REPORT OF INTERVIEW
WITH
(b)(7)(C)

On May 4, 1999, (b)(7)(C) Eaton Metal Products (EATON), Pocatello, Idaho, was interviewed by Special Agent (b)(7)(C) Nuclear Regulatory Commission, Office of Investigations, Region IV (RIV). This report relates, in substance, the information (b)(7)(C) provided regarding the alleged overexposure of EATON employees during radiography operations.

As background information, (b)(7)(C) advised that Professional Service Industries, Inc. (PSI), Lombard, Illinois, an NRC licensee, operating out of Salt Lake City, Utah, had been contracted, by EATON, to perform radiography on a 2 ½ inch thick metal vessel and were scheduled to perform the work during the (b)(7)(C) on September 14, 1998.

On the morning of September 15, 1998, he (b)(7)(C) was informed by (b)(7)(C) EATON, of a potential radiation overexposure which occurred when (b)(7)(C) and two other EATON employees (b)(7)(C) and (b)(7)(C) (b)(7)(C) crossed the rope boundary of the radiation operating area believing that PSI had finished their radiography. According to (b)(7)(C) the EATON employees had been working in an adjacent part of the facility and upon finishing their shift, were preparing to exit the building which required transiting the barricaded area. As related by (b)(7)(C) the EATON employees did not observe any PSI employees at the barricade, as they had earlier in the evening, and claimed to have observed one of the PSI employees [NFI] sleeping in the cab of the PSI truck. Believing the radiography was completed, the EATON employees proceeded to cross the boundary at which time the other PSI employee [NFI] exited the truck and shouted at them to leave the boundary area. According to (b)(7)(C) the same PSI employee conducted a radiation survey of the individuals and informed them the exposure readings were normal. (b)(7)(C) recalled being informed by (b)(7)(C) of his (b)(7)(C) illness but did not know if (b)(7)(C) went to a physician for an examination. (b)(7)(C) a (b)(7)(C) opined that he did not believe that (b)(7)(C) illness was a direct result of the potential exposure. On September 15, 1998, following his receipt of the information from (b)(7)(C) he (b)(7)(C) contacted (b)(7)(C) (b)(7)(C) PSI, and informed him of the incident. Several days later [exact date unrecalled] he (b)(7)(C) received a copy of a letter (Exhibit) from (b)(7)(C) to Chris

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SMITH, Corporate RSO, PSI, delineating PSI's evaluation of the incident.

On January 11, 1999, EATON conducted a safety meeting and provided guidance (Exhibit) to all employees regarding the prohibition of crossing visible boundaries indicating the conduct of radiography operations.

In conclusion, (b)(7)(C) stated EATON had not experienced any problems with PSI prior or subsequent to the September 15, 1998, incident.

This report was prepared on May 25, 1999, from Agent's notes.

(b)(7)(C)

(b)(7)(C) Special Agent
Office of Investigations Field Office, RIV