UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

OFFICE OF THE
GENERAL COUNSEL

January 15, 1998

Charles Bechhoefer, Chairman
Administrative Judge
Atomic Safety and Licensing Board
Mail Stop T-3 F23
U.S. Nuclear Regulatory Commission
Washington, D. C. 20555

Dr. Charles N. Kelber
Administrative Judge
Atomic Safety and Licensing Board
Mail Stop T-3 F23
U.S. Nuclear Regulatory Commission
Washington, D. C. 20555

Dr. Richard F. Cole
Administrative Judge
Atomic Safety and Licensing Board
Mail Stop T-3 F23
U.S. Nuclear Regulatory Commission
Washington, D. C. 20555

In the Matter of
Conam Inspection, Inc
Itasca, Illinois (License No. 12-16559-01)
(Order Imposing Civil Monetary Penalty)
Docket No. 30-31373-CivP

Dear Administrative Judges:

In a telephone conference held yesterday among the members of the Board and parties, the Staff agreed to provide a redacted version of the Office of Investigation Report 3-96-014. That report is titled "Conam Inspection, Inc. Alleged False Information to NRC" and is enclosed herewith.

Sincerely,

Charles A. Barth
Counsel for NRC Staff

Enclosure:: As Stated

cc w/Enclosure: Service List

DS03

SECY-EHD-001

18740

CASE No. 3-96-014

United States
Nuclear Regulatory Commission

Report of Investigation

CONAM INSPECTION, INC.

Alleged False Information to NRC

Office of Investigations

Reported by OI: RIII

Title: CONAM INSPECTION, INC.

ALLEGED FALSE INFORMATION TO NRC

Licensee:

Conam Inspection, Inc.
1245 Norwood Avenue
Itasca, Illinois 60143-1186

Docket No.: 030/31373/12-16559-01

Case No.: 3-96-014

Report Date: October 16, 1996

Control Office: OI:RIII

Status: CLOSED

Reported by:

Richard T. Anderson, Special Agent
Office of Investigations
Field Office, Region III

Reviewed and Approved by:

Richard C. Paul, Director
Office of Investigations
Field Office, Region III

SYNOPSIS

On April 8, 1996, an investigation was initiated by the U.S. Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region III (RIII), to determine if an untrained, Conam Inspection, Inc. (Conam), employee at the Gary, Indiana, office, deliberately calibrated a survey meter; to determine if a Conam employee deliberately failed to wear a film badge while calibrating survey instruments with a radiation source; to determine if Conam management deliberately failed to take appropriate action when a safety concern was brought to their attention; to determine if a Conam radiographer deliberately failed to follow the licensee's procedure in the operation of an exposure device, which resulted in an overexposure to himself; to determine if Conam radiographers deliberately failed to follow the licensee's procedure in the operation of exposure devices; and to determine if a Conam supervisor deliberately falsified a 90-day inspection report regarding an exposure device.

Based upon the evidence developed during the OI investigation, it is concluded that there was no substantiation to the allegation that an untrained Conam employee deliberately calibrated survey instruments; that there was no substantiation to the allegation that a Conam employee deliberately failed to wear a film badge while calibrating a survey meter with a radiation source; that there was no substantiation to the allegation that Conam management deliberately failed to take appropriate action when a safety concern was brought to their attention; that there was substantiation to the allegation that a Conam radiographer wilfully failed to follow the licensee's procedure in the operation of an exposure device, which resulted in an overexposure to himself; that there was substantiation to the allegation that Conam radiographers wilfully failed to follow the licensee's procedure in the operation of exposure devices; and it was not substantiated that a Conam supervisor deliberately falsified a 90-day inspection report regarding an exposure device.

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LIST OF INTERVIEWEES

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[redacted]	Conam Inspection, Inc. (Conam), Inspector	20
[redacted]	Conam Radiographer	24
FAY, Stephen L.,	Conam Laboratory Manager	17
[redacted]	Conam Radiographer Assistant	7
HASTING, Larry,	Conam Assistant Laboratory Manager	12
[redacted]	Conam Radiographer Assistant	15
SLACK, Robert J.,	Conam Radiation Safety Office	22
[redacted]	Conam Radiographer	29
SWEET, Randy,	Conam General Manager	21

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DETAILS OF INVESTIGATION

Applicable Regulations

10 CFR 30.9: Completeness and accuracy of information (1996 Edition) (Allegation 1 & 6)

10 CFR 30.10: Deliberate misconduct (1996 Edition) (Allegations 1 through 6)

10 CFR 30.34: Terms and conditions of licenses (1996 Edition) (Allegations 1 through 6)

10 CFR 34.28(b): Inspection and maintenance of radiographic exposure devices, storage containers, and source changes (1996 Edition) (Allegation 6)

Purpose of Investigation

On April 8, 1996, an investigation was initiated by the U.S. Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region III (RIII), to determine if [redacted] an untrained employee at Conam Inspection, Inc. (Conam), Gary, Indiana, deliberately calibrated survey instruments; to determine if [redacted] deliberately failed to wear a film badge while calibrating survey instruments with a radiation source; to determine if Stephen FAY, Conam Laboratory Manager, and Robert SLACK, Conam General Manager, deliberately failed to take appropriate action when a safety concern was brought to their attention; to determine if [redacted] a Conam radiographer, deliberately failed to follow the licensee's procedure in the operation of an exposure device, which resulted in an over exposure to himself; to determine if Conam radiographers deliberately failed to follow the licensee's procedure in the operation of exposure devices; and to determine if FAY deliberately falsified a 90-day inspection report regarding an exposure device.

Background

On March 26, 1996, [redacted] Conam Radiographer's Assistant reported to the NRC that [redacted] calibrated survey instruments while not wearing a dosimetry (Exhibit 1). [redacted] also stated that [redacted] had not been trained in calibration procedures. The alleger stated that this safety concern was brought to the attention of FAY, Conam's Manager. [redacted] reported, however, that FAY's reply was "not to worry about it" (Exhibit 1-2). A subsequent NRC unannounced safety inspection determined that [redacted] was not qualified to calibrate survey meters and was not wearing a dosimetry, a violation of the conditions of Conam's NRC Materials License (Exhibit 3; Exhibit 4). During the inspection, FAY claimed [redacted] was under his direct supervision and merely acted as a scribe. However, an interview with Larry HASTING indicated that FAY only spent several minutes in the storage area with [redacted] and then returned to the office. [redacted] allegedly returned to the office an hour later. Also during the inspection, it was determined that an overexposure of [redacted] a Conam radiographer, occurred on February 27, 1996. The cause of

the over exposure was due to [redacted] not following procedures requiring the source to be retracted and locked after each exposure. [redacted] told the NRC that none of the other Conam radiographers secured their cameras after each exposure as required by the procedure (Exhibit 1).

On April 16, 1996, the NRC received further information from [redacted] a Conam radiographer assistant, who stated that FAY directed [redacted] a Conam radiographer, working at an Illinois refinery, to conduct a 90-day safety and maintenance check on an exposure device. Allegedly, this conversation took place on March 18, 1996. However, when [redacted] returned to the Gary office sometime later, he observed the paper work for the completion of the safety and maintenance check for that exposure device dated March 12, 1996 (Exhibit 5).

Interview with Allegers

Interview with [redacted] (Exhibit 7)

On May 22, 1996, [redacted] was interviewed by OI:RIII at Portage, Indiana, and stated substantially as follows:

[redacted] stated that it was FAY and [redacted] a Conam radiographer, who conducted the calibration of the survey instruments. He said that [redacted] was neither trained to use radiographic exposure devices nor had he been issued to him a dosimetry. [redacted] stated that he noticed that on four separate survey meters (Exhibits 8-11), the calibration paperwork was signed by [redacted] on March 22, 1996. [redacted] stated that he and [redacted] a Conam radiographer, talked to FAY about the calibrations, but FAY allegedly said that he calibrated the meters. FAY reportedly told them that [redacted] merely signed the calibration forms under his (FAY) supervision. [redacted] said that he and the other Gary office radiographers discontinued using those survey meters.

Interview with HASTING (Exhibit 12)

On June 5, 1996, HASTING was interviewed by OI:RIII at Portage, Indiana, and stated substantially as follows:

HASTING stated that he was present on March 14, 1996, when FAY took [redacted] into the back room of Conam's Gary office to calibrate the survey meters. HASTING said that FAY was only gone 15 minutes and then returned to where HASTING was working. HASTING said that [redacted] did not return for approximately one hour and 15 minutes. HASTING said that he, personally, didn't talk to FAY about the calibration, but he overheard FAY tell [redacted] and [redacted] that [redacted] did the calibration under his (FAY) supervision. FAY reportedly asked [redacted] and [redacted] if they had a problem with [redacted] assisting FAY. HASTING said that he thought Randy SWEET, manager of the Gary, Indiana office but commuting from the Itasca, Illinois office, was aware of the calibration problem but just did not care. HASTING stated that on April 12, 1996, after the NRC conducted a safety inspection at Conam, FAY completed another 90-day calibration on two of the questionable survey meters (Exhibits 13-14).

Interview with [redacted] (Exhibit 15)

On May 22, 1996, [redacted] was interviewed by OI:RIII at Crown Point, Indiana, and stated substantially as follows:

[redacted] stated that on March 18, 1996, he was with [redacted], a Conam radiographer, at the Uno-ven work site in Illinois, when [redacted] apparently received a phone call from FAY. FAY allegedly directed [redacted] to perform a 90-day safety and maintenance inspection on the Amersham Model 660 B radiographic camera that they had at the site. [redacted] said that [redacted] did the inspection. [redacted] said that on March 23, 1996, he was in the Gary office when he saw the 90-day inspection paper work for the camera they had in Illinois (Exhibit 16). [redacted] said that he saw the inspection report, which was dated March 12, 1996, and allegedly signed "Done By [redacted] [sic]."

> Agent's Note: In Exhibits 2 and 3, the following individuals were identified: the concerned individual was identified as [redacted] Individual A was identified as HASTING; Individual B was identified as FAY; and the RSO was identified as Robert SLACK.

Coordination with the NRC Staff

On April 4, 1996, an NRC:RIII Allegation Review Board (ARB) met and requested that OI pursue these matters. The ARB set a high priority for the investigation based upon the level of management involved (Exhibit 6).

Coordination with the Regional Counsel

This investigation was initiated with the concurrence of the NRC:RIII Counsel, Bruce A. BERSON, that if substantiated, the allegation would involve violations of NRC rules and regulations.

Allegation No. 1: Alleged Untrained Employee Deliberately Calibrated Survey Meters

Evidence

Interview with FAY (Exhibit 17)

On September 5, 1996, FAY was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

FAY stated that he had recently been transferred from the Itasca, Illinois to the Gary, Indiana office due to management personnel changes in the Gary office. FAY stated that there was some animosity against him and [redacted] who was also directed to report to Gary from Itasca, by the Gary personnel since many of the Gary personnel had either been relatives or close friends of the previous management. Partly because of this animosity, FAY said that he chose [redacted] to assist him with the calibration of the survey meters. FAY said that the calibration of survey meters was not that difficult to learn, and he knew that [redacted] was a bright employee who learned fast. FAY said that no other radiographers were around when they started the calibration training.

FAY said that he set up the ionized source then calibrated the first survey meter while explaining everything to [redacted]. He said that the first meter took about one hour to calibrate. FAY said that he actually calibrated the second meter while [redacted] assisted. FAY said that the third meter was done by [redacted] while he (FAY) stood by assisting when and where needed. FAY said that the last two meters were calibrated by [redacted] however, he said that he was close by [redacted]. FAY said that on a couple of occasions he left the room to answer a phone in another part of the building, but mainly was in the general area with [redacted].

FAY said that after [redacted] finished each meter, he (FAY) reviewed [redacted] work. He said that he had [redacted] do the paper work so that [redacted] knew exactly where each copy went (Exhibits 8-11). FAY stated that he knew that each meter was properly calibrated because he, personally, recalibrated each meter himself. FAY stated that later that same day, [redacted], a radiographer, approached him and asked why [redacted] had signed the calibration sheets for the meters. FAY said that he explained to [redacted] that he (FAY) trained [redacted] in the proper procedure for calibrating survey meters. He said that he asked [redacted] if he [redacted] had a problem with that, and [redacted] reportedly said that he did not.

FAY stated that a number of days later, Randy SWEET, the Itasca General Manager, contacted him and said that some of radiographers in the Gary office were complaining about [redacted] signature on the calibration sheets for the meters. FAY said that he explained to SWEET exactly what he did, but SWEET directed him to recalibrate each meter and sign a new calibration sheet. FAY said that he did this on April 12, 1996 (Exhibit 13-14; 18-19).

Interview with [redacted] (Exhibit 20)

On September 5, 1996, [redacted] was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

[redacted] stated that on Thursday, March 14, 1996, he was in the Gary office when Stephen FAY, Laboratory Manager, directed him to assist FAY in the calibration of a number of survey meters. [redacted] stated that he inquired of FAY why FAY wanted him to assist and was told by FAY that this would be a training session. [redacted] stated that he did not read a procedural manual or any other training document regarding calibration of survey meters prior to assisting FAY. He said that the training was basically on-the-job training. [redacted] stated that FAY showed him how to remove the meter casing and adjust the calibration screws. FAY also showed him how to use the gradient markings (located on the floor) from the ionized source to assist with the calibration. [redacted] stated that at no time did he handle the ionized source. [redacted] stated that the calibration of each survey meter took approximately 20 to 30 minutes. He said that FAY actually calibrated the first meter while explaining the procedure to him. He said that with the second meter, he and FAY did the calibration together. [redacted] said that with the remaining two or three meters, he did the calibration himself; however, he said that FAY was in the same room with him at all times.

[redacted] acknowledged that the signature on the calibration sheets (Exhibits 8-11) was his signature. He said that he felt that signing the certificate of

calibration for each of the meters was part of the job training. [redacted] stated that there was no one else around when he was being trained by FAY.

Interview with SWEET (Exhibit 21)

On September 5, 1996, SWEET was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

SWEET stated that he was contacted by a couple of radiographers from the Gary office who stated that they would not use some survey meters, because [redacted] an untrained employee, had signed the calibration forms as having calibrated the meters. SWEET stated that he talked to both FAY and [redacted] regarding the calibration. He said that after hearing FAY's and [redacted] explanation regarding the training of [redacted] to calibrate the meters, he (SWEET) did not feel that any policy had been violated. However, since the radiographers reportedly said that they would not use the meters, SWEET directed FAY to recalibrate all the meters in question and fill out new calibration sheets. He said that FAY did this on April 12, 1996 (Exhibits 13-14; 18-19). SWEET said that he did not feel, after investigating the facts, that the calibration issue was a safety issue. He said that he felt that the problem identified by the Gary radiographers was really the result of personality clashes. SWEET said that the radiographers in Gary were not happy with the dismissal of the previous manager; that they were not happy with the discipline of two Gary employees; and that they did not want personnel coming from Itasca to run their operation.

Conclusion

Based upon the evidence developed during this investigation, it is concluded that there was no substantiation to the allegation that [redacted] was an untrained employee who deliberately calibrated survey meters.

Allegation No. 2: Alleged Deliberate Failure to Wear a Dosimetry

Evidence

Interview with [redacted] (Exhibit 20)

On September 5, 1996, [redacted] was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

[redacted] said that on March 14, 1996, he was directed by FAY to assist in the calibration of survey meters. [redacted] said that he had never calibrated meters before, but [redacted] told him that this would be a training session. [redacted] said that he remembered asking FAY if he [redacted] needed a film badge. He said that FAY never acknowledged the need for one. [redacted] said that he was not given a film badge. [redacted] said that FAY trained him to calibrate a number of meters. [redacted] stated that at no time did he ever handle the ionized source.

Interview with FAY (Exhibit 17)

On September 5, 1996, FAY was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

FAY stated that he directed [redacted] to assist him in calibrating a number of survey meters at the Gary, Indiana office. He said that he trained [redacted] during this time in the proper procedure for calibrating the meters. FAY said that he did not issue [redacted] a film badge. He also said that he did not remember [redacted] asking if he [redacted] should have a film badge. FAY said that it was an oversight on his part that he did not obtain a film badge for [redacted]

Interview with SLACK (Exhibit 22)

On September 5, 1996, SLACK was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

SLACK stated that all radiographers and assistant radiographers were issued dosimetry film badges, but he did not consider a survey meter calibration source as a radiographic device. SLACK stated that he was aware that [redacted] trained FAY in survey meter calibrations. He said that had [redacted] continued to perform meter calibrations on his own, then he would have expected FAY to issue [redacted] his own dosimetry. He said that [redacted] not having a dosimetry during a training session was a gray area. SLACK said that section 5.1.1 of Conam's procedures "Personnel Monitoring Requirements" (Exhibit 23) applied to radiographic equipment. SLACK pointed out that the manufacturer's calibration manual for the IC-51 survey meter calibration source did not even address the dosimetry issue.

Conclusion

Based upon the evidence developed during this investigation, it is concluded that there was no substantiation to the allegation that [redacted] deliberately failed to wear a dosimetry.

Allegation No. 3: Alleged Deliberate Failure by Management to Take Appropriate Action When Notified of a Safety Concern

Evidence

Interview with FAY (Exhibit 17)

On September 5, 1996, FAY was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

FAY said that he trained [redacted] in the proper calibration of survey meters. He said that he calibrated the first meter while explaining everything to [redacted] He said that he calibrated the second meter with [redacted] assisting. He said that the next couple of meters [redacted] calibrated, but he (FAY) was right in the immediate area to assist. After [redacted] was finished, FAY said that he, personally, recalibrated each meter to assure that [redacted] was accurate. FAY said that he then directed [redacted] to fill out the paper work regarding the calibrations. FAY said that later that same day [redacted] a radiographer, asked him why [redacted] signed the calibration sheets for the meters. FAY said

that he explained to [redacted] that he (FAY) trained [redacted] in the proper procedure for calibrating survey meters. He said that he asked [redacted] if he [redacted] had a problem with that, and [redacted] reportedly said that he did not.

Interview with SWEET (Exhibit 21)

On September 5, 1996, SWEET was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

SWEET stated that he was contacted by a couple of radiographers from the Gary office who stated that they would not use some survey meters, because [redacted] an untrained employee, had signed the calibration forms as having calibrated the meters. SWEET stated that he talked to both FAY and [redacted] regarding the calibration. He said that after hearing FAY's and [redacted] explanation regarding the training of [redacted] to calibrate the meters, he (SWEET) did not feel that any policy had been violated. However, since the radiographers reportedly said that they would not use the meters, SWEET directed FAY to recalibrate all the meters in question and fill out new calibration sheets. He said that FAY did this on April 12, 1996 (Exhibits 13-14; 18-19). SWEET said that he did not feel, after investigating the facts, that the calibration issue was a safety issue. He said that he felt that the problem identified by the Gary radiographers was really the result of personality clashes. SWEET said that the radiographers in Gary were not happy with the dismissal of the previous management; that they were not happy with the discipline of two Gary employees; and that they did not want personnel coming from Itasca to run their operation.

Conclusion

Based upon the evidence developed during this investigation, it is concluded that there was no substantiation to the allegation that FAY or SLACK, Conam managers, deliberately failed to take appropriate action when a safety concern was brought to their attention.

Allegation No. 4: Alleged Deliberate Failure by a Radiographer to Follow Licensee's Procedures for Radiographic Equipment

Evidence

Interview with [redacted] (Exhibit 24)

On September 5, 1996, [redacted] was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

[redacted] stated that he was familiar with the operating and emergency procedures for the Amersham Model 660B exposure device since he had used the camera at both SGS Industrial Service and Conam (Exhibit 25). He said that he received training from Conam's management in the "Operating and Emergency Procedures Manual" for the various cameras used at Conam .

[redacted] said that on February 27, 1996, he was working for Conam at a site in Indianapolis, Indiana. He said he was working the night shift and was alone

shooting 2" butt welds with the Amersham camera. He said that he had already completed between 12 and 15 shots. He believed that he had followed all the procedures up to that time but admitted that he might have, on occasion, become lax in assuring that the ring selector was turned to the locked position and that the plunger was depressed. He said that the area he was shooting was very congested, with each shot taking approximately 10 minutes. [redacted] stated that at approximately 6:30 p.m., he performed a shot with the camera located at the top of a six foot ladder. He stated that his dosimetry was located in a fanny pack next to his stomach. He said that after he cranked the source back, he neglected to turn the selector ring and depress the plunger. He did state that he thought he heard the slide bar kick over but could have been mistaken since it was a high noise area. He said that he surveyed the camera, but only on the sides. He said because of the camera position, he did not survey the front part. He said that he stood on the ladder near the top rung, with his leg closest to the camera, and changed the film. He said that he then reached over to unlock the slide bar but realized that the slide bar was not totally engaged. [redacted] stated that he immediately moved the slide bar to the unlock position and then exited the area. He said that when he checked his dosimetry, it was off scale.

[redacted] said that he then fully retracted the source until he heard a click. He said he checked the alarming rate meter and it was okay. At this point, he surveyed the camera totally, pulled the key, and secured the camera. [redacted] stated that he then telephoned Keith TUCKER, the Conam Gary office Radiation Safety Supervisor, and was directed to return to the Gary office the next day.

[redacted] stated that on February 28, 1996, he met both TUCKER and SLACK at the Gary office. He gave SLACK his dosimetry and then explained to them what happened. [redacted] stated that he did not follow the procedures for the camera, but he did not do it deliberately. He said that he was under pressure to increase the number of shots, and that was the reason for his carelessness.

Interview with SLACK (Exhibit 22)

On September 5, 1996, SLACK was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

SLACK said that on February 27, 1996, TUCKER called him at the Itasca office regarding an overexposure incident involving [redacted] SLACK said that he advised TUCKER to remove [redacted] from the work site and arrange for his film badge to be processed immediately. SLACK said that on February 28, 1996, he met TUCKER and [redacted] at the Gary office. He said that they had [redacted] re-enact the entire incident for them, which he did without any props (camera or ladder). [redacted] statement was taken at that time and an incident report was made (Exhibit 26). SLACK said that [redacted] reported to them that he [redacted] had the dosimetry in a fanny pack next to his stomach. [redacted] also reported that he surveyed the camera using a 360° motion. SLACK stated that [redacted] was very emphatic that he did not climb very high on the ladder containing the camera, and that he was involved in very little twisting motion. Therefore, the impression that [redacted] left with SLACK was that the dosimetry was in direct line with the source, and that the dosimetry reading, which was 4.6 REM, would be nearly accurate. SLACK said that he did not

report the incident to the NRC because the reading was below 5 REM, the standard set for being reportable. SLACK said that he reviewed the incident with Randy SWEET, the newly appointed general manager, and they issued, on February 29, 1996, a memorandum (Exhibit 27) to all radiographers re-emphasizing the proper procedure when using exposure devices.

SLACK stated that on Thursday, April 11, 1996, they met with NRC:RIII technical personnel, and [redacted] re-enacted for all of them the incident using a ladder and a camera. SLACK said he was surprised when [redacted] reported that he climbed up to the next-to-the-top step of the ladder (the camera being on the top step of the ladder). SLACK also said that [redacted] indicated that the he turned away from the source (more than just twisting a little) for a period of time while he placed the film, thereby exposing his upper left leg directly to the camera. SLACK said that the new information presented by [redacted] to the NRC certainly changed the amount of whole body exposure he received to his legs. SLACK said that in defense of [redacted] he [redacted] was probably very nervous the first time he recreated the incident and wanted to minimize his carelessness. SLACK stated that after a complete review, [redacted] was removed from all radiographic activity until January 1, 1997; he received five days off without pay; he was to be retrained in radiation safety; and he was to present a lessons learned training session to the company.

Conclusion

Based upon the evidence developed during this investigation, it is concluded that [redacted] wilfully failed to follow the licensee's procedures for radiographic equipment.

Allegation No. 5: Alleged Deliberate Failure by Conam Radiographers to Follow the Licensee's Procedures for Radiographic Equipment

Evidence

Interview with [redacted] (Exhibit 7)

On May 22, 1996, [redacted] was interviewed by OI:RIII at Portage, Indiana and stated substantially as follows:

[redacted] stated that he was aware of some radiographers who did not always lock the radiographic gauge or depress the plunger after each shot (Exhibit 25). He said that after the [redacted] incident, everyone was made aware by management in a memorandum re-emphasizing the proper use of the gauge (Exhibit 27). [redacted] said that because of the [redacted] incident, everyone now follows the proper procedures regarding the gauges after each shot.

Interview with HASTING (Exhibit 12)

On June 5, 1996, HASTING was interviewed by OI:RIII and stated substantially as follows:

HASTING acknowledged that he was a radiographer at Conam (Exhibit 28). He admitted that he, along with most of the other radiographers at Conam, was lax when operating the Amersham Model 660B exposure device. He said that he and others didn't always assure that the automatic locking mechanism was engaged; that the selector mechanism was rotated to the locked position; and that the key lock plunger was depressed (Exhibit 25). HASTING admitted that the incident on February 27, 1996, involving [redacted] frightened the radiographers (Exhibit 27). He stated that since that incident, every radiographer he had worked with had operated that model gauge properly.

Interview with [redacted] (Exhibit 15)

On May 22, 1996, [redacted] was interviewed by OI:RIII and stated substantially as follows:

[redacted] acknowledged that he was aware of different radiographers who did not routinely lock the gauge after each shot (Exhibit 25). He stated that it was just carelessness on their part. He said that he was aware of the incident involving [redacted] but stated that the company put out a memorandum about the proper use of the locking system after [redacted] incident (Exhibit 27).

Interview with [redacted] (Exhibit 29)

On August 29, 1996, [redacted] was interviewed by OI:RIII at Lemont, Illinois and stated substantially as follows:

[redacted] stated that he started with Conam Inspection in May 1993. He said that he was already a trained radiographer in May 1993, but that Bill HIESTAND, the former Conam Gary Office Manager, trained him on Conam's policy manual (Exhibit 28). [redacted] said that he was aware of the [redacted] incident in February 1996, in which the radiographer failed to secure the plunger lock on the camera after a shot and had over exposed himself (Exhibit 25). [redacted] said that it was true that before the incident, he and others were lax in locking the plunger; however, after that incident, the company issued a directive ordering everyone to follow the written procedure (Exhibit 27). [redacted] said that since then he had been diligent in following all procedures of Conam Inspection.

Conclusion

Based upon the evidence developed during this investigation, it is concluded that HASTING and [redacted] as well as other radiographers, wilfully failed to follow the licensee's procedure regarding radiographic equipment.

Allegation No. 6: Alleged Deliberate Falsification of a 90-day Inspection Report

Evidence

Interview with [redacted] (Exhibit 29)

On August 29, 1996, [redacted] was interviewed by OI:RIII at Lemont, Illinois and stated substantially as follows:

[redacted] stated that in February 1995, he was assigned permanently to the Uno-Ven Refinery, Lemont, Illinois. He said that before he started there, Keith TUCKER, Conam Supervisor, instructed him on how to do a 90-day inspection on gauges. He said that there were two gauges assigned to the Lemont site. During 1995, he said that he did at least three 90-day inspections of the gauges, which included signing the paper work. However, he said that on some occasions, the gauges were returned to the Gary office, and new gauges were brought back to Lemont.

[redacted] said that around February 1996, there was a major turnover of management personnel at the Gary office. He said that Steve FAY, who had been working out of the Itasca, Illinois office, became the new manager. [redacted] said that he was aware that during this time period, there was some confusion because of the abrupt change in management personnel. [redacted] said that he remembered that on the March 18, 1996, FAY called him and said that the gauge that he [redacted] had was due for the 90-day inspection. [redacted] said that he was instructed to do the inspection immediately, and that FAY would handle the paper work back at the Gary office. [redacted] said that he did the full inspection of the gauge immediately. [redacted] stated that the next day, March 19, 1996, he was in the Gary office and looked at the paper work (Exhibit 16) for the gauge. He said that he observed that FAY had noted that he [redacted] had done the inspection (which he said was correct), but that the date on the 90-day inspection report was reported as being done on March 12, 1996. [redacted] said that he did not think anything of it, because he knew that FAY was trying to get all the paper work, which had been left in disarray by the previous management, in order.

[redacted] stated that he did not feel that FAY was trying to deceive the NRC; that FAY was doing his best to reorganize the office, and that particular 90-day inspection was just overlooked. [redacted] said that he was aware that since that time, all gauges were inspected on time.

Interview with FAY (Exhibit 17)

On September 5, 1996, FAY was interviewed by OI:RIII at Itasca, Illinois and stated substantially as follows:

FAY stated that he called [redacted] and directed him to do the 90-day calibration on the radiography camera located at the Uno-ven facility in Lemont, Illinois. FAY said that [redacted] called him and said that the camera was calibrated by him [redacted] on March 12, 1996. FAY said that with this information, he then filled out the form for the camera calibration (Exhibit 16) and signed "Performed by [redacted] [sic] @ Unoven [sic] Refinery" and put in for the date of inspection as "3-12-96." FAY said that he expected (SOMESON) to then fill out the paper work when he came into the Gary office and sign it. FAY said that he heard later that he (FAY) allegedly lied about the date; that he (FAY) had predated the form to March 12, 1996, when, in fact, it was

allegedly done a week later. FAY said that that information was totally false; that he (FAY) had absolutely no reason to falsify that document; and that he (FAY) signed the document as being performed by [redacted] knowing full well that [redacted] was to replace that document with one signed and dated by [redacted] FAY stated that he learned later that [redacted] reportedly never filled out a new form.

Conclusion

Based upon the evidence developed, the OI investigation did not substantiate the allegation that FAY deliberately falsified the 90-day inspection record.

SUPPLEMENTAL INFORMATION

On Friday, September 21, 1996, William SELLERS, Esq., Senior Legal Advisor for Regulatory Enforcement, General Litigation and Legal Advise Section, Criminal Division, U.S. Department of Justice (DOJ), Suite 200 West, 1001 G Street N.W., Washington, D.C., 20001, was apprised of the facts developed during this investigation. SELLERS indicated that based on the position that [redacted] was disciplined, and the other radiographers were properly notified of disciplinary action if disregard for procedures continued, he (SELLERS) did not feel that the case warranted prosecution.

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LIST OF EXHIBITS

Exhibit No.	Description
1	Investigative Status Record, 3-96-014, dated April 8, 1996.
2	Memorandum from B.J. Holt to Don Funk, dated March 27, 1996.
3	Memorandum from Thomas Young to File No. RIII-96-A-0046, dated April 4, 1996.
4	U.S. NRC Materials License No. 030-31373, dated February 2, 1995.
5	Memorandum from Young to Funk, dated April 16, 1996.
6	Allegation Action Plan, Allegation No. RIII-96-A-0046, dated April 4, 1996.
7	Interview Report with [redacted] dated May 23, 1996
8	Conam Certificate of Calibration, S/N 14252, dated March 14, 1996.
9	Conam Certificate of Calibration, S/N 13241, dated March 14, 1996.
10	Conam Certificate of Calibration, S/N 13631, dated March 14, 1996.
11	Conam Certificate of Calibration, S/N 15904, dated March 14, 1996.
12	Interview Report with HASTING, dated June 6, 1996.
13	Conam Certificate of Calibration, S/N 14252, dated April 12, 1996.
14	Conam Certificate of Calibration, S/N 13241, dated April 12, 1996.
15	Interview Report with [redacted] dated May 23, 1996.
16	Conam Periodic Inspection and Maintenance of Projector Type Exposure Device, S/N 2872, dated March 12, 1996.
17	Report of Interview with FAY, dated September 10, 1996.
18	Conam Certificate of Calibration, S/N 15904, dated April 12, 1996.

19 Conam Certificate of Calibration, S/N 1033, dated April 12, 1996.

20 Interview Report with [redacted], dated September 10, 1996

21 Interview Report with SWEET, dated September 11, 1996.

22 Interview Report with SLACK, dated September 12, 1996.

23 Conam Procedure, Personnel Monitoring Requirements, dated March 29, 1993.

24 Interview Report with [redacted] dated September 9, 1996.

25 Conam Procedure, Technical Operations Model 553, 660, Capacity 100 Curies, Iridium 192, dated March 29, 1993.

26 Checklist for Incident Report, dated February 28, 1996.

27 Memorandum from SLACK to Distribution, dated February 29, 1996.

28 Conam Procedure, Personnel Training and Qualification Requirements, dated March 26, 1993.

29 Interview Report with [redacted] dated August 30, 1996.