U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Enforcement Conference Report No. 030-04041/90006(DRSS)

Docket No. 030-04041

License No. 12-00622-07 Category C(1) Priority I

Licensee: MQS Inspection, Inc.
Elk Grove Village, IL 60007

Enforcement Conference At: NRC Region III Office, Glen Ellyn, Illinois

Enforcement Conference Conducted: September 18, 1990

Inspections Conducted: May 1, 1990 (RI Assist Inspection)
August 23, 1990 (RIII Inspection)

Region III Inspector: Wayne J. Slawinski
Senior Radiation Specialist — Date: 11-1-90

Reviewed By: William H. Schultz, Chief
Nuclear Materials Safety
Section 1 — Date: 11-1-90

Approved By: Jack Grobe, Chief
Nuclear Materials Safety Branch — Date: 11-1-90

Meeting Summary

Enforcement Conference on September 18, 1990 (Report No. 030-04041/90006(DRSS))
Areas Discussed: A review of two recent offscale dosimeter events and the apparent violations identified during Region I and III inspections, a discussion of other concerns and apparent programmatic weaknesses, the licensee's corrective actions and mitigating and extenuating circumstances.

DETAILS

1. Conference Attendees

MQS Inspection, Inc.

E. Banfield, Corporate Radiation Safety Officer
H. Doran, President
D. Hurst, Manager, Delaware Facility

Nuclear Regulatory Commission

E. Baker, Deputy Director, Office of Enforcement
B. Berson, Regional Counsel
A. Davis, Regional Administrator
J. Grobe, Chief, Nuclear Materials Safety Branch
G. Holler, Office of General Counsel
C. Pederson, Director, Enforcement and Investigation Coordination Staff
W. Slawinski, Senior Radiation Specialist
C. Weil, Enforcement Specialist

2. Enforcement Conference Summary

An enforcement conference was held in the NRC Region III office on September 18, 1990. The conference was conducted to (1) discuss root and contributing causes of two offscale dosimeter events that occurred at radiographic field sites on April 19 and May 9, 1990; (2) review the apparent violations and other concerns associated with these incidents, as identified during the Region I and III inspections; (3) discuss the licensee's corrective actions; (4) determine whether there were any aggravating or mitigating circumstances; and (5) obtain other information that would help determine the appropriate enforcement action. Inspection findings are documented in Region I and III Inspection Reports No. 030-04041/90-04 and No. 030-04041/90005(DRSS) respectively, both transmitted to the licensee by letter dated September 10, 1990.

The licensee did not contest the apparent violations and indicated general agreement with the event descriptions delineated in Inspection Reports No. 030-04041/90-04 and No. 030-04041/90005(DRSS). The licensee, however, indicated that uncertainty exists regarding the actual events that transpired during the May 9, 1990 incident (Inspection Report No. 030-04041/90005(DRSS), Section 3(B)), although the latter of the two event scenarios remains the most plausible and coincides with the exposure registered by the film badge worn by radiographer No. 1. As a result of this uncertainty, the licensee indicated that the validity of the 10 CFR 34.33(a) violation for failure to wear a pocket dosimeter and film badge or TLD is not definitive. The NRC acknowledged the licensee's statements but contended that the prevalence of information supports the apparent violation.

The licensee disagreed that the apparent violations were collectively the result of a breakdown in the management control of its Wilmington, Delaware facility and indicated that Delaware radiographic personnel are adequately trained, qualified, and their field performance properly audited by management. In addition, the licensee had taken comprehensive and aggressive actions in response to prior events which should have been sufficient to prevent recurrence. The licensee further indicated that it takes strong management actions against employees that demonstrate poor safety practices. Additionally, the licensee does not consider that the management turnover at its Delaware facility is excessive and stated that the facility has employed only two managers and two radiation safety officers in the last couple years.

Based on the additional information provided by the licensee during the enforcement conference, including the corrective actions summarized below, it appears that the violations did not result from a breakdown in the management control of the Delaware facility.

The licensee also disagreed that a substantial potential for an exposure in excess of regulatory requirements existed during the May 9, 1990 event (Inspection Report No. 030-04041/90006(DRSS), Section 5(B)) since: (1) the actual circumstances and radiographer's actions during the event are uncertain; (2) it is unlikely that a radiation survey was not performed by the radiographers after the 35th and 36th radiographs and that the source was not partially shielded within the exposure device. The licensee also contended that exposure potential is subjective and its reenactment and exposure assessment was based on the "worst case" scenario.

The NRC representatives indicated that the licensee's arguments regarding overexposure potential would be considered in reaching a decision of the appropriate enforcement action.

Corrective actions taken by the licensee for the apparent violations and actions to strengthen management controls are described in the aforementioned inspection reports. Additional actions subsequently taken by the licensee and not reflected in the inspection reports included:

- Terminating the employment of the radiographer involved in the April 19, 1990 event for reasons unrelated to the event.
- Performing a total of twenty three field performance audits (from May 1990 to date) of the Wilmington, Delaware radiographic personnel.
- Contracting a consultant to evaluate radiographic personnel's behavioral traits and to provide behavioral training to facility managers.
- Initiating a safety incentive program and further developing an existing awards and wage incentive program to better promote good safety practices.
- Soliciting feedback from radiographic personnel regarding the company safety program and recommendations to improve it.

NRC representatives stated the licensee's corrective actions appear to be appropriate and comprehensive and would be considered in the decision of the appropriate enforcement action.