



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

October 11, 2005

Docket No. 03030462
EA No. 05-177

License No. 45-24974-01

Stanley J. Murphy, P.E.
Corporate Radiation Safety Officer
ECS Mid-Atlantic, LLC
14026 Thunderbolt Place, Suite 100
Chantilly, VA 20151

**SUBJECT: INSPECTION 03030462/2005002, ECS MID-ATLANTIC, LLC, CHANTILLY,
VIRGINIA SITE AND THE ASHBURN, VIRGINIA SITE**

Dear Mr. Murphy:

On August 9, 2005, Jenny Johansen of this office conducted a safety inspection at the above address and at 44961 LCSA Campus Lane, Ashburn, Virginia of activities authorized by the above listed NRC license. The inspection was limited to a review of two events where gauges were damaged while in use at temporary job sites, one on June 24, 2005 and one on July 13, 2005 and inspection of the use, control and security of a gauge in use at a temporary job site. The enclosed report presents the results of this inspection.

Based on the results of this inspection, three apparent violations were identified. One of these violations, failure to maintain control over a portable gauge during the event on June 24, 2005, is documented in Section II of the report and is being considered for escalated enforcement. No violations were identified in the review of the event on July 13, 2005. The other violations, failure to provide a second independent security barrier and failure to have durable Department of Transportation (DOT) labels with legible printing of the contents and activity in the package, as documented in Section III of the report, are not being considered for escalated enforcement. The circumstances surrounding the apparent violation involving maintaining control over a portable gauge on June 24, 2005, the significance of the issue, and the need for lasting and effective corrective action were discussed with Mr. Omer M. Duzyol of your organization at the conclusion of the inspection.

During a telephone discussion on September 12, 2005, John Kinneman of my staff informed you that the NRC did not need any additional information to make an enforcement decision regarding the violation which is being considered for escalated enforcement. Since you identified the violation and took appropriate corrective action, a civil penalty may not be warranted in accordance with Section VI.C.2 of the Enforcement Policy. However, you indicated that ECS Mid-Atlantic wanted the opportunity to submit a written response or consider a predecisional enforcement conference regarding this violation. In response to your request, you are provided with an opportunity to either (1) respond in writing to the apparent violations addressed in this inspection report within 30 days of the date of this letter or (2) request a predecisional enforcement conference. Please contact Mr. Kinneman at (610) 337-5252 within 7 days of the date of this letter, to inform us as to which of the above two options you choose. Please note that predecisional enforcement conferences are typically open for public

observation and that the NRC announces predecisional enforcement conferences to the public by issuing a press release.

If you decide to provide a written response, your response should be clearly marked as a "Response to An Apparent Violation in Inspection Report No. 03030462/2005002" and should include for each apparent violation: (1) the reason for the apparent violation, or, if contested, the basis for disputing the apparent 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. In presenting your corrective action, you should be aware that the promptness and comprehensiveness of your actions will be considered in assessing any civil penalty for the apparent violation. The guidance in the enclosed NRC Information Notice 96-28, "SUGGESTED GUIDANCE RELATING TO DEVELOPMENT AND IMPLEMENTATION OF CORRECTIVE ACTION," may be helpful. Your response should be submitted under oath or affirmation and may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate response is not received within the time specified or an extension of time has not been granted by the NRC, the NRC will proceed with its enforcement decision or schedule a predecisional enforcement conference.

In addition, please be advised that the number and characterization of apparent violations described in the enclosed inspection report may change as a result of further NRC review. You will be advised by separate correspondence of the results of our deliberations on this matter.

Current NRC regulations are included on the NRC's website at www.nrc.gov; select **Nuclear Materials; Medical, industrial, and academic uses of nuclear material**; then **toolkit index page**. The Current General Policy and Procedure for NRC Enforcement Actions are included on the NRC's website at www.nrc.gov; select **What We Do, Enforcement**, then **Enforcement Policy**. Or you may obtain these documents 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).

In accordance with 10 CFR 2.390 of NRC's "Rules of Practice," a copy of this letter and the enclosed report will be made available electronically for public inspection from the NRC's document system (ADAMS), accessible from the NRC Website at <http://www.nrc.gov/reading-rm/adams.html>.

Sincerely,

Original signed by Francis Costello

George Pangburn, Director
Division of Nuclear Materials Safety

Enclosure:

1. Inspection Report No. 03030462/2005002
2. NRC Information Notice 96-28

S. Murphy
ECS Mid-Atlantic, LLC

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cc:
Omer M. Duzyol, Radiation Safety Officer
Commonwealth of Virginia

S. Murphy
ECS Mid-Atlantic, LLC

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DATE	09/23/20058		09/23/2005		09/28/2005	09/30/2005

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U.S. NUCLEAR REGULATORY COMMISSION
REGION I

INSPECTION REPORT

Inspection No. 03030462/2005002
Docket No. 03030462
License No. 45-24974-01
Licensee: ECS Mid-Atlantic, LLC
Address: 14026 Thunderbolt Place, Suite 100
Chantilly, VA 20151
Other Locations Inspected: 44961 LCSA Campus Lane
Ashburn, VA
Inspection Dates: August 9, 2005

Inspector:	<i>Original signed by Jenny Johansen</i> _____ Jenny Johansen Health Physicist	<i>October 6, 2005</i> _____ date
Approved By:	<i>Original signed by John D. Kinneman</i> _____ John D. Kinneman, Chief Materials Security and Industrial Branch Division of Nuclear Materials Safety	<i>October 6, 2005</i> _____ date

EXECUTIVE SUMMARY

ECS Mid-Atlantic, LLC
NRC Inspection Report No. 03030462/2005002

On June 24, 2005, one of the licensee's operators was using CPN Model MCIDRP, Serial No. MD00505618, portable gauge at a temporary job site at Little River Glen II, Olley Lane and Little River Turnpike, Fairfax City, VA. After placing the gauge at the site for measurements, the gauge operator left the gauge sitting in the field and walked approximately 40 yards away from the gauge and sat in her car with her back to the gauge. While the operator was sitting in the car, the gauge was run over by a front end loader. The operator informed the licensee's RSO about the event and immediately cordoned off a 15' radius around the damaged gauge. The RSO arrived at the site and found the gauge was totally destroyed due to the impact, but the source was in the shielded position. Surveys were made and readings of 0.4 mR/hr were recorded. The gauge and source were removed from the site, leak tested and sent to NETS, a Maryland licensee, for proper recycling of the radioactive source.

On July 13, 2005, one of the licensee's operators was using CPN Model MCIDRP, Serial No. MD90404949, portable gauge at a temporary job site at Lanier Farms Section 2, Delvan Rd, Rt 621 and Linear Dr., Gainesville VA. After placing the gauge at the site for measurements, the operator who was wearing his hard hat, safety glasses, reflective vest and safety shoes and had the gauge under direct surveillance noticed a "Bobcat" construction vehicle backing up in his direction. The operator tried to stop the Bobcat by yelling at the bobcat's operator, but the operator could not stop in time and ran over the gauge. The gauge operator was able to get out of the way and was not injured. The operator informed the licensee's RSO about the event and immediately cordoned off a 15' radius around the damaged gauge. The RSO arrived at the site and found the gauge's guide tube and rod were broken, but the source was in the shielded position. Surveys were made and readings of 0.4 mR/hr were recorded. The gauge and source were removed from the site, leak tested and sent to NETS, a Maryland licensee, for proper recycling of the radioactive source.

On August 9, 2005, an announced safety inspection was conducted at ECS-Mid Atlantic, LLC, Chantilly, VA and at a temporary job site in Ashburn, VA of activities authorized by NRC License No. 45-24974-01. The inspection consisted of interviews with licensee representatives and an examination of records surrounding two events involving damaged gauges reported to the NRC on June 24, 2005 (EVENT 41795, NMED 050412) and July 13, 2005 (EVENT 41838, NMED 050454) and an inspection of licensee's use, control and security of a gauge at a temporary job site in Ashburn, VA. The inspection included a detailed review of licensee's corrective actions following each event.

As a result of this inspection, three apparent violations were identified.

- 1) Failure to maintain control over the gauge on June 24, 2004, is an apparent violation of 10 CFR 20.1802.
- 2) Failure on August 9, 2005, to have a second independent physical control that forms a tangible barrier to secure the licensee's portable gauge from unauthorized removal is an apparent violation of 10 CFR 30.34(i)

- 3) Failure on August 9, 2005 to have durable RADIOACTIVE YELLOW- II labels on the gauge which did not have legible printing as to the contents and activity of the package is an apparent violation of 10 CFR 71.5(a) and 49 CFR 172.403.

The licensee's corrective actions after the June 24, 2005 incident included the immediate termination of the gauge operator, discussion of the circumstances surrounding this event and the termination of the operator at the next monthly safety meeting which was attended by all operators and informing all other ECS offices of the event and corrective actions. The licensee has four team leaders who will check the gauge operators from their teams on-the-job at least once per month. The licensee's corrective action after the July 13, 2005 event was to discuss the incident at the next monthly safety meeting attended by all gauge operators. The licensee plans to promptly provide a lock and chains or cables to add a second barrier for gauges when stored in vehicles at temporary job sites. In addition, all gauge cases will be checked to assure DOT labels and markings are durable and the contents and activity on the gauge package are legible.

REPORT DETAILS

I. Organization and Scope of the Program

a. Inspection Scope

The inspector interviewed staff and reviewed records maintained by the licensee.

b. Observations and Findings

ECS Mid-Atlantic, LLC is a large firm with 23 separate offices in various states. Each office has a separate NRC or Agreement State license authorizing the use of portable nuclear gauges. Each license has its own named RSO. The Corporate RSO is based in the Chantilly, VA office. The Chantilly office has a large program with approximately 100 users. The licensee has an audit program that observes gauge operators at field sites at least once per month.

c. Conclusions

Inspector concluded that the organization and scope of licensee's program is as described in the license.

II. Review of Reported Events

a. Inspection Scope

The inspector reviewed the circumstances surrounding two separate events resulting in gauges being damaged at two different temporary job sites.

b. Observations and Findings

On June 24, 2005, one of the licensee's gauge operators was using CPN Model MCIDRP, Serial No. MD00505618, portable gauge containing cesium-137 and americium-241 at a temporary job site, Little River Glen II, Olley Lane and Little River Turnpike, Fairfax City, VA. After placing the gauge at the site and performing measurements, the gauge operator left the gauge sitting in the field and walked approximately 40 yards away from the gauge and sat in her car with her back to the gauge. While the operator was sitting in the car, the gauge was run over by a front end loader. The operator informed the licensee's RSO about the event and immediately cordoned off a 15' radius around the damaged gauge. The RSO and another operator arrived at the site on June 24, 2005, and found the gauge was totally destroyed due to the impact but the source was in the shielded position. Surveys were made and readings of 0.4 mR/hr were recorded. The gauge and source were removed from the site, leak tested and later sent to NETS (MD License No.13-020-02) for proper recycling of the radioactive source. The licensee reported the event to the NRC Operations Center on June 24, 2005, (EVENT #41795, NMED 050454)

The RSO provided the inspector with the licensee's internal written report of the incident (Enclosure 1) which includes pictures of the destroyed gauge, the front end loader that ran over the gauge and a picture of the operator's car in relation to the destroyed gauge. The Corporate RSO stated that the gauge operator had a degree in civil engineering and was a certified gauge user and her hazmat training was current. He and the RSO interviewed the gauge operator upon her return to the office on the day of the incident and the operator was immediately terminated for violating the licensee's operating procedures and NRC regulations. The Corporate RSO stated that the operator had been audited in the field on November 3, 2004, and had been given a written warning for leaving the nuclear gauge unattended at the job site. She was also given re-training on controlling the gauge at all times.

The licensee's corrective actions after the June 24, 2005, incident included the immediate firing of the gauge operator, discussion of the circumstances surrounding this event and the firing of the operator at the next monthly safety meeting attended by all operators and informing all other ECS offices. The licensee also has four team leaders who will check the gauge operators from their teams on-the-job at least once per month.

On July 13, 2005, one of the licensee's gauge operators was using a CPN Model MCIDRP, Serial No. MD90404949, portable gauge containing cesium-137 and americium-241 at a temporary job site (Lanier Farms Section 2) Delvan Rd, Rt 621 and Linear Dr., Gainesville VA. After placing the gauge at the site and using it for measurements, the operator, who was wearing his hard hat, safety glasses, reflective vest and safety shoes and who had the gauge under direct surveillance (the operator was within 10 feet of the gauge), noticed a "Bobcat" construction vehicle which was backing up in his direction. The operator tried to stop the bobcat by yelling at the Bobcat's operator, but the operator could not stop in time and ran over the gauge. The gauge operator was able to jump out of the way of the Bobcat and was not injured. The operator informed the licensee's RSO about the event and immediately cordoned off a 15' radius around the damaged gauge. The RSO arrived at the site with another gauge user and found the gauge's guide tube and rod were broken but the source in the shielded position. Several surveys were made and readings of 0.4 mR/hr were recorded. The gauge and source were removed from the site, leak tested and sent to NETS (MD License No. 13-020-01) manufacturer for proper recycling of the radioactive source. The licensee reported the event to the NRC Operations Center on July 13, 2005 (EVENT #41838, NMED 050454).

The RSO provided the inspector with the licensee's internal written report of the incident (Enclosure 2) which includes pictures of the damaged gauge and the Bobcat in relation to the damaged gauge with the operator taking radiation surveys. The RSO interviewed the gauge operator upon his return to the office on the day of the incident and determined that the operator was in control of the gauge (the operator was within 10 feet of the gauge), tried to get the Bobcat operator to stop backing up into his work area and had to jump out of the of way of the Bobcat to avoid injury to himself. No action was taken by the licensee against the operator as he had no previous violations of licensee operating procedures and NRC regulations. In this incident the licensee determine the gauge operator had constant surveillance and control of the gauge, tried to stop the bobcat from backing over the gauge by yelling at the operator to stop, but due to the danger of the bobcat operator's actions chose to save himself rather than the gauge.

The licensee's corrective action after the July 13, 2005, event was to discuss the incident at the next monthly safety meeting attended by all gauge operators.

Based on these events, the Corporate RSO stated that the licensee has emphasized to the gauge operators the need to inform vehicle operators and site managers of their location and times of gauge use at the field site. The licensee stated they may consider adding air horns and orange bicycle pennant flags on an aerial as audible and visual alarms to alert vehicle operators at field sites of the gauge operator's location.

c. Conclusions

One apparent violation was identified.

10 CR 20.1801 requires that the licensee secure for 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. The failure to maintain control and constant surveillance over the gauge on June 24, 2005, is an apparent violation of 10 CFR 20.1802.

III. Material Receipt, Use, Transfer, and Control

a. Inspection Scope

On August 9, 2005, the inspector visited a construction site at 44961 LCSA Campus Lane, Ashburn, VA to review the use and control of portable gauges.

b. Observations and Findings

Upon arrival at the site, the inspector was met by the gauge users on site, one of whom had the gauge stored in his SUV. They stated the gauge had not been used due to rainy weather. The inspector observed that ECS gauge #68, a CPN Model MC1DRP, Serial No. MD40307315 was in the back of the SUV. The transport case of the gauge was locked, but there were no chains and locks securing the gauge inside the SUV. The only security for the gauge was the locked SUV, without an additional chain on the gauge case which locked the gauge to the wall or floor inside the SUV, contrary to 10 CFR 30.34 (i) which requires two tangible barriers. The Department of Transportation Radioactive Yellow II labels were worn such that the contents and the activity of the licensed materials in the gauge could not be read.

The licensee's RSO stated they would take immediate corrective actions to provide lock and chains or cables to add a second barrier for security of gauges when stored in vehicles at temporary job sites and all gauge cases would be checked to assure DOT labels and markings were durable and the contents and activity on the gauge package was legible.

c. Conclusions

Two apparent violations were identified:

- 1) 10 CFR 30.34 (i) requires that each portable gauge licensee shall use a minimum of two independent physical controls that form tangible barriers to secure portable gauges from unauthorized removal, whenever portable gauges are not under the control and constant surveillance of the licensee. The failure to use a second independent physical control that forms a tangible barrier to secure the licensee's portable gauge from unauthorized removal in the SUV containing a CPN Model MC1DRP, Serial No. MD40307315 portable gauge when the gauge was not under the control and constant surveillance of the licensee at a construction site in Ashburn, VA is an apparent violation of 10 CFR 30.34(i)
- 2) 10 CFR 71.5(a) requires that a licensee who transports licensed material outside of the site of usage, as specified in the NRC license, or where transport is on public highways, 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 transportation index must be entered in the blank spaces on the label using a legible and durable, weather resistant means. The contents entered on the label must include the name of abbreviation (e.g., ⁹⁹Mo) of the radionuclides as taken from the listing in 49 CFR 173.435, or for mixtures of radionuclides, those nuclides determined in accordance with provisions of 49 CFR 173.433(f), with consideration of space available on the label. The activity must be expressed in terms of the appropriate SI units (e.g., Becquerel, Terabecquerel etc...), or in terms of appropriate SI units followed by customary units (e.g., curies, millicuries, or microcuries). Failure to maintain legible and durable RADIOACTIVE YELLOW- II labels on a carrying case used to transport a CPN Model MC1DRP, Serial No. MD40307315 portable gauge, containing cesium-137 and americium-241 which had legible printing as to the contents and activity, of the package is an apparent violation of 10 CFR 71.5 and 49 CFR 173.435.

IV. Exit Meeting

An exit meeting was held with the RSO on August 9, 2005. The three apparent violations were discussed. The licensee discussed that corrective actions were taken following the two events. The inspector reviewed the NRC enforcement policy.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

Omer Murat Duzyol, Equipment Manager, RSO
Stanley J. Murphy, P.E., Corporate RSO
Muthukumaran Arigovindan, Gauge user
Manacher Torabi, Gauge user
Mohamed Elbulok, Gauge user
John Gabba, Gauge user

Enclosure 1

Memorandum

To: To file
CC: Stan Murphy, Dave Huggins, Lori Debo, Tarig Ibrahim
From: Omer Murat Duzyol, RSO
Date: 06-24-2005
Re: An Accident Involving Chantilly Nuke #49

An accident has happened involving Nuclear Gauge #49 (CPN MC1DRP serial # MD00505618) on the Little River Glen II job site (#11012) at about 3:15 PM on 06/24/2005.

The nuke got run over by a loader operated by Juan Pablo Diatoro and destroyed while it was under the control of our technician, Sonu Shukla.

Contrary to the initial Nuke Safety Training, the gauge was sitting on the field in the path of a loader with the technician was approximately 40 yards away from the gauge sitting in her car with her back turned to the gauge. This is a direct violation to the NRC rules and ECS' written policy as she had to be within 10' of the gauge. The same technician had received a written warning for leaving her gauge unattended at her jobsite on 11/03/04, and as a result the technician was terminated the same day.

The technician informed me (Omer Duzyol, RSO) about the incident immediately and cordoned off the 15' radius of an area around the damaged gauge.

Tarig Ibrahim and I arrived the job site at around 3:50 PM.

The gauge was totally destroyed due to the impact but the source was in the shielded position. Several surveys have been made by using a survey meter (TroxaAlert calibrated 1/15/05) at one meter distance, and the readings were found to be around 0.4 mR/hr range.

The NRC Operations Center was informed about the incident at 4:10 PM, and 41795 report number was given for the incident by Steve Sandin of NRC.

All the pieces of the gauge were put in the box #49 and it was hauled back to the designated nuke storage in the Chantilly office around 5:00 PM. The remaining of the gauge will be returned to the manufacturer (CPN) for them to recycle the radioactive sources properly.

The related pictures of the incident, copy of written warning & termination reports are also attached.

Omer Murat Duzyol, RSO







TERMINATION REPORT

EMPLOYEE NAME (Last) SHUKLIA		(First) SONU		(MI)
DEPARTMENT 4	POSITION FIELD TECH	EMPLOYEE NO. 015054	SUPERVISOR TALIB IBRAHIM	
HIRE DATE 09/14/04	TODAY'S DATE 06/24/05	LAST DAY WORKED 06/24/05	TERMINATION EFFECTIVE DATE 06/24/05	
TYPE OF SEPARATION (Check One)				MAIL CHECK?
<input type="checkbox"/> Resignation (attach letter of resignation)		<input checked="" type="checkbox"/> Dismissal	<input type="checkbox"/> Retirement	
<input type="checkbox"/> Mutual Agreement		<input type="checkbox"/> Layoff	<input type="checkbox"/> Other _____	
				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
REASON FOR TERMINATION				
<input type="checkbox"/> Absenteeism/Tardiness		<input type="checkbox"/> Job Change	<input type="checkbox"/> Personal	
<input type="checkbox"/> Performance		<input checked="" type="checkbox"/> Violation of Policies/Procedures	<input type="checkbox"/> Reduction In Force	
<input checked="" type="checkbox"/> Other: CARELESSNESS				

EMPLOYEE EVALUATION (check appropriate boxes)

	Unsatisfactory	Fair	Satisfactory	Good	Excellent
Attendance			✓		
Cooperation			✓		
Initiative			✓		
Job Knowledge			✓		
Quality of Work		✓			
Job Productivity			✓		
Dependability		✓			
Work Safety	✓				
Management Skills	✓				

Recommendation: Without Reservation With Some Reservation Would Not Recommend
 Rehire? Yes No If No, Reason: **CONTINUOUS OFFENSES OF SAFETY RULES.**

ADDITIONAL COMMENTS
THE TECHNICIAN LOST CONTROL OF HER NUKE & CAUSED HEAVY DAMAGE TO THE NUKE. THIS WAS A DIRECT VIOLATION OF NRC RULES & REGULATIONS. THIS WAS THE SECOND TIME SHE LOST CONTROL HER NUKE & ON 11/3/04 SHE HAD GOTTEN WRITTEN UP FOR THE SAME OFFENSE. SEE ATTACHMENT.

Signed:  Date: **6/24/05**

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 Company Materials Returned Dental Vacation Due
 Retirement/Savings Distribution Health Days _____
 Life Hours _____

HR Signature _____ Date _____

Enclosure 2

Memorandum

To: To file
CC: Stan Murphy, Dave Huggins, Lori Debo, Mohamed Elbulok
From: Omer Murat Duzyol, RSO
Date: 07-13-2005
Re: An Accident Involving Chantilly Nuke #40

An accident has happened involving Nuclear Gauge #40 (CPN MC1DRP serial # MD90404949) on the Lanier Farms Section 2 - Retaining Wall Lots 40-41 job site (#8039-B3) at about 3:30 PM on 07/13/2005.

The nuke got run over by a bobcat operated by Oliver Antonio Hernandez of KT Enterprises (703)526 0293 and destroyed while it was under the control of our technician, Edmund Attoh.

The technician had all his PPE equipment on (hardhat, safety glasses, reflective vest & steel toed boots), and was in control of the nuke the whole time and within 10 feet of the gauge. He tried to stop the bobcat by yelling at the bobcat's operator while it was backing up on the gauge but he couldn't stop it on time.

The technician informed me (Omer Duzyol, RSO) about the incident immediately and cordoned off the 15' radius of an area around the damaged gauge.

Mohamed Elbulok, and I arrived the job site at around 4:15 PM.

The gauge's guide tube & rod were broken due to the impact but the source was in the shielded position. Several surveys have been made by using a survey meter (Troxaalert calibrated 1/15/05) at one meter distance, and the readings were found to be around 0.4 mR/hr range.

The NRC Operations Center was informed about the incident at 4:30 PM, and 41838 report number was given for the incident by Mark Abramowitz of NRC.

All the pieces of the gauge were put in the box #40 and it was hauled back to the designated nuke storage in the Chantilly office around 5:15 PM. The remaining of the gauge will be returned to the manufacturer (CPN) for them to recycle the radioactive sources properly.

The related pictures of the incident are also attached.

Omer Murat Duzyol, RSO



