UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
612 EAST LAMAR BLVD, SUITE 400
ARLINGTON, TEXAS 76011-4125

March 3, 2011

EA-10-231

Pete Millar, President
Alaska Industrial X-Ray, Inc.
4047 Kingston Drive
Anchorage, Alaska 99504

SUBJECT: NRC INSPECTION REPORT 030-10346/2009-001 AND INVESTIGATION REPORT 4-2010-023

Dear Mr. Millar:

This letter refers to the onsite inspections conducted in September 2009 and in August 2010 at your field station and at a temporary job site inspection in Anchorage, Alaska. The scope of the inspection included routine safety and security reviews, as well as compliance with the ORDER MODIFYING LICENSE EA-08-196 (Order) issued on August 20, 2008. In addition, the NRC conducted an investigation to review the facts and circumstances surrounding compliance with the Order. The inspector discussed the preliminary inspection findings with Mr. Don Millar at the conclusion of the onsite portion of the inspection in August 2010. A final exit briefing was conducted telephonically with you and Mr. Don Millar on February 3, 2011.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions in your license. Within these areas, the inspection consisted of a selected examination of procedures and representative records, observations of activities, and interviews with personnel. In addition, the inspection and investigation reviewed your compliance with the conditions of the Order.

Based on the results of this inspection and investigation, apparent violations were identified and are being considered for escalated enforcement action in accordance with the NRC Enforcement Policy. The current Enforcement Policy is included on the NRC's Web site at http://www.nrc.gov/about-nrc/regulatory/enforcement/enforce-pol.html. The first apparent violation involves a failure to meet the audit requirements of the Order (EA-08-196) and is of concern to the NRC because it appears to involve willfulness. A second apparent violation involves security-related information and is discussed in Enclosure 3, which is not being made publicly available. Your company took immediate actions to correct the security-related deficiency at the time of the inspection.

Enclosure 3 transmitted herewith contains SUNSI. When separated from Enclosure 3, this transmittal document and Enclosures 1, 2, 4, and 5 are decontrolled.

Before the NRC makes its enforcement decision, we are providing you an opportunity to meet with us in a Predecisional Enforcement Conference (PEC) to discuss the apparent violations. You may also request Alternative Dispute Resolution (ADR) for the apparent willful violation involving the failure to meet all conditions of the Order (EA-08-196). NRC is not offering ADR for the security-related apparent violation because willfulness was not involved. Therefore, if you choose ADR for the apparent willful violation, we will still conduct a PEC to discuss the security-related apparent violation. The PEC and/or ADR, should be conducted within 30 days of the date of this letter. Please contact Ms. Vivian Campbell within 7 days of the date of this letter at 817-860-8287 to schedule the PEC and to inform the NRC of whether you choose ADR in addition to a PEC.

The PEC will be closed to public observation because Security-Related Information and/or investigative information will be discussed. The conference will afford you the opportunity to provide your perspective on the apparent violations and any other information that you believe the NRC should take into consideration before making an enforcement decision. The topics discussed during the conference may include the following: information to determine whether violations occurred, information to determine the significance of the violations, information related to the identification of the violations, and information related to any corrective actions taken or planned to be taken. In presenting your corrective actions, you should be aware that the promptness and comprehensiveness of your actions will be considered in assessing any civil penalty for the apparent violations. The guidance in the enclosed excerpt from NRC Information Notice 96-28, “Suggested Guidance Relating to Development and Implementation of Corrective Action,” may be helpful.

The basis for our concern that willfulness may be associated with the apparent violation of the Order (EA-08-196) is contained in Enclosure 2, “Factual Summary.” As stated earlier, you may request ADR in an attempt to resolve this issue, in lieu of a PEC. ADR is a general term encompassing various techniques for resolving conflicts using a neutral third party. The technique that the NRC has decided to employ is mediation. Mediation is a voluntary, informal process in which a trained mediator works with parties to help them reach resolution. If the parties agree to use ADR, they select a mutually agreeable neutral mediator who has no stake in the outcome and no power to make decisions. Mediation gives parties an opportunity to discuss issues, clear up misunderstandings, be creative, find areas of agreement, and reach a final resolution of the issues. Additional information concerning the NRC's program can be obtained at http://www.nrc.gov/about-nrc/regulatory/enforcement/adr.html. The Institute on Conflict Resolution (ICR) at Cornell University has agreed to facilitate the NRC's program as a neutral third party. Please contact the ICR at 877-733-9415 within 7 days of the date of this letter if you are interested in pursuing resolution of this issue through ADR.

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.

Enclosure 3 contains Security-Related Information; its disclosure to unauthorized individuals could present a security vulnerability. Therefore, it will not be made available electronically for public inspection in the NRC Public Document Room or from the NRC’s document system (ADAMS). Enclosure 3 must be protected from unauthorized disclosure in accordance with Section IC-6 of Attachment B to NRC Order EA 05-090. Security-Related Information is also

discussed in Regulatory Information Summary RIS-2005-031, "Control of Security-Related Sensitive Unclassified Non-Safeguards Information" (ML053480073), which is available on the NRC's Web site at http://www.nrc.gov/reading-rm/adams.html.

If you have any questions concerning this matter, please contact Vivian Campbell of my staff at 817-860-8287.

Sincerely,

/RA/

Roy Caniano, Director
Division of Nuclear Materials Safety

Docket: 030-10346
License: 50-16084-01

Enclosures:
1. NRC Inspection Report 030-10346/2009-001
2. Factual Summary
3. Security Related Information – NONPUBLIC
4. Predecisional Enforcement Conference Agenda
5. NRC Information Notice 96-28

cc (w/Enclosures 1, 2, 3, and 4):
Alaska Radiation Control Program Director

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Hard copy:
RIV Materials Docket File

Hard copy w/Enclosures 1, 2, & 4:
DNMS Secretarial File

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ADAMS	☐ No	■ Yes	■SUNSI Review Complete	Reviewer Initials: JMR
☐ Publicly Available	■Non-publicly Available	■Sensitive	☐ Non-sensitive	
Category – **KEYWORD**: A.3	**MD 3.4 Non-Public A.3**			

RIV:NMSB-A	NMSB-A	DRS for DNMS	C:NMSB-A	ACES
JMRazo;dlf	ADGaines	GMVasquez	VHCampbell	RLKellar
/RA/	***/RA/***	***/RA/***	***/RA/***	***E - GMVasquez***
2/8/11	2/16/11	2/22/11	2/28/11	2/28/11
D:DNMS				
RJCaniano				
/RA/				
3/3/11				

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U.S. Nuclear Regulatory Commission
Region IV

Docket:	030-10346
License:	50-16084-01
Report:	030-10346/2009-001
EA:	10-231
Licensee:	Alaska Industrial X-Ray, Inc.
Facility:	Field Station and Temporary Job Site
Location:	Anchorage, Alaska
Dates:	September 22, 2009, through February 3, 2011
Inspectors:	Anthony Gaines, Senior Health Physicist Nuclear Materials Safety Branch A Jason Razo, Health Physicist Nuclear Materials Safety Branch A
Approved By:	Vivian Campbell, Chief Nuclear Materials Safety Branch A
Attachment:	Supplemental Inspection Information

EXECUTIVE SUMMARY

Alaska Industrial X-Ray, Inc.
NRC Inspection Report 030-10346/2009-001

This was an inspection of licensed activities involving the use of byproduct material for industrial radiography. The inspection consisted of inspections of a field station in Anchorage, Alaska, in September 2009 and August 2010, and a temporary job site inspection in Anchorage, Alaska, in August 2010. The scope of the inspection included a routine safety inspection, as well as an assessment of the licensee's compliance with the ORDER MODIFYING LICENSE EA-08-196 (Order) issued on August 20, 2008. Additionally, the NRC's Office of Investigations (OI) Region IV Field Office performed an investigation. The inspection also included in-office reviews of information obtained during the inspections and OI investigation. This report describes the findings of the inspections and investigation.

Inspection Findings Considered for Escalated Enforcement

- The licensee failed to adhere to the conditions of the Order. Specifically, the licensee failed to meet the following conditions:

    - AIX failed to ensure that an independent contractor performed field audits and submitted reports associated with those audits to the licensee and NRC, as required by Condition 1 of the Order.

    - AIX failed to ensure that an approved independent consultant began an evaluation of the effectiveness of the licensee's radiation safety and compliance program within 30 days of issuance of the Order in August 2008, as required by Condition 3 of the Order.

    These findings were identified as a single apparent violation of the Order. (Section 2.2)

Selected Corrective Actions

- In January 2010, the licensee submitted the name and credentials of a new independent contractor/consultant to perform field audits and review the radiation safety program. (Section 3.2)

- The independent contractor/consultant began performing field audits in April 2010, as required by Condition 1 of the Order. (Section 3.2)

- The consultant completed his evaluation of the licensee's radiation safety program and provided his report to the licensee and to the NRC, and the licensee provided its response to the consultant's report, in accordance with Condition 3 of the Order. As a result, the licensee returned to full compliance with the conditions of the Order in October 2010. (Section 3.2)

Report Details

1 Program Overview (87121)

1.1 Inspection Scope

The inspectors reviewed records, observed the performance of industrial radiographic operations, interviewed licensee personnel, and performed in-office reviews of information. Collectively, these observations and documents represent the licensee's radiation safety program. Inspections were performed at the licensee's field station located in Anchorage, Alaska, and at a temporary jobsite located at Ted Stevens Anchorage International Airport.

1.2 Observations and Findings

Under byproduct materials License 50-16084-01, the NRC authorized Alaska Industrial X-Ray, Inc. (AIX), to store and use radioactive materials for industrial radiography. AIX used sealed sources of iridium-192 in radiographic exposure devices. AIX's six employees included a president, radiation safety officer (RSO), radiographers, and assistant radiographers. AIX is based in Anchorage, Alaska, and has worked at temporary job sites throughout the state.

On October 19, 2007, the NRC issued an ORDER SUSPENDING LICENSED ACTIVITIES (EA-07-261) to AIX due to the preliminary information from the NRC's Office of Investigations regarding the circumstances associated with apparent violations of 10 CFR 34.41(a). On October 23, 2007, AIX responded to the suspension by submitting to the NRC an independent third-party oversight program. AIX acquired the services of an independent auditor to provide this oversight of AIX's radiographic operations in the field while the NRC completed its reviews of the violations of 10 CFR 34.41(a), also known as the two-person rule. The auditor conducted observations of AIX radiographers and sent monthly reports to AIX and to the NRC documenting the results of the audits while the NRC conducted additional reviews of investigative findings.

In June 2008, the NRC conducted a predecisional enforcement conference with AIX to discuss the violation. As a result of all the information gathered, the NRC issued the enforcement action, which included a civil penalty and an ORDER MODIFYING LICENSE (EA-08-196) on August 20, 2008. Included in the Order (EA-08-196) was a continuation of the independent oversight by the field auditor, as well as a requirement to have an independent consultant evaluate the effectiveness of its radiation safety and compliance program, among other requirements. The NRC also took civil enforcement action against several employees of the licensee for their deliberate misconduct.

2 Inspection Findings (87121)

2.1 Inspection Scope

The inspectors reviewed the conditions of the Order (EA-08-196) along with the licensee's radiation safety program and records at the field station. An inspector observed a crew perform radiography activities at a temporary job site.

2.2 Observations and Findings

The Order (EA-08-196) added conditions to AIX's NRC license, number 50-16084-01, including requiring additional oversight both internally by AIX and externally by an independent contractor or consultant. The supplemental internal oversight by AIX included weekly notifications to NRC of work schedules and increasing the audit frequency of radiographers in the field from semiannual to quarterly intervals. Through a review of records and interviews with personnel, the inspector verified that AIX complied with the internal oversight requirements of the Order.

The Order (EA-08-196) also required increased external oversight by an independent contractor. Specifically, Condition 1 of the Order required, in part, that the contractor attempt to conduct the field audits in a manner and location where he was undetected by the AIX crew. The Order required the audits to be conducted at least twice a month during months when AIX was actively performing radiography. The Order required that half of the audits be conducted outside of normal business hours. During the period when field audits were being conducted, the results indicated that AIX was operating in compliance with NRC rules and regulations. No items of safety or security significance were identified during the field audits that required immediate or long-term corrective actions by AIX.

In a letter dated August 12, 2009, AIX requested discontinuation of the internal and external oversight required by the Order, as outlined above. The NRC scheduled an inspection for September 2009 to assess compliance with the Order and to gather information to assist in the decision whether to relax or rescind all or parts of the Order.

Before arriving on site in Alaska, the inspector reviewed docketed correspondence received from AIX and the independent consultant. The consultant submitted monthly summaries of his field audits to the NRC through August 2008. The inspector determined that the NRC had not received any records of independent audits performed from August 2008 through September 2009, except for a report involving a temporarily misplaced personal dosimeter in April 2009.

During the onsite inspection in Anchorage, Alaska, on September 22, 2009, the inspector reviewed training records for all employees. The extra training mandated by the Order included a review of: (1) radiation mishaps involving radiography devices, (2) potential actions that NRC may take against an individual, (3) NRC requirements and AIX license conditions, and (4) Operating and Emergency Procedures. Through record reviews and discussions with AIX management, the inspector verified that the AIX president performed quarterly audits of radiographers in the field. Dates on selected AIX utilization logs matched the weekly work notices that AIX had been submitting to the NRC via facsimile. These findings verified that AIX complied with the internal oversight requirements of the Order.

During the onsite inspection, AIX was not able to locate any correspondence from the consultant indicating that field audits had been performed or reports had been produced from August 2008 through September 2009, except for the report in April 2009. In

addition, the AIX staff indicated that they could not recall his presence since July 2008, except on the one occasion when he was notified of the temporarily misplaced personal dosimeter in April 2009.

When interviewed, the independent consultant stated that he performed a few field audits from August 2008 through June 2009. This audit frequency did not meet the requirement of at least twice per month. The consultant also stated that he did not perform any field audits after June 2009. In addition, even though a few audits were performed, no monthly reports were produced or sent to AIX or to the NRC by the consultant starting in August 2008. As a result, the inspector determined that these aspects of Condition 1 of the Order had not been met. As discussed in Section 3 below, the licensee contracted with a second consultant who started performing the field audits and submitting audit reports to AIX and NRC in April 2010. Therefore, the licensee appeared to have not met the requirements of Condition 1 of the Order from August 2008 through March 2010.

Condition 3 of the Order required an independent consultant to evaluate the effectiveness of AIX's radiation safety and compliance programs. The evaluation was to commence within 30 days of NRC's approval of the consultant, which was concurrent with the issuance of the Order on August 20, 2008. The evaluation was to include: (1) assessment of AIX's training program, (2) recommendation to AIX management for radiation safety program improvement, (3) review of AIX's Operating and Emergency Procedures, and (4) determinations of the effectiveness and ability of the AIX RSO to oversee the program. The consultant was to submit the results of his evaluation to AIX and to NRC within 30 days following completion of the review. And, within 30 days of receiving the consultant's report, AIX was required to provide the NRC its position on how it planned to address the consultant's findings. As discussed in Section 3 below, this was all completed by October 2010. Therefore, the licensee appeared to have not met the requirements of Condition 3 of the Order from September 2008 until October 2010.

2.3 Conclusions

The inspector identified that two conditions of the Order appeared to have not been met: (1) from August 2008 through March 2010, AIX may have failed to have an independent consultant or contractor perform field audits and to submit the reports of the audits to the licensee and the NRC as required by Condition 1; and (2) from September 2008 through October 2010, AIX may have failed to have an independent consultant or contractor evaluate the effectiveness of the AIX radiation safety program, as required by Condition 3. These two examples were identified as one apparent violation of the requirements of the ORDER MODIFYING LICENSE EA-08-196 issued to AIX on August 20, 2008. (030-10346/2009-001-01)

3 Corrective Actions (87121)

3.1 Inspection Scope

The NRC reviewed the immediate and long-term corrective actions associated with the apparent violation. The inspector reviewed documents submitted to support progress made towards compliance with the Order.

3.2 Observations and Findings

By January 2010, the NRC determined that field audits had stopped in June 2009. On January 4, 2010, NRC conducted a conference call with AIX management to discuss the status of compliance with Condition 1 of the Order (EA-08-196). By letter dated January 7, 2010 (ML100130241), AIX submitted the names and credentials of two proposed independent auditors. The NRC evaluated the qualifications of each individual and approved one of them by letter dated March 1, 2010 (ML100601030). The approved auditor began performing field audits of AIX crews in April 2010. The auditor submitted monthly reports of the results of the field audits to the NRC beginning in April 2010, as required.

In order to comply with Condition 3 of the Order, the same independent auditor began an evaluation of the effectiveness of the AIX safety program and reviewed the licensee's radiation safety manual on June 3-7, 2010. The consultant submitted the results of his assessment to the NRC on June 11, 2011 (ML101620560), as required by Condition 3 of the Order. The auditor continued performing his assessment of the AIX radiation safety program through October 2010 and submitted the results to the NRC and to the licensee by e-mail dated October 15, 2010 (ML102930053). Areas covered in the evaluations included a NUREG 1556 audit, assessment of the RSO's capabilities, training for the staff, and a review of Operating and Emergency Procedures. These areas met the requirements of Condition 3 of the Order. AIX responded to the consultant's comments and findings as required by Condition 3 of the Order on October 25, 2010 (ML103060317). Overall, the auditor concluded that the licensee's radiation safety officer was performing well in that the radiation safety officer thoroughly evaluated the job performance of two radiographers and maintained required records. The auditor did not identify any safety significant problems with the radiation safety program or the manual, and he stated that he did not find problems with the program.

In August 2010, two NRC inspectors returned to the AIX facility to follow-up on commitments made by the licensee and to perform a thorough inspection of AIX radiographic activities. The inspectors verified by audits of radiographers in the field that required refresher training was conducted for all employees. The inspectors reviewed dosimetry and daily utilization records. Doses were commensurate with the scope of operations, and utilization records included all required information.

In addition, an inspector reviewed operations at a temporary job site at Ted Stevens Anchorage International Airport. The radiographer and assistant followed all AIX safety procedures and had all required safety equipment. No safety significant violations were identified as a result of the NRC's thorough inspections. In fact, NRC inspection results were consistent with the auditor's assessment of the licensee's performance.

4 Exit Meeting Summary

A preliminary exit briefing was conducted at the conclusion of the onsite inspection with Mr. Don Millar. A final telephonic exit briefing was conducted with Mr. Don Millar and Mr. Pete Millar of AIX on February 3, 2011, to review the inspection findings as presented in this report. Mr. Don Millar acknowledged the inspector's findings. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

Don Millar, Radiation Safety Officer
Pete Millar, President
Patrick Kelly, Radiographer
Joe Krivenko, Assistant Radiographer

INSPECTION PROCEDURES USED

87121 Industrial Radiography Programs

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

030-10346/2009-001-01 AV An apparent violation involving a failure to follow Conditions 1 and 3 of the ORDER MODIFYING LICENSE EA-08-196.

Closed

None

Discussed

None

LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
ADR	Alternative Dispute Resolution
AIX	Alaska Industrial X-Ray, Inc.
AV	apparent violation
EA	enforcement action
ICR	Institute on Conflict Resolution
ML	[ADAMS] Main Library Number
NRC	Nuclear Regulatory Commission
OI	Office of Investigations
Order	ORDER MODIFYING LICENSE EA-08-196
PEC	predecisional enforcement conference
RSO	Radiation Safety Officer

Factual Summary
Office of Investigations Report OI-4-2010-023

On January 29, 2010, the Nuclear Regulatory Commission's (NRC), Office of Investigations (OI), Field Office Region IV initiated an investigation to determine if Alaska Industrial X-Ray, Inc. (AIX) employees willfully failed to comply with portions of NRC Confirmatory Order EA-08-196.

Confirmatory Order EA-08-196 required that an independent auditor be obtained by AIX to perform field audits of their radiographic operations. The field audits were to be unannounced and were to be conducted at least twice monthly as long as work was being performed. An inspection conducted in September 2009 had discovered that AIX was not in compliance with the Order beginning in August 2008 for failure to maintain audit reports and beginning in July 2009 for failure to maintain an independent auditor to conduct field reviews and program assessments.

The independent auditor was required to conduct unannounced surveillance visits twice weekly to worksite locations provided by AIX and the results of the visits were to be forwarded to AIX and the NRC as part of the relaxation of Order EA-07-261, which became effective October 19, 2007. Order EA-08-196, which became effective in August 2008, changed the frequency of the unannounced surveillance visits to occur twice monthly. Auditor 1 subsequently provided the following dated letters of the site visits that documented the audits that had been performed: November 30, 2007 (7 audits), January 4, 2008 (4 audits), February 4, 2008 (6 audits), April 6, 2008 (2 audits), May 4, 2008 (5 audits), June 6, 2008 (6 audits), July 14, 2008 (8 audits), August 15, 2008 (6 audits), April 2009 (1 audit).

When interviewed by an OI Special Agent, Auditor 1 claimed that he had been informed by the NRC inspector that he should conduct two announced audits at least twice a month when work is being performed by AIX. Auditor 1 confirmed that, once he had been approved as the independent auditor, both he and AIX were responsible for compliance with the requirements of the NRC Order. Auditor 1 admitted that he had been noncompliant with the requirements with Section 3 of the NRC Order. Further, he stated that he remembered discussing the requirements with the AIX President and, after a period of time had gone by, nothing was said. The requirement, "…kind of fell off the back burner for me, because I am very busy with my job and life in general."

Auditor 1 admitted that he failed to perform the minimum requirement of two audits per month between January 1, 2009, to December 2009 and that no audits had been performed after June 2009. Auditor 1 confirmed that he continued to receive e-mails identifying the AIX worksites and received compensation from November 2007 to August 2009, even when he was not performing audits. He also advised that AIX had not been informed when he was going out of the country because he did not want AIX to know his schedule and he wanted AIX to assume that he was still working.

When interviewed by an OI Special Agent, Auditor 2 admitted that he had participated on a phone call with the NRC regarding the requirements for conducting the audits of AIX. Auditor 2 stated that he was doing the best he could to keep AIX in compliance with the audit oversight program, but said it was his understanding that another party would be conducting the assessments of the AIX radiation safety program. Further, Auditor 2 also stated that AIX had

been timely about sending him e-mails announcing the work locations, but that the AIX work opportunities had diminished and he didn't think he would be doing much additional work with AIX.

When interviewed by an OI Special Agent, the AIX Radiation Safety Officer (RSO) stated that over the past 3 years he had notified Auditor 1 through e-mails and the NRC using a facsimile of the location of AIX worksites. The AIX RSO also stated that Auditor 1 had begun providing third-party oversight of AIX radiographic operations during the November 2007 time frame until approximately November 2009. Based on the September 2009 observations of the NRC inspector, the AIX RSO decided to replace Auditor 1 with Auditor 2 on January 4, 2010. The AIX RSO confirmed that he was knowledgeable of the requirements for independent oversight of the AIX operations that were contained in NRC Order EA-08-196, Section IV(1)(a) through (d).

When asked by the OI Special Agent whether AIX was in compliance with the requirements of the NRC Order, the AIX RSO stated, "To a degree, yes, we were." When asked whether he was checking to ensure that the requirements of the NRC Order were being fulfilled by Auditor 1, the AIX RSO stated, "No, I did not." However, the AIX RSO stated that he and the AIX President were providing information to Auditor 1 through e-mail from November 7, 2007, through July 2009, explaining where they would be working so that the independent audits could occur. The e-mails were halted in July 2009, when AIX lost work with two companies.

The AIX RSO acknowledged that both he and the AIX President were responsible for ensuring that the requirements of the NRC Order were adhered to by AIX and Auditor 1 and that the failure to conduct the audits placed AIX into a noncompliant status.

The AIX RSO confirmed that he was knowledgeable of the requirements for independent consultant to evaluate the effectiveness of the radiation safety and compliance programs that were contained in NRC Order EA-08-196, Section IV(3)(a) through (e). The AIX RSO stated that AIX had tried as best as they could to get Auditor 1 to comply with this portion of the Order, but admitted that there was noncompliance to this portion of the Order when using Auditor 1.

When interviewed by an OI Special Agent, the AIX President was questioned about the 5-month gap in audit reports from July 28, 2008, to December 31, 2008, and a year-long gap beginning in January 2009. The AIX President admitted that he had no contact with Auditor 1 during that time period and later learned that Auditor 1 had been out of the country. When questioned whether AIX was in compliance with the NRC Order, regarding audits being conducted twice a month, the AIX President responded, "Well, a lot of it had to do with our workload. It dropped off drastically. There wasn't that much work going on … So I guess that had quite a bit to do with it … I don't think he could have monitored twice a month the workload that was taken place … We lost a contract with two companies, and that was probably 80 percent of workload." The AIX President provided a financial report showing evidence of 18 payments that had been made to Auditor 1 from November 19, 2007, through August 3, 2009. The report also provided evidence of one payment to Auditor 2 on June 16, 2010.

Based on the evidence gathered during the OI Investigation, it was concluded that AIX willfully failed to comply with portions of NRC Confirmatory Order EA-08-196.

PREDECISIONAL ENFORCEMENT CONFERENCE AGENDA

ALASKA INDUSTRIAL X-RAY, INC.
DATE, TIME, AND LOCATION TO BE DETERMINED

1. INTRODUCTIONS/OPENING REMARKS --
ROY CANIANO, DIRECTOR, DIVISION OF NUCLEAR MATERIALS SAFETY

2. ENFORCEMENT PROCESS --
RAY KELLAR, SENIOR ENFORCEMENT SPECIALIST

3. APPARENT VIOLATIONS & REGULATORY CONCERNS --
VIVIAN CAMPBELL, CHIEF, NUCLEAR MATERIALS SAFETY BRANCH A

4. LICENSEE PRESENTATION --
ALASKA INDUSTRIAL X-RAY, INC.

5. BREAK - 10 MINUTES

6. RESUMPTION OF CONFERENCE

7. CLOSING REMARKS --
ALASKA INDUSTRIAL X-RAY, INC.

8. CLOSING REMARKS --
ROY CANIANO, DIRECTOR, DIVISION OF NUCLEAR MATERIALS SAFETY