

## RI - DNMS Licensee Event Report Disposition

Licensee: Pennoni Associates  
 Event Description: Lost Gauge  
 License No: 37-17637-02 Docket No: 03017570 MLEP-RI: 2006-037  
 Event Date: 08/19/06 Report Date: 08/21/06 HQ Ops Event #: 42790

### 1. REPORTING REQUIREMENT

<input type="checkbox"/>	10 CFR 20.1906 Package Contamination	<input type="checkbox"/>	10 CFR 30.50 Report
<input checked="" type="checkbox"/>	10 CFR 20.2201 Theft or Loss	<input type="checkbox"/>	10 CFR 35.3045 Medical Event
<input type="checkbox"/>	10 CFR 20.2203 30 Day Report	<input type="checkbox"/>	License Condition
<input type="checkbox"/>	Other _____		

### 2. REGION I RESPONSE

<input type="checkbox"/>	Immediate Site Inspection	Inspector/Date	
<input checked="" type="checkbox"/>	Special Inspection	Inspector/Date	<u>Rolph / 9/18/06</u>
<input checked="" type="checkbox"/>	Telephone Inquiry	Inspector/Date	<u>Rolph / 8/21/06</u>
<input type="checkbox"/>	Preliminary Notification/Report	<input type="checkbox"/>	Daily Report
<input checked="" type="checkbox"/>	Information Entered in RI Log	<input type="checkbox"/>	Review at Next Inspection
<input type="checkbox"/>	Report Referred To: _____		

### 3. REPORT EVALUATION

<input checked="" type="checkbox"/>	Description of Event	<input checked="" type="checkbox"/>	Corrective Actions
<input checked="" type="checkbox"/>	Levels of RAM Involved	<input type="checkbox"/>	Calculations Adequate
<input checked="" type="checkbox"/>	Cause of Event	<input type="checkbox"/>	Additional Information Requested from Licensee

### 4. MANAGEMENT DIRECTIVE 8.3 EVALUATION

<input type="checkbox"/>	Release w/Exposure > Limits	<input type="checkbox"/>	Deliberate Misuse w/Exposure > Limits
<input type="checkbox"/>	Repeated Inadequate Control	<input type="checkbox"/>	Pkging Failure > 10 rads/hr or Contamination > 1000x Limits
<input type="checkbox"/>	Exposure 5x Limits	<input type="checkbox"/>	Large# Indivs w/Exp > Limits or Medical Deterministic Effects
<input type="checkbox"/>	Potential Fatality	<input type="checkbox"/>	Unique Circumstances or Safeguards Concerns
<input type="checkbox"/>	If any of the above are involved:	<input type="checkbox"/>	Considered Need for AIT
<input type="checkbox"/>	Considered Need for IIT		
	Decision/Made By/Date: _____		

### 5. MANAGEMENT DIRECTIVE 8.10 EVALUATION (additional evaluation for medical events only)

<input type="checkbox"/>	Timeliness - Inspection Meets Requirements (5 days for overdose / 10 days for underdose)
<input type="checkbox"/>	Medical Consultant Used-Name of Consultant/Date of Report: _____
<input type="checkbox"/>	Medical Consultant Determined Event Directly Contributed to Fatality
<input type="checkbox"/>	Device Failure with Possible Adverse Generic Implications
<input type="checkbox"/>	HQ or Contractor Support Required to Evaluate Consequences

### 6. SPECIAL INSTRUCTIONS OR COMMENTS

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Non-Public

Public-SUNSI REVIEW COMPLETE

Inspector Signature: [Signature]

Branch Chief Initials: JDK

Date: 9-25-06  
 Date: 9/25/06

Location of File: G:\Reference\Blank Forms\LER FORM.wpd

Rev. 02/25/05



September 21, 2006

Administrator  
U.S. Nuclear Regulatory Commission  
Region I  
475 Allendale Road  
King of Prussia, PA 19406-1415

**Re: USNRC License 37-17637-02  
Report of Loss of Licensed Material**

Dear Sir:

On August 21, 2006 our Radiation Safety Officer (Charles M. Snyder) telephoned your office and the NRC Operations Center in Washington, D.C. to report a loss of a moisture/density gage. This report is being submitted in accordance with 10CFR20.2201.

This gage is identified as follows:

Manufactured by Humboldt Scientific

Model No. 5001, Serial No. 4746

Contains the following sealed radioactive sources (Spec. Form Type "A"):

Cs137 - 0.37GBq, serial no. 5874CM

Am241:Be - 1.48GBq, serial no. NJ05012

The transit case is a Type A unit, labeled Radioactive II-Yellow, with a Transit Index of 0.2

A summary of the circumstances of loss is as follows:

During the late evening of August 19, 2006, our technician, Donald Benway, was approached by his ex-sister-in-law requesting the use of this automobile for a brief but urgent errand. Mr. Benway agreed to the request and allowed the use of his vehicle by his ex-sister-in-law.

At the time of the vehicle loan, the moisture/density gage was in the back seat of the vehicle, secured to the seat by a locked cable.

Mr. Benway's ex-sister-in-law did not return the vehicle as promised, but instead loaned the vehicle to another person.

When Mr. Benway was unable to contact his ex-sister-in-law the next morning, he notified the police department of the City of Bethlehem, PA of the missing vehicle and the gage that it contained. Mr. Benway informed his immediate supervisor (Delbert Thomas), who in turn notified the RSO. The RSO, Mr. Charles Snyder, contacted Mr. Benway, who related the events to date and stated that he expected the car to be returned to him that night. Under these circumstances, it appeared unlikely that an exposure would result to anyone.

The logo for Pennoni, featuring the word "Pennoni" in a bold, italicized sans-serif font, enclosed within an oval border.

On Monday, August 21, upon learning that the vehicle had not been returned, Mr. Snyder contacted the NRC Region I office and the NRC Operations Center to report the missing gage because while it still seemed unlikely that an exposure would result, Mr. Snyder felt the uncertainty over the location of the car increased the possibility that an exposure could result. Mr. Snyder also contacted Officer Conrad of the Bethlehem police to describe the gage and possible hazards to the public.

On Wednesday August 23, Mr. Benway was able to reach the person who had obtained his car from his ex-sister-in-law and was informed of the location of the car's contents (including the gage). Mr. Benway's ex-wife was able to gain control of the car and return it to his residence. The gage was not in the car. Mr. Benway passed this information on to Edward Sander (regional technology head).

Mr. Sander visited Mr. Benway's residence to document the condition of his car, noting that the cable was still locked to the vehicle.

Mr. Benway was successful in obtaining the location where the gage had been discarded. Mr. Sander visited the reported site of the gage and found the gage in its case as well as other items that had been in Mr. Benway's vehicle. Mr. Sander returned the items to Bethlehem office.

Mr. Snyder secured the gage in the designated storage room and checked the gage and case with a survey meter, finding no abnormal readings.

It was observed that the source rod lock was in place and locked. There were no items missing from the case interior. The case handle that had been locked to the car via a cable had been removed from the case by having its four screws removed.

Mr. Snyder telephoned both the NRC Region I office and the NRC Operations Center to inform both parties that the gage had been located and secured in its designated storage location at the Bethlehem office.

The licensed material had not been removed from the gage and is therefore in the possession of the license holder and being utilized in an appropriate manner.

Pennoni believes there was no exposure of radiation to any individual. Because the gage was locked in Mr. Benway's vehicle at an appropriate distance from the driver, it is believed that the ex-sister-in-law was exposed to no or virtually unrecordable radiation. The person who obtained the gage from the ex-sister-in-law refused to cooperate in any manner except to provide its location. There was no evidence that the gage had been removed from its case and since the source rod lock was in place, there could not have been any contact with the encased source. As such, any exposure would be similar to that received by the RSO when conducting semi-annual leak tests, which is less than 10 mrem.

Mr. Sander, in his discussions with Mr. Benway, reinforced the regulations on maintaining control of the gages, reminding him that this subject was a part of his formal training and is reviewed at the annual inspectors meeting by the RSO. Mr. Sander informed Mr. Benway that since his actions were not in accordance with the established policies for use and transport of a gage, that he would be disciplined accordingly.

The gage was properly secured, including meeting the two barriers to removal regulation. The storage in his locked vehicle at his residence was also in accordance with regulations up to the point of his giving up



control of the car. When Mr. Benway released his vehicle with the gage in it, he violated security instructions he was provided in his initial training, subsequent retraining and contained in the company policy brochure. Although the established policies meet NRC regulations, they will be reviewed for refinement or amplification. A policy governing the storage of gages when off duty will be implemented. A review of security procedures, including methods to maintain the two barriers to removal regulation will be made with the technicians.

With any questions or if additional information is needed please contact the Radiation Safety Officer, Chas M. Snyder, P.E. at 610.231.0600 extension 5027.

Very truly yours,

PENNONI ASSOCIATES INC.

A handwritten signature in black ink, appearing to read "Chas M. Snyder".

Chas M. Snyder, P.E.  
Radiation Safety Officer