CONSOLIDATED
X-RAY SERVICE CORPORATION
P.O. Box 20185
DALLAS, TEXAS 75220
PHONE (214) 241-3361 / TELEX 79-1608

June 19, 1980

U.S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76012

Attention: Mr. Karl V. Seyfrit
Director

RE: License No. 42-08456-02

Gentlemen:

Pursuant to your correspondence dated May 23, 1980, we offer the following response to the items of noncompliance as listed in your notice of violation.

1. Regulation: 10 CFR 20.101 (b) (1)

Violation: A radiographer working in a restricted area at the Winslow, Indiana, site on October 10, 1979, received an apparent whole body exposure of 8.60 rems.

Corrective Action: Upon learning of potential exposure, the radiographer was instructed by the Assistant Radiation Safety Director to cease any further activities involving exposure to radiation. His film badge was processed immediately. After receiving film badge results, the radiographer was permanently removed from the project, returned to Dallas for a medical exam, and was reinstructed on proper use and handling of radiation monitoring equipment. He was maintained in a lay off status preventing any further exposure to radiation until such time he could be reassigned in accordance with NRC Regulations.

Management Action: In an effort to prevent a reoccurrence of this violation as well as other items of noncompliance, the Radiation Safety Director conducted a meeting on May 15, 1980, attended by the Assistant Radiation Safety Directors and Radiation Safety Officers. The purpose of the meeting was to discuss the causes, circumstances and management action required to prevent reoccurrance of various items of noncompliance. Special emphasis was placed on the necessity of periodically reinstructing radiographic personnel in the use of radiation safety monitoring devices. Such instructions should be in accordance with Section I. Paragraph D of our Operating and Emergency Procedures. An assessment was made of the allocation of time spent on various phases of the training programs regarding Assistant Radiographers and it was determined that a greater effort should be made to be sure that an Assistant Radiographer demonstrate competence in the use of radiographic exposure devices. Accordingly, our testing programs and related documentation will reflect the demonstrated competency of an individual upon completion of the training. Additionally, it was determined during this meeting that we would conduct unannounced job site audits with increased frequency.

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2. Regulation: 10 CFR 34.33 (a)

Infraction: On September 17, 1979, at the Dale Indiana site, an assistant radiographer was not wearing a film badge while performing radiographic operations.

Corrective Action: Assistant Radiographer was terminated. The cause of termination was failure to follow prescribed operating and emergency procedures with regards to wearing personal monitoring equipment and not following the Assistant Radiation Safety Director's instructions.

Management Action: Radiation Safety Director issued an inter-company memo (copy attached - memo #1) re-emphasizing that under no circumstances will an employee perform duties of a radiographer or assistant radiographer without the requisite personal radiation detection devices. Additionally, we have established a company policy whereby we will strive to require all personnel to report to one of our offices prior to being dispatched to a project, thereby helping to assure that such personnel will be properly equipped on arrival at a project.

3. Regulation: 10 CFR 34.33 (b)

Infraction: A radiographer's dosimeter discharged beyond its range on September 17, at the Dale Indiana site and his film badge was not sent for processing until September 18, 1979, after he had performed additional radiographic operations.

Corrective Action: The radiographer was reprimanded and reinstructed pursuant to Section I, Paragraph B of our Operating and Emergency Procedures as well as applicable State and Federal regulations.

Management Action: Radiation Safety Director issued an inter-company memo (copy attached - memo #1) delineating the need for strict adherance to the requirements contained in our Operating and Emergency Procedures, Section I, Part B. Additionally, the increased frequency of unannounced job site audits will enhance enforcement of the requirements.

4. Regulation: 10 CFR 34.43 (b)

Infraction: On September 17, 1979, a survey was not performed at the Dale, Indiana site after an radiographic exposure to determine if the 53 curie iridium 192 source had been returned to its shielded condition.

Corrective Action: As mentioned in Item #3 above, radiographer was reprimanded and reinstructed.

Management Action: See Management Action, Item #3 above.

5. Regulation: 10 CFR 34.31 (b) (2)

Infraction: An individual was permitted to act as an assistant radiographer on September 17, 1979, at the Dale, Indiana site before he had demonstrated his competence to the licensee.

Corrective Action: See Corrective Action, Item #2 above.

Management Action: See Management Action, Item #1 above.

6. Regulation: 10 CFR 34.22 (a)

Infraction: On September 17, and October 10, 1979, at the Dale and Winslow,

Indiana sites a sealed source assembly was secured by the locking mechanism between the locking ball and the cable connector allowing the source to slip up the "S" tube into an unshielded position.

Corrective Action: Radiographic personnel were advised to be particularly cautious with regard to the position of the source prior to engaging the lock on various radiographic devices. See copy of attached memo (Memo #2).

Management Action: During a conference on May 12, 1980 with NRC personnel, it was demonstrated that should a Gamma Century device be locked with the locking pin on the wrong side of the locking ball, the ensuing physical survey would not reveal that the source was not in a fully shielded position. However, with the device in this condition it is possible for subsequent movement of the control cables to allow the source to move slightly out of a fully shielded position. This condition has also been brought to the attention of the manufacturer of these devices. Until such time as design modification can preclude a reoccurrence of this type, we have issued an inter company memo (copy attached - memo #2) to all company personnel and instructed them to proceed with extreme caution when utilizing these devices.

It is my intent to assure that Consolidated X-Ray Service Corporation at all times conduct its activities in strict adherance to all applicable regulations. Should you require additional actions or information, please contact me.

Sincerely,
CONSOLIDATED X-RAY SERVICE CORP.

John E. Wright

John E. Wright, President
Radiation Safety Director

JEW/ja
cc: U. S. Nuclear Regulatory Commission
c/o Document Management Branch
Washington, D.C. 20555

CONSOLIDATED
X-RAY SERVICE CORPORATION
P.O. Box 20195
DALLAS, TEXAS 75220
PHONE (214) 241-3361 / TELEX 79-1608

December 11, 1979

MEMO

TO ALL PERSONNEL:

As you are aware our Operating and Emergency Procedures as well as State and Federal Regulations require all personnel to have on their person when engaged in the performance of radiography the following:

A. Film Badge
B. Operable and Calibrated Dosimeter
C. Operable and Calibrated Survey Meter

There has been an occasion when an individual performed radiographic duties without the above requisite equipment. This situation led to an overexposure. Obviously, we cannot tolerate a reoccurrence. Therefore, I want to re-emphasize that such conduct is cause for immediate termination and will be strictly enforced by Company management.

In addition to the above, in compliance with the same regulations, should your dosimeter go off-scale, this will constitute an emergency, and emergency procedures outlined in our Operating and Emergency Procedures, Section I, Part B will be in effect. You should discontinue operations immediately. Telephone your Radiation Safety Officer for further instructions regarding the disposition of your film badge.

John E. Wright
President and Radiation Safety Director

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P.O. Box 20195
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PHONE (214) 241-3361 / TELEX 79-1608

May 16, 1980

MEMO

TO ALL PERSONNEL:

We have had an occassion where one of our radiographers received an over exposure while utilizing a Gamma Century camera. As mentioned, in past memos it is imperative that you perform the physical survey of a device upon completion of each exposure. However, it has been demonstrated that it is possible to lock a camera with the source in a shielded position but not fully retracted. When you lock the device and the source is in this position, the locking pin will engage the cable behind the lock ball rather than in front of the lock ball. If this occurs, subsequent movement of the control cable can allow the source to move slightly out of the fully shielded position. If this occurs after you have made your survey, then it is extremely dangerous since you will be operating under the impression that the source is fully retracted. In order to prevent this at the conclusion of each exposure, perform the physical survey of the device and exposure tube. Lock the device, manipulate the control cables and then perform another survey of the camera before handling. Should the second survey indicate the source is not fully shielded, unlock the device, retract the source to the fully shielded position and repeat the above steps.

John E. Wright

John E. Wright, President
Consolidated X-Ray Service Corp.