FRANK R. LAUTENBERG
NEW JERSEY

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WATER RESOURCES, TRANSPORTATION
AND INFRASTRUCTURE
HELSINKI COMMISSION

United States Senate
WASHINGTON, DC 20510

December 8, 1989

Mr. Ken Carr, Commissioner
U.S. Nuclear Regulatory
Commission
Washington, D.C. 20555

Dear Commissioner Carr:

I am enclosing a copy of a letter I have received from Mr. Marc Arnold.

Please provide any information you might have regarding this issue in order that I might be able to respond to my constituent's inquiry. Please return the enclosed correspondence with your report and mark the envelope to the attention of Tom Dosh.

With best wishes,

Sincerely,

Frank R. Lautenberg

FRL:klp
Enclosure

REPLY TO:

☐ 717 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-4744

☐ ONE GATEWAY CENTER SUITE 1510
NEWARK, NEW JERSEY 07102
(201) 645-3030

☐ THREE COOPER PLAZA
SUITE 408 SOUTH
CAMDEN, NEW JERSEY 08103
(609) 757-5353

MARC ARNOLD
ATTORNEY AT LAW
51 NEWARK STREET
HOBOKEN, NEW JERSEY 07030
(201) 659-1141

1989 NOV 13 PM 5:05

October 25, 1989

The Honorable Frank Lautenberg
United States Senate
Washington, DC 20510

RE: United States Testing Co.
Hoboken, New Jersey
ILLEGAL RADIATION HAZARDS/VIOLATIONS
NRC Report Dated September 22, 1989

Dear Senator Lautenberg:

As a resident of Hoboken, I would request your assistance concerning a serious situation here.

Enclosed is a Notice of Violations issued by the NRC and five (5) page cover letter dated September 22, 1989, directed to U.S. Testing Company with regard to dangerous and illegal activities conducted in the City of Hoboken involving Gamma radiation exposure and improper handling, transportation, etc., of highly radioactive substances. This documentation was obtained by me from NRC Regional Attorney Michael B. Blume in California. $280,000.00 in civil penalties are being assessed. U.S. Testing has 30 days to answer the charges.

The NRC documentats are unusual in their vehemence and strong language against a licensee. Nevertheless, the NRC has apparently decided not to suspend or revoke U.S. Testing's license and opts instead for monetary fines only. Despite U.S. Testing's documented arrogance and contempt for the law, the NRC cites "management changes" and "corrective action," otherwise unspecified, as the reason for its lienency. This is not reassuring for Hoboken,

I would request that all pressure be brought to bear to have the NRC impose more severe penalties for these flagrant and unprecedented violations, dangerous to residents of Hoboken. U.S. Testing should be forced to discontinue storage and use of highly radioactive materials in the most densely populated community in New Jersey. Their miserable record, as documented by the NRC, speaks for itself. Please review the enclosed report and do whatever you can. I will help in any way.

Very truly yours,

Marc Arnold

MARC ARNOLD
Attorney for Hoboken Action
for Nuclear Disarmament Inc.

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION V
1450 MARIA LANE, SUITE 210
WALNUT CREEK, CALIFORNIA 94596

SEP 2 2 1989

RECEIVED OCT 1 6 1989

Docket No. 030-20402
License No. 04-23240-01
EA 87-52

United States Testing Company, Inc.
Unitech Services Group
ATTN: Mr. L. Lazar, President
and Chief Executive Officer
Post Office Box 6673
3540 Oakdale Road, Suite A
Modesto, California 95355

MICHAEL B. BLUME
REGIONAL ATTORNEY
U.S. NUCLEAR REGULATORY COMMISSION
REGION V
1450 MARIA LANE, SUITE 210
WALNUT CREEK, CA 94596
(415) 943-3737
(FTS) 463-3737

Gentlemen:

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTIES - $280,000 (NRC INSPECTION REPORT NO. 87-01)

This letter refers to the Nuclear Regulatory Commission (NRC) inspection conducted by a team of inspectors from February 10 to June 1, 1987 at United States Testing Company sites under NRC jurisdiction in the continental United States. The inspection examined the activities authorized by License No. 04-23240-01 as they relate to radiation safety and to compliance with NRC regulations and the conditions of your license.

During the first three days of the NRC inspection, it became clear that a wide variety and substantial number of serious violations may have occurred during licensed activities performed by more than 300 of your radiographic personnel and managers. On February 13, 1987, based on these apparent violations, the NRC issued to you a Confirmatory Action Letter confirming actions taken on your part to assure compliance with radiography training and certification procedures. You were also requested to make all radiation safety records available to NRC inspectors for review and copying. Following an extensive NRC evaluation of your radiation safety program, the NRC issued Inspection Report 87-01 on June 1[illegible], 1987. On June 9, 1987, the NRC held an exit interview with you at the NRC offices in Bethesda, Maryland. During that exit interview, we discussed with you the severity, variety and extent of your apparent violations of NRC requirements. On July 8, 1987, the NRC sent you a letter summarizing the exit interview.

On June 17, 1987, the NRC issued to you an Order Modifying License, which required:

a. The appointment of a qualified Radiation Safety Officer (RSO) at every job site.

b. Additional RSO training and certification.

c. Closure of all licensee job sites until requirements a and b were met.

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

8909290075

d. Maintenance by the RSO and Radiation Safety Director (RSD) of all required radiation safety records.

e. Delegation to the RSO of authority to stop work with licensed material for radiation safety violations.

f. Performance by the RSD of quarterly audits of radiation safety records and job sites.

g. Delivery of quarterly status reports to the NRC Region V Office.

h. Performance of a third party independent audit of the radiation safety program.

i. Report to the NRC of audit findings, with corrective actions and completion times specified.

During the inspection conducted between February 10 and June 1, 1987, NRC inspectors identified an unusually large number of violations, which are described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalties (Notice). These violations are set out in three groups: (1) violations involving use of untested and uncertified radiographers and assistant radiographers; (2) violations involving unauthorized use of the Hoboken facility; and (3) violations involving radiation protection, unauthorized use of equipment, transportation, recordkeeping, and audit requirements.

We delayed this enforcement action pending completion of the NRC Office of Investigations (OI) inquiry as to whether certain of the violations were willful. On December 15, 1988, OI completed its investigation. A copy of the Synopsis of the OI Report is enclosed. The OI Report concluded that your former RSO knowingly allowed numerous violations of NRC requirements to occur, constituting a disregard for the NRC license conditions and the safety of your employees. The OI Report further concluded that your former President and Vice President willfully neglected their responsibilities to manage radiographic activities in a safe manner throughout the United States. Finally, the Report concluded that management's neglect was motivated by profit incentives to give you an unfair business advantage over your radiography competitors.

The violations noted above demonstrate, at a minimum, a careless disregard for radiation safety and a serious breakdown in management oversight and control of licensed activities at many of your facilities and job sites in the United States. To emphasize the importance of complying with license and regulatory requirements and ensuring effective management oversight of licensed programs, I have been authorized, after consultation with the Commission, the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Materials Safety, Safeguards, and Operations Support, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalties in the amount of Two Hundred Eighty Thousand Dollars ($280,000) for the violations described in the enclosed Notice.

The violations have been classified in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 50 Fed. Reg. 47718 (November 20, 1985) (Enforcement Policy).

The violations described in Section I of the enclosed Notice involve the use of 44 individuals as radiographers on 935 separate occasions and the use of 41 individuals as assistant radiographers on 700 occasions, without completing the training, examination and certification process required by your license. These violations range from no training and no examination to training and testing without grading the exam. These violations normally would have been categorized in the aggregate at Severity Level III, but in this matter have been classified in the aggregate as a Severity Level I problem. They have been classified at this highest Severity Level in accordance with the Enforcement Policy for the following reasons: (1) there were an exceedingly large number of violations; (2) high-level managers established the practice of using unqualified radiographers; (3) this practice was established to enhance the company's competitive edge and for economic gain; (4) this practice was conducted in careless disregard for the safety significance of that conduct and the Commission's requirements.

The violations described in Section II of the enclosed Notice involve performing radiographic operations at an unauthorized location on 18 occasions. You had requested a license amendment in order to conduct radiographic operations at a site in Hoboken, NJ, across the street from your headquarters. In a letter dated January 16, 1986, NRC raised several questions concerning the facility, including seeking information about the adequacy of shielding and the visual and audible alarm system. Your February 10, 1986 response changed the request to authorization for storage only, and you advised that the facility was being used for storage only. Nevertheless, radiography was conducted at the site. Your President admitted to being aware that NRC had not approved the site for operations, but denied knowing that the operations had been conducted. The Vice-President told OI that he knew that the operations were conducted, and assumed that they were authorized. You conducted unauthorized radiographic operations at the facility with questionable shielding. Further, there was no visual alarm, and the installed audible alarm had been defeated on the occasion of an NRC inspection. Both of these alarms are required by 10 CFR Part 34 and are important controls for high radiation areas. Each of these violations normally would have been categorized at Severity Level III, but in this matter have also been classified in the aggregate at Severity Level I for the following reasons: (1) the operations were conducted in careless disregard for the safety significance of the conduct and the Commission's requirements; (2) high-level managers knew or should have known of the operations; (3) the operations were conducted numerous times; and (4) the operations had the potential for overexposures to other persons in the building, including persons not employed by UST.

The violations described in Section III of the enclosed Notice involve health physics and recordkeeping violations. The violations include three overexposures, failures to conduct a survey following exposure incidents, failures to report overexposures to NRC, use of an inoperable survey meter, inadequate surveys and surveillance of radiation areas, an improper source transfer, transportation of a source in an unplacarded vehicle, failure to maintain exposure records,

numerous errors and omissions in utilization logs, failures to conduct audits or conducting them at improper intervals, failures to record dosimeter readings, and missing training and examination records (where the testing and examining may have occurred, unlike the matters covered in Violation I). These violations normally would have been categorized in the aggregate at Severity Level III, but in this matter have been classified in the aggregate as a Severity Level II problem for the following reasons: (1) the wide range of violations reflects a breakdown of the radiation safety program; (2) the conduct reflects careless disregard for the safety significance of that conduct and the Commission's requirements; (3) the conduct involved the RSD and other middle and upper-level managers; and (4) the conduct demonstrates a casual attitude concerning matters that affect personal safety.

Industrial radiographers are normally classified in category f in Table 1A of the Enforcement Policy as "Industrial users of material." However, the Enforcement Policy, Section V.B., states that "in cases involving willfulness, flagrant NRC-identified violations, repeated poor performance in an area of concern, or serious breakdown in management controls, NRC intends to apply its full enforcement authority, including issuing appropriate orders and assessing civil penalties for continuing violations on a per day basis, up to the statutory limit of $100,000 per day." In addition, a penalty may be increased or decreased on a case-by-case basis if Table 1A does not reflect the ability to pay.

The violations involved in this action are flagrant, repetitive violations reflecting at least careless disregard for NRC requirements (i.e., willful violations) and a casual attitude concerning personal safety. They have potential safety implications throughout the country. The seriousness, diversity and number of violations are virtually unprecedented in NRC materials enforcement cases. Moreover, many of these violations occurred with the approval of senior managers and demonstrate a serious breakdown in management controls. The obvious purpose of many of these actions was economic gain. In addition to the very numerous violations under NRC jurisdiction that are cited in this Notice, the staff is also aware of other violations in Agreement States. In one instance, an untrained individual attempting to perform radiography for U.S. Testing suffered an overexposure. Therefore, to emphasize the need to assure that lasting corrective action is taken, and given the size of the UST program, significant penalties are warranted.

The NRC is exercising its enforcement discretion and increasing the penalty for Violation I to $100,000. Similarly, considering the failure of management to exercise oversight, and the potential for injury, Violation II is also assessed a civil penalty of $100,000. Violation III is assessed a civil penalty of $80,000, based on applying the 80% factor in Table 1B of the Enforcement Policy to the amounts assessed for Severity Level I violations. The total proposed civil penalty is $280,000.

The staff recognizes that, since these violations occurred, significant corrective action has been taken by U.S. Testing. The corrective action involved major management changes, including the resignation of the Vice President and Radiation Safety Director, and the retirement of the President. The civil penalty reflects that corrective action. But for these changes that appear to have addressed the root cause of the violations, NRC would have initiated action to suspend or revoke your license in addition to the civil penalty.

You are required to respond to this letter and the enclosed Notice, and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further action, including possible modifications of the June 17, 1987 Order or your license, is needed to ensure compliance with regulatory requirements. We must emphasize that a license to use byproduct material is a privilege granted by the NRC. Future significant failures to control licensed activities may result not only in a significant civil penalty, but in suspension or revocation of your license.

In accordance with Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedure of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, P.L. No. 96-511.

Sincerely,

/s/ John B. Martin
Regional Administrator

Enclosures:
1. Notice of Violation and Proposed Imposition of Civil Penalties
2. Synopsis of OI Report

cc: United States Testing Company, Inc.
1415 Park Avenue
Hoboken, NJ 07030

NOTICE OF VIOLATION
AND
PROPOSED IMPOSITION OF CIVIL PENALTIES

United States Testing Company, Inc.
Unitech Services Group
Modesto, California

Docket No. 030-20402
License No. 04-23240-01
EA 87-52

During the NRC inspection conducted on February 10 through June 1, 1987, numerous violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 50 Fed. Reg. 47718, (November 20, 1985), the Nuclear Regulatory Commission proposes to impose civil penalties pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalties are set forth below:

I. Violations Associated With Uncertified or Untrained Workers

A. 10 CFR 34.31(a)(3) and 34.31(a)(4) require the licensee to use as radiographers only those individuals who have demonstrated competence to use radiographic exposure devices and related equipment by successfully completing written and field examinations before being allowed to act as radiographers.

Contrary to the above, between January 1, 1985 and March 31, 1987, the licensee permitted forty-four (44) individuals to act as radiographers on 935 separate occasions before these individuals had completed the required examination and certification process. (Additional details regarding the examples of this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, page 11, and Appendix B.)

B. 10 CFR 34.31(b) permits the licensee to use as assistant radiographers only those individuals who have demonstrated an understanding of the licensee's operating and emergency procedures and competence regarding use of radiographic exposure devices and related equipment under the personal supervision of a radiographer by successfully completing a written or oral examination and a field examination.

Contrary to the above, between January 1, 1985 and March 31, 1987, the licensee permitted forty-one (41) individuals to act as assistant radiographers on 700 separate occasions before these individuals had completed the required examination and certification process. (Additional details regarding the examples of this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, page 12, and Appendix B.)

These violations are categorized in the aggregate as a Severity Level I problem (Supplement VI).

Cumulative civil penalty - $100,000 (assessed equally between the violations).

II. Violation Associated With Unauthorized Uses Of Licensed Material

10 CFR 30.3 states, in part, that no person shall use byproduct material except as authorized in a specific or general license issued pursuant to NRC regulations. License Condition 10, as it pertains to the licensee's radiographic cell in Hoboken, New Jersey, authorizes only the storage of licensed material.

License Condition 15 states, in part, that the licensee shall conduct its program in accordance with the statements, representations, and procedures contained in the letter dated February 10, 1986, signed by the Radiation Safety Director. Item 1 of the February 10, 1986 letter, in reference to the Hoboken facility, states in part: ".... We would, therefore, like to change the request to storage only. The facility is presently being used for storage only."

Contrary to the above, the radiographic cell at the licensee's Hoboken, New Jersey facility was used for radiographic operations utilizing licensed material on the following dates:

July 8 and 30, 1986
August 11 through 14, 1986
November 24 and 26, 1986
December 2, 10, and 16, 1986
January 2, 9, 12, 13, 20, 26, and 30, 1987

This is a Severity Level I violation (Supplement VI).

Civil Penalty - $100,000.

III. A. Violations Associated With Radiation Protection

1. 10 CFR 20.101(a) states, in part, that no licensee shall possess, use or transfer licensed material in such a manner as to cause any individual in a restricted area to receive in any calendar quarter from radioactive material a total occupational dose in excess of 1.25 rem.

Contrary to the above, three radiographers received whole body doses in excess of the quarterly limit (as documented by film badge records) during radiographic operations or radiation incidents that occurred at the jobsites and during the calendar periods indicated below:

Radiographer	Exposure Period (Calendar Quarter-Year)	Jobsite	Dose Received
A	2nd Qtr - 1986	Lakehurst, NJ	1.94 rem
B	3rd Qtr - 1986	LaBarge, WY	1.63 rem
C	3rd Qtr - 1986	LaBarge, WY	1.86 rem

The exception specified in 10 CFR 20.101(b) was not applicable in that the licensee had not determined on Form NRC-4 or equivalent the accumulated occupational doses received by the individuals prior to the radiation incidents.

2. 10 CFR 20.201(b) requires each licensee to make such surveys as may be necessary to comply with the requirements in Part 20 and which are reasonable under the circumstances to evaluate the extent of radiation hazards that may be present. As defined in 10 CFR 20.201(a), "survey" means an evaluation of the radiation hazards incident to the production, use, release, disposal, or presence of radioactive materials or other sources of radiation under a specific set of conditions.

   Contrary to the above requirement, at the time of the inspection, the licensee had not conducted surveys to evaluate the extent of radiation hazards that existed and that led to the exposure of radiographic personnel on August 9, 1986 at La Barge, Wyoming, and on July 10, 1986 at Lakehurst, New Jersey when the licensee had knowledge that significant exposures may have occurred on these days and, in addition, when the licensee was made aware that the quarterly exposures were in excess of regulatory limits.

3. License Condition 15 states, in part, that the licensee shall conduct its program in accordance with the procedures referred to in the letter dated November 27, 1985, that submitted the licensee's Radiation Safety Program Manual.

   The Radiation Safety Program Manual, Paragraph 7.1 of Section III, "Operating and Emergency Procedures," requires a survey to establish the restricted area boundary.

   Contrary to the above requirement, the licensee did not conduct any surveys to establish the restricted area boundaries on thirteen (13) separate occasions between March 14, 1986, and October 3, 1986. (Additional details regarding this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, pages 32-33.)

4. 10 CFR 20.405 requires each licensee to make a report in writing within thirty (30) days of each exposure of an individual to radiation in excess of the applicable limits in 10 CFR 20.101. 10 CFR 20.101(a) states, in part, that no licensee shall possess, use or transfer licensed material in such a manner as to cause any individual in a restricted area to receive in any calendar quarter from radioactive material a total occupational dose in excess of 1.25 rem.

   Contrary to the above requirement, at the time of the inspection, for the three radiographers who received whole body doses in excess of the quarterly limit, as described in Violation III.A.1, the licensee had failed to report these exposures to the NRC.

5. 10 CFR 34.33(b) requires radiographers and assistant radiographers to wear direct reading pocket dosimeters, and to read and record the indicated exposures daily.

   Contrary to this requirement, five individuals working as radiographers or assistant radiographers at Lakehurst, New Jersey did not record pocket dosimeter readings on twelve (12) occasions between March 5 and September 18, 1986.

6. License Condition 15 states, in part, that the licensee shall conduct its program in accordance with the procedures referred to in the letter dated November 27, 1985, that submitted the licensee's Radiation Safety Program Manual.

   The Radiation Safety Program Manual, Section VIII, "Qualification Procedure," requires formal classroom instruction and examination of new employees to be administered by an RSO, Monitor, or Project Manager/Supervisor who is a certified radiographer before the new employees are allowed to perform radiography using licensed material.

   a. Contrary to the above requirements, an employee worked as a radiographer on four separate occasions during March and April 1986, and as either a radiographer or assistant radiographer on thirty-one (31) occasions between August 1985 and May 1986, without having received any formal classroom instruction from an RSO, Monitor, or Project Manager/Supervisor. (Additional details regarding this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, Appendix B, page 13.)

   b. Contrary to the above requirements, between June 24 and September 22, 1986, an individual employed as an assistant radiographer at the Hoboken, New Jersey facility, was administered three examinations by an individual other than an RSO, Monitor, or Project Manager/Supervisor.

7. 10 CFR 34.41 requires radiographers or radiographer's assistants to maintain direct surveillance of radiographic operations to protect against unauthorized entry into high radiation areas during radiographic operations.

   Contrary to this requirement, no radiographers or radiographer's assistants maintained direct surveillance over all parts of radiography high radiation areas during three radiographic operations on February 13, 1987 at Limerick, Pennsylvania. In addition, neither a radiographer nor radiographer's assistant maintained surveillance over high radiation areas on August 9, 1986, at a temporary jobsite in LaBarge, Wyoming, and on July 10, 1986, at a temporary jobsite in Lakehurst, New Jersey.

8. 10 CFR 34.22(a) requires that each sealed source assembly be secured in the shielded position each time the source is returned to that position.

   Contrary to this requirement, on or about April 23, 1986, an 84 curie iridium-192 sealed source was not locked in a Technical Operations Model 660 exposure device following source exposure and during transport of the device.

B. Violations Associated with Use of Equipment

1. 10 CFR 34.24 requires that the licensee maintain sufficient calibrated and operable radiation survey instruments to make physical radiation surveys as required by 10 CFR Parts 20 and 34.

   Contrary to this requirement, the licensee had no operable survey meter during industrial radiography operations on September 5, 1986 at the Susquehanna Steam Electric Station in Berwick, Pennsylvania.

2. 10 CFR 30.3 states, in part, that no person shall use byproduct material except as authorized in a specific or general license issued pursuant to NRC regulations.

   License Condition 9.F authorizes the use of only Industrial Nuclear Model IR-50 source changers for storage and replacement of iridium-192 sealed sources used in Technical Operations Model 660 exposure devices. Also, License Condition 9.H. authorizes the use of only Industrial Nuclear Model 50 or 130 source changers for storage and replacement of iridium-192 sealed sources used in Industrial Nuclear Model IR-100 exposure devices.

   Contrary to this requirement, on April 23, 1986, at the licensee's Hoboken, New Jersey facility, an eighty-four (84) curie iridium-192 source was transferred from a Technical Operations Model 660 exposure device to an Industrial Nuclear Model IR-100 exposure device, using equipment not approved for this purpose.

3. License Condition 15 states, in part, that the licensee shall conduct its program in accordance with the procedures referred to in the letter dated November 27, 1985, that submitted the licensee's Radiation Safety Program Manual.

   The Radiation Safety Program Manual, Section IV, "Maintenance Procedure," requires a quarterly maintenance inspection of each exposure device which includes removing the entire drive cable from the crank assembly to inspect for flexibility, wear, rust, broken wires, and length.

Contrary to this requirement, drive cables had not been removed from crank assemblies as part of the quarterly maintenance inspections conducted from January to October 1986 at Susquehanna, Pennsylvania.

C. Violation Associated With Transportation Of Radioactive Material

10 CFR 71.5 requires each licensee who transports licensed material outside of the confines of its plant or other place of use to comply with the applicable requirements of 49 CFR Parts 170 through 189. 49 CFR 172.504 requires "Radioactive" placarding of any vehicle transporting a package requiring a radioactive yellow III label as defined in 49 CFR 172.403 and 172.440.

Contrary to these requirements, on or about April 23, 1986, an eighty-four (84) curie iridium-192 source contained in a Technical Operations Model 660 exposure device was transported from a temporary jobsite in Brooklyn, New York, to the Hoboken, New Jersey facility in an unplacarded vehicle. The exposure device required a radioactive yellow III label.

D. Violations Associated With Recordkeeping

1. 10 CFR 20.401(a) requires each licensee to maintain records on Form NRC-5, or the equivalent, of radiation exposure data for individuals who are required by 10 CFR 20.202 to use personnel monitoring devices.

   Contrary to the above requirement, from January 1, 1985 to March 31, 1987, radiation exposure data had not been maintained on Form NRC-5, or the equivalent, for twenty-three (23) radiographic personnel who were required to use personnel monitoring devices. (Additional details regarding the examples of this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, page 36.)

2. 10 CFR 34.27 requires licensees to maintain current utilization logs, which are to be kept available for two years from the date of each radiographic operation, which identify the exposure devices used, the responsible radiographers, the plant or site where used, and dates of use. These records are to be maintained at the address specified in the license.

   a. Contrary to the above requirement, the licensee was unable to identify the responsible radiographers on 248 utilization log entries corresponding to radiographic operations performed between January 1, 1985 and March 31, 1987. (Additional details regarding the examples of this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, pages 28-30.)

b. Contrary to the above requirement, no utilization logs were maintained for radiographic operations conducted at Surry, Virginia on May 23 and 26, 1985, June 9 through 25, 1986, November 2 through 26, 1986, and January 13, 1987. (Additional details regarding the examples of this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, page 28.)

3. License Condition 15 states, in part, that the licensee shall conduct its program in accordance with the procedures referred to in the letter dated November 27, 1985, that submitted the licensee's Radiation Safety Program Manual. Instructions written on Form 160A in Exhibit 1 of the Radiation Safety Program Manual direct the radiographer to complete the form whenever radiography is performed and mail Form 160A to the Radiation Safety Officer's office no later than the Tuesday of the week following form completion.

Contrary to the above requirement, utilization logs (Form 160A) corresponding to field radiography operations at temporary job sites conducted between February 13, 1986 and February 10, 1987, had not been completed and forwarded to the Radiation Safety Officer.

4. 10 CFR 34.43(d) requires each licensee to retain for three years the records of storage surveys of radiographic exposure devices which are made pursuant to 10 CFR 34.43(c), when the storage survey is the last one performed in the work day.

Contrary to this requirement, the licensee had no records of the final storage surveys following the use of exposure devices for the following dates and locations:

(a) Hoboken, New Jersey; July 8 and 10, 1986
(b) Lakehurst, New Jersey; March 5, 1986
(c) Paulsboro, New Jersey; May 17, 1985, and June 20, 1985
(d) Limerick Nuclear Generating Station, Limerick, Pennsylvania; September 10, 1986
(e) Surry Nuclear Power Plant, Surry, Virginia; January 28, 1987.

5. License Condition 15 states, in part, that the licensee shall conduct its program in accordance with the procedures referred to in the letter dated November 27, 1985, that submitted the licensee's Radiation Safety Program Manual.

The Radiation Safety Program Manual, Section III, "Operating Emergency Procedures," provides instructions for Form 160A, entitled "Daily Inspection of Exposure Device." These instructions require the radiographer completing the daily exposure device inspection to sign his or her name in the column provided.

Contrary to this requirement, the licensee had not maintained a Form 160 A, including radiographer's signature, of daily exposure device inspections for radiographic operations performed between January 27 and October 14, 1986 at Susquehenna, Pennsylvania.

6. 10 CFR 34.31(c) requires that records of training, including copies of written tests and dates of oral tests and field examinations, be maintained for three years.

Contrary to this requirement, the licensee had no records of training and examinations covering a three year period for nineteen (19) individuals who had worked as radiographers or assistant radiographers at six job sites under NRC jurisdiction between January 1, 1985 and March 31, 1987. (Additional details regarding this example are provided in NRC Inspection Report 87-01 of June 16, 1987, page 12.)

E. Violations Associated With Audit Deficiencies

10 CFR 34.11(d) requires the licensee to have an inspection program which will audit the performance of each radiographer and radiographer's assistant during an actual radiographic operation at intervals not to exceed three months. Records of these audits must be retained for two years, pursuant to 10 CFR 34.11(d)(3).

License Condition 15 states, in part, that the licensee shall conduct its program in accordance with the procedures referred to in the letter dated November 27, 1985, that submitted the licensee's Radiation Safety Program Manual. The Radiation Safety Program Manual, Section X, "Audit Procedure", requires personnel audits to be conducted for certified radiographers and assistant radiographers at intervals not to exceed three months.

1. Contrary to the above requirement, the licensee did not audit twenty-six (26) radiographers or radiographer assistants who had worked for more than three months at jobsites under NRC jurisdiction from January 1, 1985 to March 31, 1987. (Additional details regarding this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, pages 23-5.)

2. Contrary to the above requirement, between January 1, 1985 and March 31, 1987, the licensee conducted thirty-one (31) audits of individuals at intervals greater than three months from the previous audit. (Additional details regarding this violation are provided in NRC Inspection Report 87-01 of June 16, 1987, pages 23-5.)

Collectively, the above violations have been categorized in the aggregate as a Severity Level II problem (Supplements IV and VI).

Cumulative Civil Penalty - $80,000 (assessed equally among the 22 violations).

Pursuant to the provisions of 10 CFR 2.201, United States Testing Company, Inc. is hereby required to submit a written statement or explanation to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, within 30 days of the date of this notice. This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each alleged violation: (1) admission or denial of the alleged violation, (2) the reasons for the violation if admitted, (3) the corrective steps that will be taken and the results achieved, (4) the corrective steps that will be taken to avoid further violations, and (5) the date when full compliance will be achieved. If an adequate reply is not received within the time specified in this Notice, an order may be issued to show cause why the license should not be modified, suspended, or revoked or why such other action as may be proper should not be taken. Consideration may be given to extending the response time for good cause shown. Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

Within the same time as provided for the response required above under 10 CFR 2.201, the licensee may pay the civil penalty by letter to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, with a check draft, or money order payable to the Treasurer of the United States in the amount of the civil penalty proposed above, or the cumulative amount of the civil penalties, or may protest imposition of the civil penalty in whole or in part or by a written answer addressed to the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission. Should the licensee fail to answer within the time specified, an order imposing the civil penalty will be issued. Should the licensee elect to file an answer in accordance with 10 CFR 2.205 protesting the civil penalty, in whole or in part, such answer should be clearly marked as an "Answer to a Notice of Violation," and may: (1) deny the violations listed in this Notice in whole or in part, (2) demonstrate extenuating circumstances, (3) show error in this Notice, or (4) show other reasons why the penalty should not be imposed. In addition to protesting the civil penalty, such answer may request remission or mitigation of the penalty.

In requesting mitigation of the proposed penalty, the factors addressed in Section V.B of the Enforcement Policy, as revised, 50 Fed. Reg. 47718 (November 20, 1985), should be addressed. Any written answer in accordance with 10 CFR 2.205 should be set forth separately from the statement or explanation in reply pursuant to 10 CFR 2.201, but may incorporate parts of the 10 CFR 2.201 reply by specific reference (e.g., citing page and paragraph numbers) to avoid repetition. The attention of the licensee is directed to the other provisions of 10 CFR 2.205, regarding the procedure for imposing a civil penalty.

Upon failure to pay any civil penalty due which subsequently has been determined in accordance with the applicable provisions of 10 CFR 2.205, this matter may be referred to the Attorney General, and the penalty, unless compromised, remitted, or mitigated, may be collected by civil action pursuant to Section 234c of the Act, 42 U.S.C. 2282c.

The responses to the Director, Office of Enforcement, noted above (Reply to a Notice of Violation, letter with payment of civil penalty, and Answer to a Notice of Violation) should be addressed to: Director, Office of

Enforcement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region V, 1450 Maria Lane, Walnut Creek, California 94596.

FOR THE NUCLEAR REGULATORY COMMISSION

for John B. Martin
Regional Administrator

Dated at Walnut Creek, California
this 23rd day of September 1989

SYNOPSIS

On February 13, 1987, the NRC Office of Investigations Field Office, Region V (OI:RV), initiated an investigation of the United States Testing Company (UST). The investigation was initiated based on information that UST had:

1. Performed radiographic testing utilizing radiographic personnel untrained, untested, and/or not certified in radiation safety,
2. Failed to report radiological overexposures, and
3. Utilized a storage only facility to conduct radiographic activities in violation of the NRC License issued to UST, the UST Radiation Safety Program, and Title 10 of the U.S. Code of Federal Regulations (10 CFR).

The investigation was conducted during the period from February 13, 1987, to April 28, 1988, in conjunction with NRC inspecti. activities. The investigation and inspection included numerous interviews of UST officials and employees at various UST jobsites throughout the United States and extensive review of UST records, contracts, jobsite records, source utilization logs, and safety training records at UST Headquarters in Hoboken, New Jersey and Corporate Offices in San Leandro, California.

On June 16, 1987, NRC Region V (RV) issued an Inspection Report containing the conclusions of an extensive inspection of UST activities. On October 29, 1987, RV provided OI:RV with additional information regarding a review of UST radiation safety training and certification records. These inspections concluded that a widespread breakdown had occurred in UST's administration of the Radiation Safety Program resulting in extensive violations of NRC Rules, Regulations, and License Conditions. These violations included the utilization of noncertified personnel, failure to report radiation exposures, failure to properly maintain radiographic equipment, failure to maintain surveillance of high radiation areas, failure to properly maintain radiographic utilization logs, utilization of a nonapproved shielded cell to perform radiography, and numerous additional administrative violations of NRC License Conditions.

Investigation revealed that the UST Radiation Safety Director (RSD), who was responsible for implementing the UST Radiation Safety Program, failed to implement and enforce the program and failed to properly perform his duties as required by UST's NRC License.

Allegations made by the RSD that he was directed by his superiors, the UST President and Vice President, to not report radiation overexposures to the NRC could not be substantiated.

Investigation further revealed that the UST President and Vice President failed in their NRC License mandated oversight of the RSD and the Radiation Safety Program and routinely placed radiation safety as a lower priority than radiographic work performance. Although no direct evidence was developed to show that the UST President and/or Vice President directed that provisions of the Radiation Safety Program not be implemented, their negligent practices contributed to the widespread nature of the violations. Their desire to control operating costs were in direct conflict with NRC regulatory compliance and allowed unsafe practices to continue for approximately one and a half years.