U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 030-10749/90002(DRSS)

Docket No. 030-10749

License No. 48-16296-01

Category C(1)

Priority 1

Licensee: Midwest Inspection Service, Ltd.

P.O. Box 28023

Green Bay, WI 54304

Enforcement Conference Conducted: September 13, 1990

Enforcement Conference At: U.S. Nuclear Regulatory Commission

Region III Office - Glen Ellyn, Illinois

Inspectors: D. R. Sethon
D. E. Gibbons

Radiation Specialist

L. Cameron kadiation Specialist 10/5/80

Reviewed By: W. H. Schultz, Chief

Nuclear Material Safety

Section 1

10-5-90 Date

Approved By:

Nuclear Materials Safety Branch

10-9-90 Date

Meeting Summary

Enforcement Conference on September 13, 1990 (Report No. 030-10749/90002(DRSS)) Areas Discussed: A review of the apparent violations identified during a July 24 through August 13, 1990 safety inspection. The licensee described corrective actions taken or planned. The enforcement options pertaining to the apparent violations were discussed with the licensee.

DETAILS

1. Conference Attendees

Midwest Inspection Service, LTD

Donald Paschen, President and Radiation Safety Officer

U.S. Nuclear Regulatory Commission, Region III

C. J. Paperiello, Deputy Regional Administrator

J. A. Grobe, Chief, Nuclear Materials Safety Branch

- C. D. Pederson, Director, Enforcement and Investigation Coordination Staff
- G. M. McCann, Chief, Nuclear Materials Safety, Section 1
- V. P. Lougheed, Enforcement Specialist James Dockery, Office of Investigations
- D. R. Gibbons, Radiation Specialist
- J. L. Cameron, Radiation Specialist
- R. C. Brady, Enforcement Specialist, OE HQ (via telephone)

2. Enforcement Conference

An enforcement conference was held in the Region III office on September 13, 1990. This conference was held to discuss: (1) the apparent violations and causes; (2) the licensee's corrective actions; and (3) obtain any information which would help determine the appropriate enforcement action.

Messrs. Paperiello and Grobe opened the meeting by stating the purpose of an enforcement conference, and expressed concern about management's knowledge of existing regulations and the licensee's radiation safety program, and the licensee's lack of control of its program. Mr. McCann presented the apparent violations (9) and asked the licensee to indicate whether the information was correct, to present corrective actions taken or planned, and to discuss what the licensee determined to be the causative factors.

Mr. Paschen did not contest the apparent Violations No. 1, 2, or 3 (see attachment), but he did explain that although the limits in 10 CFR 20.101(a) were exceeded, he assumed that he had met the requirements of 10 CFR 20.101(b) by initiating a Form NRC-4 after the exposure occurred. He stated that the NTC inspectors explained the Form NRC-4 and clarified the requirements during the inspection on August 7-8, 1990. He also stated that he would submit the report required by 10 CFR 20.405(a) which would include his evaluation of the incident. He acknowledged that the report would be late.

Mr. Paschen presented some daily use logs that were unavailable during the inspection, but he stated that he had not had time to read the September 11, 1990 report, and was unable to collect all of the records pertaining to the utilization logs and daily reporting requirements. He stated he would attempt to locate more data pertaining to recording of daily dosimeter readings, annual checks of two pocket dosimeters, and data pertaining to the survey instrument described in Violation No. 9. Mr. Paschen did not contest the violation, but expressed some doubt that the instrument was used out of calibration, and he had misplaced the calibration record.

Mr. Paschen submitted a letter to Region III on September 19, 1990 with additional information regarding the survey instrument. That information clearly showed that the survey instrument was used beyond its calibration due date.

The licensee, in general, agreed with the NRC's findings regarding the other violations, and explained that some of the corrective actions had been implemented. Mr. Paschen presented a stencil representing the markings on the outer packages used to transport radiography devices and stated that the outer containers were all properly labeled with Radioactive Yellow-II labels. The licensee also discussed other actions planned to improve its radiography program, and will submit more corrective actions upon receipt of the Notice of Violation.

Mr. Paschen submitted two other letters dated September 17 and 20, 1990 providing additional information regarding the apparent violations. After review of that information, NRC has concluded that the apparent violations remain valid.

Apparent Violations No. 4, 6, and 7 (attached) are under further review by the Commission.

Mr. Grobe expressed NRC's concerns and explained the enforcement options available to the NRC and the appropriate time frame for notifying the licensee of the final action in this case.

Dr. Paperiello expressed NRC's concerns pertaining to the use of untrained or unqualified personnel and the licensee's apparent lack of knowledge pertaining to the regulations of radiography programs. Mr. Paschen was put on notice that Midwest Inspection Service's license would be suspended if more violations were identified during future follow-up inspections.

Attachment: Apparent Violations 1 thru 9

ATTACHMENT

Midwest Inspection Services, Ltd. Apparent Violations

Apparent Violation No. 1

10 CFR 20.101(a) requires that the licensee limit the whole body dose of an individual in a restricted area to one and one quarter rems per calendar quarter, except as provided by 10 CFR 20.101(b). Paragraph (b) allows a whole body radiation dose of three rems per calendar quarter provided specified conditions are met.

Contrary to the above, an individual working in the licensee's restricted area received a whole body radiation dose of 1.390 rems during the fourth quarter of 1989 and the conditions of Paragraph (b) were not met.

Apparent Violation No. 2

10 CFR 34.22(a) requires that, during radiography operations, the sealed source assembly be secured in the shielded position each time the source is returned to that position. In addition, Section 9.2.2.(19) on page 17 of the licensee's Operating and Emergency Procedures Manual submitted with the May 1, 1981 letter requires the exposure device to be locked after each exposure.

Contrary to the above, on December 18, 1989, a radiographic exposure device was not secured, or locked, following return of the source to the shielded position at the termination of a radiographic exposure.

Apparent Violation No. 3

10 CFR 20.405(a) requires that, within 30 days, each licensee make a written report to the Commission concerning each exposure to radiation in excess of any applicable limit in Part 20 or in the NRC License.

Contrary to the above, as of August 8, 1990, a report had not been made to the Commission of an exposure which exceeded the limits specified in 10 CFR 20.101(a) (1.250 rems) during the fourth quarter of 1989.

Apparent Violation No. 4

10 CFR 34.31(b)(3) requires that the licensee not permit any individual to act as a radiographer's assistant until such individual has demonstrated his understanding of the instructions provided him, by successful completion of a written test. In addition, License Condition No. 20 requires that the licensee conduct its program in accordance with the statements, representations, and procedures contained in the application dated April 30, 1980 and letter dated May 1, 1981. The referenced letter dated May 1, 1981 in Attachment 6(f)

requires that an individual complete certain criteria before being certified as a radiographer's assistant. Part E of that attachment requires an individual to pass an examination of 25 questions with a grade of at least 80 percent.

Contrary to the above, the licensee allowed an individual to perform the duties of a radiographer's assistant since May 11, 1990, and that individual had not successfully completed a written examination with a grade of at least 80 percent.

Apparent Violation No. 5

License Condition No. 20 requires that licensed material be possessed and used in accordance with the statements, representations, and procedures contained in the referenced letter dated May 1, 1981. Attachment 6(g) of the referenced letter requires the licensee to conduct quarterly field inspections of radiography personnel.

Contrary to the above, a field inspection of a radiographer's assistant was not performed in the second quarter of 1990. The radiographer's assistant worked at least five days during the second quarter of 1990.

Apparent Violation No. 6

10 CFR 34.33(b) requires that pocket dosimeters be read and exposures recorded daily. 10 CFR 34.33(e) requires that records of daily pocket dosimeter readings be kept for inspection by the Commission until the Commission authorizes their disposal.

Contrary to the above, a radiographer failed to record his pocket dosimeter reading on June 27, July 24, 30, 31, and August 1 and 2, 1990.

Apparent Violation No. 7

10 CFR 34.27 requires that the licensee maintain current utilization logs for three years to show for each sealed source a description of the radiographic exposure device in which each source is located, the identity of the radiographer to whom the source is assigned, the site where used, and the dates of use. In addition, the licensee has incorporated other data required to be recorded on Form 1A described in Appendix A of the Emergency and Operating Procedures Manual submitted with the May 1, 1981 letter and referenced in License Condition Number 20, including transportation data, survey results, survey instrument information, and daily dosimeter readings.

Contrary to the above, the licensee failed to record any of the above required data on Form 1A when source Serial No. EI-18 was used at temporary job sites on July 24, 30, 31, and August 1 and 2, 1990.

Apparent Violation No. 8

10 CFR 34.33(c) requires that pocket dosimeters be checked at intervals not to exceed one year for correct response to radiation.

Contrary to the above, licensee personnel used a pocket dosimeter Serial No. 9062095 on September 29, 1989, and failed to check the dosimeter for correct response from January 25, 1988 to January 17, 1990. Pocket dosimeter Serial No. 7080642 was used on December 18, 1989, and was not checked for correct response to radiation from August 1988 to the day of the inspection, August 8, 1990.

Apparent Violation No. 9

10 CFR 34.24 requires that each survey instrument used to conduct physical radiation surveys be calibrated at intervals not to exceed three months and after each instrument servicing.

Contrary to the above, on nine occasions from April 9 through April 20, 1990 physical radiation surveys were conducted with a survey instrument which was last calibrated on November 30, 1989.