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

May 20, 2005

Docket No. 030-35107 License No. 45-25475-01
EA 05-061

Julio Venegas
President
Precision Testing and Inspection
504 Shaw Road, Suite 201
Sterling, VA 20166

SUBJECT: OFFICE OF INVESTIGATIONS REPORT NO. 2-2004-052

Dear Mr. Venegas:

This letter refers to an investigation completed by the NRC's Office of Investigations (OI) on February 25, 2005. The purpose of the OI investigation was to determine if (1) a radiographer deliberately failed to provide proper safety barriers for a radiography work area, and (2) if a licensee official, deliberately failed to provide true and accurate information to the NRC inspector during an inspection completed on October 7, 2004, the report of which was sent to you on October 12, 2004. (Reference: Inspection Report 30-35107/2004-001).

Based on the results of the investigation, OI concluded that (1) the radiographer established proper safety barriers for the work area on July 13, 2004, and did not engage in any deliberate activities which violated NRC requirements, and (2) a licensee official, deliberately provided false and inaccurate information to the NRC during the NRC inspection referenced above. A Factual Summary of the OI investigation is enclosed.

Notwithstanding the OI conclusion regarding the second finding described above, the NRC staff determined that there was insufficient evidence to conclude that a licensee official deliberately provided false and inaccurate information. Therefore, we plan no further action relative to this matter. However, you should be aware that deliberate violations of NRC requirements, including providing false and inaccurate information to the NRC, are a very serious concern to the NRC because the NRC regulatory program relies, in part, on the honesty and integrity of NRC licensees and their employees. Such violations may subject the responsible individual to significant NRC enforcement action, including consideration of an Order prohibiting involvement in NRC licensed activities. A violation of 10 CFR 30.10, "Deliberate Misconduct," may also lead to criminal prosecution. You are not required to respond to this letter. However, we will be glad to discuss any questions that you may have in this matter. If you have any questions, please contact Mr. John Kinneman of my staff at 610-337-5252.

Current NRC regulations and guidance are available at the NRC Web sites listed below or by contacting the Government Printing Office (GPO) toll-free at 1-888-293-6498. The GPO is open from 7:00 a.m. to 9:00 p.m. EST, Monday through Friday (except Federal holidays).

Your cooperation with us is appreciated.

Sincerely,

Original signed by Christiana Lui

George Pangburn, Director
Division of Nuclear Materials Safety

Docket No. 030-35107
License No. 45-25475-01

Enclosure:
Factual Summary of OI Investigation No. 2-2004-052

cc:
Commonwealth of Virginia

NRC Web site addresses
NRC regulations
http://www.nrc.gov/reading-rm/doc-collections/cfr/
Licensing guidance
http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/sr1556/
General Policy and Procedure for NRC Enforcement Actions
Http://www.nrc.gov/what-we-do/regulatory/enforcement/enforc-pol.pdf
206 of the Energy Reorganization Act of 1974
http://www.nrc.gov/who-we-are/governing-laws.html

DISTRIBUTION w/encl:
ADAMS (PARS)
SECY
CA
OEMAIL
OEWEB
LReyes, EDO
MVirgilio, DEDMRS
FCongel, OE
SFigueroa, OE
JMoore, OGC/LChandler, OGC
Melwood/KRemsburg, OGC
JStrosnider, NMSS
CMiller, NMSS
RPierson, NMSS
CMiller, OEDO
GMorell, NMSS
Enforcement Coordinators RII, RIII, RIV
SGagner, OPA
HBell, OIG
PLohaus, STP
GCaputo, OI
LTremper, OC
DScrenci, RI/NSheehan, RI
GPangburn, RI
JKinneman, RI
KFarrar, RI
DHolody, RI
JWray, RI
DCorlew, RI
Region I OE Files (with concurrences)

SISP Review Complete: JDK (Reviewer's Initials)
After declaring this document "An Official Agency Record" it **will** be released to the Public.
DOCUMENT NAME: E:\Filenet\ML051400139.wpd

To receive a copy of this document, indicate in the box: "**C**" = Copy w/o attach/encl "**E**" = Copy w/ attach/encl "**N**" = No copy

OFFICE	DNMS/RI	N	DNMS/RI		ORA/RI/OE		ORA/RI/OGC	
NAME	Jkinneman jdk		Gpangburn gcp		Dholody djh		Kfarrar klf	
DATE	4/29/05		4/29/05		5/4/05		5/3/05	

OFFICE	ORA/RI/OI	N	OE		OGC			
NAME	Ewilson epw		Fcongel *		JMoore*			
DATE	5/4/05							

*J Luehman for F Congel/K Kannler for J Moore w/comments from J Longo
(Based on e-mail from A Hayes to J Wray dtd 5/17/05

FACTUAL SUMMARY FOR OI REPORT 2-2004-052

This investigation was initiated by the Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region II, on October 20, 2004, to determine if (1) a radiographer employed by Precision Testing and Inspection (PTI) deliberately failed to establish proper safety barriers for a radiography work area, and (2) whether a licensee official deliberately failed to provide true and accurate information to the NRC during an inspection completed on October 7, 2004.

Based on the evidence developed during this investigation, OI concluded (1) that the radiographer established proper safety barriers for the work area on July 13, 2004, and did not engage in any deliberate activities which violated NRC requirements, and (2) that a licensee official deliberately provided false and inaccurate information to the NRC during an inspection completed on October 7, 2004, when he failed to provide details of the July 13, 2004 radiography boundary violation when asked by the inspector.

In making the conclusion that the radiographer established proper safety barriers, the NRC considered a member of the public who entered the work area on July 13, 2004, admitted to OI that the area was properly posted when he violated the barrier.

Regarding the OI conclusion that a licensee official deliberately provided false and inaccurate information to the NRC, OI considered that, prior to the inspection conducted between September 22 and 24, 2004, and on October 7, 2004, the licensee official (1) conducted an investigation into the boundary incident, (2) received and reviewed a written report of the incident prepared by the radiographer, and (3) discussed the incident with an outside party. Nonetheless, the written report of the incident prepared by the radiographer, as well as a log of boundary violations maintained by PTI, were not made available to the inspector during the inspection. Notwithstanding the OI conclusion, the NRC staff, determined that there was not sufficient information to support that the licensee official deliberately provided false and inaccurate information. Accordingly, the NRC plans no further action regarding these matters.