1990 through the summer of 1991, and from the end of 1992 to July 1993. The bases for this conclusion are: (1) the transcribed interview of your RSO on March 20, 1995; and (2) the fact that you were previously cited for the same violation in November 1989.

This violation is of significant regulatory concern because of the careless disregard exhibited for NRC requirements and its repetitive nature. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety by ensuring that all NRC requirements are met. Therefore, Violation A in the Notice has been categorized in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 FR 34381; June 30, 1995), at Severity Level III.

GCME, Inc.

- 2 -

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 is considered for a Severity Level III violation. Because the Violation A in the Notice was willful, the NRC considered whether credit was warranted for *Identification and Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. We concluded that credit is warranted for identification because the RSO identified the violation in July 1993. Credit is also warranted for your comprehensive corrective actions. Personnel monitoring devices have been distributed to, and used by, gauge users since July 1993. In July 1993, the RSO requested and received assistance from another nuclear gauge RSO. You employed this individual in February 1994 and he was delegated responsibility for your radiation safety program including distribution of personnel monitoring devices. The new individual is named as RSO in your application for license renewal dated August 7, 1995.

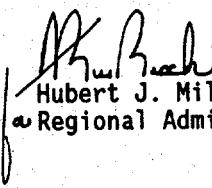
Therefore, to encourage identification and prompt, comprehensive correction of violations, I have been authorized, after consultation with the Director, Office of Enforcement, not to propose a civil penalty in this case. However, similar violations in the future could result in a civil penalty.

Violation B, which involves the failure to conduct tests for leakage and/or contamination for three gauges from November 22, 1991, to February 11, 1993, is categorized at Severity Level IV in the Notice.

The NRC has concluded that information regarding the reason for the violations, the corrective actions taken and planned to correct the violations and prevent recurrence is already adequately addressed on the docket in Inspection Report No. 030-31195/95001(DRSS) and your response dated October 5, 1995. Therefore, you are not required to respond to this letter unless the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to provide additional information, you should follow the instructions specified in the enclosed Notice.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

Sincerely,

  
Hubert J. Miller

Regional Administrator

Docket No. 030-31195  
License No. 48-23409-01

Enclosure: Notice of Violation

NOTICE OF VIOLATION

GCME, Inc.  
DePere, Wisconsin

Docket No. 030-31195  
License No. 48-23409-01  
EA 95-154

During an NRC inspection conducted on January 10, 1995, with continuing review through August 9, 1995, and an interview conducted by the NRC Office of Investigations on March 20, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600 (60 FR 34381; June 30, 1995), the violations are listed below:

A. Condition 18 of License No. 48-23409-01 issued July 27, 1989, requires that licensed material be possessed and used in accordance with the statements, representations and procedures contained in an application dated May 8, 1989.

Item 1.A.3 of the application states that Kurt Weinfurter has been designated as the company Radiation Safety Officer and will assume the duties and responsibilities that include assuring that all users wear personnel monitoring equipment when utilizing the equipment (nuclear moisture density gauges). Item 2.B.3 of the application requires that, when using the equipment, authorized users will wear the personnel monitoring device that has been assigned.

Contrary to the above, from October 1990 to July 1993, the licensee's Radiation Safety Officer failed to ensure that authorized users were wearing personnel monitoring devices when using moisture density gauges. (01013)

This is a Severity Level III violation (Supplement VI).

B. Condition 12 of License No. 48-23409-01 issued July 27, 1989, requires that sealed sources containing byproduct material be tested for leakage and/or contamination at intervals not to exceed six months.

Condition 18 of License No. 48-23409-01 issued July 27, 1989, requires that licensed material be possessed and used in accordance with the statements, representations and procedures contained in an application dated May 8, 1989.

Item 2.C.3 of the application states that gauges will be leak tested at intervals not to exceed six months.

Contrary to the above, from November 22, 1991, to February 11, 1993, a CPN Nuclear Density Meter (Model No. MC-1DR, Serial No. MD0059535), and two Humboldt Nuclear Density Gauges (Model No. 5001, Serial Nos. 1041 and 696) were not tested for leakage and/or contamination, a period exceeding six months. (02014)

This is a Severity Level IV violation (Supplement VI).

Notice of Violation

- 2 -

The NRC has concluded that information regarding the reason for the violations, the corrective actions taken and planned to correct the violations and prevent recurrence is already adequately addressed on the docket in Inspection Report No. 030-31195/95001(DRSS) and the licensee's response dated October 5, 1995. However, GCME, Inc. is required to respond to the provisions of 10 CFR 2.201 if the description therein does not accurately reflect GCME, Inc.'s corrective actions or position. In that case, or if GCME, Inc. chooses to respond, clearly mark the response as a "Reply to a Notice of Violation," and send it to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region III, 801 Warrenville Road, Lisle, Illinois 60532-4351, within 30 days of the date of the letter transmitting this Notice of Violation.

Dated at Lisle, IL  
this 16 day of November 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

July 27, 1995

EA 95-116

Mr. John Marshall  
Vice President, Operations  
HNU Systems, Inc.  
160 Charlemont Street  
Newton Highlands, Massachusetts 02161-9987

SUBJECT: NOTICE OF VIOLATION  
(NRC INSPECTION REPORT NOS. 030-31621/95-001 AND 030-31622/95-001)

Dear Mr. Marshall:

This refers to the NRC inspection conducted on June 7 and 8, 1995 of HNU Systems, Inc., Newton Highlands, Massachusetts. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements. The inspector discussed the preliminary findings of the inspection with you at the conclusion of the inspection, during which ten violations of NRC requirements were identified. The inspection report was forwarded to you on June 28, 1995. On July 14, 1995, a predecisional enforcement conference was conducted with you and your Radiation Safety Officer (RSO) to discuss the violations, their causes, and your corrective actions. A copy of the enforcement conference report is enclosed.

The violations, which are described in the enclosed Notice of Violation, involved the failures to (1) have an RSO at your facility for approximately two years; (2) maintain records; (3) provide training to workers; (4) perform required inventories; (5) perform required leak tests; (6) conduct required surveys; (7) perform annual audits; (8) assess dose to workers; (9) file quarterly reports of transfers under 10 CFR 32.51; and (10) calibrate instruments.

The violations appeared to be a direct result of the RSO leaving the facility in early 1993 as part of a downsizing effort. After the RSO left the facility, there was a decrease in the management oversight of NRC licensed activities at the facility. The NRC acknowledges that you recognized, in March 1995, that additional attention was needed for the radiation safety program, and you rehired the RSO as a consultant to correct problems at the facility. Nonetheless, the violations collectively represent a significant lack of attention toward licensed responsibilities. The NRC entrusts responsibility for ensuring radiation safety to the management of the organization to which we issue licenses. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety, including the health and safety of its employees, by assuring that all NRC requirements are met. In this case, adequate management control was not provided

at your facility. Therefore, the violations are classified in the aggregate as a Severity Level III problem in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) (60 Fed. Reg. 34381, June 30, 1995).

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 was considered for this Severity Level III violation to emphasize the need for, and importance of adequate management attention to the radiation safety program. Because your facility has not been the subject of past escalated enforcement (your only other inspection was in 1992), the NRC considered whether credit was warranted for *Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. Credit was warranted for your prompt and comprehensive *Corrective Action* which were taken in response to the inspection findings and an NRC Confirmatory Action letter issued to you on June 15, 1995. These actions, which were described in your letters, dated June 23, 1995, and July 10, 1995, included (1) retention of the Radiation Safety Officer on a part time basis; (2) conduct of an inventory of all radioactive material at the facility; (3) performance of an audit of the radiation safety program; (4) conduct of training of the staff at the facility, including training regarding the radiation safety procedures; and (5) overall correction of the specific violations identified during the inspection.

Therefore, to encourage prompt identification and comprehensive correction of violations, and in recognition of the absence of previous escalated enforcement action, I have been authorized not to propose a civil penalty in this case. However, any similar violations in the future could result in more significant escalated enforcement action, including issuance of a civil penalty.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information, so that it can be placed in the PDR without redaction.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket Nos. 030-31621; 030-31622  
License Nos. 20-27938-03G; 20-27938-02

Enclosures:

1. Notice of Violation
2. Enforcement Conference Report

cc w/encls:

Commonwealth of Massachusetts

ENCLOSURE 1

NOTICE OF VIOLATION

HNU Systems, Inc.  
Newton Highlands, Massachusetts

Docket Nos. 030-31621  
030-31622  
License Nos. 20-27938-03G  
20-27938-02  
EA 95-116

During an NRC inspection conducted on June 7 and 8, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 Fed. Reg. 34381, June 30, 1995), the violations are listed below:

A. Condition No. 11.B. of License No. 20-27938-02 lists Abraham Berger as the Radiation Safety Officer (RSO).

Contrary to the above, from February 1993 to March 1995, Abraham Berger was not employed by the licensee and did not act as the RSO, and no one else was named as the RSO at the facility.

B. Condition No. 14 of License No. 20-27938-02 requires, in part, that a physical inventory be conducted every six months to account for all sources and/or devices received and possessed under the license.

Contrary to the above, from February 1993 through March 1995, physical inventories were not conducted to account for all sources and/or devices received under the license.

C. Condition No. 12.A of License No. 20-27938-02 requires, in part, that sealed sources and detector cells be tested for leakage and/or contamination at intervals not to exceed 6 months.

Contrary to the above, from February 1993 through June 8, 1995, sealed sources and detector cells were not tested for leakage and/or contamination, an interval in excess of 6 months.

D. Condition No. 20 of License No. 20-27938-02 requires, in part, that licensed material be possessed and used in accordance with statements, representations, and procedures contained in a letter dated July 3, 1990.

1. Item 6 of Page 3 of the July 3, 1990 letter, states, in part, that all survey results will be entered in a bound notebook, dated and signed. It further states that this notebook will also be used to record the arrival and shipment of all sources and the survey results that accompany the arrival or shipment.

Contrary to the above, from February 1993 to June 8, 1995, survey results were not entered in a notebook, and a notebook was not used to record the arrival and shipment of all sources and survey results that accompany the arrival or shipment. More specifically, survey results, shipment and arrival receipts, and their accompanying survey results were not maintained.

2. Item 2 of Page 1 of the July 3, 1990, letter specifies, in part, initial training to be provided to staff, and also requires that all personnel will receive refresher training at least once per year.

Contrary to the above, as of June 7, 1995, licensee staff had not received initial training nor refresher training.

3. Item 6 of page 3 of the July 3, 1990, letter requires, in part, that area surveys be conducted at least monthly.

Contrary to the above, from February 1993 through June 8, 1995, area surveys were not performed monthly.

4. Item 4 of page 2 of the July 3, 1990, letter states, in part, that the licensee's survey instrument will be calibrated at six month intervals.

Contrary to the above, from February 1993 through June 8, 1995, the survey instrument was not calibrated, an interval greater than six months.

- E. 10 CFR 20.1101(c) requires, that each licensee periodically (at least annually) review the radiation protection program content and implementation.

Contrary to the above, during 1993 and 1994, the licensee did not periodically (at least annually) review the radiation protection program content and implementation.

- F. 10 CFR 32.52(a) requires, in part, that each person licensed under 10 CFR 32.51 report to the NRC, all transfers of such devices to persons for use under the general license in 10 CFR 31.5 of this chapter.

Contrary to the above, from July 28, 1993 to June 8, 1995, the licensee, licensed under 10 CFR 32.51, did not report to the NRC all transfers of such devices to persons for use under the general license in 10 CFR 31.5 of this chapter.

G. 10 CFR 20.1502 requires that each licensee shall monitor exposures to radiation and radioactive material at levels sufficient to demonstrate compliance with the occupational dose limits of this part.

Contrary to the above, on an indeterminate number of occasions in 1993, 1994, and 1995, the licensee did not monitor exposures to radiation and radioactive material at levels sufficient to demonstrate compliance with the occupational dose limits of this part. Specifically, for individuals using radioactive material, dosimetry badges were not consistently distributed, or exchanged, or the results evaluated.

These violations represent a Severity Level III problem (Supplements IV and VI).

Pursuant to the provisions of 10 CFR 2.201, HNU Systems, Inc. is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region I, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Because your response will be placed in the NRC Public Document Room, (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, Pennsylvania  
this 27th day of July 1995.



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001

EA 94-256

August 7, 1995

Mid American Inspection Services, Inc.  
ATTN: Terry L. Wilkins, President  
650 Alpine Road  
Gaylord, Michigan 49735

SUBJECT: NOTICE OF VIOLATION  
(NRC Investigation Report No. 3-93-014R)

Dear Mr. Wilkins:

This refers to the investigation conducted by the NRC Office of Investigations (OI) between November 1993 and October 1994 to review possible violations of NRC requirements involving performance of radiography by Mid American Inspection Services, Inc. (Licensee) at a gas line project near Kalkaska, Michigan. The OI investigation, which was initiated after you reported the violations, concluded that two deliberate violations did occur, and the synopsis of the OI report was mailed to you on February 28, 1995. A transcribed enforcement conference was held on March 8, 1995, in the NRC Region III office. Attending the enforcement conference were you, Ms. Cynthia D. Pederson, Director, Division of Radiation Safety and Safeguards, and other members of the NRC Region III staff. The enforcement conference report was sent to you on March 17, 1995.

The OI investigation found that from approximately October 1992 to April 1993, two radiographers assigned to the Kalkaska project deliberately failed to supervise radiographer's assistants while the assistants conducted radiographic operations. The OI investigation also found that one radiographer's assistant deliberately failed to wear a film badge during radiographic operations.

The violations are fully described in the enclosed Notice of Violation (Notice). The most significant violation represents the conduct of radiography by technically unqualified individuals. The deliberate performance of licensed activities by an unqualified individual has been categorized as a Severity Level II violation in accordance with the "Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) (60 FR 34381, June 30, 1995).

The second issue identified by OI is a failure to wear required dosimetry during radiographic operations. A radiographer's assistant admitted to OI that he did not always wear a film badge during radiographic operations. However, apparently he wore the other dosimetry required by NRC regulations. Therefore, under the circumstances of this case, the violation is being categorized at Severity Level IV.

The root causes of the violations and the subsequent corrective actions were discussed during the March 8, 1995, enforcement conference. You attributed the cause of the violation to the collective improper actions of the individuals who also falsified radiographic films. A contributing cause was a failure by the managers of Mid American Inspection Services to regularly observe radiographic operations that extended over time at a single job site. Your corrective actions consisted of terminating the individuals involved and emphasizing to the remaining employees the need for adherence to NRC regulations. You also proposed to use fully qualified radiographers on jobs instead of assistants whenever possible and to increase the number of field audits.

The NRC license issued to Mid American Inspection Services authorizes you to appoint users of byproduct material without prior approval by the NRC. Therefore, the NRC entrusts responsibility for radiation safety to the management of Mid American Inspection Services and the NRC expects effective management oversight of the licensed program. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety, including the health and safety of its employees, by assuring that all requirements of the NRC license are met and any potential violation of NRC requirements is identified and expeditiously corrected.

Therefore, in accordance with the NRC Enforcement Policy, (60 FR 34381, June 30, 1995), enforcement discretion is normally exercised to assess a civil penalty for a Severity Level II violation to ensure that NRC licensed activities are conducted by technically qualified individuals and to emphasize that the NRC will not tolerate deliberate violations of its regulations and requirements. However, after consultation with the Commission, a civil penalty is not being issued, to encourage prompt identification and reporting of any deliberate violation of NRC requirements, as you did when you immediately reported the violation and took initiative to determine its extent. Your strong corrective action was also considered. Nonetheless, the NRC emphasizes that any similar violations in the future could result in escalated enforcement action including civil penalties.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, please ensure that you describe the actions you have taken to strengthen the management and oversight of your NRC licensed program. In addition to your specific response to the violation, please also address the actions you have implemented or plan to take to ensure timely and lasting improvement in your radiation safety program. You should address the management of the program and any improvements needed in the procedures and practices to achieve and maintain compliance with NRC requirements and license conditions.

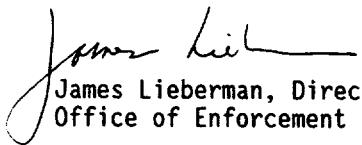
Mid American Inspection  
Services, Inc.

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not contain any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Public Law No. 96-511.

Sincerely,

  
James Lieberman, Director  
Office of Enforcement

Docket No. 030-31160  
License No. 21-26060-01

Enclosure: Notice of Violation

## NOTICE OF VIOLATION

Mid American Inspection Services, Inc.  
Gaylord, Michigan

Docket No. 030-31160  
License No. 21-26060-01  
EA 94-256

During an NRC investigation concluded on October 19, 1994, violations of NRC requirements were identified. In accordance with the "Statement of Policy and Procedure for NRC Enforcement Actions," 60 FR 34381, (June 30, 1995), the violations are listed below:

A. 10 CFR 34.44 requires that whenever a radiographer's assistant uses radiographic exposure devices, uses sealed sources or related source handling tools, or conducts radiation surveys required by 10 CFR 34.43(b) to determine that the sealed source has returned to the shielded position after an exposure, he shall be under the personal supervision of a radiographer. The personal supervision shall include: (a) the radiographer's personal presence at the site where sealed sources are being used; (b) the ability of the radiographer to give immediate assistance if required; and (c) the radiographer's watching the assistant's performance of the operations referred to in this section.

Contrary to the above, on multiple occasions from October 1992 to April 1993, an individual acted as a licensee radiographer's assistant, used radiographic exposure devices and was not under the personal supervision of a radiographer, in that the radiographer was not present at the site during, or was not watching, the performance of operations, including the exposure of the source. (01012)

This is a Severity Level II violation (Supplement VI).

B. 10 CFR 34.33(a) requires that the licensee not permit any individual to act as a radiographer or radiographer's assistant unless, at all times during radiographic operations, the individual wears a direct-reading pocket dosimeter, an alarming ratemeter, and either a film badge or a thermoluminescent dosimeter.

Contrary to the above, on various occasions during the period from October 1992 to April 1993, a licensee radiographer's assistant, did not wear either a film badge or thermoluminescent dosimeter while conducting radiographic operations. (02014)

This is a Severity Level IV violation (Supplement VI).

Pursuant to the provisions of 10 CFR 2.201, Mid American Inspection Services, Inc. is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region III, 801 Warrenville Road, Lisle, Illinois 60532-4351 within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps

that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a demand for information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at Rockville, Maryland  
the 7th day of August 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION III

801 WARRENVILLE ROAD  
LISLE, ILLINOIS 60532-4351

December 29, 1995

EA 95-221

Eugene Lohr, General Manager  
Nekoosa Papers, Inc.  
100 Wisconsin River Drive  
Nekoosa, Wisconsin 54469

**SUBJECT: NOTICE OF VIOLATION (NRC Inspection Report No. 030-06772-95001)**

Dear Mr. Lohr:

This refers to the special safety inspection conducted from September 12 to October 6 1995, at Nekoosa Papers, Inc., Nekoosa, Wisconsin, in response to a September 8, 1995, report that maintenance workers were inadvertently exposed to NRC-licensed materials. Significant violations of NRC requirements were identified during the inspection and the report was mailed to Nekoosa Papers on October 20, 1995.

The inspection found that on January 5, 1995, the shutter of a level measuring gauge, attached to Paper Digester No. 6, was locked open rather than closed in preparation for allowing workers to enter the vessel. At various times during the period from January 5 to April 19, 1995, eight workers passed through a radiation field created by a nominal 600 millicurie (22.2 GBq) cesium-137 sealed source. The procedure to lock out the shutter specified four steps be performed prior to allowing anyone to enter the vessel. The only step that was accomplished was locking the shutter, albeit in the wrong position.

The inspection also determined that on April 19, 1995, a contractor employee removed the device from service so that it would not be damaged during cutting and welding operations in the vicinity of the gauge. The shutter of the gauge was still locked open at that time. On June 5, 1995, the gauge was again moved with the shutter open. Neither individual was authorized by the NRC or an Agreement State to remove a gauge from service or otherwise relocate a device. The Radiation Safety Office (RSO) did not learn until August 31, 1995, that the shutter was locked open, the device had been removed from service, and then moved a second time.

Dose calculations were made and the maintenance workers passing through the radiation field received a maximum radiation dose of 55 millirem (0.55 mSv). The dose calculations for the two individuals who moved the device indicated a maximum dose of 14.4 millirem (0.14 mSv). The exposures are less than the regulatory limit for an occupational worker.

Based on the information developed during the inspection and the information that you provided in letters dated October 5, November 8 and December 1, 1995, the NRC has determined that violations of NRC requirements occurred. The violations are cited in the enclosed Notice of Violation (Notice) and the

circumstances surrounding them are described in detail in the subject inspection report. The violations were attributed to a failure to follow the lock-out procedure by not checking the level instrumentation for the gauge and the shutter position indicator. Further, the contract workers were not aware that they were not permitted to move the gauge. Another factor was the failure by the engineering department to inform the Radiation Safety Officer (RSO) of the work being performed near the gauge.

In sum, the violations represent both the performance of NRC-licensed activities by technically unqualified individuals and a breakdown in the management control of your radiation safety program. Therefore, the violations are classified in the aggregate as a Severity Level III problem in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 FR 34381; June 30, 1995).

The NRC entrusts responsibility for radiation safety to the management of your organization; therefore, the NRC expects effective management of licensed programs. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety, including the health and safety of its employees, by assuring that all requirements of the NRC license are met and any potential violation of NRC requirements is identified and expeditiously corrected. In this instance, the procedure for locking the shutter of a gauge was not followed. Furthermore, unqualified individuals removed a gauge from service and later moved it again without recognizing that the shutter of the device was open. Fortunately, the workers received only a small radiation dose. However, the circumstances could have been significantly more serious had just one factor differed (e.g. the length of time in the unshielded radiation beam or the distance between the individual and the radiation beam). The fact that a nuclear gauge had been removed from service without the knowledge of the RSO further demonstrates that ineffective and insufficient management of the radiation safety program existed at Nekoosa Papers, Inc.

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$2,500 is considered for a Severity Level III problem. Because your facility has not been the subject of escalated enforcement actions within the last two inspections, the NRC considered whether credit was warranted for *Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. Credit was warranted for the following corrective actions: (1) revising the vessel entry procedure with more specific steps to lock the gauge; (2) providing additional training to the individuals charged with locking gauges; (3) posting signs on the nuclear gauges that the device should not be moved without contacting the RSO; and, (4) training supervisors, employees and contractors on the subject of radiation safety.

Therefore, to emphasize the need to follow radiation safety procedures, to encourage prompt and comprehensive correction of violations, and in recognition of the absence of previous escalated enforcement action, I have been authorized, after consultation with the Director, Office of Enforcement, not to propose a civil penalty in this case. However, significant violations in the future could result in a civil penalty.

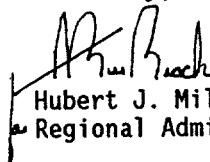
Nekoosa Papers, Inc.

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The NRC has concluded that information regarding the reasons for the violations, the corrective actions taken and planned to correct the violations and prevent recurrence is already adequately addressed on the docket in Inspection Report No. 030-06772/95001 and letters from Nekoosa Papers, Inc., dated October 5, November 8, and December 1, 1995. Therefore, you are not required to respond to this letter unless the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to provide information, you should follow the instructions specified in the enclosed Notice.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, the enclosed Notice, and your response if you chose to respond, will be placed in the NRC Public Document Room (PDR).

Sincerely,

  
Hubert J. Miller  
Regional Administrator

Docket No. 030-06772  
License No. 48-12749-01

Enclosure: Notice of Violation

NOTICE OF VIOLATION

Nekoosa Papers, Inc.  
Nekoosa, Wisconsin

Docket No. 030-06772  
License No. 48-12749-01  
EA 95-221

During an NRC inspection conducted on September 12 and 13, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600 (60 FR 34381; June 30, 1995), the violations are listed below:

A. Condition 16 of Byproduct Material License No. 48-12749-01 requires that relocation, removal from service, maintenance, and repair of devices containing sealed sources shall be performed by persons specifically licensed by the Commission or an Agreement State to perform such services.

Contrary to the above:

On April 19, 1995, an employee of a licensee contractor removed from service a gauge containing NRC-licensed material (cesium-137) and the individual was not authorized by the Commission or an Agreement State to perform such service.

On June 5, 1995, another employee of a licensee contractor relocated a gauge containing NRC-licensed material (cesium-137) and the individual was not authorized by the Commission or an Agreement State to perform such service. (01013)

B. Condition 19 of Byproduct Material License No. 48-12749-01 requires, in part, that the licensee assure the shutter mechanism is locked in the closed position during periods when a portion of an individual's body may be subject to the direct radiation beam.

Contrary to the above, from approximately January 5, 1995, to April 19, 1995, on at least a weekly basis, individuals entered a vessel where the shutter mechanism was not locked in the closed position and the individuals were subject to the direct radiation beam from a nominal 600 millicurie (22.2 GBq) cesium-137 sealed source. (01023)

C. 10 CFR 20.1301(a)(2) requires that the licensee conduct operations so that the dose in any unrestricted area from external sources does not exceed 2 millirem in any one hour.

Contrary to the above, on April 19, 1995, licensee operations resulted in a dose rate of 60 millirem in one hour in the vicinity of Paper Digester Vessels No. 5 and 6, an unrestricted area. (01033)

This is a Severity Level III problem (Supplements IV and VI).

The NRC has concluded that information regarding the reasons for the violations, the corrective actions taken and planned to correct the violations and prevent recurrence is already adequately addressed on the docket in Inspection Report No. 030-06772/95001 and letters from Nekoosa Papers, Inc.,

Notice of Violation

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dated October 5, November 8, and December 1, 1995. However, you are required to respond to the provisions of 10 CFR 2.201 if the description therein does not accurately reflect your corrective actions or your position. In that case, or if you choose to respond, clearly mark your response as a "Reply to a Notice of Violation," and send it to the U. S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region III, 801 Warrenville Road, Lisle, Illinois 60532-4351, within 30 days of the date of the letter transmitting this Notice of Violation (Notice).

Dated at Lisle, Illinois  
this 29th day of December 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION III

801 WARRENVILLE ROAD  
LISLE, ILLINOIS 60532-4351

December 8, 1995

EA 95-208

Steve Filips, Vice President  
and General Manager  
North Star Steel Ohio  
2669 Martin Luther King Jr. Blvd.  
Youngstown, Ohio 44510

SUBJECT: NOTICE OF VIOLATION (NRC INSPECTION REPORT NO. 030-18258/95001)

Dear Mr. Filips:

This refers to the special safety inspection conducted on September 5 and 6, 1995, at North Star Steel Ohio, Youngstown, Ohio, in response to notification from the Radiation Safety Officer (RSO) that an event occurred on August 27, 1995. At that time, molten steel overflowed onto a measurement gauge containing a nominal 1 curie (37 GBq) cesium-137 sealed source. The sealed source was not breached by the molten steel. The inspection identified a significant regulatory problem and a predecisional enforcement conference was held on October 5, 1995. The inspection report was mailed to North Star Steel Ohio on September 22, 1995, and the report of the predecisional enforcement conference was sent on October 20, 1995.

Based on the information developed during the inspection and the information that was provided during the conference, the NRC has determined that several violations of its requirements occurred. The violations are cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding them are described in detail in the inspection report. The root causes of the violations were attributed to the many responsibilities assigned to the RSO in addition to those associated with the radiation safety program. The RSO is also the superintendent of the casting department. As the casting department superintendent he also had an operational function to perform during the incident. That factor divided his attention and he did not appropriately consider the regulatory requirements applicable to the radiological aspects of this event. As discussed at the predecisional enforcement conference, the NRC is concerned about the minimal time allotted to the RSO to fulfill his radiation safety responsibilities, including time to become familiar with NRC requirements and license conditions.

Another contributing factor was the frequent turnover in the RSO position as demonstrated by the appointment of five different individuals to that position since 1988. These frequent transitions caused a lack of continuity and familiarity with NRC regulations and the conditions of the NRC Byproduct Material License by the current RSO.

In sum, the violations represent a breakdown in the control of licensed activities involving a number of violations that are related that collectively represent a potentially significant lack of attention or carelessness toward

licensed responsibilities. Therefore, the violations were considered in the aggregate to represent a Severity Level III problem in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 (60 FR 34381; June 30, 1995).

The NRC entrusts its licensees with the responsibility to maintain radiation safety at the places of use designated in the NRC Byproduct Material License; therefore, the NRC expects effective management of its licensed programs. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety, including the health and safety of its employees, by assuring that all requirements of the NRC license are met and any potential violation of NRC requirements is identified and expeditiously corrected. The failure to promptly notify the NRC of the event is a repetitive violation. The repeat notification violation, the other violations identified during the current inspection, and the failure to perform an audit as described in a letter of August 23, 1993, in response to an earlier violation, demonstrate that ineffective and insufficient management of the implementation of the radiation safety program existed at North Star Steel Ohio.

In accordance with the Enforcement Policy, a civil penalty of \$2,500 is usually considered for a Severity Level III problem. Because North Star Steel Ohio has not been the subject of any escalated enforcement actions, the NRC considered whether credit was warranted for Corrective Action in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. Corrective actions consisted of: (1) developing a "Radiation Safety Procedures Checklist" to be used in emergency situations; (2) scheduling all plant staff authorized to handle NRC licensed gauges for a 40 hour refresher training course; (3) purchasing "High Radiation" and "Radiation" signs for use during emergencies; (4) a commitment to conduct an annual audit of the radiation safety program beginning in November 1995; and, (5) a commitment that Cargill Corporation, the parent company of North Star Steel Ohio, will conduct an annual audit of the radiation safety program.

Therefore, to encourage prompt and comprehensive corrective actions, I have been authorized, after consultation with the Director, Office of Enforcement, not to propose a civil penalty in this case. However, significant violations in the future could result in a civil penalty.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. Your response should also include the actions taken by North Star Steel Ohio to assure that the RSO has sufficient time to perform his duties. In addition, the response should include a description of the proposed internal and external audits that will be used to assess the effectiveness of the NRC-licensed program. After reviewing your responses to this letter and the enclosed Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

North Star Steel Ohio

- 3 -

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Public Law 96-511.

Sincerely,

  
Hubert J. Miller  
Regional Administrator

Enclosure:  
Notice of Violation

## NOTICE OF VIOLATION

North Star Steel Ohio  
Youngstown, Ohio

Docket No. 030-18258  
License No. 34-20328-01  
EA 95-208

During an NRC inspection conducted on September 5-6, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600 (60 FR 34381, June 30, 1995), the violations are listed below:

A. 10 CFR 30.50(b)(2) requires, in part, that each licensee notify the NRC within 24 hours after the discovery of an event involving licensed material in which equipment is disabled or fails to function as designed when: (i) the equipment is required by regulation or license condition to prevent releases exceeding regulatory limits, to prevent exposures to radiation and radioactive materials exceeding regulatory limits, or to mitigate the consequences of an accident; (ii) the equipment is required to be available and operable when it is disabled or fails to function; and (iii) no redundant equipment is available and operable to perform the required safety function.

Contrary to the above, on August 27, 1995, an event occurred at the licensee's facility involving NRC-licensed material in which equipment of the type described above was disabled and the licensee failed to notify the NRC within 24 hours after discovering the event.

Specifically, molten steel overflowed a mold onto a gauging device (containing a nominal one curie (37 GBq) cesium-137 sealed source) and melted the lead shielding of the device. This event was not reported to the NRC until September 1, 1995, a period greater than 24 hours. (01013)

This is a repeat violation.

B. 10 CFR 20.1003 defines a "High Radiation Area" as an area, accessible to individuals, in which radiation levels could result in an individual receiving a dose equivalent in excess of 0.1 rem (1 mSv) in 1 hour at 30 centimeters from the radiation source or from any surface that the radiation penetrates.

1. 10 CFR 20.1601(a) requires, with exceptions not applicable here, that the licensee ensure that each entrance to a high radiation area has one or more of the following features: (1) a control device that, upon entry into the area, causes the level of radiation to be reduced below that level at which an individual might receive a deep-dose equivalent of 0.1 rem in one hour at 30 centimeters from the radiation source or from any surface that the radiation penetrates; (2) a control device that energizes a conspicuous visible or audible alarm signal so that the individual entering the high radiation area and the supervisor of the activity are made aware of the entry; or (3) entryways that are locked, except during periods when access to the areas is required, with positive control over each individual entry.

10 CFR 20.1601(b) provides that, in place of the controls required by 10 CFR 20.1601(a) for a high radiation area, a licensee may substitute continuous direct or electronic surveillance that is capable of preventing unauthorized entry.

Contrary to the above, from August 27 to August 31, 1995, entry to the reclamation yard at the west end of the "Melt Shop," a high radiation area with radiation levels of about 800 millirem per hour at the surface of the source and approximately 200 millirem per hour at 30 centimeters from the radiation source stored therein, was not controlled by any of the methods described in 10 CFR 20.1601(a) or (b). (01023)

2. 10 CFR 20.1902(b) requires that the licensee post each high radiation area with a conspicuous sign or signs bearing the radiation symbol and the words "CAUTION, HIGH RADIATION AREA" or "DANGER, HIGH RADIATION AREA."

Contrary to the above, from August 27 to August 31, 1995, a "High Radiation Area" with radiation dose rates of approximately 200 millirem per hour at 30 centimeters from the radiation source stored therein, existed in the reclamation yard at the west end of the "Melt Shop," and that area was not posted with a conspicuous sign or signs bearing the radiation symbol and the words "CAUTION, HIGH RADIATION AREA" or "DANGER, HIGH RADIATION AREA." (01033)

- C. Condition 17 of Byproduct Material License No. 34-20328-01 requires, in part, that prior to initial use and after installation, relocation, dismantling, alignment, or any other activity involving the source or removal of the shielding, the licensee shall assure that a radiological survey is performed to determine radiation levels in accessible areas around, above, and below the gauge with the shutter open.

Contrary to the above, on September 1, 1995, the licensee installed a gauging device that contained NRC-licensed material (a cesium-137 sealed source of nominally one curie) and failed to assure that a radiological survey was performed to determine radiation levels in accessible areas around, above, and below the gauge with the shutter open. (01043)

- D. Condition 21 of Byproduct Material License No. 34-20328-01 requires the licensee to conduct its program in accordance with the statements, representations, and procedures contained in certain documents, including a letter dated November 18, 1993.

The letter dated November 18, 1993, provides, in part, that for personnel monitoring, film badges will be used by authorized personnel while performing any of the licensed service activities.

Condition 16 of Byproduct Material License No. 34-20328-01 specifies the authorized service activities as: installation, initial radiation survey, relocation, or removal from service of devices containing sealed sources.

Contrary to the above:

- On December 14, 1994, and August 27, 1995, devices containing sealed sources were removed from service and film badges or other personnel monitoring devices were not used by the individuals involved in the service activity.
- On September 1, 1995, a device containing a sealed source was installed and film badges or other personnel monitoring devices were not used by the individuals involved in the service activity. (01053)

This is a Severity Level III problem (Supplements IV and VI).

Pursuant to the provisions of 10 CFR 2.201, North Star Steel Ohio is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region III, 801 Warrenville Road, Lisle, Illinois 60532-4351 within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at Lisle, Illinois  
this 8th day of December 1995



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

July 6, 1995

EA 95-127

Ms. Rose McNew, President  
Professional Inspection and Testing Services, Inc.  
2060 Lincoln Way East  
Chambersburg, Pennsylvania 17201

Dear Ms. McNew:

**SUBJECT: NOTICE OF VIOLATION**  
(NRC INSPECTION REPORT NO. 030-32721/95-001)

This refers to the special safety inspection conducted on June 13, 1995, at the Defense Depot-Region East (DDRE), Fitness Center Extension Project, Mifflin and F Avenues, New Cumberland, Pennsylvania of activities authorized by the above listed NRC license. The inspection was conducted to review the circumstances associated with an event involving damage to a portable moisture density gauge containing NRC licensed material. In addition, our inspection was continued in the Region I office until June 28, 1995, to review additional information provided to the NRC in your letter, dated June 21, 1995. During the inspection, two violations of NRC requirements were identified. A copy of the NRC inspection report is enclosed. This also refers to the telephone conversation between you and Dr. Susan Shankman on July 7, 1995, during which you indicated you did not see a need for an enforcement conference on this matter.

In a telephone conversation with your Radiation Safety Officer on June 13, 1995, you informed us that on that same day, a Troxler soil moisture/density gauge containing licensed materials (sealed sources of 8 millicuries of cesium-137 and 40 millicuries of americium-241) was damaged at a construction site on the DDRE Fitness Center Extension Project in New Cumberland, Pennsylvania. The inspection disclosed that the gauge user, while at the DDRE temporary jobsite, left the portable gauge near his last test area and walked about 50 feet away to discuss the poor test results with the job supervisor and heavy equipment operator. During this discussion, the heavy equipment operator went back to his roller, which was between the user's line-of-sight and the device and backed up over the gauge (with the roller's rear tractor tire striking the device), causing damage to it with the source tip rod protruding 2-3 inches out of the bottom of the device.

Although the user stated to the inspector that he felt "comfortable" leaving the device while he talked with the two individuals, since the jobsite was very small and only the three individuals were at the site, his failure to maintain sufficient surveillance and control of the device contributed to the gauge being damaged. That violation demonstrates a significant failure to control licensed material and is categorized at Severity Level III in accordance with the "Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) (60 FR 34381, June 30, 1995).

The NRC entrusts responsibility for radiation safety to the management of your organization; therefore, the NRC expects effective management oversight of its licensed programs. Incumbent upon each NRC licensee is the responsibility to protect the public health and safety, including the health and safety of its employees, by assuring that all NRC requirements are met. In this case, the user did not provide sufficient control of the material at the temporary job site.

The NRC recognizes that prompt and comprehensive corrective actions were initiated to correct the violation and prevent recurrence. These actions, which were described in your letter, dated June 21, 1995, included development of appropriate procedures; meeting with all employees and informing them that any employee that does not follow all safety guidelines will be terminated immediately; and submittal of a nuclear safety quiz covering such issues. The NRC also recognizes that this event was reported promptly to the NRC when identified, and the gauge user took action, after the gauge was damaged, to move the damaged gauge from the original crush site to a point about 25 feet away, while the source rod tip was protruding 2-3 inches out of the bottom of the device, in order to make it easier to restrict access. The user also placed the protruding source tip into the ground for shielding. The NRC further recognizes that there was no leakage of radioactive material from the damage to the gauge.

Nonetheless, in accordance with the Enforcement Policy, I considered issuance of a base civil penalty of \$2,500 in this case to emphasize the need for strict control of access to licensed material. However, after considering the fact that you identified and promptly informed the NRC of the occurrence, took prompt and comprehensive corrective actions, and had no violations identified during the only other NRC inspection of your license in 1992, I have decided that a civil penalty will not be assessed. However, any similar violations in the future could result in more significant escalated enforcement action, including issuance of a civil penalty.

A second violation also was identified during the inspection and is described in the enclosed Notice. The violation is classified at Severity Level IV.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information, so that it can be placed in the PDR without redaction.

Professional Inspection and  
Testing Services, Inc.

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The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,



Thomas T. Martin  
Regional Administrator

Docket No. 030-32721  
License No. 37-28744-01

Enclosures:

- \* 1. Notice of Violation
- 2. Inspection Report

cc w/encls:  
Commonwealth of Pennsylvania

\* Not published in the NUREG.

ENCLOSURE 1

NOTICE OF VIOLATION

Professional Inspection and  
Testing Services, Inc.  
Chambersburg, Pennsylvania 17201

Docket No. 030-32721  
License No. 37-28744-01  
EA 95-127

During an NRC inspection conducted on June 13, 1995, at a temporary job site in New Cumberland, Pennsylvania, and continued in the Region I office until June 28, 1995, to review additional information provided to the NRC in a letter dated June 21, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381, June 30, 1995), the violations are listed below:

A. 10 CFR 20.1801 requires that the licensee secure from unauthorized removal or access licensed materials that are stored in controlled or unrestricted areas. 10 CFR 20.1802 requires that the licensee control and maintain constant surveillance of licensed material that is in a controlled or unrestricted area and that is not in storage. As defined in 10 CFR 20.1003, *unrestricted area* means an area, access to which is neither limited nor controlled by the licensee.

Contrary to the above, on June 13, 1995, the licensee did not secure from unauthorized removal or limit access to a portable moisture density gauge containing 8 millicuries of cesium-137 and 40 millicuries of americium-241 located on the construction site of the Defense Depot Region East (DDRE) Fitness Center Extension Project, in New Cumberland, Pennsylvania, an unrestricted area, nor did the licensee control and maintain constant surveillance of this licensed material.

This is a Severity Level III violation (Supplement IV).

B. 10 CFR 71.5(a) requires that a licensee who transports licensed material outside of the confines of its plant or other place of use, or who delivers licensed material to a carrier for transport, comply with the applicable requirements of the regulations appropriate to the mode of transport of the Department of Transportation (DOT) in 49 CFR Parts 170 through 189.

49 CFR 172.403 requires, in part, with exceptions not applicable here, that each package of radioactive material be labeled, as appropriate, with two RADIOACTIVE WHITE-I, RADIOACTIVE YELLOW-II, or RADIOACTIVE YELLOW-III labels on opposite sides of the package. The contents, activity, and transport index must be entered in the blank spaces on the label.

Contrary to the above, on June 13, 1995, the licensee transported outside the confines of its plant licensed material and the RADIOACTIVE label affixed to the package did not identify the contents, activity, or transport index.

This is a Severity Level IV violation (Supplement V).

Pursuant to the provisions of 10 CFR 2.201, Professional Inspection and Testing Services, Inc. is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region I, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Because your correspondence will be placed in the NRC Public Document Room, PDR, to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at King of Prussia, Pennsylvania  
this 6<sup>th</sup> day of July 1995

**BIBLIOGRAPHIC DATA SHEET**

*(See instructions on the reverse)*

**2. TITLE AND SUBTITLE**

Enforcement Actions: Significant Actions Resolved  
Material Licensees  
Semiannual Progress Report  
July - December 1995

**5. AUTHOR(S)**

Office of Enforcement

**8. PERFORMING ORGANIZATION - NAME AND ADDRESS** *(If NRC, provide Division, Office or Region, U.S. Nuclear Regulatory Commission, and mailing address; if contractor, provide name and mailing address.)*

Office of Enforcement  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555-0001

**9. SPONSORING ORGANIZATION - NAME AND ADDRESS** *(If NRC, type "Same as above"; if contractor, provide NRC Division, Office or Region, U.S. Nuclear Regulatory Commission, and mailing address.)*

Same as above

**10. SUPPLEMENTARY NOTES**

**11. ABSTRACT** *(200 words or less)*

This compilation summarizes significant enforcement actions that have been resolved during the period (July - December 1995) and includes copies of letters, Notices, and Orders sent by the Nuclear Regulatory Commission to material licensees with respect to these enforcement actions. It is anticipated that the information in this publication will be widely disseminated to managers and employees engaged in activities licensed by the NRC, so that actions can be taken to improve safety by avoiding future violations similar to those described in this publication.

**12. KEY WORDS/DESCRIPTIONS** *(List words or phrases that will assist researchers in locating the report.)*

Diagnostic Radiopharmaceuticals, Teletherapy, Brachytherapy,  
Radiation Safety Program, Safety Evaluation, Quality Management  
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