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April 6, 2009

United States
Nuclear Regulatory Commission
Washington, DC 20555

Attention: Document Control Desk

Reference: **Reply to Notice of Violation**
Docket No. 03006579; License No. 45-08890-01
NRC Inspection Report No. 03006579/2009001
Froehling & Robertson, Inc., Richmond, VA

Gentlemen:

We are in receipt to your correspondence of March 26, 2009 concerning the results of the February 24, 2009 inspection conducted by your Mr. Thomas Thompson. The inspection was an examination of our licensed activities relative to radiation safety and compliance with regulations and license conditions. We will acknowledge that certain areas were not in full compliance. Following is a breakdown of the violations and corrective actions taken to date:

A. 10CFR34.47 required personal monitoring.

1. Radiographer did not wear the required direct-reading dosimeter, film badge or alarming rate meter while initiating a radiographic operation demonstration for the inspector. The source was not exposed; but the radiographer handled the device and made the attachments of the drive cable and guide tube.

ACTION: The radiographer was admonished for this failure to both wear the required personal protection equipment. He could offer no valid excuse for this lapse of attention even for a demonstration. We will admit that he was somewhat nervous; but basics are basics.

2. The radiographer did not recharge his dosimeter before the start of the shift.

ACTION: Same as above. The radiographer also admitted to making a statement about zeroing the dosimeter that may have been misconstrued. Once again, this is a basic action.

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3. Failure to submit film badges for assay on a timely basis.

ACTION: The RSO noted that there was a perceived problem with that particular month; and did admit to being remiss. Since that time, all badges have been submitted on a timely basis and reports received through to January 5, 2009 filed accordingly.

B. There were lapses in record-keeping during the last two quarters of 2008. In the case of the RSO, certain reports were lost or misplaced. Regardless, the reports were not in the files for inspection. The Radiographer had also failed to record certain surveys upon removing the material for use at the facility. It was also noted that the Radiographer had failed to complete certain inspection and maintenance procedures.

ACTION: The Radiographer has been admonished for his record-keeping lapses; and will be closely monitored to assure improvement. The RSO has assumed fault for the missing reports, as well his failure to recognize the record-keeping omissions of the Radiographer.

The RSO is both experienced and capable; and the Radiographer is considered as conducting safe operations, The key is more attention to detail, which may be easier for the RSO since we added an assistant to take care of some of his other duties; and additional training and monitoring of the Radiographer. We intend that the action detailed, as well as continued actions and vigilance in the future, will serve to prove our commitment to radiation safety.

Respectfully submitted,
Froehling & Robertson, Inc.

Samuel H. Kirby, Jr., P.E.
President

cc: Regional Administrator
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Radiation Safety Committee
File