Calumet Testing Services

Date: 11-25-08 Page 1 of 4

To: Bob Gattone Company: USNRC

Reference: EA-08-286 (Response Letter)

Bob:

As requested, attached is a copy of the Response Letter we discussed yesterday afternoon.

I left all the text intact, including the original date, but I have deleted the "Exempt from Public Disclosure" footer.

Please contact me with any questions.

Sorry for the inconvenience.

Thanks again for your help.

* Original to follow via mail.

-Art

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EA-08-286

November 13, 2008

Steven A. Reynolds, Director - Division of Nuclear Materials Safety
United States Nuclear Regulatory Commission – Region III
2443 Warrenville Road, Suite 210
Lisle, IL 60532-4352

Subject: Response to Apparent Violation
Report No. 030-10856/2008-001; EA-08-286
Cal Testing Services, Inc. - License No. 13-16347-01

Dear Mr. Reynolds:

This letter is in response to the violation of Condition 20 of our NRC License No. 13-16347-01, which was identified during the routine inspection of our facility on September 29-30, 2008. On July 22, 2008, a source disconnect resulted from the failure of a radiography crew to connect the drive cable to the source assembly before cranking the source out of the camera.

Condition 20 requires in part, that our program is conducted in accordance with procedures contained in our application and letter dated May 27, 1998, which includes our Operating and Emergency Procedures. Table 10.3 of our Operating and Emergency Procedures requires in part, that the control cable be connected to the source assembly before cranking the source out of the camera.

Reason for the Violation:

While setting up for a radiographic operation at a local jobsite, one of the two safety connector pins fell out of the drive control safety connector assembly. After experiencing difficulty re-inserting the pin, the radiography crew attached the connector assembly to the camera without the pin, in order to align the connector holes. The device selector ring was turned from the "connect" position to the "lock" position to hold the connector assembly in place, which allowed the radiographer to re-insert the pin back into the connector.

However, the radiographers failed to connect the drive cable to source assembly. The source was then cranked out of the exposure device, which resulted in the incident, due to the inability to retract the source.

Corrective Action

1. Review and Investigation: The radiographers involved in the violation were initially interviewed at the jobsite where the violation occurred. This interview included the RSO, management, and training personnel. All operation steps leading up to the incident were reviewed in detail with the radiographers during this initial interview. During this interview, it was noted that the connector pins periodically fall out of the safety connector assembly and can be difficult to reinsert. It was also noted that some increased force may have been applied to push the Posilock button to the unlocked position on the exposure device.

A check of the equipment verified that all connecting components were in good working order. Further investigation included communication with the equipment manufacturer to discuss the possibility of equipment failure. As a precaution, the drive control assembly was taken out of service and shipped to the manufacturer, who was unable to make the connection as described by our radiographers.

Also, the radiographers involved in the incident were interviewed individually to confirm their recollection of the events that occurred. We took this opportunity with our radiography personnel to reinforce our procedures and regulations, particularly the requirement to verify that the drive cable and source assembly are properly connected. The radiographers were also reinstructed to stop operations if they experience unusual resistance in any of the mechanisms or components.

2. Root Cause: The root cause of the incident was the failure to connect the drive cable to the source assembly. Contributing factors include the lack of attention to detail caused by the distraction in replacing the safety connector pin, and that increased force may have been applied when mechanism resistance was encountered.

3. Immediate Corrective Action: Immediate corrective action was taken as follows:

a) The drive cable assembly was temporarily taken out of service and shipped to the manufacturer for evaluation. Equipment was found to be in good condition.
b) The radiographers involved were reprimanded for failing to make and verify the cable to source connection.
c) All radiography personnel were instructed to never use the exposure device as an alignment tool when replacing safety connector pins, and that any necessary pin replacement shall be done away from the exposure device.
d) Misconnect tests were conducted on all equipment to ensure satisfactory connections.
e) All personnel were instructed of their obligation to stop operations if they notice any unusual resistance in any of the mechanisms.

4. Corrective Action to Prevent Recurrence:

a) Misconnect tests will be included as part of our quarterly maintenance procedures.

b) Redesigned safety connector pins were obtained from the manufacturer and distributed to applicable personnel to minimize pin loss.

c) A radiation safety meeting was conducted by management and the RSO on August 26, 2008 and included all radiography and supervisory personnel. Among general radiation safety topics and a review of operating and emergency procedures, the incident of July 22, 2008 was discussed in detail.

Date of Full Compliance: We feel that we have satisfactorily addressed and responded to the incident and are currently in full compliance.

Please contact me with any questions or comments.

The assistance and guidance provided by your office has been greatly appreciated.

Sincerely,

Lawrence R. Kondrat, President
Cal Testing Services, Inc.