TEAM®

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February 6, 2019

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Subject: Response to an Apparent Violation
USNRC License No.: 42-32219-01
Docket No.: 030-35252
NRC Inspection Report 030-35252/2018-003; EA-18-124

Dear Sir or Madam:

Team Industrial Services, Inc.("TEAM"), provides the following written response to the Inspection Report and Investigation Report identifying an apparent violation issued as a result of the investigation conducted October 12, 2017 through August 27, 2018 concerning actions taken by TEAM radiographers at a temporary jobsite aboard the USS Harpers Ferry. The apparent violation, as described in the Notice, is summarized below for reference followed by our response.

"Contrary to Team Operating and Emergency Procedure 30.J.2, Revision 14, Section 14, Step 14.4.3.e.1, on August 29. 2017, the licensee moved a radiographic exposure device to another physical location and failed to ensure that the device was placed in the fully locked position. Specifically, the radiographers carried a radiographic exposure device from the location of their truck at the pier to on board the USS Harpers Ferry.

The licensee's failure to lock the exposure device prior to moving it to another physical location was identified as an apparent violation of License Condition 25 of NRC Materials License 42-32219-01."

Reason for the violation: Since the issuance of the Notice of Apparent Violation we have conducted a further investigation into the incident including additional interviews with the Facility Radiation Safety Officer for our Los Angeles operations. Our investigation of the apparent violation indicates the issue appears to be the result of a radiographer's failure to fully lock the exposure device following a pre-job inspection of the equipment. Radiographer "A" stated that following his inspection of the exposure device at the truck, prior to boarding the USS Harpers Ferry, which included required tolerance and operational checks of the equipment, he failed to fully engage the plunger lock on the device. The exposure device was then handed to Radiographer "B" who hand-carried the exposure device aboard the USS Harpers Ferry. Once aboard the ship where the radiographs were to take place, Radiographer "B" became aware of the unlocked situation and immediately locked the plunger until it was time to connect the equipment and conduct operations. Discussions with TEAM's Facility Radiation Safety Officer, who interviewed both individuals following the apparent violation, indicated

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Radiographer "A" performed the daily equipment inspection at the truck to save time once aboard the USS Harpers Ferry. There was no intent to leave the device in an unlocked state prior to boarding the USS Harpers Ferry.

Our investigation further indicated both Radiographers were trained on TEAM's Operating and Emergency Procedures and were knowledgeable in the requirements, including the requirement to fully lock the exposure device prior to relocating to another physical location.

Mitigating factors: Although the exposure device was in fact moved from the truck at the pier to aboard the USS Harpers Ferry in an unlocked condition, there was no willful intent to do so. Based on the Radiographers statements to their RSO, the daily equipment inspection was performed prior to boarding to save time once on board. As part of the inspection the plunger was unlocked to verify proper operation. Unfortunately, the Radiographer failed to relock the plunger prior to moving it from the truck.

Additionally, the exposure device being utilized was a QSA Global Model 880 Delta which by design incorporates three independent locking mechanisms to prevent accidental movement or exposure of the source. The lock incorporates a positive locking mechanism (slide bar) which secures the source assembly from movement, a selector dial which prevents movement of the positive locking mechanism, and a keyed plunger lock which prevents the dial from being rotated. With only the plunger lock engaged, the source assembly was still secured within the exposure device with limited risk of movement or exposure with the selector dial still set in the locked position.

Results of investigation: Based on the results of our investigation, we conclude a violation of Team's Operating and Emergency Procedure 30.J.2 did occur in that the exposure device was transported from the truck at the pier to aboard the USS Harpers Ferry without being in the fully locked condition. However we do not consider this to be a deliberate misconduct violation as there was no willful intent involved.

Corrected steps taken and results achieved: Once the exposure device was identified by Radiographer "B" to be in an unlocked condition, it was immediately locked correcting the noncompliance. Discussions were held with the Facility RSO following the incident and additional actions were/will be taken as follows:

1) Immediately upon notification of the incident, both radiographers were provided disciplinary action in the form of a written warning placed on file for failure to adhere to Team's Operating and Emergency Procedures.
2) Both radiographers were also provided reinforcement training immediately following notification of the issue in the form of a review of the Operating and Emergency Procedures specifically covering Section 14 and the steps for properly locking the exposure device prior to relocating.
3) The incident including the resulting violation will be reviewed with all radiographic personnel from the Los Angeles Facility during upcoming annual refresher training. If scheduling allows, we are requesting the two Radiographers involved present the topic during this training.

Steps taken to avoid further violations: The incident and resulting violation were presented during a recently held meeting with all company Radiation Safety Officers so that the issue could be shared with all locations as part of their annual refresher training. Additional field audits of both radiographers involved are also being considered, provided both remain actively performing radiographic operations, to ensure corrective actions have been and remain effective.

Date when full compliance will be achieved: Based on the results of our investigation and the corrective actions that have been and will be taken, we consider full compliance to be complete.

If you should require any additional information or have any questions regarding this reply, please contact me at 219/310-8560 or 219/229-2909 or by email at David.Tebo@TeamInc.com.

Sincerely,

David P. Tebo
Corporate Radiation Safety Officer
TEAM Industrial Services

cc: Regional Administrator, Region IV
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